CHAPTER THREE

Review of Literature
CHAPTER III

REVIEW OF LITERATURE

"Review of literature does for us what a map does for traveler"

Introduction

Review of literature is key step in research process. The primary purpose of review of literature is gain abroad background and understanding of the information related to research problem of interest. According to Polit and Hunggler (1991:58), the task of review of literature involves the identification, selection, critical analysis and reporting of existing information on the topic of interest.

Review of literature provides basis for further investigations, justifies the application and through the light on the physisbility of the study. The constrains of data collection relates the findings from one study to another with the hope to establish a comprehensive body of scientific knowledge in professional discipline from which valid pertinent theories may be developed.

The social researcher generally undertakes literature review to familiarize them with that knowledge base. It further states that it is through scan of available literature or information on the research problem. Hence it helps us as follows,
Understanding of propose research problem and refine the statement.

To identify the study variable and conceptualization of relationship.

May help in formulation and selection of hypothesis.

To find out findings reported by other on the same topic.

To be familiarize with various methods and design of research methodology.

The Advent of AIDS and the rapid increase in the prevalence of HIV has had major repercussions throughout the world. AIDS is a fatal disease with almost no hope of availability of a cure or preventive vaccine in near future. HIV / AIDS illness has affected the people in the world to such an extent that it has a devastating effect. It has already caused millions of death in South- Saharan Africa and Western countries.

HIV transmission occurs in many different behavioral and social contexts, which can determine who in the population, may be exposed and how they might respond. Cultural factors are very important in determining the types of sexual behavioral.

In this study review of literature was done in order to gain information related to knowledge, awareness and attitude of college student about HIV / AIDS. The information gained from the review of literature in this chapter under following studies:
The related literature reviewed as categorized into following section:

1. Magnitude of the problem and National AIDS Control Programme
2. Young peoples knowledge and awareness on HIV / AIDS
3. AIDS prevention among school children/ Street children
4. HIV / AIDS education in school / college curriculum
5. Peer education intervention
6. Women and HIV infection
7. Stigma and discrimination related to HIV / AIDS
8. Socio-economic Consequences.

3.1 Magnitude of the problem

Since the beginning of epidemic in 1987, the prevalence of infection has increased exponentially with a doubling time of 6-12 months. The HIV infection appears to be spreading geographically as well as increasing in areas already infected. Available evidence suggests that in South East Asia, since 1988 about 5.2 million people have become infected by HIV, the majority of them in India and in Thailand.

The history of AIDS is a short one. As recently as the 1970s, no one was aware of this deadly illness. Since then the global AIDS epidemic has become one of the greatest threats to human health and development. At the same time, much has been learnt about the science of AIDS, as well as how to prevent and treat the disease.
Although HIV and AIDS are found in all parts of the world, some areas are more afflicted than others. The worst affected region is sub-Saharan Africa, where in a few countries more than one in five adults is infected with HIV. The epidemic is spreading most rapidly in Eastern Europe and Central Asia, where the number of people living with HIV increased 150% during 2001 and 2007.

The spread of HIV and AIDS

The HIV epidemic in India is characterized by a number of distinct epidemics, sometimes coexisting within the same state, among the various vulnerable groups at different stages of maturity and impact. Transmitted mainly through unprotected sex in the south and injecting drug use in the north-east of the country, HIV has spread beyond the “at risk” groups to the general population and from urban to rural areas. As many as 111 districts are considered as high prevalence areas with HIV prevalence of more than 1% in antenatal women and/or more than 5% in high risk behavior groups. The states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu are considered “high-prevalence” states. Data generated from sentinel surveillance 2005 shows that the HIV prevalence among the ANC population remained more than 1% in the high prevalence states

Yet the vast majority of HIV infections are transmitted through sex between men and women. Nearly half of all adults living with HIV are female. Many Western countries, such as the UK, have increasing rates of HIV
transmission through heterosexual sex. In America, where more than a million people are living with HIV, heterosexual sex accounts for one third of new diagnoses.

As a sexually transmitted infection, HIV particularly affects adolescents and young adults. Deaths of young adults have an especially damaging impact on their families and communities: skills are lost, workforces shrink and children are orphaned. In some African countries, life expectancies have fallen below 40 years, whereas they would have been above 60 without AIDS. There are around 15 million living children who have lost a parent to AIDS.

There is much that can be done to reduce the consequences of AIDS, beginning with the prevention of HIV transmission. Averting sexual transmission involves encouraging safer sexual behaviour including delayed first sex, partner reduction and condom use. The spread of HIV through injecting drug use can be slowed by outreach work, needle exchange and drug substitution treatment. And mother-to-child transmission can be almost eliminated through use of medicines and avoidance of breastfeeding.

There is still no cure for AIDS, but treatment for people with HIV has improved enormously since the mid-1990s. Those who take a combination of three antiretroviral drugs can expect to recover their health and live for many years without developing AIDS, as long as they keep taking the drugs every day.
Yet although it is known how to prevent and treat AIDS, few people have access to the necessary services. Access to prevention tools such as HIV education, condoms, clean needles and programmes to prevent mother-to-child transmission is utterly inadequate.

Challenges:

Apart from inadequate funding, major obstacles in tackling the global AIDS epidemic including weak infrastructure and shortages of health workers in the worst affected countries. Political or cultural attitudes are also significant: for example some authorities are opposed to condom promotion, while others refuse to support needle exchanges for injecting drug users. Many are reluctant to provide young people with adequate education about sex and sexual health.

Another very serious issue is stigma and discrimination. People known to be living with HIV are often abused by community members, employers and even health workers. As well as causing much personal suffering, this sort of prejudice discourages people from seeking HIV testing, treatment and care.

The future:

Based on recent trends it is likely that AIDS around the world will keep getting worse for many years to come. Millions more will become infected with HIV and millions will die of AIDS. In 2005 the world's leaders pledged to try to achieve universal access to HIV prevention, treatment and care worldwide by 2010. This would be one of the greatest health achievements in history – saving
millions of lives and giving new hope to suffering nations. But meeting this challenge will take bold leadership and a massive increase in effort; otherwise the promise is sure to be broken.

**National AIDS Control Programme**

**National and State Response:** A High Power Committee was constituted in 1986 and a National AIDS Control Program was launched in 1987. The National AIDS Control Organization (NACO) was established in 1993 and is now running the second phase of National AIDS Control Project (NACP-II). State AIDS Cells later name as State AIDS Control Societies were created for the effective implementation and management of National AIDS Control Program and for effective utilization of funds registered state societies were constituted. The NAPCP 2002 has been announced with the aim of bringing AIDS transmission at zero level by 2007.

**NATIONAL AIDS CONTROL PROGRAMME (NACP)**

The HIV / AIDS have become a major health problem in the State. Maharashtra which estimated 7.47 lakh persons infected with HIV stands second in the country. As per the latest sentinel surveillance report, the State has HIV prevalence of 18.4% amongst STD patients and 1.8% in ANC. One new infection every 15-20 seconds, 30-40% male (<16 yrs) are exposed to sexual experience. Predominant route is heterosexual (96%). There is no
statistical significant increase or decrease in HIV prevalence. Therefore strengthening comprehensive, well co-ordinate HIV prevention activities involving NGOs, CBOs and the community in general and evolving care and support activities to HIV affected individuals and families are crucial issues.

The first AIDS case was reported from Mumbai in 1986. An implementation of an effective HIV services programme in the state resulted in better understanding of epidemiological scenario in the state. The HIV infection is not restricted to the core groups in the state but has spread into bridge as well as low risk operation. Few cities in the state have already entered into 3 phases of the epidemic. It is now evident that spread of HIV in Maharashtra is not restricted to high risk behavior individual, in urban cities but it has established its roots in low risk population as well as distant rural area of the state. It gives very serious Impact on state: such as 1) Dangerous threat to family life 2) Decline in life expectancy 3) Increased expenditure on health care 4) Increased number of orphans 5) Decreased productivity of work force 6) Adverse effect on national development.

The Maharashtra State has worked out the AIDS Control strategy in two phases.

First Phase (1992-98)

It was a five years project, named “National AIDS Control Project (NACP)” a hundred percent centrally sponsored scheme in all the States and
Union Territories. With the first and the prime initiative taken by the Prime Minister and labeling HIV / AIDS as the most important public health problem, the project got a considerable boost and began its function with the main aims:

1) To slow the spread of HIV
2) To decrease morbidity and mortality associated with HIV infection
3) To minimize socio economic impact resulting from HIV infection.

First Phase (1992-98) activities:

1. The State has started the AIDS Cell in the Directorate of Health Services, in 1992.
2. Established 12 sero-surveillance centers.
3. IEC activities for NGO and Health staff.
4. AIDS prevention education programmes in schools with UNICEF support.
5. 71 Blood Banks modernized.
7. 46 Zonal Blood Testing Centers established.
8. Voluntary Blood donation promoted.
9. STD Clinics provided with drugs and training.

The Phase I project was continued upto 31st March 99.

Soon after the Govt. of India, Ministry of Health and Family Welfare through National AIDS Control Organization (NACO), accorded sanction to the launching of the phase II programme for Preventions and Control of AIDS in India with assistance from World Bank. The main aims & objectives of the phase II programme are:

1) Shift the focus from raising awareness to changing behaviour through interventions, particularly for groups at high risk of contracting and spreading HIV;

2) To support decentralization of service delivery to the States and Municipalities and a new facilitating role for NACO. Program delivery would be flexible, evidence based, participatory and rely on local programme implementation plans; to protect human rights by encouraging voluntary counseling and testing and discouraging mandatory testing;

3) To support structured and evidence based annual reviews and ongoing operational research; and

4) To encourage management reforms, such as better managed State level AIDS Control Societies and improved drugs and equipment procurement practices.

These reforms are proposed with a view to bring about a sense of ‘ownership’ of the programme among the states, Municipal Corporations, NGOs and other implementing agencies. To effectively implement
the AIDS control activities, two societies i.e. one for Mumbai Corporation and other for rest of Maharashtra were established in July 1998. National AIDS Control Organization decided to undertake NACP activities with World Bank support from 1999 to 2004 as a Centrally Sponsored Programme.

GOALS SET FOR 1999-2004

- Reduce Blood Born Transmission to less than 1%.
- Introduce Hepatitis "C" mandatory test.
- Increase voluntary blood collection to more than 60%.
- Increase Annual blood collection from 3.5 to 5 lakh units.
- Create awareness in 90% youth and adults.
- Involve NGOs in "Targeted Intervention Activity"
- Promote Condom Use
- Organize Family Health Awareness Campaign for RTI/STI.
- Establish at least one voluntary testing centre per district.
- Undertake area and group specific awareness campaign.
- Cover all schools with AIDS prevention activities.
- Cover all Universities through "University Talk AIDS Program"
Focus is given on following activities:

1. Advocacy and General awareness on HIV / AIDS

2. STD Control measures.
   40 STD Clinics in operation.
   STD Clinics upgraded, and staff trained.

3. Family Health Awareness Campaign.

4. Sentinel Surveillance for HIV.

5. Blood safety. 236 Licensed Blood Banks out of which 227 are functional.
   71 Blood Banks, 7 Blood components separation units and 16 Zonal Testing
   Centres have been modernized.
   Every collected Blood Unit is tested for Malaria, Syphilis, Hepatitis-B,
   Hepatitis-C and HIV.

6. Hospital Infection Control Measures.

7. Care and Support for people leaving with HIV / AIDS. Continuum of care
   centre for AIDS cases on pilot basis started at Bel Air Hospital, Pachgani,
   Dist. Satara.

8. Establishment of Voluntary Counseling and Testing Centres. At 12 places
   the Centres are established, out of which 6 are in Mumbai. All District and
   Major Hospitals will have one centre in the next two years.

   Blood Transfusion Services.
10. NGO collaboration.

For targeted intervention and school AIDS education programme

NACP-III will focus on young people, women, workers and mobile populations. The program will aim at reducing risk, vulnerability and stigma through increased awareness and behavior changes. Indicator is 95% of population who can recall three modes of transmission and two methods of prevention. Increased awareness through communication, community mobilization and advocacy. Integration and expansion of service delivery.

NACP-III: Objectives

1. To prevent new infections
   i. Saturation of coverage of High Risk Groups through targeted interventions.
   ii. Scaling up intervention among the general population

2. Care, Support and Treatment
   i. Improved treatment access for opportunistic infections and continuation of care.
   ii. ART(Antiretro viral therapy)
   iii. Integration of Prevention with care, support and treatment
iv. Greater focus on women and children
v. Children infected and affected by HIV / AIDS
vi. Community Care and support programs
vii. Collaboration with PLHA network
viii. Impact mitigation and linking livelihood support

3. Strengthening the capacities at District, State and National Levels.
   i. Strengthening of National AIDS Control Organization
   ii. States AIDS Control Societies
   iii. District AIDS prevention and control units

4. Strengthening Strategic Information Management System (SIMS).
   i. One Nationwide strategic information management system.

Organizations working for prevention of HIV / AIDS in INDIA

The National Youth Policy, 2003, the National Health Policy, the National HIV / AIDS Prevention and Control Policy, the Millennium Development Goal (MDG) and the SAARC Social Charter 2004 have all recognized and reiterated the need for empowering the young people against HIV / AIDS.

Since 1991, national level of Organizations of youth volunteers (OYV) i.e. NSS, NYKS have been doing very good work on preventive education through University Talk AIDS and Village Talk AIDS programs. Their full
potential as peer leaders and educators on HIV and youth health remains under-utilized.

The Ministry of Youth Affairs was the pioneer in the country to have launched a massive awareness campaign involving one million volunteers from 140 universities and colleges. Now the country has 21 million student and non-student youth volunteers working in different organizations i.e. NSS NYKS, Scouts and Guides, Youth Red Cross/Junior Red Cross, NCC. As a part of their activities, every year these organizations hold about 17000 camps in community/village settings. Together they have the potential to reach out and cover the entire adolescents and youth population in the country through institutional and community based activities.

In addition, a National Adolescents Education Program (AEP) has already covered 93,000 secondary and senior secondary schools out of the proposed 1,44,409 schools in the country, content on HIV prevention education have been integrated into the school curriculum. Sensitized students coming out of their schools will be another force and source of support for HIV education among youth as peer educators and peer leaders.

The Ministry of Youth Affairs and Sports, in consultation with NACO has prepared a five year plan and action agenda called YUVA - Youth Unite for Victory on AIDS. YUVA envisages reaching out to the adolescents and youth in all parts of the country to ensure that by 2010 all young people have accurate
information, skills and access to HIV prevention services/facilities in a conducive, safe and supportive environment.

In order to strengthen these efforts, NACO have proposed to set up Youth friendly Information Centre/Services (YFIC) in youth development centers and universities to provide youth oriented counseling, life skill education, counseling and guidance in a confidential and enabling environment. Now it is proposed to involve Panchayati Raj Institutions in this process so that young people in all the villages know what to do to avoid infection and protect themselves from risk situations and lead a responsible and productive life. The National Council on AIDS the Hon'ble Prime Minister has proposed a three-pronged approach for the national campaign involving 21 million youth

- education and awareness for prevention
- care, support and counseling for rehabilitation
- Creating an enabling environment against stigma and discrimination.

"Goal is to cover at least 95 percent of the young people by 2010 through intensive intervention programs, through a networking of NSS, NYKS, NCC, Scouts and Guides, Youth Red Cross, Red ribbon and YUVA. Vision: Young People are the key determinants of the future course of the HIV epidemic. The behaviors they adopt now and those that they maintain throughout their lives will determine the direction of the epidemic for decades to come. The commitment is to equip the young people with prevention education and life skills for promoting healthy and safe behavior and practices among them.
Focus and priority: Prevention will be the mainstay of the response and interventions in all youth programs on HIV / AIDS / STI. Young people at the highest risk of new infection will be the program's focus. Migrant and mobile youth workers will be reached on priority.

Rural youth are covered through youth clubs and youth development centers and student youth through institution based programs and hard to reach youth segments through NGO/CBOs. Parents, Teachers, community leaders, Panchayati-raj institutions and health care providers are involved in this process to scale up and saturate the coverage. All active youth volunteers oriented to function as peer educators.

Successful prevention efforts include providing education about high-risk behaviors, distributing and promoting condoms, diagnosing and treating STIs, providing voluntary counseling and testing, preventing mother-to-child transmission, ensuring the safety of blood and blood products, and reducing the stigma attached to HIV / AIDS. Comprehensive care includes post exposure prophylaxis psychosocial support, support for orphans and children of AIDS patients, prevention and treatment of opportunistic infections, home-based care, antiretroviral therapy, and palliative care. In order to empower young people to reduce their vulnerability, programs' key strategies are:

- Provide comprehensive education on HIV / AIDS prevention, treatment, care and support within a context of sexuality relationships and broader reproductive health concerns.
• Create a safe space to explore, understand and internalize information
• Enhance the provision of services that cater for the needs young people especially girls
• Foster a social environment that support young women and girls' access to information and services
• Involve young women and girls, in program design and implementation.

3.2 Young peoples knowledge and awareness on HIV / AIDS

AIDS education for young people

The problem seems to stem from the fact that HIV is often sexually transmitted, or is transmitted via drug use. Any subject that concerns sex between young people or drug use tends to be seen from a moralistic perspective. Many adults – particularly those of the religious right – believe that teens need to be prevented from indulging in these high-risk activities. They believe that young people shouldn't – and don't need to be – provided with any education about these subjects, other than to be told that they are 'wrong', and not to do such things.

There are other difficulties in taking an exclusively moral approach to HIV education. Firstly, this is what tends to perpetuate stigmatization of HIV+ people. By teaching young people that indulging in 'immoral' sex and drugs will lead to HIV infection, educators imply that anyone who is HIV+ is therefore involved in these 'immoral' activities. This stigmatization tends to make people reluctant to
be tested for HIV, and therefore more inclined to remain ignorant of their status and perhaps go on to infect others.

AIDS education shouldn’t ever include a moral judgment – it is one thing to teach young people that promiscuous sex and intravenous drug use are unsafe, another thing to teach them that these things are morally wrong. Many AIDS educators around the world are disturbed at this growing trend of providing AIDS education from a moralistic perspective, and argue that AIDS education ought to be non-judgmental, making young people aware of how HIV can be transmitted and how they can avoid becoming infected - without passing moral judgment on those who engage in infection-related behaviors, whether they do so safely or not.

The opposing, more conservative viewpoint, argues that young people shouldn’t be taught about sexual health and drug-related dangers at all. They feel that teaching them about these things, even teaching about their dangers, may encourage young people to indulge in these risk behaviours. Research suggests that this is not the case at all, and certainly young people themselves tend to be very enthusiastic about the fact that they need sex and sexual health education. Unfortunately, curriculum planners tend not to listen to the young people who will be their students. This viewpoint can result in no AIDS education at all being offered.

Many young people become sexually active long before adults would prefer them to do so, or expect them to do, and teens are not all ‘innocent’. If
teens are having sex, they need sexual health information. Fortunately, many curriculum planners and legislators have recognized this, and provide young people in many countries with abstinence-plus or comprehensive sex and HIV education. Young sex workers constitute one of the most vulnerable groups for HIV infection and transmission. Of the estimated two million women involved in sex work in India, 25-30% is minors. According to the Social Welfare Board of India, two out of five sex workers are under the age of 18 years. One of the highest HIV prevalence rate is among sex workers and their clients. HIV surveillance of 2005 reveals that around 13% of female sex workers in Andhra Pradesh, 18% in Karnataka and more than 23% in Maharashtra were infected with HIV. In Mumbai (Maharashtra) HIV prevalence among female sex workers has remained around 52% since 2001. The overall HIV prevalence in female sex workers was estimated to be 8.44% in 2005. An increasing trend was noted among female sex workers of Nagaland, West Bengal, Rajasthan and Bihar compared to earlier years. Early initiation into commercial sex, exposure to multiple partners, and no negotiating power for safe sex leading to low or no condom use, exposure to STIs, newly infected with HIV is steadily rising. Almost 38% of all Indians living with HIV currently are women. The HIV prevalence rates for young women also exceed those for young men. According to the WHO health indicators, the HIV prevalence was 0.46% for 15-24 year old females while it was 0.22% for men in the same age group.
Different approaches to AIDS education for young people

Most countries in the world offer teens some sort of sexual health and HIV education in their schools at some stage. AIDS education can also be targeted at young people in non-school environments – through their peers, through the media, and through doctors or their parents. In some countries, individual schools are allowed to determine what AIDS education they will offer.

AIDS education for young people today falls generally into one of two categories: either 'abstinence-only', or 'comprehensive'. These are actually types of sex education, rather than AIDS education specifically - AIDS education in many schools becomes a part of sex education program, if it occurs at all. The type of AIDS education program that is offered usually depends on the attitudes of those who determine the syllabus content.

Abstinence-only education teaches students that they must say no to sexual activity until they are married. This approach does not teach students anything about how to protect themselves from STDs or HIV, how pregnancy occurs or how to prevent it, and teaches about homosexuality and masturbation only as far as to say that they are wrong. Those who favour this method of education claim that teaching young people about sex will make them want to try it, thus increasing their risk of contracting HIV, amongst other things.

Abstinence-only education is popular in America. A House of Representatives report at the end of 2004 found that "over 80% of abstinence-only curricula contained false or misleading information". This is not only a
concern for those living in America, but increasingly for the rest of the world. This is particularly worrying in that abstinence-only programmes have been shown not only to fail to reduce the numbers of sexually transmitted infections and unplanned pregnancies seen in pupils, but recent studies indicate that they might actually be related to an increase in these problems.

Comprehensive AIDS education teaches about sexual abstinence until marriage, and teaches that it is one way of protecting yourself from HIV transmission, STIs and unwanted pregnancy. It also teaches that there are other ways of preventing these things, such as condom use. People who favour this approach take the perspective that, while abstaining from sex until marriage is a good idea and should possibly be encouraged, there will always be some young people that do not choose to abstain – and these people must be provided with information that enables them to protect themselves. This type of education also teaches not only about the dangers of drug use, but also about methods of HIV-prevention that drug users can employ i.e. the use of clean needles.

Abstinence-only and comprehensive AIDS education has been combined to produce abstinence-plus education. This type of education focuses on sexual abstinence until marriage as the preferred method of protection, but also provides information about contraception, sexuality and disease prevention.

Fifteen percent of Americans believe that schools should teach only about abstinence from sexual intercourse and should not provide information on how to obtain and use condoms and other contraception. Forty-six percent
believe that the most appropriate approach is abstinence-plus. Almost half of those surveyed felt that the word ‘abstinence’ included not only sexual intercourse, but ‘passionate kissing’ and ‘masturbation’, too.

**AIDS education offered outside schools**

Not all young people are fortunate enough to attend school. This might be for one of a variety of reasons. In some countries, it is necessary to pay for schooling, and poor families may be unable to afford to send a child to school, or may be unable to send all their children to school. Sometimes children will be required to work, making them unavailable for school. In other areas, young people may live in areas where a local school is not accessible. In some situations, young people may have been excluded from school for reasons that might be due to the young person’s behavior, academic or intellectual abilities, or due to discrimination. Some young people play truant, and will have only very limited attendance. The proportion of young people who attend school differs markedly in various parts of the world.

Although AIDS education offered through the school might reach many young people, it will not reach all, and other forms of education are required. One of these is the media. Most young people will, at some time, be exposed to the media. This can include newspapers, television, books, radio, and also traditional media such as street performances or murals. One advantage of media-based AIDS education is that it can target specific groups amongst the
population. If the message is to be targeted at young people, then it will be placed in media that are favored by this audience.

Many countries have tried some form of AIDS education advertisements, films, or announcements. A good example of this is the LoveLife campaign in South Africa, an education program 'by young people, for young people'. LoveLife used eye-catching posters and billboards to tell young people that sex was fun, but that it could be dangerous, too. The campaign also inserted its message into TV soaps that were popular with young people, and used rap and kwento music to get its message across.

Another way in which young people receive information about sex and HIV is through their peers. This is something that happens anyway to a great extent – many young people receive their first information about sexuality from their friends, although this information is often distorted and inaccurate. This type of peer education can be harnessed, though, and used to convey accurate, targeted information. Peer education is, the process by which a group is given information by one of their peers who has received training and accurate information. This is a method often used with groups which have been marginalized. Such groups might have cause to distrust information given to them by an authority figure; if the same information comes from a member of their own group, they may well listen. This method of information-provision is often used with such groups as sex workers, the homeless, or drug-users.
Indeed, it is particularly appropriate for young people who do not attend schools and will not have an opportunity to benefit from an AIDS education curriculum.

Studies continue to show that being informed about the facts and the dangers of HIV and AIDS enables young people to protect themselves and is a crucial tool in the battle against HIV. There is no AIDS cure or vaccine for HIV, so prevention is the only way in which we can place any limits on the epidemic. One of the most economical and effective means of HIV prevention is education – involving young people themselves in the HIV prevention effort.

Whenever educators and planners ask, and listen to young people, they are replying again and again that young people overwhelmingly asked for adequate AIDS education. In most parts of the world, this means more AIDS education than they are presently getting. Young people know that they have the right to the information that enables them to safeguard their lives and those of their sexual partners – they must be listened to, and provided with that information clearly, openly and honestly.

It is essential to keep in mind that it is the man who spreads the virus much more effectively than women; it is the man who, in most cases has multiple partners before and outside marriage. It is a man who is mobile and spread the disease from one region to another it is the man, who has the power to protect all by using safer sex.
3.2.2 HIV / AIDS knowledge and awareness among adolescents/young

Young adults are the centre of HIV epidemic in terms of rate of infection, vulnerability impact, and potential to change. They are particularly susceptible to HIV infection and they carry the burden of caring for family member living with HIV / AIDS. A variety of demographic, behavioral, social and economic factors place young people at risk for becoming infected. HIV does not discriminate; the virus usually spreads people indulging in high risk behavior into the mainstream through the bridge population.

Data from the National Behavioral Surveillance Survey (2001:32) reveals that awareness level on STIs is very low among Indian youth (15-24 years). Only 28.75 had heard of STIs. The awareness of the linkage between STIs and HIV was even lower in this age group, especially among rural youth and young women. Less than 20% of the young people served were aware, that someone who has STI runs a higher risk of HIV infection.

Although surveys demonstrate a steady increase in the number of young people worldwide who have heard about the HIV/AIDS epidemic, many still lack knowledge about how to protect themselves and about how the virus spreads. Even in countries with high HIV prevalence, many sexually active youth do not perceive themselves to be at risk. In addition, the majority of HIV-infected young people are not aware they are infected. Most of them are not aware that people with HIV can look normal and healthy.
Why are young people still getting HIV? The common assumption is that they have the information to protect them but are not changing behavior. Consultation with young people repeatedly include request for more information. The assumption must be challenged to better understand what they actually know.

Young people’s knowledge and awareness on HIV / AIDS: a global review

Monasch R, Bull N (2000: 9-14) Young people getting HIV / AIDS, the common assumption is that they have the information to protect themselves but are not changing behaviour.

Methods: comparative analysis of 32 Demographic and Health Survey (1994-1999) Levels of knowledge, awareness, and perception of risk for 15-25 years old were linked to HIV prevalence rates at time of survey.

Result: The percentages of 15-19 years old girls who have heard of HIV / AIDS vary by region. In high prevalence area e.g. South Africa, Uganda and Zambia over 98% had heard of AIDS. Low prevalence countries showed a lower proportion having heard of HIV / AIDS-17% Bangladesh. Awareness that a healthy looking person can have HIV / AIDS is low in all countries. High incident countries like Mozambique show that 66% of girls (15-19) not a healthy looking person can have HIV / AIDS. In South Africa figures are over 50% .Uganda has the highest level of awareness in Africa with 23% not knowing. This still leaves a significant proportion of adolescent women ill informed. High HIV prevalence
countries have less young women (20-24) who feel they have no risk at all of getting AIDS. Despite this high % of young women still do not perceive themselves at risk: 68% in Haiti and 50% Zimbabwe.

**Conclusions:** Large number of young people in all countries does not perceive themselves at risk of HIV / AIDS. Existing information has not been internalized by them. Significant proportion does not have basic knowledge to protect them. Information provision is key component of effective programmes. A deeper understanding of what is known/ believed is needed. Effective communication mechanisms for sharing information need to be developed with young people.

Adolescents is a crucial phase of life not only health education and health promotion in general but also for the HIV prevention and AIDS. As a developmental task sexuality may entail a potential risk of HIV infection. Since, youngsters usually changes before they establish long term intimate partnership. Furthermore a large majority gather their initial and subsequent sexual experiences without condom practice.

During the discussion at Yaoundé Conference, five facts of developmental demands have been demonstrated which bear a significant relationship to HIV prevention are body, sexuality, role, risk taking, and peers. (Peter Franzkowik: 1990:87). Preventing HIV infection among adolescent is also critical to slowing the epidemic because young people form a large segment of the population which is more than 1/5 of total population. Knowledge, perception
and behavior related to sexuality among the adolescent reflects vulnerability to risk of having HIV / AIDS.

A research study conducted by M.P. Lilly Kamala in 1994, to access knowledge among adolescent shows that there is low awareness among adolescents related to HIV / AIDS disease. There is considerable knowledge gap about the sexuality and related issues. The need for a health education intervention is appreciated by the adolescent

According to Michal Kurbe the only vaccine for HIV / AIDS disease is knowledge. Information and education on AIDS are fundamental to prevention for the simple reason that HIV is transmitted by specific acts which are largely subject to individual control. Identifying the knowledge of adolescents in relation to HIV / AIDS is very important to provide education scientifically and to prevent the incident HIV among adolescents. Also adolescents being the main pillars of the society in future their knowledge, awareness and development of responsible behavior for a healthy life style will save the country from the scourge of AIDS in future.

A study of 409 student’s age of 18-24 in Mumbai, New Mumbai and Solapur centres by Chitale and others (1992), found that 10% of students in Bombay, 23% in new Bombay and 34% in Solapur were not aware of AIDS. However, 95% of Bombay students, one half of New Bombay and 48% of Solapur student knew that it was an infectious disease. Students and youths are more vulnerable to HIV infection due to age factor.
The MCRC, JMI, conducted a study of AIDS awareness among adolescent in the city of Madras in which a total of 498 respondents of both the sexes within the age group of 13 to 24 years of high, middle and low income group, in and out of the formal educational system were interviewed. Among the respondents, 64.1 percent reported of having heard of STDs while 49.2 percent women were aware of STDs only 56.3 percent men were aware about it. As many as 94.2 percent respondents knew something about AIDS while 77.3 percent of the illiterate were aware of AIDS, as many as 96.3 Percent of the school students were aware of the disease.

Until a vaccine or cure for AIDS is found the only means of prevention available is health education to enable people to make life saving choices. The national AIDS control programme phase II was officially launched on 15th December, 1999. One of the measures for this is the information, education, communication and social mobilization to raise awareness, improve knowledge and understanding among the general public specially the vulnerable group of population. (K. Park : 2001: 23) The theme for the 11th Annual world AIDS day was “Force for change world AIDS campaign with young people” This theme reflect the fact that world wide five young people are infected with HIV every minute, and infection rate is 600 /day in the age group of 15-25 years, making AIDS and HIV a very real part of every day life for young people of the 36 million people alive today with HIV infection, one third is young people aged 10-24 years (AIDS research review 1998).
The average age of getting down into drug use is 16 years. According to 'Sankalp' rehabilitation trust report shows that high incidence of HIV transmission among injecting drug users. This also indicates the need for identification of knowledge among adolescents.

Information and education on AIDS are fundamental to prevention for the simple reason that AIDS is transmitted by specific acts which are largely subject to individual control. As an impact of rapid change in the society especially the spread of non-traditional values, college students are exposed to a wide range of behavior from which to choose and they need to be influenced to adopt healthy life style pattern. Being the main pillars of the society in near future, their perfect knowledge, awareness, responsible behavior, health and life style will save the country from another scourge of AIDS in future. Periodic assessment of knowledge about AIDS among the college students and to develop appropriate health education programme for them thus become an essential activity towards the AIDS control in the community. (Velhal G., D, Danial E. 1994:52) A study was undertaken to assess the exiting status of knowledge about AIDS among undergraduate students from colleges in Mumbai. Study reveals over all poor performance expressed in terms of the mean score. Significant difference observed in the mean score obtained by male and female students as well as students from different area, faculties, year of study, economic status group and in various interactions, average percentage score not exceed beyond 45% for any group. It indicates a very strong need to introduce a special well directed, on
going continuous educational programme to improve the knowledge and to create a sense of responsibility among them towards avoiding and controlling the spread of the infection.

The research study conducted by R. K. Mutatkar and Hemant Apte (1998:12) on “Sexual behavior amongst adolescents in rural western Maharashtra” shows out of 500 adolescents taken for study forty percent reported premarital sex. Several studies among adolescents in India have found that adolescent particularly male are likely to indulge in unsafe sexual activities making themselves vulnerable to sexually transmitted infections including HIV infection. AIDS attack not just the human body but it thrives of human ignorance, fear and threatens the social fabric of society. A population of adolescents constitutes one of the risk and vulnerable group. They are in the process of forming sexual habits and therefore can be influenced to develop proper attitudes. Rapid changes in the society especially the spread of non traditional values, adolescents are exposed to a wider range of behavior choice and need to be influenced to adopt healthy life style pattern.

Research with adolescent and college students focused on their perception of nature and extent of sexual behavior practices, like premarital sex, misconception and need for the sex education and AIDS awareness, sexual abuse, sexual negotiation, contraception and abortion, and the role of peer pressure in life style changes.
A study co-coordinated by Mhendra Vasta reveals that the Indian youth are facing a dilemma because of the disparities between traditional norms and western pattern of expression of life styles are changing. There are greater opportunities for youth to experiment and participate in unsafe sex practices resulting in STDs at ages ranging from 16-19 years. The mean age of first sexual experience document in various studies varied from 16.5 to 19.5 years, earlier in males than in females.

There is growing evidence of early onset of sexual activity among young people in India. Studies in different cities showed that almost 10% of young women and 15-30% of young men indulged in premarital sex. Research suggests that young people who become sexually active during adolescence are more likely to have sex with high risk partners or multiple partners. Early sexual debut of Indian women is generally in the context of marriage while young men become sexually active by the age of 16-19 years.

Behavioral Surveillance Survey (2001) findings shows that young men aged 15-19 years and 20-24 years reported more casual sex compared to females in the same age groups. Rural males reported more casual sex compared to urban males. More than 54% urban male respondents in the age group of 15-19 years and more than 64% in the 20-24 year age group reported using condoms with their last casual sex partner. However, only about 36% urban males in the 15-19 age group and 40% in the 20-24 year age group, of
those reporting casual sex in a year’s recall, stated that they had consistently used condoms.

An increasing number of young people are also experiencing forced sexual activity. Though young women are generally more vulnerable to sexual coercion and violence, young men and boys also experience non-consensual sex.

A Various Studies Coordinated by Anita Rego and Vimla Nadkarni (2001:4) on Gender and HIV / AIDS reveals that gender differences in the knowledge or awareness have been inclusive, while there is greater awareness in boys and urbanites. Knowledge gaps were noticeable through misconceptions on mode of transmission, information on availability of diagnostic tests, prevention strategies and protection by condom. The media and the press continued to provide maximum sources on general knowledge and information on HIV / AIDS. Students had access to other sources of information such as phonographic films, magazines and cinema. Students who are sexually active are not necessary aware of safer sex practices. Women reported lesser sexual activity compared to men. While there could be an element of truth in this, there is also a possibility of concealing information due to social conditioning. Even, though attitude towards people living with HIV was not favorable. There was a sense of openness in some informed students. Students demonstrated an interest to learn about HIV and in one of the studies expressed desire to volunteer for activities related to HIV /AIDS (Thomas: 1997)
A few studies documented the importance of media for women specifically as they have very little options to gather information (Sunder and Chatterjee, 1999:85). The same study explored discussion of information within the social circle and reported better learning among those who had discussed with significant others. Another study on partners of health care workers demonstrated that information sharing becomes greater among women health care workers when compared to men health care workers. There is no study to suggest that the finding are also applicable to other women.

For all the groups, comprising of students, community respondents and health care providers, the media was the main source of information. It could not clarify the confusion and bridge the knowledge gaps. There is some indication to suggest that the buildup created by the media had generated confusion and fear, further linking HIV/AIDS to high-risk groups. This has distanced people from the infection and has depersonalized risk perception. While most of the studies were carried out in the early phase of epidemic, there has not be an attempt to explore the impact of the IEC material that is being disseminated widely or to look at the immediate and long term lessons learnt from the sensitization programs.

The Behavioral Surveillance Survey (2001) revealed that there was a high level of awareness among young people in general about HIV/AIDS with urban males in India. Most of the respondents knew that at least two common modes of transmission of HIV. However, awareness among rural females
especially in Jharkhand, Gujarat, Chhattisgarh, Uttar Pradesh and West Bengal was low. Although a significant proportion of young people were aware of HIV/AIDS, their knowledge on prevention modalities was low. Only about half the respondents of the behavioural surveillance (2001) were aware of two important modes of prevention of HIV transmission: consistent condom use and sexual relationships with uninfected faithful partners. Rural and young female respondents had poorer awareness levels than the urban youth while older respondents were more informed than the younger ones. Respondents also harboured misconceptions on the modes of HIV transmission. Less than 30% were certain that a mosquito bite or sharing a meal with an infected person cannot transmit HIV and that a healthy looking person can transmit HIV. Even urban males with higher literacy levels had incorrect knowledge on these three aspects. More than half of the respondents were aware that there is no known cure for AIDS. The same survey revealed that the young people who had received education beyond the standard VIII level were more aware of HIV related issues than those with lesser levels of education.

Most young adults and adolescents were aware of condoms. Males had better awareness compared to females in both urban and rural areas. Urban respondents reported more condom use (59.4%) compared to the rural ones (50.1%). Males reported higher condom use as compared to females. Regarding access to information, the survey reveals that most young people obtained information on HIV/AIDS/STIs from the mass media. Television, radio
and newspapers were quoted as the most common source of information. Interpersonal communication for obtaining information was less indicating that there are few discussions on these issues within the family or the community. In general, young people adopt risky behaviours since they are poorly informed about their physical attributes, sexuality, and consequences of unprotected sex. They also lack the skills to negotiate safe sex or say no to unwanted sex. In addition, experimentation with drug use including injecting drugs also becomes a contributing factor in compounding the vulnerabilities of young people to HIV. Lack of access to correct information and discrimination due to age and gender further impede prevention.

**Young sex workers**

Young sex workers constitute one of the most vulnerable groups for HIV infection and transmission. Of the estimated two million women involved in sex work in India, 25-30% are minors. According to the Social Welfare Board of India, two out of five sex workers are under the age of 18 years. One of the highest HIV prevalence rates is among sex workers and their clients. HIV surveillance of 2005 reveals that around 13% of female sex workers in Andhra Pradesh, 18% in Karnataka and more than 23% in Maharashtra were infected with HIV. In Mumbai (Maharashtra) HIV prevalence among female sex workers has remained around 52% since 2010. The overall HIV prevalence in female sex workers was estimated to be 8.44% in 2005. An increasing trend was noted.
among female sex workers of Nagaland, West Bengal, Rajasthan and Bihar compared to earlier years. Early initiation into commercial sex, exposure to multiple partners, and no negotiating power for safe sex leading to low or no condom use, exposure to STIs, newly infected with HIV is steadily rising. Almost 38% of all Indians living with HIV currently are women. The HIV prevalence rates for young women also exceed those for young men. According to the WHO health indicators, the HIV prevalence was 0.46% for 15-24 year old females while it was 0.22% for men in the same age group.

Jayanta kumar Basu study, which was conducted by AVERT society, showed that the proportion of male students having sexual intercourse with commercial sex workers has declined from 23 percent in 2004 to 5 percent in 2006 to 3 percent in 2008. On other hand the number of surveyed students having sex with non-commercial sex partners (girlfriends, classmates or relatives) went up from 11 percent in 2004 to 16 percent in 2008.

It seems that the government's HIV / AIDS awareness campaigns have managed to scare young men away from commercial sex workers, but given them the mistaken impression that they are not at risk if they are having unprotected sex with girlfriends.

3.3 AIDS prevention among street children

The very large number of children who live and work on the street of large cities and towns are in a very high risk environment and susceptible to HIV
infection, these children have either been abandoned by their parents or have fled from their homes. Living outside social institutions like family or school, they are under no social control and often indulge in high risk behavior like unprotected sex and drug abuse.

Children In Need Institution (CINI-ASHA), a non governmental organization help to improve quality of life of deprived children, began intervention directed at preventing HIV /AIDS in street children.

**AIDS Prevention among street children in Calcutta**

An attempt was made by S.N. Chaudhari: to understand the street children and to assess their attitude, knowledge and practices with special emphasis on high risk behavior.

**Methodology:** focus group discussions and depth in- interviews revealed some interesting facts about their sexual behavior.

**Findings:** When a child comes on street, he begins acceptance in a group or gang which teaches them to survive i.e. how to earn money, break laws, dodge the authorities, get cheap food and clothing etc. The physical proximity and easy accessibility lead the boys to practice homosexual activities. Among girls, once settled on the street, they involved in three sorts of sexual relationships

- With boys with whom they have an emotional relationship.
- With local hoodlums for protection against abuse.
• For commercial purposes. The girls engage in such practices when they need money desperately.

Taking in to consideration these attitudes and general behavior of street children, CINI-ASHA planned the strategies for HIV prevention like:

• Training of street children as peer educators for AIDS awareness, to equip with knowledge and skills necessary to become, effective educators

• Preparation and use of friendly training material

• Identification and training of community influencers who could influence the behavior of these children i.e. sex worker, coolies, vendors and spouses of these people. The project aim at changing the behavior of these community influencers from ‘abuses of children’ to ‘supporters of children’

One of the more important components of the intervention is to improve the self-esteem of children through counseling and education. Once the self-esteem is improved, the child is keen to adopt safer sex behavior. The children are also educated and motivated to use condoms when engaging in sexual activities. Children and youth are extremely shy of buying condoms from the existing condom shops. To overcome this, friendly outlets, where they feel comfortable to pick up condoms from, have been identified. The innovative methods of carrying condoms have been devised. While girls are given purses, boys are provided knickers with packets.

**Result:** As a result these interventions about 2,000 children on the streets in the project area are more aware of the health care issues as well
about STD/HIV and AIDS. Health care seeking behavior of the children has increased with more children attending clinics for treatment than ever before. Some reduction in teenage pregnancy has also been seen among the street girls. While implementing the project several lessons have been learned. First, it is important to improve the self-esteem of the children so that they are motivated to improve the quality of their lives through knowledge on STD/HIV and want safer sex methods. Second, it is also necessary to build a social environment which supports the adoption of behavior change by street children.

HIV/AIDS prevention among adolescents

Adolescents are difficult to engage in the care needed for the diagnosis and treatment of HIV disease. Adolescents believe that they are invincible and tend to deny they are at risk. This belief may cause them to engage in high-risk behavior, delay HIV testing, or delay or refuse treatment when they have tested positive for HIV. Thus prevention is the key weapon in reducing the incidence of adolescent HIV/AIDS (Wood 1998:45).

Study the knowledge and attitude of adolescent girls regarding prevention of HIV/AIDS was conducted by Mehrzad Taghizade (2002:40) a sample of 100 adolescent girls (17-19 years) was selected from a selected colleges of South Delhi. A multiple choice questionnaire related to magnitude of problem of AIDS and the attitude scale develops for the study.
Objectives were:

1. To assess knowledge of adolescent girls regarding prevention of HIV / AIDS.
2. To identify the attitude of the adolescent girls regarding prevention of HIV / AIDS.
3. To find out a co-efficient of correlation between the knowledge and attitude of adolescent girls.
4. To find out the relationship between the knowledge and selected factors.

Study reveals that adolescent girls had inadequate knowledge regarding magnitude of problem of AIDS, mode of transmission, incubation period, treatment, control and prevention of HIV / AIDS. Assessing the attitude is an important aspect, which makes the individual differ from each other. Attitude is concern with belief, idea, thinking of person and affect on behavior of individual. According to finding of this study, adolescent girls had less favorable attitude towards the HIV / AIDS. It is evident that there is no significant relationship between knowledge and attitude of adolescent girls. The findings also show knowledge and selected factors are not influencing each other there is no associated relationship between knowledge and selected factors. There is a need to include the education program in the curriculum of college/ school to increase the knowledge and develop most favorable attitude towards the prevention of HIV / AIDS. The finding justify the need for program that apprise
parents and peers to guide adolescent's life style and sexual health needs while at same time equipping them to make informed.

Adolescents are powerful force for community reach out on the topic of AIDS. Velhal G.D (1994) report of study was undertaken with objectives as:

i. To assess the existing status of knowledge about AIDS among undergraduate students from colleges of Mumbai.

ii. To study the relationship of factors like age, sex, socio-economic status, location of the college, faculties with their level of knowledge.

iii. To identify their sources of information about AIDS.

iv. To identify the educational needs of college students about AIDS.

Findings: Study reveals that over all poor performance expressed in terms of the mean score. Average score of all students is 35.04% male students are better than female students. Students from colleges of western suburbs are better among all. Science faculty student perform better as compared to Arts and Commerce faculty students. And students belong to III year (senior) classes are better than those belongs to first and II year. Economic status of the student also affects the level of knowledge.

Students in schools generally have a limited access to information about sex, sexuality and human reproduction. Incidental information that they get from their friends, magazines and mass media, may even be misleading. Incidental Information that they get from their friends, magazines and mass media, may even be misleading. Integrating information regarding sexuality, STDs and AIDS
into the family life education course designed for school students can, therefore, be considered as a necessity.

A study by Caroline Andersson and Camilla Westergren 2004, knowledge about HIV/AIDS among teenagers in Solapur District, Maharashtra State. The aim of study was to investigate and compare the knowledge about and attitudes to HIV/AIDS among teenage students in the city and the rural area in India.

Methods - 260 standardized questionnaires concerning knowledge and attitudes towards HIV/AIDS, socio-cultural factors and private life were filled in by teenage students in the rural area and the urban area in the Solapur district in the state of Maharashtra. 39 personal interviews with more open questions regarding the same subject were also done in the same area.

Results - Study showed that almost all of the students (99%) had heard about HIV/AIDS. Most of the students were aware of the sexual transmission (96.6% in the village and 99.3% in the city) and many knew that the disease can be spread through breast feeding (82.8% in the village and 76.8% in the city). Still there are misconceptions about the transmission of HIV, about one third of all the students thought that HIV can be spread by kissing and 14.3% of the female students in the village thought that you can get HIV if you wash or change clothes for someone who has the infection. 93% of the students in the city and 74% in the village claimed that there are ways to protect against HIV and answers that were mentioned were protected sex and use of disposable
syringes. The knowledge about condoms was insufficient among the students, especially among the females. Only 18% of the females and 29% of the males knew how to use a condom.

Conclusion - The knowledge about how HIV is transmitted is incomplete among the students. 99% of the students had heard about the HIV/AIDS but there are still many misconceptions about the disease. The majority of the students first heard about HIV/AIDS from media. Media is an effective way of spreading information but the school also plays an important role. The awareness of protection against HIV is insufficient among the students and there are misunderstandings about it. Many of the students would like to test themselves for HIV but a lot of them don't know where they can do the test. The most important way to prevent the rapid spread of HIV is to raise the level of knowledge about the transmission of and the protection against HIV.

S.M. Bhadkamkar and S.V. Gore (1993: 2-6) of Sevadham Trust a non­governmental organization based in Pune in Western Maharashtra, took up AIDS Prevention education for young students. The objectives were to
i. To impart updated knowledge on Family Life Education including sexuality, STD and AIDS to the teachers and students through training of selected nodal teachers and peer educators in Family Life Education.
ii. To facilitate a healthy attitude amongst students towards sex and sexuality.
iii. through development of their skills to protect them against HIV / AIDS.

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Through advocacy, the political support of education ministry and the SSC board has played a major role in inclusion of STDs/AIDS subject in the state school curriculum. At school level, the AIDS Education Committee was constituted in each school under the chairmanship of the headmasters, and of which the nodal teachers, peer educators and parents, as members. Teaching modules were developed and distributed to all nodal teachers and peer educators. In the five years, the project covered 651 secondary and higher secondary schools in Pune district, trained about 4000 peer educators, 250 nodal teachers and about seven lakh students, both in urban and rural areas.

The education of children, both in school and out of school, is also an effective way of preventing HIV/AIDS education in the school curriculum, supplemented by peer education is proving to be an effective strategy in many countries of our Region. Following Lesson were learnt:

- Most of the peer educators, both boys and girls have been able to conduct effective and efficient AIDS Education sessions. The students feel free to raise questions and obtain more information from them.
- Proper selection of both boys and girls as peer education is the key to the success of peer education.
- Initial training including practice sessions and supply of teaching and health education materials facilitate peer education activities; finally, taking parents to participate in the programme, was very helpful.
A study conducted by Sinha and Kumar to assess the existing knowledge and create further awareness of HIV / AIDS in adolescents and young adult in New Delhi revealed that 20.00% of respondents of age less than 25 years had poor or very little knowledge of HIV / AIDS as compared to 9.30% of respondents of age more than 25 years. The study also revealed that counseling had been effective for adolescents as compared to elderly. Adolescents group with poor knowledge declined from 19.80% to only 5.70% after counseling and in the elderly group there was negligible decline i.e. from 9.20% to 8.00%.

Francis P.T. (1992:65) conducted a study among twelfth class students in south Delhi revealed that 94.00% knew HIV / AIDS is transmitted by sexual contact, 89.00% recognized the risk by having multiple sex partners, 62.00% knew kissing do not transmits HIV / AIDS. 76.00% thought that having single faithful sex partner will reduce the chances of getting HIV / AIDS. 62.00% knew that infected patients could be symptom less, 70.00% thought condom can reduce the chances of getting AIDS, and 61.00% knew that there is no cure for AIDS. No students had obtained information from teachers or parents. In this study it was observed though the general level of knowledge about HIV / AIDS was not poor but there were a number of misconceptions.

Thomas William (1996:66) conducted a study among the college students in Tamil Nadu. It was found that knowledge about general aspects of HIV / AIDS and the transmission were adequate and the knowledge about
preventive and curative aspects of the disease was not known. Though female students were aware of the basic information of HIV, they were also ignorant about the curative and preventive aspect of the disease.

**Awareness on HIV / AIDS and STDs among Young Adult Population (15-24 Years) of Villages of Anand District (U.S. Singh: 2006:301)**

*Methodology:* This is a community based cross-sectional study and was conducted from August 2003 to January 2004 in 36 villages of Anand district. The Sample size was calculated by presuming awareness regarding HIV / AIDS about 30%, the sample size came to 323. Multistage sampling technique was applied. First, by simple random method 36 villages (10% of total) were selected among 365 villages and then each village was divided into five parts and from each part 2 males and 2 females randomly identified for study purposes. A structured questionnaire was prepared both in English and local language i.e. Gujarati. The questions related to awareness of HIV / AIDS, mode of disease transmission, its prevention and assessment of health service utilization. EPIINFO package was utilized for statistical analysis.

*Findings:* About 57% of the study subjects were in the 15-20 years and 43% in 20-24 years age group, among them 44% were married. Among all those who had heard about HIV / AIDS (76.6%), 85.8% were males and 67.5% females. Twenty two percent correctly knew about the sexually transmitted infections.
About the source of information, television was the main source identified by 64% males and 60% females followed by relative/friend (50% and 58%), newspaper (22% and 21%), literature (18% each), and health personnel (10% and 11%) respectively among male and female. Sexual route was considered most common mode of transmission by 77.2% males and 67.5% females. This followed by infected blood 46% and 11%, parent to child 13% each and infected needle and syringes 57% and 48% respectively among males and females. HIV / AIDS non-transmission route was known to 52% of literates who had given 4-6 correct answers among all, but it was only 13% when illiterates were asked.

Knowledge of prevention was very good as 76% of males and 52% of females had the opinion of having sex with single partner is a most important way of life to prevent HIV / AIDS transmission. Use of condom to prevent transmission from high risk sex was also identified by same no. of subjects. Mostly condom promotion was learned by television advertisement. Proper treatment of STDs is also a way of prevention was identified by 25% of males and 14% of females, among all educated class. Only 10% males and 13% females were looking hopeless by saying nothing can be done.

It was surprised to see the popularity of local so called doctors (Quacks) as 30% of the individuals still have the opinion to visit them to get treatment for problem related with their genitalia. Most of them (>90%) were uneducated. Among the educated class, 70% were interested to visit PHC and Skin and VD
department of medical college hospital. About two-fifths (40%) of them were not interested in doing anything for the infected person.

Conclusion: Their is a need to aware people about HIV / AIDS, so that people can take responsible decision about their well being and keep away from this infection not the infected persons.

Trends in HIV-1 in young adults in south India from 2000 to 2004: A prevalence study Rajesh Kumar MD, Prabhat Jha

Background: Major increases in HIV-1 prevalence in India have been predicted. Incident infections need to be tracked to understand the epidemic's course, especially in some southern states of India where the epidemic is more advanced. To estimate incidence, the prevalence of HIV-1 in young people attending antenatal and sexually transmitted infection (STI) clinics in India.

Methods: Analyzed unlinked, anonymous HIV-1 prevalence data from 294 050 women attending 216 antenatal clinics and 58 790 men attending 132 STI clinics in 2000—04. Southern and northern states were analyzed separately.

Findings: The age-standardized HIV-1 prevalence in women aged 15—24 years in southern states fell from 1·7% to 1·1% in 2000—04 (relative reduction 35%; p<0·0001, yearly reduction 11%), but did not fall significantly in women aged 25—34 years. Reductions in women aged 15—24 years were seen in key demographic groups and were similar in sites tested continuously or
in all sites. Prevalence in the north was about a fifth of that in the south, with no significant decreases (or increases) in 2000—04. Prevalence fell in men aged 20—29 years attending STI clinics in the south (ptrend<0·0001), including those with ulcerative STIs (ptrend=0·0008), but reductions were more modest in their northern counterparts.

Interpretation: A reduction of more than a third in HIV-1 prevalence in 2000—04 in young women in south India seems realistic, and is not easily attributable to bias or to mortality. This fall is probably due to rising condom use by men and female sex workers in south India, and thus reduced transmission to wives. Expansion of peer-based condom and education programmes for sex workers remains a top priority to control HIV-1 in India.

3.4 HIV / AIDS and schools

Basic AIDS education remains fundamental to the global effort to prevent HIV transmission. AIDS education can - and does – target all ages, and sexually active adults are one principal target. AIDS education is also vitally important for young people and the school offers a crucial point-of-contact for their receiving this education. Providing AIDS education in schools is sometimes a contentious issue.

Many young people lack basic information about HIV and AIDS, and are unaware of the ways in which HIV infection can occur, and of the ways in which HIV infection can be prevented. Schools are an excellent point of contact for
young people – almost all young people attend school for some part of their childhood, and while they are there, they expect to learn new information, and are more receptive to it than they might be in another environment. Most young people become sexually active in their teens, and by the time this occurs they need to know how to prevent themselves becoming infected with HIV.

Young people might access AIDS education may not be universal – not all young people will access the same media, or access the same medical services. The school is a place where almost all young people can receive the same message.

In these days type of basic information about reproduction is insufficient and will not give young people the information they need to be able to protect themselves. Parents may not provide even this limited information because they are too embarrassed, or because their beliefs oppose it. Young people, too, may be embarrassed discussing sexual matters in a situation where their parents are present. At school they are in a situation where they are independent, and not subject to parental disapproval.

In some countries, young people may not be able to access family planning or sexual health clinics because of their age – or they may be able to access such services but think that their age precludes them from access. Young people often know that they require information, especially if they are becoming sexually active, but may feel too embarrassed to actively seek out sexual health information, or may fear that their parents may find out. In many
parts of the world, the fear of 'what if they tell my parents' still prevents young people from approaching medical staff, especially family doctors who may know their parents.

The principal reason that AIDS education in schools is so important is that all over the world, a huge number of young people still become infected with HIV. Most young people become sexually active in their teens, and by the time this occurs they need to know how to prevent themselves becoming infected with HIV.

**Attitudes to AIDS education in schools**

The main obstacle to effective AIDS education for young people in schools is the adults who determine the curriculum. These adults – parents, curriculum planners, teachers or legislators – often consider the subject to be too 'adult' for young people – they have an idea of 'protecting the innocence' of young people. This often occurs for moral or religious reasons, and can cause very heated debate.

There is also obstruction to adequate AIDS education from adults who are concerned that teaching young people about sex, about sexually transmitted infections, HIV and pregnancy – that providing them with this information will somehow encourage young people to begin having sex when they otherwise might not have done.
Some of the observed comments from the young are: "I come from a family who believes that having sex out of marriage is not the moral thing to do. I also don't think sex education is something that young kids should be learning. Learning sex at a young age is like provoking more young people to have sex just for the fact they want to experience it for themselves instead of just getting information about it."

This attitude still prevents adequate HIV and sex education from being taught in schools, in spite of the fact that it is a view that the majority do not share. Many schools in many countries do provide adequate AIDS education—but many, still, do not. Young people are rarely asked for their opinions by those adults who decide what they will study—but when they are asked, they almost always demand more comprehensive sex and HIV education.

In some places, legislation may dictate the type and quality of AIDS education that schools are allowed to offer—some countries have no policies on AIDS education, allowing schools to include it or not, as they decide. Other countries may have policies that specifically preclude AIDS education, or certain types of AIDS education.

It is within the context of these attitudes and beliefs that teachers and educators must work to provide the most effective information and education they are able to. Education which teaches about sex and sexuality can also teach about preventing pregnancy and STI infection. AIDS education should start at about seven or eight years of age.
Important points to consider when planning an AIDS education lesson or curriculum are: Age of students, Classroom prejudices, Current knowledge, Active learning, Involving parents and guardians, Other sources, Legislation, Considering cultures, Materials are already available, Making it cross-curricular, Teaching the teachers, and Listening to the learners.

In spite of all the efforts that the past two decades have seen in AIDS prevention, the epidemic still presents a serious challenge to societies around the world. Every year, increasing numbers of people globally are infected with HIV, and people continue to die. AIDS education for young people is a crucial weapon in the HIV-prevention arsenal, young people are one of the main groups who must be targeted, and the school is the most important means of reaching them.

Still, however, schools in many countries around the world do not have adequate AIDS education curriculum. Although it is not a legislative requirement in all countries that AIDS education is provided, it remains a requirement of the global effort against AIDS. Every young person who passes through the school system anywhere in the world should come out knowing how to protect themselves from AIDS. This is not only the responsibility of every adult who is involved – it is the right of young people everywhere.

Across the world, school play a major role in shaping the attitude, opinions and perhaps most importantly) the behavior of young people. Today
A generation of school children have been born into a world where AIDS is a harsh, unavoidable reality - a situation that their time at school can help them to prepare for. As well as providing an environment in which people can be educated about AIDS, schools often act as a centre-point for community discussion and activity; such as can be vital tool in monitoring the epidemic and co-coordinating a response to it. With a capacity to reach large number of young people with information that can save their lives, basic school education can have such a powerful preventive effect that it has been described as a social vaccine.

**Integrating HIV / AIDS in school curriculum: An example from Sri Lanka**


The Educational system in Sri Lanka is the responsibility of the ministry of education and higher education. The formal school curriculum is operated by the ministry. The National Institute of Education (NIE) is responsible for designing and development of curricula, syllabus as teacher guides and resource materials both for teachers and students.

The curricula used in schools were revised in 1985, HIV / AIDS not included in the curricula. But with the increasing demand for information on HIV / AIDS prevention, entry points in the curricula were identified. Health, physical education, science and social studies were identified as subjects where HIV / AIDS massages could be introduced. For this purpose, a separate teaching
module was developed by National Institute of Education Bureau in 1994. In this module, the HIV / AIDS prevention module was introduced from years 6 to 13 with an adequate number of 40 minute periods for each level.

In this teaching module, information appropriate for each year/age is included under five different sections. Each section contains the curriculum content suitable for respective age group. While during year 6-8, more general information is given, under the secondary and collegiate levels, attitude and behavioral messages with the emphasis on more technical details about HIV / AIDS and STIs are provided. Teachers training was carried out in 1994. Two teachers from each of the 285 schools were trained. The modules used for all school throughout the country.

Findings: This module attempts to help the teacher initiate changes in the behavioural patterns of the children regarding prevention of HIV / AIDS through the formal school curriculum.

HIV / AIDS Education at Schools in Nepal: Students, Teachers and Parents Perceptions and Preferences. (Karki KB: 2004:56)

Background: Schools have potentials to act as a key resource to assist young people in order to achieve optimal HIV AIDS Education. Study was conducted to investigate the practices and preferences of the young people on sex education particularly HIV/AIDS in schools and to identify the parents and
teachers perceptions and preferences on HIV / AIDS education including sex education.

**Methods:** The data were collected from the school children, parents and teachers of Dhading, Morang and Lalitpur districts of Nepal. Thirty focus group discussions (FGD) with different stakeholders were conducted in the schools.

**Results:** The result revealed that the teaching practices on the issues connected to sexual health including HIV / AIDS found poor as there is no two way communication between teachers and students about the sex and sexual issues. It was found that the teachers do not have adequate knowledge, skills and confidence for teaching the sexual issues like sex, masturbation and reproductive organs, therefore the teachers found to be shy and sometimes embarrassed. The teachers also admitted that they do not know appropriate techniques to impart knowledge and skills in regards to sexual health. Boys take part more than girls during the teaching sessions. Parents found unaware of education provided on sexual health issues at schools. The students and teachers stressed the need of sex education in school, which helps prevent STI / HIV / AIDS and unwanted pregnancy. Majority of the students, teachers and parent's expressed that education on sexual issues should be started at the age of 12-13 years and the best ways for the sex education is classroom teaching.

**Conclusions:** Sex Education focusing on HIV / AIDS should be mainstreaming into education system. It also needs an improvement through training and open interactions with the teachers. Parents from the rural or semi-
rural areas of Nepal are to be provided with adequate information on the importance of education to young people on sexual issues through appropriately designed awareness intervention.

A study to assess the awareness and knowledge among of students as class IX and XI of selected government and private school HIV / AIDS was carried out in Nepal using pretested questionnaire. 160 students from selected secondary and higher schools were interviewed. The average age of the students was 16.6 years. Over all class IX students were better informed than class XI students and students from private schools better than those in government school while about 90% of students were aware of STIs, only about 1.2% had a real understanding of the diseases.

Fever of long duration, weight loss and recurrent infections were identified as common symptoms of AIDS by 67.9% of the students, while over 77% felt that AIDS could be recognized by looking at a patient. 88-95% of the students said reuse of contaminated syringes/needles, blood transfusions and unsafe sexual practice could cause the transmission of HIV / AIDS and STIs could be transmitted from an infected mother to her newborn child. Many students also thought that mosquito bites, sharing food with and hugging infected persons could transmit HIV / AIDS. However about 95% of students from government as well as private schools were aware that the correct use of condoms could prevent both AIDS and STIs, While 73% said that HIV / AIDS could be prevented if only screened blood was used when required.
Television was the next common source of information followed by newspaper/books and radio. Dada revealed that awareness was high; high school students had several misconceptions and insufficient in-depth knowledge on HIV/STIs. These lacunae need to be addressed through proper educational programs.

Training Teacher to Educate adolescents

The success of sexual health programs for in-school/adolescents and young adults depends on orienting a group of dedicated teacher's who care sensitive to the need of this target population and who can disseminate relevant information objectively. Because of the extremely sensitive nature of the issues involved, training teacher becomes an important component of prevention programs aimed at changing attitude and behavior (Bhatt, 1998: p 5-6).

S.D. Bhatt report of the experiences of 195 teachers and 10 NGO staff that underwent training in imparting information on HIV/AIDS to secondary students in the state of Uttaranchal. The focus group methodology was employed. Discussions were triggered from of a numbers of open-ended key questions pertaining to knowledge, attitudes, beliefs and practices, including among others, why AIDS was a special case deserving attention from everyone, what specifies on HIV infected person ought to know; why in this region, including in India, youth preponderate among newly infected people and what sex had meant to individual participants before and after the training. Other questions
focused on why HIV/AIDS prevention was more effective when tailored to adolescents, on understanding the sexual behavior patterns most prevalent among young people could overcome negative peer pressures and how youth could translate HIV/AIDS related knowledge into effective behavioral practices. At the end of the discussions, observers asked participants individually if they had any additional comments relevant to specific tools used. Another innovative approach included slogan-writing, poster and chart competitions, debates and drama competitions.

An analysis of the discussions showed that teachers had gained the trust and confidence of their pupils and they were no longer embarrassed about dealing with sensitive topics. To be able to build good rapport with their students and overcome a deep-rooted taboo on discussing sexuality with students in co-educational schools was itself an achievement. This encouraging development indicated that there was a high possibility that the teacher's advice would be accepted and results in the desired change in behavior.

Teachers have to be trained to confront their own attitudes towards HIV/AIDS and to people living with the disease. They have to feel comfortable with related issues and need to be highly motivated to put in the extra effort required to meet this social challenge effectively.
A sociological study of "Delhi teacher's attitude awareness and commitments, awareness and comments towards AIDS and STDs by Avimanyu panda (2003)

Youth in India contributes about 40% of the population. Impart of HIV / AIDS/STD's on youth through the period of adolescence where the most youth, especially students affected in a situation where these diseases are spreading through hetero sexual activities. Children especially adolescent students are at a high risk of contracting AIDS virus from different sources. Adolescent is a period between the age group of 12-19 years of age. During this period most of the adolescent are studying in class IX-XII. It seems unethical to deny young people information on AIDS/STDs/HIV prevention that may save their lives. Yet most students have to still go through their school year without meeting a caring adult who discusses sexual health with them. Their knowledge to seek to understand and explore relevant facts and strategies, in the field of HIV / STDs/ AIDS in infection is important to be explored. This needed from the communities of family sources. Adolescence students needs have to be addressed on several levels i.e., physical, psychological, medical and through education in a society.

Objective was to study the school teacher's knowledge of causes of transmission, infection and to measures attitude of school teachers towards AIDS and STDs education.

Materials and Methods: Initially 500 school teachers were contacted who are teaching science (biology) social studies and languages but the matter of
fact is that only few teachers agreed and gave their views to come before the interview by the researcher A total of 98 school teachers teaching in class IX-XII in the secondary and senior secondary schools of Delhi and 144 secondary and senior secondary school students (from class IX to XII) are constituted in the study sample. The teachers included in this study are randomly selected which indeed male and female married and unmarried urban and semi urban school teachers. Teachers teaching science (Biology), social studies, and languages have been repeatedly interviewed after taking permission from the respective school teaching heads. The study is conducted by social survey method in form of interview and the following aspects of data have been collected from the teachers as well as the students. Source of information on AIDS, when learnt about these diseases, Understanding how AIDS/ STDs are contracted, The cure and preventive measure available for HIV / AIDS/STDs, Teachers attitude towards sex, sex education teach about it and how, Facilities/teaching aids/encouragement available in their and AIDS/STDs/HIV education in open class room teaching, How much do they respective schools VIII Difficulties and problems faced by them.

Results: 1. this study revealed that the Indian school teachers although much aware of AIDS and my; but there exist a tremendous form of misconception regarding Sexual Transmitted Diseases, transmission and prevention of AIDS/STDs/HIV.
2. The adolescent students especially studying in rural or semi urban schools have a limited awareness, and knowledge of transmission and prevention about AIDS/HIV or other STDs.

3. A negative commitment of secondary and senior secondary school teachers in class-room teaching learning program/within the prescribed syllabus in their respective curriculum, especially at secondary (class IX to X) school level resulted in the poor reproductive knowledge among the adolescent student.

4. Partially/poor teaching of male and female reproductive system in the biology/science subject in open class room system has directly cast a stigma on the sex morality with rigid cultural heritage among the secondary and senior secondary school teachers of present Indian society leading various misconceptions on reproductive health knowledge and care among the adolescent school students in their personal and future married life.

5. The attitude of the school students for the better knowledge on STDs/ AIDS/HIV is a better indication towards the prevalent of STDs/ AIDS/HIV which probably need students-teachers interactions in an open classroom set up with free and frank mind from both ends in India.

Discussion: National AIDS Control programs are still too narrowly conceived as government or official programs rather than as combining the efforts of central government, state governmental organizations, and the private sectors. Looking towards the result of this study Indian teacher are not prepared
to share the challenge and not prepared to take this task because the teachers are bounded with traditions and taboos and are also embarrassed to discuss sex related issues with their students which include their socio-economic status and stability in the present Indian society.

3.5 Peer education /intervention approach:

Research consistently indicates that positive sexual health outcomes are most likely to occur when sexual health education effectively integrates knowledge, motivation, skill-building opportunities, and environmental support for sexual health.

There is a gap between knowledge and practice. Project experience confirms that young people are able and willing to learn both knowledge and life skills, and to share them with their peers. Peer education has been increasingly recognized as an effective tool to bring about positive change in attitudes, beliefs and behaviour. It also examines key elements that contribute to the success of peer education programmes.

Young People – Partners in HIV / AIDS Prevention is intended as a contribution to building a common understanding of life-skills and peer education approaches among policy makers, programme managers, youth trainers and youth workers, who are in a position to support young people in their life skills development for HIV / AIDS prevention.
Case studies from Bangladesh, China, India, Nepal and Thailand underscore young people's effectiveness as peer educators, be they former drug users, trishaw drivers or students.

HIV / AIDS and violence: Adolescence is a period in which rehearsal of intimate relationships begins and thus, it is an ideal time to challenge common notion of gender norms, violence, sexual behavior and reproductive health. Heidi Lary (2004:14).

A study by Heidi Lary, Suzanne, Jessie (2003) in the capital Dar es Salaam, has revealed a clear relationship between violence against women, and the ever-increasing HIV rates among women. The formative project was designed to develop an understanding of adolescent sexual relationships and to provide the foundation for developing an intervention targeting young men. The ultimate goal of the program is to enable adolescent to negotiate safer sexual relationship, by working with young men to change their attitude and behaviors related to sexual health and the use of violence against women. First, the project aims to reduce adolescent male' HIV-risk behaviors, which will in turn keep young women safer from HIV risk. Second it aims to change attitudes that condone the use of violence in youth partnerships. Qualitative data was collected about young people's attitudes and behaviors concerning sex, violence, and gender. The data consisted of 60 in-depth interviews and eleven focus group discussion among young men and women aged 14-24 years. The
youth were recruited by purposive and snowball-sampling approaches from venues in the community frequently by youth.

The formative research revels that power dynamics in youth relationship are complicated and crosscutting. The two main area in which men exerts power and control their female partners are linked to social expectation of gender roles, and to economic issues inherent in young dating relationships. Knowledge of HIV, its routes of transmission, ways of prevention and effects is very high among these young. However, there are many gaps in their knowledge. For instance, many youth claim they do use condom, but are not aware of the specifics of correct and consistent use. Peer health support is effective tool for HIV prevention particularly among adolescents.

Intervention through Peer-based Approach-A Lesson from Sonagachi

Smarajit Jana (1999,2:58-63) Realizing the vulnerability to HIV and epidemiological importance of core groups, a baseline survey was carried out in Sonagachi area in 1992 by the All India Institute of Hygiene and Public Health. The study was planned to identify issues of social demography, behavioral practices and prevalence of STIs and HIV amongst sex worker and behavioral practices of their clients. The STDs/HIV intervention programme was launched in Sonagachi is one the oldest and largest red-light area in Calcutta. At that time, HIV intervention programme amongst 'at risk' categories were based on various behavior change model such as information-motivation-behavioral skill
model (IMB). The sex workers lacked peer support to adopt the safer sex practices, communication skill and empowerment. Sonagachi is one of the oldest and largest red light areas in Calcutta. The success of the project leads to undertaking a rapid assessment of sex-trade by situational analysis of different red-light areas of West-Bengal. The concept of ‘Peer educators were introduced in community and the project staff. The peer educators were recruited from among the sex worker.

This project was successful, not only in controlling the rising trend of HIV infection and prevalence of STDs. The rise in HIV prevalence rates in Calcutta is lower compared to other places. Effective advocacy and empowerment has resulted in social mobilization. Community participation is the key for long term sustainability. Effective intervention in the red light area is important in control of HIV infection.

HIV / AIDS and Children in the Sangli District

Study by Ravi K. Verma, S. Sailil and others (2002) In order to assess the impact of an adult HIV / AIDS-related death on the household in general and children in particular, a comparative study of the three types of households was undertaken in Sangli district of Maharashtra. A total of 118 households with an HIV / AIDS death, 100 households with a non-HIV / AIDS related death and 100 households with no deaths were included in the survey. A significant negative impact on the economy of households where an active adult has died due to
HIV / AIDS was clearly evident from the responses. Households with HIV / AIDS deaths have reported reduced savings during the period of observation, reduced expenditures on consumer durable items, and disposal of assets in order to raise or supplement income. On social front they have reportedly experienced discriminations and few of them have had to send their children away to distant relatives, and withdraw children from school. Adult deaths due to HIV / AIDS also impacted negatively upon children's ability to access both health and education. While the members of the extended family provide orphans with the shelter, it is obvious that several of these children do not receive continued education and health care when needed.

The impact on both households and children is much more negative in case of those which are socially and economically disadvantaged. The negative attitude towards people with HIV / AIDS was found to be quite widespread. People living with HIV / AIDS spent huge amount of money to get cure. This study clearly points out towards a need of a comprehensive response to HIV / AIDS which includes efforts to reduce stigma and discrimination at all levels; developing supportive network system for the women and the orphans; and more specifically preparing families to provide for children in the eventuality of death of either the parents or one of the parents.
Work place intervention:

The interlinked trio of Industrialization- Urbanization- Migration leads to a number of phenomena that increases the risk of an individual to be afflicted with sexually transmitted diseases including HIV / AIDS. Work place intervention helps to minimize the impact of HIV / AIDS, particularly among the productive and sexually active population in the industries. Avert society identified workplace place intervention as a theme to strengthen and expand the response of the business coalition. The primary objective of the study to identify the extend of risk pertaining to HIV / AIDS amongst the workforce in the industries and to understands the extent of awareness about HIV / AIDS. Two sample segments namely workers and management in the workplace were interviewed.

A vast majority of the workers were young, below 35 years of age. About 80% of the male and female workforce was in the age group of 18- 35 years most of worker did not have proper accommodation to reside in. More than half the worker both men and women were 19-25 years old when they first had sex. Most all (93%) of them male and over ¾ of the female had heard of HIV. Half of the male worker indicated that sex with sex worker and without condom, could cause AIDS. A large proportion of industries expressed their willingness to take up workplace intervention.

Rao and others (1994) study near Calcutta on 100 truck drivers and their helpers show that 39% had never heard about AIDS, a few (13%) knew that AIDS has no cure and 63% who had heard about AIDS are aware that AIDS
could be transmitted through sexual relations. Another study in Delhi (Singh et. al., 1992), presented that only 20% had heard of HIV/ AIDS and only a quarter of them knew that HIV could be transmitted through sexual intercourse. 78% admitted to being hetero-sexually promiscuous.

According to Iswar Gilada, of Indian Health Organization, Over 60% of the truck drivers are suspected carriers of HIV. In all 64% had very little knowledge about AIDS, while 24% are totally ignorant.

**HIV / AIDS among rural population**

The report published is CARC Calling in 1989 and 1990 on sero-surveillance for HIV infection are definite indicate that the AIDS has gained a foot hold in India. Trends in seropositivity among heterosexuality promiscuous population and intra-venous drug abuser are disturbing and are a definite indicator that unless appropriate preventive measures are taken the disease will spread. It is also true that education of masses regarding AIDS, its mode of spread and preventive measures is the only way to prevent the spread of the disease. Controlling the spread of HIV infection is a very important task facing the Government of India. Efforts are made being made to educate masses through television, radio, posters and other printed material.

Objective: To provide education to the society on information, prevention and counseling on AIDS through 'Community AIDS-awareness Programme' (CAP).

Methods: To create awareness through information systems and prevention methods to the Society. In high schools and colleges through mass media, holding of seminars, formation of groups, organizing talks, discussions, expert speeches, slides, distribution of educative literature etc. In urban and rural areas arranging public meetings, audio, video shows, films, playlets, dramas, folk dances, skits and music mixed with AIDS information etc. Promoting the suspected persons to go for HIV screening and counseling the affected.

Results: AIDS-awareness campaigns in high schools, colleges, urban and rural areas of Chittoor district last year. All were enthusiastic and full of questions. They required follow-up talks on health and sex education. The suspected persons willingly coming forward for HIV screening. We detected 40 'ELISA' positive cases out of 400 screened. Finally confirmed 38 cases with 'Western blot' positive and counselled the needed action.

Discussion and conclusion: The spreading of AIDS is mainly due to unnecessary panic in urban and unawareness in rural community. Hence it is an emergency to provide AIDS awareness to the community through information, education and communication (IEC).
A study on “AIDS Awareness in Rural Community” was conducted by the Department of Preventive and Social Medicine, Rural Medical College of Pravara, Medical Trust Loni, Ahmednagar with the help of US Aid in 1992-93. The survey was conducted in 20 villages and covered 50 houses, each using random sample thus covering 1000 respondents. A total of 712 males (71.2 percent) and 288 females (28.8 percent) above 16 years of age were interviewed for AIDS awareness. Among the 34.5 percent illiterate respondents, as many as 17.4 percent were found to be aware of AIDS while among the literate 52.2 percent were found to be aware of the AIDS In all 29.4 percent respondents reported that they acquired knowledge about AIDS through television and radio, while 6.5 percent came to know about it from doctors and 4.1 percent from the nurses, while 94.4 percent respondents did not know anything about the signs and symptoms of AIDS, 77.1 percent showed ignorance about any preventive measures.

C.S.Chuttani, P.Gupta,(1998:20)the study was undertaken to find out the degree of awareness and knowledge among men and women living in rural areas in order to assess the impact of the audio-visual media used for AIDS education.

Method- The survey was carried out in three villages of Delhi and two villages of Haryana. Adult men (699) and women (829) in the age of 15-50 years were interviewed. Information was collected regarding their educational level, marital status, their level of awareness and knowledge about AIDS, its mode of
spread, symptoms and preventive measures, and various sources of information from which they acquired the knowledge about AIDS.

Results- Only 56.2% men and 13.6% women were aware of AIDS. The awareness among women was significantly lower than men. There was a direct correlation between awareness of the disease and level of literacy. With rise of literacy status there was increased level of awareness also. More than 50% of the women populations were absolutely illiterate and awareness was just 2.3% among them. Even among the literate women up to high school level the awareness was between 8.6 to 38.7% as compared to men among whom the awareness was between 30 to 67.7 percent. Both men and women with higher educational status had high awareness.

There were multiple responses on the account of source of information: Newspapers, magazines, formed the main source of information among 72.8% of men and 89.8% of women who were aware of this disease. Television formed one of the sources of information only in 8% of men and 54% of women; friends and relatives were important source of information in 63% of men and 38% of women.

The survey shows that the awareness of AIDS among sexually active men and women in rural areas is very poor even in villages around capital city of Delhi. It is likely to be far worse in remote villages of other states with much lower literacy levels even those are aware of the disease, the knowledge about its modes of spread, incurability and preventive measures is lacking.
Direct correlation of awareness and knowledge to literacy level is very significant. Unfortunately the literacy level in the country is so low that we have chosen other methods to educate masses regarding the diseases among each other. The audio-visual media like television and radio can play an important role in spreading the awareness and correct knowledge about this disease, only people have easy access to this media and also have time to listen to these programmes. The timings for programmes will have to be adjusted accordingly and the massage should be clearly stated.

In an illiterate and poor society far more efforts will have to be made by the health workers, voluntary organizations, and school and college teachers to make people aware of this disease and its seriousness through direct talks and person to person communication. Government and other agencies have to make serious efforts to prevent this epidemic before it is too late.

Srivastava and others (1992:22-23) randomly selected 182 teachers from a rural area of Lucknow district to assess their awareness and knowledge about AIDS 79.70% was aware about AIDS. Awareness was more 89.60% in the graduates than undergraduates (60.00%). Newspapers (60.00%) formed the main source of information followed by television (30.00%). 68.30% knew about sexual transmission and 25.50% knew blood to be the mode of transmission 6.20% responded that AIDS was mosquito borne, 2.00% believed condom usage makes sex safer.
Tanjua Raut and others (1995) conducted a cross sectional survey in an urban slum to assess the AIDS awareness amongst housewives and to study the source of information and knowledge about AIDS. Out of 293 housewives 51.20% had not even heard about AIDS. Awareness was more in the age group of 20 – 40 years and among those who were literate. It was observed that main source of knowledge was television and still misunderstanding about AIDS e.g. vaccination medication etc. was prevailing.

Balaganesh G. and others (1996) did a cross sectional study among 100 males and 100 females aged between 15-45 years in a rural South Indian community. Among literates, 64.20% educated up to primary and secondary level and 92.30% beyond secondary school were about AIDS. It was observed that 52.98% of literates 2.23% of illiterate attributed transmission by infected blood transfusion. 49% of the respondents felt that prostitute's spread the disease. None of the literates knew about use of condom in prevention. Where as 19.40% of literates knew about safety offered by condom. 25% of women knew that Aids is not a curable disease. It had been found that 31.34% of respondents gained knowledge either News or Doordarshan. The recommended that government health sector should take more responsibility in educating the people and creating awareness on AIDS. Non government agencies should involve themselves in creating awareness on AIDS.

A survey conducted by Gupta and Kushawah (1997) among 144 individuals from varied sections of society to assess their level of knowledge and
attitude about HIV / AIDS revealed that 94.40% of respondents had heard of HIV, 96% males and 98% females believed in safe sex and only 26.90% opine the use of condom as the method of prevention.

Health Personnel awareness

A study conducted among health care professionals by M.Dobe (1995) revealed that the knowledge about natural history of the disease was relatively poor. Misconceptions regarding modes of transmission were prevalent among majority of paramedical personnel.

Kubde and others (1995) studied 204 nursing students and it showed 80.90% knew AIDS is a life threatening disease. 63.70% have quoted spread by sexual, 88.2% knew perinatal transmission, and 61.8% knew that use of condom for prevention. 38.8% had wrongly stated that there was vaccine against AIDS 25 students did not know the etiology while 69% accepted correctly about viral etiology. About 55% had believed AIDS to be not a problem of India.

In study conducted among ICDS functionaries by Ray S K and others (1994 – 95) pre assessment and post assessment were done before and after one day awareness program in a rural and urban area in West Bengal. Pre assessment score was more in urban areas where there was access to media support like Television and posters. Awareness on modes of transmission and prevention showed poor scores in both urban and rural area. There was a
significant improvement in the post assessment score in all the knowledge components (>90.00%) in both the groups.

Similar study is conducted by Bhattacharya (1994) Anganwadi workers and factory laborers. Findings were anganwadi workers better informed than factory workers. Modes of transmission other than sexual route was poor. Information on testing and treatment not known. Source of information were TV/Radio followed by partners, colleagues and neighbors. Primary health care workers were poor. Misconceptions were present and poor on HIV related health education (Garg, Behl, 1993).

Bansal Srivastava(1994) and Chowdary (1997) study on understanding and responses by general practitioners, Indigenous medical practitioners and RMP in central India, shows general practitioners had poor information on signs and symptoms, epidemiological information, MTCT treatment, vulnerability and risk factors.

The Information sources for medical practitioners studied continue to be no different from general populace and that the misconceptions or knowledge gaps carry similar trends. Gaining knowledge from scientific journals and sources of literature did not emerge to be very strong. This becomes significant as more often than not, they educate the public and those tested positive for infection. This knowledge gap also extends to information on social vulnerability and risk factors. The increased fear of being at risk due to profession, leads to
lack of openness in treating the people living with HIV / AIDS and attitude towards them.

3.6 Women and HIV infection in India

Worldwide, some 60% of HIV positive youth are young women and an estimated 57% of the daily infections are among young women and girls. Recent studied show that adolescent girls are three times more likely to be infected with HIV than boys the same age. Young's vulnerability is both physiological and social. Physiological factors account for the more efficient transmission of HIV infection, the socio-cultural norms around gender, age, femininity and masculinity, which restrict young women and girl's access to knowledge, skills, and opportunities to protect themselves from the affects of HIV and AIDS. (Sanyukta Mathur and Geeta Rao Gupta, 2004:p 1-4)

Findings in National Family Health Survey2002 revels that many women lack knowledge of AIDS. About 61 % of women in Maharashtra have heard women with knowledge of AIDS, much higher than the national level 100 of 40 percent. However, 2 out of every 5 women 75 have no knowledge of AIDS. Women in urban areas (81 percent) have heard of AIDS compared to 47 % in rural areas. Many women lack knowledge of AIDS. Television is by far the most import and source of sources of information about AIDS with about 3/4th of 100 77 women receiving information from that source 75. Other sources are friends, relatives (33%), newspapers, magazines (23 %) and radio (22 %).Only 7 % of
women report receiving information about AIDS from a health worker. One third of women who have heard of AIDS do not know any way to avoid infection. Among women who report that something can be done to prevent AIDS, the most common ways mentioned are having only one sex partner (38 percent) and avoiding sex with commercial sex workers (33 percent). Only 20 percent reported that condoms could prevent AIDS.

Study of knowledge, perception and attitude of adolescent girls towards STIs/HIV, safer sex and sex education: (a cross sectional survey of urban adolescent school girls in South Delhi). The aim of the study was to evaluate adolescent school girls' knowledge, perceptions and attitudes towards STIs/HIV and safer sex practice and sex education and to explore their current sexual behaviour in India.

A cross sectional study was carried out in 2005 in South Delhi, India to investigate the perception, knowledge and attitude of adolescent urban school girls towards sexually transmitted Infections (STIs), HIV / AIDS, safer sex practice and sex education. The self-administered questionnaire was completed by 251 female students from two senior secondary schools.

More than one third of students in this study had no accurate understanding about the signs and symptoms of STIs other than HIV / AIDS. About 30% of respondents considered HIV / AIDS could be cured, 49% felt that condoms should not be available to youth, 41% were confused about whether the contraceptive pill could protect against HIV infection and 32% thought it
should only be taken by married women. Though controversial, there is an immense need to implement gender-based sex education regarding STIs, safe sex options and contraceptives in schools in India.

**Norms of femininity**

Norms about female behavior greatly influence the access of young women to information and service and the possibility they have to protect themselves from abusive and risky relationships. Ignorance about sex, reproductive anatomy, and HIV prevention increases young girl's vulnerability to HIV infection or even possible for them to reduce their HIV risk. Studies have shown that lack of knowledge makes it difficult for women to be proactive in negotiating safer sex. Further, the virginity ideal can pressure girls into risky behavior both knowingly and unknowingly.

Marriage and mother- Along with the ideals of virginity and purity, million of girls in the developing world are married early (before the age of 18 years), and as a result are denied schooling, good health economic opportunities, and friendship with peers. Recent data shows that married adolescent girls tend to have higher rates of HIV infection than their sexually active unmarried peers.

Motherhood is another powerful feminine ideal that puts them at risk. Bearing children is critical and in many cases the only way for young married women to secure their social identity, marriage, and status in the household. Related to motherhood ideal is the common norm that girls are responsible for
the family's well-being. As a care giver this norms places the greater burden of the effect of HIV / AIDS on young women and girls.

Various studies in the late 1980, and early 1990, have revealed that HIV / AIDS is increasingly affecting the poor women who by reasons of their socio economic dependency are unable to take step to protect themselves against the risk of infection factors such as low level of education and literacy, lack of access to adequate medical care, the low status of women and the corresponding powerlessness to control the basis upon which their sexual relationship with men take place, increase the risk. In India apart from targeting commercial sex worker, there is a total lack of focus on women in the context of HIV infection.

Women are considered to be ‘reservoir ’ of the disease, as' vector' of transmission to their children and male sexual partner rather than individual who are themselves infected or are at risk of HIV infection .They are in urgent need of information education to protect themselves.

Hence issue of women and HIV needs to be placed in a border social and cultural context. Women's vulnerability to HIV is enhanced by the inequalities and discrimination they face in the society all these factor combine to increase women's vulnerability and abstract any effective prevention campaign. There is necessity to understand the interaction between HIV infection and cultural values, the rights and needs of women and socioeconomic pattern in the society which render women vulnerable to HIV infection.
Recent UNAIDS sponsored research in India and Uganda shows that women with HIV / AIDS may be doubly stigmatized both as women and as people living with HIV / AIDS. When their identity becomes known, like Black people themselves stigmatized as both Infected and Black. (WHO, UNAIDS 2002).

Studies in Africa indicate that young married women are at higher risk of HIV infection than their unmarred peers. Violence against women and girls severally undermine their power to negotiate safer sex, destroy their self confidence and increase their chance of getting HIV /STIs. It is estimated that four million women are coerced into marriage and trafficked into slavery or prostitution. Half of all victims of sexual abuse are under the age of 15 years. Mother-to-child transmission of HIV remains public health problem worldwide, and spreading rapidly in India. Child bearing is considered essential for women and accorded a high priority in our society.

A study to assess the knowledge of HIV positive mother about the transmission of HIV from mother to child. Study Shows most of mothers did not know about their own HIV status, few were know that they are HIV, but not awareness the seriousness of the disease. Study gives an idea that whether they were detected to be HIV positive before conception they would have decided to have a baby. So number of HIV positive children can be reduced.

Evidence from 13 states, Deborah Balk and Subrata Lahiri (1997:421-465), Program on population, East – West centre, Honolulu, by International
Institute for Population sciences, Mumbai shows that: Over 30,000 ever married women in (out of 25) Indian states where HIV is thought to be highly prevalent – Maharashtra, West Bengal, Tamil Nadu, and ten other less populous states – were surveyed about their awareness and knowledge of AIDS. Only one in six women had heard of AIDS. Among those, knowledge about transmission and prevention is poor. Multivariate analyses reveal that rural, poorly educated and poor women are the least likely to be AIDS aware and if aware, have the poorest understanding of the syndrome. Despite low levels of awareness and knowledge, it is found that a strong positive association between AIDS awareness and knowledge and condom use.

In the 13 Indian states where questions about were included in the National family Health Survey (NFHS) questionnaire, only one in six ever married women had heard of AIDS. This multivariate analysis has revealed that educated, wealthier, and urban women were much more likely than other women to be AIDS aware. Women exposed to any form of mass media (television, radio, film) were also more likely to be aware of AIDS. Women in the northeastern states, except Assam and Tripura were likely to be AIDS aware. Other things being equal pornographic factors, for the most part were not important predictors of AIDS awareness.

Among AIDS – aware women, the level of knowledge was low. Only 30 percent of AIDS – aware women gave correct answers to more than half of the possibly answers, and only one percent could answer 75 percent correctly.
Although schooling and wealth were also important determinants of AIDS knowledge, the effects are observable only at high levels of schooling and wealth. For example, any formal education appears to enhance significantly. The odds that a woman is aware of AIDS out she needs at least a high school education to have a significantly greater understanding of town dwellers is worse than that of village dwellers, other things being equal. All working women, except agricultural laborers, had a greater understanding of AIDS. This was especially the case for women working in professional, managerial or clerical occupations. Women in Nagaland and Goa had best overall knowledge about AIDS and women in Tami Nadu and Delhi had less AIDS knowledge, based on summary indices, than women in Maharashtra the reference state, women from the other states in the sample had more general knowledge (than Maharashtra women) but less knowledge about false transmission. This is taken as evidence that women in the states which were reported to have first established AIDS control and education programmes. Maharashtra, Manipur, Nagaland, and Tamil Nadu were not uniformly more likely than women in other states to be knowledgeable about AIDS. The more sources of AIDS - specific information - women had, the greater was her knowledge about AIDS. The most common sources of AIDS information, television, radio and print media, were those that are readily available to women who are wealthier, urban and liberal. Nevertheless, the vast majority of television viewers and radio listeners were unaware about AIDS.
Despite the very low levels of awareness and knowledge of AIDS in India, study finds a strong association between women’s ever having used condoms and her AIDS awareness and knowledge. This study has looked at what Indian women know about AIDS, but it has not been able to make comparisons between Indian women and men. Many assume that Indian women’s lower status in relation to men will place them at greater risk of contracting HIV and even if they are fully informed, inhibit their ability to protect themselves. This in all its complexity need to be explored.

Shanmuganatham and Samarajalingam (1992) found that there was a high degree of awareness among working (71.00%) women compared to household women. AIDS awareness was considerably noticed to be higher on AIDS origin rather than preventive aspects particularly among household women. Adolescent women (43.00%) were exposed to the awareness of the risks of AIDS. They concluded through this study that there is a need to tune special health education measures of AIDS suitable particular for women and also campaign for household women with the help of the voluntary agencies and social clubs.

Chattenee Nilesh (1994:35) randomly interviewed 350 married women in Greater Bombay to assess the knowledge and attitudes on HIV / AIDS and found 67.00% had heard of AIDS and 71.00% had obtained information from television. For those who knew about AIDS years of education and media exposure were significant predictors. The education of women has been
confirmed throughout the study as a very important variable in awareness and knowledge about AIDS. The study recommended that there is a definite need for increased educational and awareness campaign especially among the hard to reach married women population of urban.

Chatterji (1994:32) in his study on married women observed that the low social; and economic status of women in India and their subservient roles do not provide autonomy to exercise their opinion on sexual behavior. Migrant worker in industrial area where the prevalence of HIV was high observed that sex and drinking were diversionary activities easily available with poor living and working condition. Important of condom usages were not perceived necessary despite fair knowledge level and women lacked ability to negotiate.

National family health survey was conducted in 1995 in New Delhi. In this survey it was found that only 36.00% of the women interview had heard of the disease despite relatively high literacy rates and an extensive media campaign.

3.7 Stigma, Discrimination and Human rights

AIDS-related stigma refers to the prejudice and discrimination directed at people living with HIV / AIDS (PLWHA), and the groups and communities that they are associated with. It can result in people living with HIV / AIDS being rejected from their community, shunned, discriminated against or even physically hurt.
AIDS stigma and discrimination have been seen all over the world, although they manifest themselves differently between countries, communities, religious groups and individuals. They are often seen alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be associated with behaviours often considered socially unacceptable such as prostitution or drug use.

Stigma directed at PLWHA not only makes it more difficult for people trying to come to terms with and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. Fear of contagion coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV / AIDS.

Factors that contribute to HIV / AIDS-related stigma:

- HIV / AIDS is a life-threatening disease.
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies.
- Most people become infected with HIV through sex. Sexually transmitted diseases are always highly stigmatised.
- There is a lot of inaccurate information about how HIV is transmitted.
- HIV infection is often thought to be the result of personal irresponsibility.
• Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

From early in the AIDS epidemic a series of powerful images were used that reinforced and legitimised stigmatisation.

• HIV / AIDS as punishment (e.g. for immoral behaviour)
• HIV / AIDS as a crime (e.g. in relation to innocent and guilty victims)
• HIV / AIDS as war (e.g. in relation to a virus which must be fought)
• HIV / AIDS as horror (e.g. in which infected people are demonised and feared)
• HIV / AIDS as otherness (in which the disease is an affliction of those set apart)

Negative responses and attitude towards people living with HIV /AIDS are strongly linked to general levels of knowledge about AIDS and HIV, and in particular to the causes and routes of HIV transmission. In most societies, AIDS is associated with groups whose social and sexual behaviour does not meet with public approval. In the study by Ambati and Rao (1997), 60 % of respondents believed that only gay men, prostitutes and drug users can get AIDS.
Studies have documented HIV / AIDS related Discrimination, Stigma and denial in contexts such as the family, community, the health care system and work place. Discriminatory restrictions have also been reported in relation to travel, migration, insurance and health benefits.

In most developing countries, families and community are generally supportive setting for illness and management and treatment (Bharat, 1999). Negative responses are particularly evident in the case of HIV positive women. Form of discrimination against women with HIV included being refused shelter, being denied a share of household properties, being denied access to treatment and care, and being blamed for a husband's HIV diagnosis, especially when the diagnosis made soon after marriage.

Family responses to infected relatives are heavily influenced by community perceptions of the disease. Families that include an individual with HIV may fear isolation and ostracism within the community. Consequently, they may try to conceal HIV diagnosis because most of people living with HIV in India maintain secrecy; the epidemic is not socially visible.

HIV / AIDS threaten not only heath and life of millions of people but it also threatens individual dignity, autonomy and human rights. The spread of HIV illustrates how the disadvantaged in our society are particularly vulnerable to infection and how those infected must bear not only the burden of the disease but also the burden of discrimination based on their HIV status.
Every individual is equal in dignity and rights including the right to life, health and non-discrimination secondly, every individual and every social and political institution must engage in rational and responsible behavior. Thirdly, the response to HIV / AIDS must be in a "spirit of brotherhood"

Discrimination, stigmatization and the related loss of human rights increase vulnerability to HIV infection and AIDS in several ways. Once infected, individuals and those associated with them including their children, spouses and other family members, friends and associates face further discrimination, denial of human rights and stigmatization.

HIV-related stigma and resulting discrimination is a key barrier to all HIV activities from prevention to care and treatment. A study investing the causes, manifestations and consequences of HIV-related stigma in Ethiopia, Tanzania and Zambia unraveled the complexities of stigma and was used to develop interventions. Key reasons for why stigma persists are a lack of in-depth knowledge, which allows fear of casual transmission to endure, strong norms about "improper" and "proper" sex and its association with HIV, and a lack of recognition of stigmatizing attitude and behavior.

Stigma and discrimination have had a negative impact on the responses to HIV / AIDS in South Africa. People living with HIV / AIDS are left to struggle with emotional devastation, anger, denial, self-blame, withdrawal, and the need for disclosure.
People Living with HIV / AIDS

Millions of men, women and children are living with HIV today. People living with HIV often understand each other's situation better than anyone else and are well placed to educate, counsel and advise one another. Around the world wherever HIV is present people living with HIV have established support, advocacy groups and networks. Increasingly members of these groups are called on to participate in decision and policy making forums.

Since AIDS emerged, people living with HIV have been a key driving force in the AIDS response and few of the advances made in the last 25 years would have happened without the tremendous efforts, expertise and advocacy of people living with HIV and affected communities. With appropriate support, people living with HIV can and must take a central role in their own country, region, or locality in the direction and delivery of AIDS programmes. Their involvement gives personal power and immediacy to AIDS efforts, improves the relevance of programmes and inspires others into action.

Tackling the stigma and discrimination experienced by many people living with HIV and affected communities is also fundamental to creating the kind of environment where people living with HIV can contribute in a meaningful way.

To ensure the greater and meaningful involvement of people living with HIV in the AIDS response, UNAIDS works closely with key networks of people living with HIV. They include the Global Network of People Living with HIV / AIDS (GNP+), the International Community of Women living with HIV / AIDS
(ICW) and the International Treatment Preparedness Coalition (ITPC). Work with all organizations is currently focused on the urgent need secure increased active participation of people living with HIV in the key global and national forums. People living with HIV have been at the forefront of advocating for universal access to treatment. Ensuring people living with HIV have universal access to treatment, along with appropriate prevention and care services, must go hand in hand with the efforts described above.

A Needs Assessment Study of People Living with HIV / AIDS

The study is based on the necessity to listen to the voices of people living with HIV / AIDS (PLHIV) to create a truly national network. The study, initiated in May, 1999, was held in New Delhi, Mumbai, Bangaluru and Imphal covering over 100 respondents from the PLHIV. The study has covered the whole gamut of the life of PLHIV with an emphasis on care and support, discrimination and access to information.

The study highlights the intensity of stigma and discrimination faced by the PLHIV in India Societal aversion towards PLHIV, partly manifest in moral or fear based HIV prevention campaigns and a persuasive social environment has driven the epidemic underground, making it harder to tackle. As the social acceptance of people living with HIV and the visibility of the epidemic are interlinked, messages giving proper and accurate information to promote an enabling social environment for PLHIV AND sensitive prevention and care.
programs are required to encourage PLHIV to live openly and with dignity. Groups/ networks of people living with HIV should be supported to give visibility to the epidemic.

Vaishali Sharma, Mahendra. (2004:3-4) article reported that 90% of doctors in Tamil Nadu refuse to treat PLWHA. Research has shown that stigma and discrimination in hospital setting go beyond delay in treatment and denial of care to include unwarranted referral to other facilities, segregation on wards, labeling of patient’s beds and files, etc. In response to problem, the NACO and Horizons designed an intervention to response to hospital based stigma and discrimination, and monitored attitude and behavior changes among hospital managers and health worker before and intervention.

The project team first identified indicators and developed the “PLWHA-friendly checklist”, a self-assessment tool for hospital mangers to measure whether a hospital was free of stigma and discrimination. A baseline KAP survey was conducted among all levels of hospital staff to better understand stigma and discrimination towards PLWHA. Using this data and The PLWHA-friendly checklist, hospital managers developed action plans for strengthening policies, training, communications, and service delivery to reduce AIDS-related stigma and discrimination.

Effective reduction of stigma and discrimination in the health sector requires a partnership approach by government, private non-profit and research groups. In addition to attitude change, information, training and supplies and
hospital guidelines are equally important for reducing AIDS related stigma and discrimination by health worker, as many lack adequate knowledge and training in the basics of HIV transmission, infection control, and clinical management of HIV / AIDS. It is also essential to involve all levels of health workers, from ward staff to hospital superintendents, rather than simply trying to effect change from top down.

Russia has potentially massive HIV epidemic. People highly educated know little about HIV and have very negative attitude towards PLWHA. In this context pregnant HIV positive mother and newborn already vulnerable to discrimination on a considerable scale, have to make decision as to whether or not to keep their children. The care received during pregnancy to HIV mother is poor, and some time non-existent. Up to 20% of their children may be abandoned at birth, ending up either in specialized orphanages for HIV positive children or else in isolation in hospital ward.

Indian Network for people living with HIV / AIDS, year not mentioned studied 115 people living with HIV / AIDS contacted through state level network of INP+. Significant findings are they experienced indifference form hospital care providers. Discrimination from family, workplace and schools was reported. NGOs and PWA organizations were sources of support.

Discrimination and negative societal reactions has been observed in other sectors also. It has been documented that loss of employment, travel
restrictions and denial of school admission is other ways in which they have been discriminated and stigmatized.

Findings on family responses have been mixed. Evidence has also suggested that while family responses of the people living with AIDS are fairly positive, it based on the relationships between caretaker and caregiver. Bharat (1999) study significant findings are multiple sources of discrimination such as hospitals, work place, schools, childcare institutions, insurance companies and families. Marginalized groups doubly discriminated. Fear and prejudice emerged central themes in discrimination and stigmatization. Gender played and important role in mitigating the impact of stress.

Sonawat, Mathur (year not mentioned) studied 30 HIV positive individuals from a HIV clinic with a minimum one-month period after testing. Significant findings are Disclosure of positive status to family, spouse, relatives and peers was perceived to be a major threat due to fear of discrimination. While stigma has been described across genders, it has been documented that women experience greater negative effects. It has been mirrored through partners refusing testing when woman is tested positive, creating blocks in partner notification when man is tested positive and favoring men for acceptance, care and support over the woman. The repercussions of such desolate positions, the course of the illness and arrangement for survival expose a vast range of options for research.
Maitra, Sen Chakrabati, (2000) studied multiple group, using stakeholder workshop, focus group discussions, key informant interviews. Significant findings are positive women experienced discrimination and ostracization from doctors and neighborhoods. Women police, through low in knowledge indicated a non-discriminatory attitude towards people living with HIV / AIDS.

Khan (1994:108) Studied informal meetings, discussions, shared interviews, anecdotal research, communication exchanges, questionnaires participatory work 1200 South Asian men who have sex with men were studied. Significant findings are gay acceptance in south Asians lower compared to western counterparts. Desire to sustain their marriage lead to unattached emotional relations with other men. Sexual gratification by availability of sex, lack of support groups, lack of socially acceptable spaces for meeting other men were other issues in gays.

3.8 Socio-economic implications of HIV / AIDS

Infection with HIV and AIDS are urgent problems world-wide with social, cultural, economic, political and legal implications. The social impact of AIDS is linked to the selective loss of persons at a time when socially and economically they are highly productive. In many countries 20-40 years old men and women are the economic support not only of children but also of older person, for whom family may be the only form of social security. AIDS thus is a danger treat to family life. It also threatens free travel between countries and open international communication and exchange.
During the next years, AIDS will have a very selective and severe impact on mortality rates of young and middle aged adults in industrial and developing countries. It is likely that increases in child mortality due to HIV / AIDS will be more than the gains achieved over the past two decades by child survival programmes in many developing countries.

The economic consequences due to AIDS are most important in log run. The number of AIDS cases reported to WHO continues to rise rapidly. Providing health care to all these patients will further strain the countries resources. Data available show that in some African countries 80% of the hospital beds are filled with AIDS patients and AIDS would claim up to half of all national expenditure for health in some countries.

There is no doubt that direct cost of AIDS will be substantial, but the indirect cost of pandemic will be even much greater. There will be decrease in productivity of the workforce due to HIV infection. Millions of young adult's lives will be lost resulting in a dramatic loss of potential productive years to society. AIDS related sickness and death will affect the urban industrial sectors to begin with, but later the agriculture which remains the backbone of economy in many areas will likely to be affected. Eventually the entire socioeconomic system would be eroded resulting in tremendous negative effect on national development.

AIDS is a threat but through it we may realize the promise of health promotion and the potential of primary health care, so as to come close to the
dream of health for all. By now it is clear that control of AIDS is far away beyond the capacity of medical profession alone. One only has to remember that even, where there is an effective and simple treatment available for STIs, we have not succeeded in controlling them. STIs have their origin in the culture of the societies in which we live. Medical profession alone will accomplish nothing with the active cooperation and participation of the society and strong political commitment.

Young people are in the centre of a double jeopardy. On one hand, they live in a world of increasing poverty, low levels of education, and high levels of unemployment. On the other, 50 percent of all new HIV infections are in the age group of 15-24. Young people urgently need to be in the mainstream of economic and social opportunities to enable them to fight the consequences of their highly vulnerable and risky contexts. There are several ways in which youth unemployment and poverty lead to HIV infections. Many young men and women around the world are coerced into early sexual activity to earn money. In many circumstances, young people and/or their families may feel that they have no alternative. For young girls and women, economic dependence on men can lead to HIV exposure because they may not have the ability to negotiate safe sex.

A Study by Deshpande AP, Prakasam CP (Unpublished 2005) focuses on socio-economic implications of HIV / AIDS among college students in Mumbai. A sample of 143 students studying in second year of M.B.B.S, and 144 students studying in B. Ed in Mumbai, during 1994 is selected for the study.
Objectives of the study; it makes an attempt 1) To find out the Knowledge, Attitude, Behaviour and Prevention (KABP) towards AIDS among the respondents and also try to understand their KABP towards factors leading to exposure to HIV infection. 2) To examine the socio-economic characteristics of the students and their parents in relation to KABP towards AIDS and high risk factors leading to exposure to HIV infection. Statistical analysis was carried out for finding out relationship between the socioeconomic characteristics and HIV / AIDS in the study area.

Findings show that parents belonging to higher socio-economic strata can influence better awareness about the disease AIDS and its methods of prevention among the respondents. Among the seven background variables only three were observed to be significantly correlated with the knowledge of AIDS and attitude towards AIDS, one with the prevention towards AIDS, four with the sexually transmitted diseases, two with the intoxicating drugs and three with the homosexuality. Examination of the coefficient of variations indicates the heterogeneous understanding of KABP and high risk factors leading to exposure to HIV infection among the respondents. The study recommends the periodic assessment of knowledge among students and to develop appropriate health education program for youth and women, which is an essential activity towards HIV / AIDS control in community.

Even though there is no concrete connection between HIV /AIDS and poverty and poor health was interrelated (pandav ,Anand 1997) Illness had a
faster impact on poor rather than on the rich, as those in manual and unskilled jobs could not afford to take even a day off from work without loss of income. In addition, medical care incurred the highest expenditure (54%), the costs increasing with longer period of infection. The impact was higher on younger individuals, males, those with lower incomes, having at least one child and suffering from at least one illness. There were no specific government provisions to complement household economic loss.

Basu, Gupta, Krishna (1999) in their study found that only 21% had access to any kind of formal insurance, most of whom were likely to be from organized labor, economically better off, or could avail of relatively better measures provided by state or employers to meet the cost of illness. Presence of an extended family, where there was possibilities of pooling resources to meet the cost of illness or death was reported to be beneficial. Self-employed were better able to cope with events when there were other household members to substitute the incapacitated individual. When working women were infected, the family was greatly affected as her income formed an essential part of family income. Infection or death in women, working or otherwise, had a negative effect on finances and financial management in the house. In the event of disability or economic loss of productive members, women’s were restricted in entering the labor force, due to cultural and social inhibitions (Gupta 11997).
Burden on family caregivers of HIV / AIDS patients

A study conducted by Sr.Rosamma Abraham and Dr.O.C.Abraham. The purpose of the study was to determine the level of burden on family caregivers of HIV / AIDS patients and the relationship between the selected socio-demographic variables of the caregiver and the burden. It was found that the family members experienced severe burden in the areas such as social stigma(92.5%), effect of mental health on others(80%), financial burden, spiritual distress and disruption of routine family activities.(48.7%) Moderate burden was experienced in areas such as disruption of family interaction(66.2%) and subjective burden on others (53.8%). Mild burden was identified in areas such as effect of physical health on others(58.8%) and disruption of the family leisure(48.7%). The overall burden experienced by family caregivers was severe for 50% of the sample, moderate for 46.25% of the sample and mild for 3.57% of the sample.

Other relevant Foreign Studies

Di Clemente J Ralph and others conducted a study among the White, Black and Latino adolescents in San Francisco in May 1985 with a mean age of 16 years to assess the knowledge about the cause transmission and treatment of AIDS. The observations were as follows 68.30% of White adolescents correctly responded as AIDS is caused by a virus 92.80% felt AIDS is a life threatening disease. 94.70% believed transmission is by sexual contact,
93.00% thought receiving blood transfusion with infected blood transmits the disease, 91.50% said that the transmission by infected needles, 92.90% states mother to child transmission, 71.70% had recognized condoms in the prevention of HIV / AIDS. 43.70% HAD misconceptions that kissing could transmit and 22.30% thought touching as a mode of transmission.

Joseph and others conducted a survey of the knowledge altitudes and practices of 3928 Ugandans concerning AIDS were done in August 1987. The study comprised 1819 males and 2107 females with the mean age of 33 years. 37.00% felt the disease could be transmitted from insect bites, by touching, 21.00%, and 92.00% believed sexual transmission. Answers for methods of avoiding infection with AIDS virus included avoiding sex with prostitutes (92.00%), reducing the number of sexual partners (89.00%), using condoms 41.00%, and using antibiotics (23.00%), 62.00% were aware that it was incurable, 15.00% thought it could be cured and 23.00% were unsure. Regarding attitudes about AIDS, 56.00% agreed that an AIDS patient should be nursed at home, 56.00% thought that AIDS patients should be isolated from the community and 1.00% said that the condoms were too expensive.

Forster and Farley conducted a survey in 1988 in Uganda to ascertain the knowledge, attitude of the 204 people. The main points noted were 3.60% of the response mentioned that AIDS as a problem Uganda, 79.00% of women had heard of AIDS.
Pauw Johanna et al (1991) conducted a KAP study in Managna among 2160 participants to evaluate the impact of health education intervention. The observations were 80.00% if men and women mentioned the possibility of sexual transmission of HIV. It is found that in both the sexes, older age was associated with higher knowledge levels and knowledge levels were strongly associated with education. The health education intervention appeared to have had some effect; however, sustained efforts were needed to improve levels of information.

Saidi H Kapiga et al (1991-92) collected data by interviewing in private 2285 women attending three family planning clinics in Tanzania about knowledge of AIDS and other STDs. All respondents had heard of AIDS. Ninety percent of women were aware that HIV infected people may look healthy, 98.30% mentioned HIV is transmitted sexually, 66.40% knew transmission through infected needles, and 29.80% knew transmission by infected blood transfusion. Only 2.10% told about maternal child transmission. Only 9.60% of women had one of the following misconceptions like touching, mosquito bite. Level of education was the most consistent predictor of knowing of AIDS. 95.90% said reduction in sexual partners as a means of prevention 42.80% mentioned use of condom as a preventive measure. Younger and more educated women were likely to mention use of condoms for AIDS prevention.

A program of surveys was undertaken in collaboration with District Health authorities by Ford N in 1992 to assess the AIDS awareness among 2955
young people aged 16-24 years in the South West of England. The survey indicated fairly reasonable levels of knowledge about HIV / AIDS but very low personally perceived vulnerability to infection.

In a study conducted by Kathryn Bellingham and Pamela Gillis (1992) 173, experimental and 164 control group of young adults in Nottingham, England were found to have overall high knowledge level at pre-test (74.00%) but uncertainty still prevailed at pre-test about the transmission of HIV from blood donation (44.00% correct answers), insect transmission (48.00% correct). No statistically significant differences were observed in attitudes between groups at pre post testing.

In a study conducted among the persons presenting with STDs in Urban, Malawi in 1995 by Wynendate et al there was a high awareness of general aspects of AIDS – AIDS is a dangerous STD (91.00%). Counseling had a positive effect on attitudes towards condom use. Counseling did have an impact on behavioral changes.

In a study conducted among 834 young Thai men by Sweat M.D. in 1995 showed that general fear of HIV / AIDS was high yet personal perception of risk of acquiring HIV / AIDS was low. Many believed that AIDS could be cured or prevented with folk medicines.

According to survey conducted (1995) among 2018 Italian male young people by Carlucci et al , the AIDS awareness was greater among the high
educated subjects and positively influenced by mass media and school as source of information.

Gray Liz Beth et al in 1996 studied 500 female college students in India and observed that 95.00% of the students had accurate knowledge pertaining to the transmission of HIV by contaminated blood and transmission from mother to child. Ninety five percentage of students indicated that they have received no information about HIV / AIDS from family members. 90.00% gained most information from television and radio.

Nor K.F. et al (1996) did an in depth interval with 56 urban women in Botswana. The study revealed that many of the women expressed confusion about AIDS as an illness, its symptoms and latent period. Nearly all the women were aware that AIDS is sexually transmitted and believed that condoms are effective prevention. One third had incorrect knowledge on transmission of AIDS through casual contact. Two third believed that they were at risk of getting AIDS usually because they did not trust their partners and lacked control over their partners.

Various Studies Coordinated by Anita Rego and Vimala Nadkarni, Gender and HIV / AIDS: A Critique of Social Science Research in India, paper presented at the reproductive health research review dissemination workshop Dec 2001 organized by Tata Institute of Social Sciences are sited below -
Table No 3.1 Understanding and responses to the epidemic across gender Responses of Adolescents

<table>
<thead>
<tr>
<th>Author</th>
<th>Methodology</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Mathai,Ross, Hira, 1997</td>
<td>Students in modal age 16-17 were interviewed</td>
<td>Men were better informing than women. Knowledge was related to age, education, gender and parental education</td>
</tr>
<tr>
<td>Khaparde, Purthran and Pansare year not mentioned</td>
<td>4557 boys and 4206 girls from community</td>
<td>Overall poor knowledge on HIV / AIDS, reproductive health and sexuality. Gender differentials were noted on knowledge. High risks behavior reported by boys.</td>
</tr>
<tr>
<td>Ponnuraj, 1994</td>
<td>307 men and 292 Women. University Level students.</td>
<td>More than fifty percent were unaware of Modes of transmission. Sexual modes of transmission better known to girls.</td>
</tr>
<tr>
<td>Mukhopadhya, Biswas and Mukerjee, 1997</td>
<td>250 men and 244 women, first year students.</td>
<td>63% had satisfactory knowledge. Women better informed than men. Misconceptions present, personal risk perception poor, 50% had favorable attitudes ,were open to sex education.</td>
</tr>
<tr>
<td>Aggarwal, kannan, Grover et al., 1997</td>
<td>181 men and 199 women, college youth</td>
<td>89% had heard about HIV .Common modes of transmission known ,poor knowledge on diagnostic test or prevention</td>
</tr>
<tr>
<td>Lal, Kumar, Ingle et al.1994</td>
<td>222 men and 100 women ,college youth</td>
<td>Urbanites were better informed than rural Students. Women compared to men less knowledgeable on sexual modes of transmission. Newspaper main source of information. Discriminatory Attitude present.</td>
</tr>
<tr>
<td>Rahate, Zodpey and Bhalkule, 1995</td>
<td>261 rural college students</td>
<td>Poor Knowledge in 50%+ of students, misconceptions existed, Risk behavior present, were favorable to sex education</td>
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<td>Verma, Pavri, 1988</td>
<td>93 Metropolis and 43 small town students</td>
<td>Knowledge of HIV fair better in metropolis students. Foreign magazines and newspaper sources of information. Benefits of condom usage known to metropolis students. Keen to join HIV campaign</td>
</tr>
<tr>
<td>Sundar, Mathai, Kavitha, 1997</td>
<td>1128 mixed groups of students from schools, colleges, professional institutes</td>
<td>Varied knowledge across groups. Boys less informed than girls.</td>
</tr>
<tr>
<td>Francis, Gill Chowdhary, 1992</td>
<td>716 public and government school Students.</td>
<td>Aware of HIV, AIDS, STD: sexual modes of transmission known, misconception present, multiple sources of information; girls less informed</td>
</tr>
<tr>
<td>Tikkoo, Bollman, Berger, 1995</td>
<td>893 students, 10-17 years of age</td>
<td>Poor knowledge especially on HIV and reproductive health issues. Boys were better informed than girls.</td>
</tr>
<tr>
<td>Abirami, Thangmani, 1999</td>
<td>NSS students</td>
<td>Gender differences in the Knowledge on vectors of transmissions with boys opining commercial sex workers as carriers of disease and disease more prevalent in women and girls considering those in multiple sexual partner relationships as affected and transmission more prevalent in men.</td>
</tr>
<tr>
<td>Bhasin, Pandit, kannan et al.,</td>
<td>294 boys and 333 girls from XI and XII</td>
<td>While both groups had information about HIV, it was inadequate. Girls were better</td>
</tr>
</tbody>
</table>

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Wadhva, Waahb, Gupta et al., 1997 | 718 secondary school students | Students were aware of HIV but were misinformed on availability of vaccine for prevention. Also had misconceptions.

Kumar, Lal, Ingle, 1996 | 329 urban and rural university students | While information was not complete, there were no rural-urban differences.

<table>
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<th>Table No 3.2 Understanding and response of Community</th>
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<td>Ghosh Chowhary 228 slum developers</td>
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<td>Balaganesh, Chandrasekar, Sai. 1994 200 each rural men and women, age 15-45</td>
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<td>Balaganesh, Ramakrishna, Rao, 1993 200 each rural men and women</td>
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<td>Goyal, Kulkarni somaundaram, 1994 712 men and 288 women</td>
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<td>Poddar, Mandal, 1996 206 slum dwellers</td>
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<td>Balaganesh, Ramakrishna, Rao, 1993</td>
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<td>Srivastava, Nirupam, Chandra, 1992</td>
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