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PERCEPTION OF HIV/AIDS AMONG THE SENIOR STUDENTS OF ITANAGAR, ARUNACHAL PRADESH

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ABSTRACT

Aim of the study was to investigate the knowledge of, attitude toward and practices on HIV/AIDS among the senior students. The cluster sampling technique was used to select a sample of 550 students (530 sample were taken for final analysis) from the identified sampled educational institutes from the twin capital cities of Arunachal Pradesh. A structured and self-administered questionnaire was used to collect data. The majority of the students were aware that HIV could be transmitted through unprotected sex (83%), through sharing of needle-syringe (71%) and through unscreened blood transfusion (72%). However, the large scale of misconceptions also observed regarding virus transmission and its prevention modes. It is observed that there were a free and relaxed attitude toward sexual affairs, on such statements as pre- marital affairs becoming normal practice (54%), no problem having multiple sexual partners (27%) and no big deal of having extra-marital affairs (17%). It also highlighted some discriminatory and retrograde attitude toward PLHIV and HIV/AIDS in the gender perspective. Again, the study also revealed very casual sexual behaviours among the students, viz. early sexual initiation at age less than 22 years (41%), multiple partnership (20%), and sexual affairs with same sex (10%), and the consequent STI prevalence (4%) among the respondents. The knowledge deficit, unfavourable attitude and risky behaviour patterns are major hindrance of preventing the rapid spread of HIV/AIDS. There is, thus, an urgent need to address the gap in knowledge about HIV/AIDS, STIs, safer sexual behaviours and reproductive and sexual health through the appropriate measures targeting the youth population.

Keywords: Knowledge, Attitude, Practice, senior students, People Living with HIV, Sexually Transmitted Infection

1. INTRODUCTION

Since the first cases over 30 years ago, the human immunodeficiency virus (HIV) has caused a

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pandemic that has produced devastating consequences throughout the world. One- third of all currently infected individuals are youth, of age 15 to 24 years, and half of all new infections occur in youth of the same age group. More than five young people acquire HIV infection every minute; over 7,000 each day; and more than 2.6 million each year (UNAIDS, 1999). Arunachal Pradesh, till very recently recorded very less number of cases of HIV/AIDS infection, is started witnessing slow but steady rising trend of prevalence rate (Arunachal Pradesh State AIDS Control Society, 2013). The state is, however, still considered to be low HIV burden state, but speculate to be high potential hotspot to erupt with infection having reached specific point. The further heightened vulnerability of state is on account of its closed proximity with the HIV high prevalence neighbouring states (Manipur, Nagaland and Mizoram), which is also bordering the heroin producing Golden Triangle of Laos, Myanmar and Thailand (Armstrong, 2014). Out of the sheer ignorance and negligence, people of the state have very casual approach toward the infection, and such approaches are also appeared to have moulded by age-old cultural values and norms and social practices (Sirah, 2018). The social/structural approaches need to be emphasised in dealing with HIV/AIDS as a long term strategy (Auerbach, 2011).

Rather than mere health and medical problem, HIV/AIDS is a socio-psychological problem for which remedies to be essentially sought in context of prevailing socio-cultural and political set up. The vexing reality is that social and cultural factors continues to play a significant role in determining who is most at risk of infection and how the epidemic disproportionately affects certain communities (Link and Phelan, 1995). As on-going intervention programs focusing on knowledge dissemination and behavioural change communication have not appeared to brought forth desired results, focus should be given in designing the program that are relevant and compatible with prevailing socio-cultural values and beliefs system (Terserus, 2008). Thus, there is necessity and pertinent to investigate upon the degree of interconnection between the prevailing cultural values and norms and social practices on the one hand and ever rising rate of HIV/AIDS prevalence on the other hand among youth cohort of Arunachal Pradesh.

2. BACKGROUND

The first HIV case in Arunachal Pradesh was detected in 1998, which has increased and shot up to 269 in 2015 and again 343 in March 2018. Papum Pare is the highest prevalence district, followed by undivided Lohit and East Siang districts. The undivided Lohit district has been categorised as the only ‘A’ category district in the state because of having HIV prevalence rate of more than 1% among general pregnant women as per HIV Sentinel Surveillance.

Nevertheless, the district of Kurung Kumey, Upper Subansiri and Anjaw have not detected any HIV cases so far (APSACS, 2018).

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The distinct characteristics of youth and their environment shape their attitude and knowledge that in turn determine their sexual behaviour. In formative period, their attitude not firmly established, they likely to adapt to any message that seems appealing but may place one into vulnerable situation of acquiring STIs, including HIV (Diana, 2010). It is significant to explore whether factors such as religion, culture and family background and demographic characteristics and also their physical, social, psychological and economic conditions shape youth's perception, attitude towards and behaviour pertaining to HIV/AIDS.

It is argued that there is a large extent societal relaxed approach and tolerance on sexual affairs among youth of the tribes of Arunachal Pradesh. The pre-marital affair is not considered as a taboo and polygyny, as a form of marriage, is being practiced among well-to-do families (Zehol, 2006). The pre-marital sexual affairs are characterised by lack of condom and contraceptive use, by coercion means and multiple partnerships, and it has the consequences, such as, amongst others, contracting STIs (including HIV), unwanted pregnancy and then abortion, single parenthood and family disorganisation.

The most popular and indigenous religion of the state, Donyi Polo is considered to be very open and tolerant towards so-called the risky behavioural patterns, specifically on sexual and other related behaviours (Sirah, 2018). However, there is typical patriarchal notion and practices, tend to be unfavourable toward women, prevalent in society. Till very recently, women were not much have say in matter related to marital and sexual affairs, and they were subjected to child, arranged and even forced marriages and were deprived of inheritance of properties neither from parents nor from in-laws (Bharali, 2010).

3. MATERIAL AND METHODS

3.1 Sampling Technique

A cross-sectional study was carried out among the students of the twin capital city, Itanagar and Naharlagun of Arunachal Pradesh. The twin city is a cosmopolitan in nature on account of its having population representativeness of almost all tribes of the state and with a high influx of migrants from the rest of the country. The cluster sampling technique was adopted to select necessary sample of senior students (from senior secondary to post-graduation level) for the study. Some Educational Institutes out of many listed Institutes have been selected by using sampling technique. Again, by adopting the same sampling technique, one or two class rooms were selected from each chosen institutes from where all students were taken as samples and invited to participate in the study. The total of 550 samples of students selected for the study, out of which 300 were from Itanagar (146 male and 154 female) and 250 from Naharlagun (128 male and 122 female). However, out of 550 total participants, 530 have fully responded the provided

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questionnaire, which have been finally incorporated in the study analysis, by making response rate at 96%.

3.2 Method of Data Collection

The structured Questionnaire consisted of 80 items was used to generate data from the students from two study areas. The questionnaire was divided into four sections: Section I contains details on the demographic data of the respondents, which consisted of 12 items. Section II (21 items) contains closed-ended type of questions related to awareness and knowledge on HIV/AIDS. The multiple options for each question were provided, out of which correct option/s needed to be ticked by the respondents. Section III contains statements to assess attitude towards HIV/AIDS. This section has 20 statements, each having five point Likert Type of Scale, where the subject had to respond to either of the available options ranging from "strongly agree, agree, neutral, disagree and strongly disagree." Finally, Section IV contains questions to assess practices and behaviour pattern of the students pertaining to HIV/AIDS and it consisted of 27 items. The respondents were asked to respond out of the provided multiple options for each question in closed-ended type of question.

The questionnaire were administered to the student from various identified sampled Educational Institutions and got responded in class room situation. The prior permission was sought from the Head of the Institutions and convenient day and time was stipulated before proceeding for the data collection. The subjects were appropriately instructed and clarified how to respond to the questionnaire and sufficient time of 1 hour was provided to complete the filling up of the questionnaire.

3.3 Data Processing and Analysis

The collected data were entered, processed and analysed using the Statistical Package for Social Sciences (SPSS) Software Version 20.0. The assessment of knowledge level, attitude towards and practices on HIV/AIDS were carried out and have presented in the corresponding suitable frequency tables.

3.4 Ethical Consideration

The research clearance was obtained from the Ethic Committee of Rajiv Gandhi University, Itanagar Arunachal Pradesh and the formal permission letters written to the Head of all the selected educational institutions for desirable cooperation and support during data collection. The nature, purpose and process of the study were explained to the participants after which verbal consent obtained from those who agreed to participate in the study. The respondents were

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assured of confidentiality, privacy and anonymity of information provided and given the choice to withdraw their participation from the study at any point of time.

4. RESULT

4.1 Sample Characteristics

The age group of the students were classified into 15-18 years (44%), 19-21 years (36%) and 22-24 years (19%). The male subjects consisted of 49.8% compared to 50.2% female counterparts. The most of the respondents were belonged to Arunachal Pradesh Schedule Tribe (85%). With regard to religious affiliation of the respondents, 57% were the Christians and 17% were the followers of Donyi Polo belief system. While 65% of them have senior secondary level and 27% were graduate in their education qualification. Further, 48% of the respondents' parental occupation were of service category and around 21% of them engaged in farming occupation (Table 1.1).

4.2 Awareness and Knowledge of HIV/AIDS

All the student were shown to be having heard of HIV/AIDS. It has shown that out of 530 respondents, 440 (83%) of them were aware that HIV/AIDS were non-curable, while 271 (51%) of them knew it was preventable. Further, 297 respondents, representing 56%, heard about STI/STD and 431 (81%) of them responded that it was not possible to identify HIV infected person easily without laboratory test. 454 (86%) of them aware that there was a risk of acquiring infection even after testing negative once. Again, 95% of the respondents aware that STI/HIV transmit not only through female (Table 1.2).

In table 1.3, 441 respondents, representing 83% knew that HIV transmit through unprotected sex with infected person, and 381 (72%) and 377 (71%) knew that transfusion of infected blood and sharing of contaminated needle-syringe could be possible routes of HIV transmission respectively. Again, out of the total respondents, 417 (79%) were aware that correct and consistent use of condom were the appropriate preventive method, and 307 (58%) and 292 (55%) of them have believed that use of sterilized needle-syringe and faithfulness to one single partner were appropriate preventive modes respectively (Table 1.3).

Table 1.4 shows some of the misconceptions on HIV transmission routes and preventive measures, where 24% of them have believed that HIV could be transmitted through mosquito bites and 19% of them considered the virus could be transmitted through kissing and hugging with infected person. Again, 17% and 16% of the respondents have the idea that HIV could be prevented through having sex with only healthy looking person and isolating and confining

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people living with HIV/AIDS respectively.

4.3 Attitude toward HIV/AIDS

In table 1.5, it is observed that more than 90% of the respondents were have positive attitude on the statement 'one should go for HIV test,' and more than half of the them (54%) have had favourable attitude that 'sex before marriage is becoming a normal practice' while one-fourth (27%) of them believed that keeping more than one sexual partners were not a problem. Similarly, 16% of them viewed that only immoral person could acquire HIV infection. Nevertheless, out of 530 respondents, 83% of them were have favourable attitude on using condom consistently and correctly. Whereas, only 27% of them have shown favourable attitude for providing free needle-syringe to the injected drug users. On the other hand, 83% of them have shown their positive attitude with regard to introducing sex education at school level (Table 1.5).

Table 1.1: Socio-demographic Characteristics

Variables	Description	Frequency	Percent
Age of Respondent	15 - 18	231	43.6
	19 - 21	189	35.7
	22 - 24	98	18.5
	No answer	12	2.3
Gender of Respondent	Male	264	49.8
	Female	266	50.2
Community of Respondent	APST	449	84.7
	Tribe of Other State of India	17	3.2
	General Category of India	30	5.7
	Schedule Caste/OBC	34	6.4
Religion of Respondent	Hindu	76	14.3
	Islam	6	1.1
	Christian	301	56.8
	Buddhist	34	6.4
	Donyi Polo	88	16.6
	Indigenous	21	4.0
	No answer	4	.8
Education qualification	Up to Primary Level	9	1.7
	Up to Senior Secondary	342	64.5
	Graduate	144	27.2
	Post Graduate/M.Phil/PhD	16	3.0
	No answer	19	3.6

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Occupation of Parent/Guardian	Unemployed	29	5.5
	Self Employed Profession	28	5.3
	Service (Govt./Pvt.)	256	48.3
	Business/Trade	87	16.4
	Manual/Unskilled Worker	5	.9
	Farmer	113	21.3
	Other	3	.6
	No answer	9	1.7
Total		530	100.0

Table 1.2: Awareness and Knowledge of HIV/AIDS

Knowledge Variables	**Frequency**	**Percent**
Have you ever heard of HIV/AIDS	530	100.0
HIV/AIDS is not completely curable	440	83.0
Is HIV/AIDS preventable	271	51.1
Have you ever heard about STI/STD	297	56.0
It is not possible to identify HIV infected person easily	431	81.3
There is a risk of getting infected with HIV even after testing negative once	454	85.7
Do STI make easier for HIV to transmit	236	44.5
STI/HIV transmits not only through female	504	95.1
Both man and woman are equally prone to acquire HIV and STI	354	66.8
Is government awareness and preventive program serving the purpose	338	63.8

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Table 1.3: Awareness and Knowledge of HIV Transmission Routes and Preventive Modes

Knowledge Variable on HIV Transmission Routes and Prevention Modes	Frequency	Percent
HIV transmit through unprotected sex	441	83.2
HIV transmit through sharing of used needle-syringe	377	71.1
HIV transmit through blood transfusion	381	71.9
HIV transmit from infected mother to inborn baby	319	60.2
Correct and consistent use of condom is preventive mode	417	78.7
HIV may be prevented by treating STIs promptly and appropriately	114	21.5
Faithfulness to one single sexual partner is preventive step of HIV	292	55.1
Use sterilized needle while injecting prevents HIV transmission	307	57.9

Table 1.4: Misconceptions on HIV Transmission Routes and Preventive Modes

Misconceptions on HIV Transmission Routes and Preventive Modes	Frequency	Percent
HIV transmit through the mosquito bites	129	24.3
HIV transmit through sharing Bathroom and Toilet with infected person	34	6.4
HIV transmit through sharing towel and clothes with infected person	19	3.6
HIV transmit through kissing and hugging with infected person	102	19.2
HIV could be prevented by not sharing food and utensils with infected person	55	10.4
HIV could be prevented by having sex with only healthy looking person	88	16.6
HIV could be prevented by restricting breast feeding to infant	79	14.9
HIV could be prevented by isolating people living with HIV/AIDS	84	15.8

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Around half of the respondents (48%) were of believe that 'biological and socio- cultural set up make women more vulnerable to acquire HIV and STIs.' About 11% of respondents have stated that woman cannot get HIV from her husband. Again, 44% of the respondents believed and responded that banning prostitution could control spread of the epidemic and 34% of them have expressed that women were more responsible than men for prostitution. However, only around half of the respondents were expressed their attitude in favour of PLHIV for mingling up with the general population (Table 1.6).

4.4 Practices on HIV/AIDS

The table 1.7 presents the frequency distribution of the respondents' practices pertaining to HIV/AIDS. Out of 530 respondents, only 71 (13%) of them have tested for HIV at some point of time. Again, 21 (4%) of them have disclosed of having had some forms of STI whereas 113 (21%) of them did not respond to the question. Similarly, 107 (20%) of them have admitted that they have more than one sexual partners and 173 (33%) of them reluctant to disclose on their having such partners. It has further shown that 52 (10%) of them were reportedly indulged in sexual relation with same sex. Out of the total respondents, 42 (8%) of them have admitted that they have confronted with violence on sexual affairs with spouse or other sexual partners. Again, it is shown that nearly 22% of them were maintained or intent to maintain distance from People Living with HIV/AIDS. Around 47% of them have admitted that they use to drink alcohol. While 14% of them reportedly have shown their preference of drinking alcohol before sexual activities and another 24% refused to divulge on such practice. Similarly, 20% of them admitted that they have pre-marital sex and 30% of them have refused to disclose on such affairs. However, around one-third (36%) of the respondents did not know how to use condom correctly and around 21% of them did not disclose on it (Table 1.7).

Table 1.5: Attitude towards HIV/AIDS and Sexual Affairs

Attitude Statements		Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
One should go for HIV test	Frequency	281	204	34	8	3
	Percent	53.0	38.5	6.4	1.5	.6
Sex before marriage is becoming normal practice	Frequency	94	192	107	92	45
	Percent	17.7	36.2	20.2	17.4	8.5
There is no problem having more than one sexual partner	Frequency	20	121	101	183	105
	Percent	3.8	22.8	19.1	34.5	19.8

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One should not have extra marital affair	Frequency	146	211	84	67	22
	Percent	27.5	39.8	15.8	12.6	4.2
Only person who lead immoral live get HIV infection	Frequency	23	60	163	231	53
	Percent	4.3	11.3	30.8	43.6	10.0
Condom should be consistently and correctly use in all sexual inter course	Frequency	156	281	72	16	5
	Percent	29.4	53.0	13.6	3.0	.9
Free availability of condom promotes promiscuity	Frequency	50	190	182	99	9
	Percent	9.4	35.8	34.3	18.7	1.7
Free needle-syringe should not be provided to injected drug users	Frequency	164	142	83	102	39
	Percent	30.9	26.8	15.7	19.2	7.4
Sex education should be introduced at school level	Frequency	224	217	51	18	20
	Percent	42.3	40.9	9.6	3.4	3.8

Out of 530 respondents, 137 (26%) of them reportedly have had their first sex during 15-18 years of age and 49 (9%) of them during 19-21 years of age. Again, 6% of them have first sex before 15 years of age (1.1% before 10 years of age). And another 167 (32%) of them were reluctant to disclose their age of first sexual affair. Nevertheless, 130 (25%) of the respondents have revealed that they did not have sex ever (Table 1.8).

Table 1.6: Attitude towards PLHIV and HIV/AIDS in gender perspective

Attitude Statements		**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
Women are more vulnerable to get infected with HIV	Frequency	41	217	141	90	41
	Percent	7.7	40.9	26.6	17.0	7.7
Biological and socio-cultural set up make women more vulnerable to HIV and STIs	Frequency	29	227	189	76	9
	Percent	5.5	42.8	35.7	14.3	1.7
Woman cannot get HIV from her husband	Frequency	10	48	42	286	144
	Percent	1.9	9.1	7.9	54.0	27.2
Banning prostitution can control the spread of HIV	Frequency	103	131	81	177	38
	Percent	19.4	24.7	15.3	33.4	7.2
Women are more responsible than men for prostitution	Frequency	52	126	104	163	85
	Percent	9.8	23.8	19.6	30.8	16.0
People Living with HIV should be isolated from	Frequency	61	123	86	197	63

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general people for the safety of others	Percent	11.5	23.2	16.2	37.2	11.9
Allow People Living with HIV to works in same office room and study in same class room	Frequency	121	238	100	56	15
	Percent	22.8	44.9	18.9	10.6	2.8
Treatment of PLHIV/AIDS in the Health centre is risky for health workers and co-patients	Frequency	35	99	90	239	67
	Percent	6.6	18.7	17.0	45.1	12.6

5. DISCUSSION

Due to exposure to higher education, mass media and various forms of awareness activities in urban areas and also on account of extent and severity of the epidemic prevalence, HIV/AIDS is reportedly heard by all the students. More than half of the respondents having had awareness on HIV/AIDS with regard to its non-curability, its preventability, awareness on STIs and non-possibility to identity HIV infected person through its appearance. In supporting this study findings, Tuntufye *et al.* (2014) also observed identical percentage on HIV/AIDS curability and preventability awareness among the secondary and university students in Kenya and Yadav *et al.* (2011) among the youth of Saurashtra. However, if we look at other side of the coin, some disturbing facts observed from the study is that the large section of the respondents were either not aware about or uncertain with regard to non-curability of HIV/AIDS (17%), possibility of preventing HIV by guarding of behaviour patterns (49%), an idea on STI/STD (55%), impossibility of easy identification of HIV infected person (19%) and possibility of getting infected with HIV in future even after testing negative once (14%). This finding is supported by Tehrani and Malek-Afzali (2008) study findings of similar misconceptions among the Iranian general youth, the truck drivers and the female sex worker with regard to HIV/AIDS.

Table 1.7: Practices on HIV/AIDS

Practices on HIV/AIDS		**Yes**	**No**	**No answer**
Have ever conducted HIV/AIDS test	Frequency	71	444	15
	Percent	13.4	83.8	2.8
Have ever had sign and symptom of STI	Frequency	21	396	113
	Percent	4.0	74.7	21.3
Have ever had multiple sexual partners	Frequency	107	250	173
	Percent	20.2	47.2	32.6
Have ever had sexual relation with same sex	Frequency	52	364	114
	Percent	9.8	68.7	21.5
Have ever experienced injecting intravenous drugs	Frequency	11	454	65

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	Percent	2.1	85.7	12.3
Have ever experienced violence on sexual affair with spouse or other sexual partner	Frequency	42	359	129
	Percent	7.9	67.7	24.3
Have you ever paid or received cash or kind in return of sex	Frequency	22	407	101
	Percent	4.2	76.8	19.1
Will/have maintain/ed distance from PLHIV/AIDS	Frequency	116	312	102
	Percent	21.9	58.9	19.2
Do you drink alcohol	Frequency	249	256	25
	Percent	47.0	48.3	4.7
Do you prefer drinking alcohol before having sex	Frequency	76	322	132
	Percent	14.3	60.8	24.9
Will/have experience/d pre-marital sex	Frequency	106	266	158
	Percent	20.0	50.2	29.8
Do you know how to use condom correctly	Frequency	194	224	112
	Percent	36.6	42.3	21.1

Table 1.8: Age of Sexual Initiation

		Less than 10 years	**10-14 years**	**15-18 years**	**19-21 years**	**22 and more years**	**No sex so far**	**Don't remember**	**No answer**
Age of Sexual Initiation	Frequency	6	26	137	49	1	130	14	167
	Percent	1.1	4.9	25.8	9.2	.2	24.5	2.6	31.5

On the question of the knowledge of transmission routes and preventive modes of HIV, it is disappointing to note that large number of respondents not having satisfactory awareness, viz. the virus transmit through the sharing of contaminated needle-syringe (29%) and from infected mother to infant (40%). Again, the respondents were not certain that the treating of STIs appropriately and promptly (79%) and maintain faithfulness with one single sexual partner (45%) were preventive measures of HIV/AIDS. This finding is in consonance with the findings of Thanavanh *et al*. (2013) among the students in Lao People's Democratic Republic and Agyemang *et al*. (2012) among young people of Ghana on knowledge level of HIV transmission and preventive modes.

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It is also observed that there were large amount of misconceptions and false beliefs with regard to transmission routes and preventive measures on HIV/AIDS, which reflect poor quality of knowledge among the students. Many respondents have a misconception that HIV could be transmitted through mosquito bites (24%) and through kissing and hugging with infected person (19%). Some of them also believe that transmission of infection was possible through sharing of bathroom and sharing of towel and clothes. And again the similar number of the respondents have an idea that preventive measures of HIV includes having sex only with healthy looking person (17%), isolating and confining people living with HIV/AIDS (16%) and not sharing of food and utensil with infected person (10%). This observation is similar to the study done at the North Eastern part of India (Meena *et al*., 2013) and among the female senior secondary students of Srinagar (Gaash *et al*., 2003).

It is disheartening to observe that the youth of Arunachal Pradesh have poor knowledge concerning transmission routes and prevention methods of HIV/AIDS, which reflect its unpreparedness to face the looming danger of the dreaded monster. The reasons for poor level of knowledge and awareness on HIV/AIDS could be attributed to its ineffectiveness of the awareness and preventive programmes of the government agencies that did not reach to the targeted youth population; the subjects related to HIV/AIDS did not find its place in school curriculum; the societal and familial environment did not permit for open discussion on the topic of HIV/AIDS and related matters; and no first-hand experience and exposure in handling HIV/AIDS cases, due to which there are very casual approach towards HIV/AIDS (Sirah, 2018).

The study revealed mixed level of attitude towards sexual affairs, PLHIV and HIV/AIDS in gender perspective among the respondents. Out of the total respondents, more than half of them have conceded to the statement that ‘sex before marriage is becoming normal practice.’ Another 27% of them have supported to the statement that ‘there is no problem having more than one sexual partners.’ And 17% of them express unfavourable attitude on the statement that ‘one should not have extra marital affair.’ It is interesting to note that such a large percent of the respondents have such a relaxed attitude towards sexual affairs and were more accepting attitude towards having sex with multiple casual partners. This finding is supported by the findings of similar studies of Nonnemacher *et al*. (2015) and among the out- of-school youth in China by Wang *et al*. (2007). Nevertheless, a majority of the respondents have shown favourable attitude towards consistent condom use (82%), as a matter of fact, the condom is the most suitable form of preventive method of HIV. It is appalling, however, to note that around two-third of the respondents were not in favour of free distribution of needle- syringe to Injected Drug Users (IDU). In fact, with or without awareness of inherent risk involved, they tend to share used needle-syringe among co-users, through which large scale transmission of HIV infection occurred, which is true specifically for neighbouring states of Manipur, Nagaland and Mizoram

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(Armstrong *et al*., 2014). Nevertheless, 80% of the respondents have expressed their favourable attitude on the statement that 'sex education need to be introduced at school level.' This finding is in agreement with the findings of similar another study on 'Sex Education/Family Life Education' among the youth of India by Tripathi and Sekher (2013).

Another interesting points came to light from the study is that out of the total respondents, 11% of them have an attitude that 'women cannot get HIV from her husbands,' 44% of them believed that 'banning prostitution could control the spread of HIV/AIDS' and 34% of them have viewed that 'women are more responsible than men for prostitution.' The typical patriarchal attitude, unreasonably unfavourable toward woman, is appeared to have expressed by the respondents. In so-called information age such an extent of prejudice and misconceptions is not expected from the youth, which would have the wide implication in the social life in general and the spread of HIV/AIDS in particular (Sirah, 2018). The similar findings regarding such gender biased cultural attitude reported from the study of Terry *et al*. (2006), among the university students of Zimbabwe. Again, only around half of the respondents have shown having favourable attitude towards People Living with HIV/AIDS (PLHIV), viz., in mingling up and working together, treatment along with general public in the health centre and so on. The prevalence of such discriminatory attitude could be perceived of having non-satisfactory awareness and misconceptions pertaining to HIV/AIDS. This was also the case in Pakistan when Khan *et al*. (2017) found an inverse relationship between knowledge about HIV and discriminatory attitudes toward people living with HIV. The similar discriminatory attitude were also reported from the Coastal Karnataka (Unnikrishnan *et al*., 2010).

Another key discussion point of the study is concerned with the practices and behavioural patterns pertaining to HIV/AIDS among the students in their daily life. In fact, some disturbing facts observed while gauging HIV/AIDS-related behaviour patterns: 84% of respondents have never tested for HIV; 4% of them have had sign and symptom of STI; 20% of them have multiple sexual partners; 10% have sexual relationship with same sex; and 2% of them have experienced intravaneous drug use. Right to their expressed attitude, many respondents' sexual life were relaxed and casual one, such as pre-marital, multiple partnerships and sexual affairs with same sex which would have wide ramification in the light of looming danger of HIV/AIDS. The findings were supported by other similar studies of Guha (2013) and Joshi and Chauhan (2011), which observed similar pre-marital and unsafe sex among the youth of India.

The study also revealed that the respondents have encountered or experienced violence in course of sexual affair with the partners (8%); have engaged in transactional sex either for cash or kind (4%); preferred drinking alcohol before sex (14%); have experienced or intent to experience pre-marital sex (20%); and did not know how to use condom correctly (42%). These behaviour

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patterns are considered as one of the most risky forms of behaviours in sexual affairs. These risk behaviour patterns would have the implication, such as heightening of the incidence of HIV/AIDS and other STIs, unwanted pregnancy and illegal abortion, adolescent and single motherhood, abandoned child and juvenile delinquency amongst others (Sirah, 2018). It have been gauged that such behaviour patterns and practices occur due to lack of knowledge on these consequences, specifically on HIV/AIDS, thus, it is suggested that the systematic efforts need to be directed towards improving knowledge level and promoting awareness among the students. These findings are in closed consortium with the findings of Dave *et al*. (2013), where they observed increased pre-marital and live-in relationships, with a large scale unprotected and unsafe sex, among the young people of Jamnagar City of Gujarat; Jaya and Hindin (2009) also found high heterosexual pre-marital sex among the youth in Delhi; and Schensul *et al*. (2006) have shown some findings on extra-marital sex in Mumbai. It is again appalling to note that 22% of the respondents have had maintained or would be cautious to maintain distance from PLHIV. The impact of such a social stigma and discrimination, as well as the self-stigma, make a person isolate oneself from services (counselling and treatment) and social relationship. Thus, HIV/AIDS-related stigma become a major obstacle to HIV prevention and treatment efforts. The study is supported by a similar finding by Bharat and Chakrapani (2014) on HIV- related stigma in India; and Rai (2007) on stigma against PLHIV in Nepal.

It is also revealed that the respondents have their first sex during 15 – 18 years of age (26%), during 19-21 years (9%) and age below 14 years (6%). The pre-marital sexual experiences are characterised by multiple and casual partnerships, but distressing facts come to light is that the respondents did not use condom consistently with these casual partners. Similar findings of early sex debut and pre-marital affairs have been reported by IIPS (2010) in its study on the 'youth in India: situation and needs' and Majra and Silan (2016) on multiple partnerships and non-consistent use of condom by youths of India.

6. LIMITATION

It is pertinent to acknowledge some of unavoidable limitation of the study. This study used a self-report survey to investigate perception of HIV/AIDS among the senior students and no further validation exercise of the responses undertaken. Secondly, administering the survey questionnaire in class room situation might not have resulted into honest response from some of the participants, particularly matter related to personal and sensitive questions. Finally, sampled Educational Institutes for data collection might not have been adequate representative of the twin capital city Arunachal Pradesh. Nevertheless, this study provides useful information and insight, and will serve as preliminary ground for further study on knowledge, attitude and practices of HIV/AIDS in the state.

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7. CONCLUSION AND RECOMMENDATIONS

There were overall non-satisfactory level of awareness and knowledge of transmission routes and preventive measures of HIV/AIDS. The student have had very free and relaxed attitude toward sexual affairs and there were also some adversarial attitude toward PLHIV and HIV/AIDS in gender perspective. Another fact highlighted by the study is that the large scale indulging into risky behaviour pattern, specifically sexual behaviour by the students, such as having sexual debut at early age, pre-marital and multiple partnership affairs, sexual affairs with same sex, violence sex and preference of having alcohol before sex. The more disheartening fact observed is that many of them did not know how to use condom properly and some of them were not intent to use it even with non-regular sexual partners, and the obvious consequence was high prevalence of STI cases among the youth. An inadequate knowledge, negative attitude and risky practices are major hindrance of preventing the spread of HIV/AIDS.

Targeting the youth as a priority group for preventive interventions is an important strategy, as this section of population of the society is the one who would determine the future course of HIV/AIDS. The knowledge they acquire, attitude they possess and behaviours they adopt and maintain in sexual lives would give direction to epidemics in decades to come. Hence, there is an urgent need to address the gap in knowledge about HIV/AIDS, STIs, safer sexual behaviours and reproductive and sexual health. Sex education, thus, need to be introduced at school level.

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