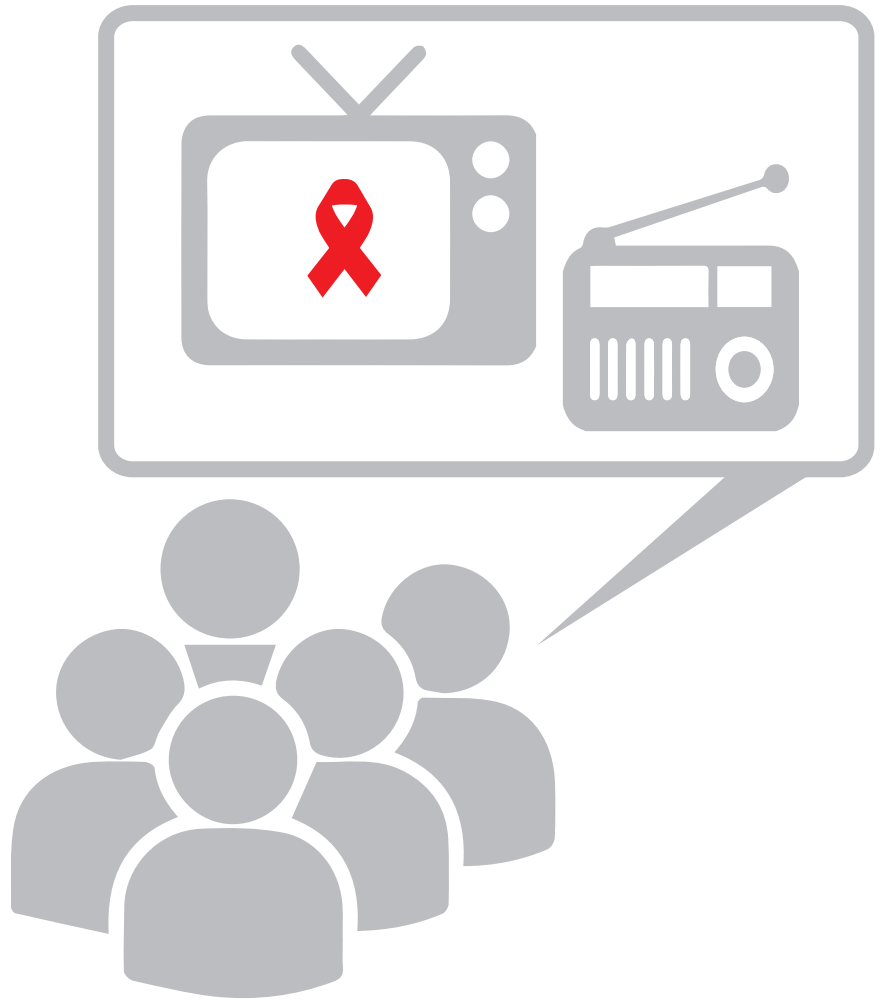


# Long format program



## Long Format Program by NACO

Reach & Recall Study  
2014



India's voice against AIDS  
National AIDS Control Organisation  
Ministry of Health & Family Welfare,  
Government of India  
[www.naco.gov.in](http://www.naco.gov.in)



# **NACO Long Format Program Mass Media Campaign**

.....  
Reach & Recall Study

**2014**

## Reach and Recall Study of Long Format Program by NACO

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## List of Abbreviations

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AD	Advertisement
AHS	Annual Health Survey
AIDS	Acquired Immune Deficiency Syndrome
AIR	All India Radio
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BPL	Below Poverty Line
DAC	Department of AIDS Control
DD	Doordarshan
FHI	Family Health International
GOI	Government of India
HH	Household
HIV	Human Immunodeficiency Virus
ICMR	Indian Council of Medical Research
ICTC	Integrated Counselling and Testing Center
IHBP	Improving Healthy Behaviors Program
LFP	Long Format Programs
MOHFW	Ministry of Health and Family Welfare
NAC	National AIDS Committee
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
OBC	Other Backward Classes
PPS	Probability Proportional to Size
PPTCT	Prevention of Parent-To-Child Transmission
PSU	Primary Sampling Unit
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SC	Scheduled Caste
SCR	Socio Cultural Region
SEC	Socio Economic Classification
SRI	Social and Rural Research Institute
ST	Scheduled Tribe
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TV	Television
USAID	United States Agency for International Development
VBD	Voluntary Blood Donation

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## Executive Summary

A national level initiative, the National AIDS Control Organization (NACO), was established by the Government of India (GOI) in 1992 to provide a focused solution against Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS). During the same year, with support from the World Bank, a program known as the National AIDS Control Programme (NACP) Phase I was launched. After two successful rounds of NACP, the GOI recognized the importance of behavior change communication (BCC) in combating HIV and shifted its focus from awareness creation during the NACP Phase III in 2007. This led to the conception of long format television (TV) and radio programming as BCC channels. Since then, the long format programs (LFPs) have been implemented by NACO throughout the country via the State AIDS Control Societies (SACS) in various formats such as:

- Phone-in programs
- Panel discussions
- Documentaries
- Dramas

The objectives of these LFPs are to increase knowledge and favourable attitudes regarding HIV/AIDS prevention, treatment, and care and support while addressing associated stigma and discrimination. They are usually 15-30 minute episodes on HIV and AIDS - related issues, based on themes chosen via the national mass media calendar prepared by NACO. The target audience for these programs are the general population aged 18-65 years, having access to the target media. Television and radio are the channels for these programs and they are telecasted/broadcast on public service broadcasters, namely, Doordarshan (DD) regional channels and All India Radio (AIR) as applicable.

### *Reach and Recall Study*

A reach and recall study is done to measure the efficacy of a communication campaign. The main objectives of a reach and recall study in general are to understand how many people were reached by the campaign (to measure campaign exposure) and how many recall the key messages of the communication. Other indicators related to knowledge, attitudes, and intention to act may also be assessed.

### *The Study and Settings*

The present study “*Reach and Recall of the LFPs*” was conducted by the Improving Healthy Behaviors Program (IHBP) in collaboration with NACO in the states of Jammu & Kashmir, Madhya Pradesh, Bihar, Tripura, Maharashtra, and Kerala; covering a total of 124 rural Primary Sampling Units (PSUs) and 56 urban PSUs distributed across 24 districts. The study was executed by the Social and Rural Research Institute (SRI-IMRB) between September to November of 2014.

### Long Format Program Campaign

The following long format programs aired by NACO as per their records in the last one year in each of the study states were studied:

State	TV Program	Radio Program
<b>Jammu &amp; Kashmir</b>	1. Documentary on Combating AIDS 2. Documentary on Blood Safety	--
<b>Madhya Pradesh</b>	<i>Aao Baat Karein</i>	<i>Zindagi Zindabad</i>
<b>Bihar</b>	<i>Jagriti</i>	<i>Kitne Paas Kitne Door</i>
<b>Tripura</b>	Role of Antiretroviral Therapy (ART)	--
<b>Maharashtra</b>	Hello Doctor	<i>Kiti zawal kiti dur</i>
<b>Kerala</b>	<i>Veettu Vishesham</i>	1. <i>Snehithan</i> 2. <i>Jyothis Sanjeevani</i>

### Target Groups

The target population was selected based on a listing exercise conducted in 180 PSUs, across the 6 states which aimed to locate eligible respondents for the study. All males and females between 18-65 years having an exposure to either TV or radio were included as a part of the sampling frame. After the listing exercise, 22 eligible households were selected randomly for the interview using systematic random sampling from each PSU. In each household, only one person was interviewed and in case of multiple eligible members, the selection was done by utilizing a random number table.

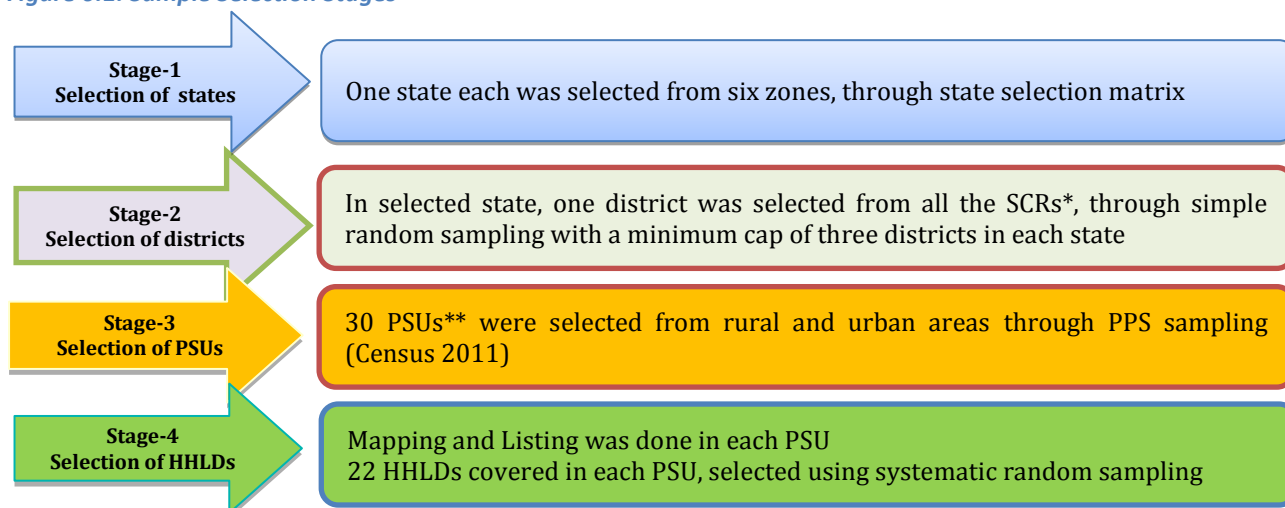
### Data Collection

The process of data collection was done at 180 PSUs (124 villages and 56 wards) among 3,856 respondents through a structured questionnaire for both male and female respondents. To collect the data in the field, all enumerators and supervisors were trained extensively for three days for the listing component and five days for the main component in the presence of research teams from SRI-IMRB and also technical specialists from the IHBP team.

Overall 1,931 male and 1,925 female respondents were interviewed across 180 PSUs from 6 states. Of these 180 PSUs, half the PSUs were allocated to cover male respondents and the balance PSUs were allocated for covering female respondents.

The data was collected through face-to-face structured questionnaires and the data was entered by trained data entry operators at a central location (Delhi).

Figure 0.1: Sample Selection Stages



\*Exception Jammu & Kashmir where all the districts were selected from one SCR due to natural calamity and security issues.

### Measurement

The study assessed the reach and recall of the long format programs developed by NACO in the six study states. Reach of the campaign was measured separately for TV and radio programs. Reach was measured in two ways: 1) spontaneous mention of any of the episodes of LFP, and 2) aided recall by showing the storyboard for TV programs, and playing the audio for the radio program. If the respondent had seen or heard any of the programs, as indicated by either spontaneous or aided recall, it was counted as “reach” or “exposed” for that particular LFP. Respondents who did not report having seen or heard any of the episodes of the LFP, as indicated by either spontaneous or aided recall, were classified as “non-exposed”.

Key messages recalled were captured from respondents who were exposed to these programs. In order to assess the recall, a detailed assessment of the contents/ discussion points of each of the program was also conducted among the exposed group.

Apart from this, information on certain demographic indicators such as age, education, occupation, caste, and religion was also collected. Respondents were also accessed on knowledge and attitudes regarding six key thematic areas inclusive of sexually transmitted infections (STIs)/sexually transmitted diseases (STDs), HIV/AIDS, integrated counselling and testing centre (ICTC), prevention of parent-to-child transmission (PPTCT), blood donation and usage of condoms. The thematic areas were developed after reviewing the episodes broadcasted under the LFP campaign.

The study hypothesized that those who were exposed to the campaign would have higher knowledge and favourable attitude regarding HIV/ AIDS prevention, treatment, and care and support as compared to those who were not exposed to the campaign.

## Key Research Findings

This subsection presents a snapshot of the key findings for the study based upon the information collected from all respondents covered under this study.

### Respondent Characteristics

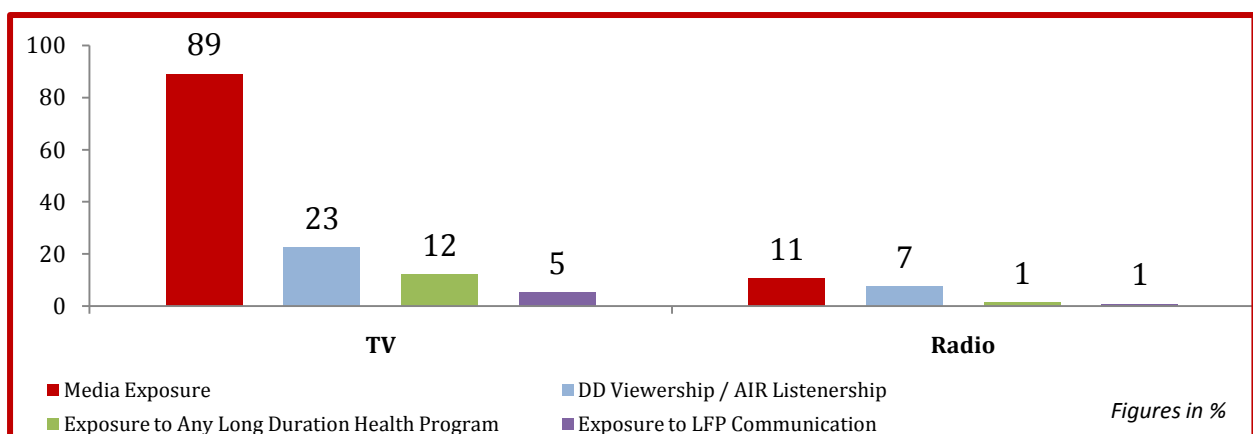
The median age for male respondents was around 38 years (SD=11.86) and the same for female respondents was around 36 years (SD=11.51). Skewedness towards higher age bracket was observed in the age of the respondents and higher proportion (30.8%) belonged to the 28-37 years age group. Close to 78% of the respondents belonged to Hindu religion while around 15% were Muslims. Overall, around 15% respondents reported being illiterate while close to 14% had completed schooling till Class XII and around 20% were educated till Class X. Around one third of the interviewed sample had a below poverty line (BPL) card. Large percentages of the respondents were currently married (83.7%) and majority of the families were nuclear (64.2%). More than half of the respondents (58.6%) reported that they had worked for money in the last 12 months. This proportion was more among males (87.7%) than females (26.3%).

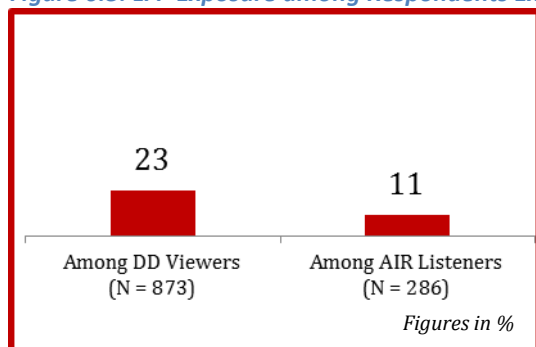
The most common source of media to which respondents were exposed was TV (89%) followed by newspapers (44.8%). Among TV programs, serials and news were among the top genres preferred and the top genres among radio programs were news and music.

### Reach and Recall of LFPs

Overall, reach of the LFPs remained low across the states, this being true for both LFPs being aired on TV as well as broadcast on radio. Main reasons which came up during analysis were (1) low penetration of Doordarshan (DD) channel viewership (23%) and All India Radio (AIR) listenership (7%); and (2) a low inclination to watch long duration health program among the respondents - 12% among TV viewers and 1% among radio listeners.

Figure 0.2: LFP Campaign Exposure



**Figure 0.3: LFP Exposure among Respondents Exposed to Media & Channel Viewers/Listeners**

The reach of LFP campaign among the DD viewers was close to one-fourth and among the AIR listeners it was found to be one-tenth.

State-wise analysis shows that reach of LFP campaign was higher among respondents from Maharashtra (10%) and Kerala (9%).

Most of the respondents who were exposed to TV LFPs recalled HIV/AIDS as the main discussion topic (81%) followed by voluntary blood donation which was recalled by close to one third of the respondents.

### *Impact of the LFP campaign*

Results show that the respondents who were exposed to LFPs were having greater knowledge levels against various issues critically related to HIV/AIDS. It was also found that exposure to the NACO's LFP was significantly associated with increased knowledge levels.

Greater proportions (85.3%) of respondent exposed to LFP have heard about STIs/STDs. Similarly, the exposed category of respondents possessed higher knowledge levels in context of HIV/AIDS (97.4% - exposed to LFP; 78.8% - not exposed to LFP) and were comparatively more aware about the places where testing for HIV is done (55.4% - exposed to LFP; 31.8% - not exposed to LFP).

Knowledge about PPTCT was also observed as high among the respondents exposed to LFP (47.8%) than those who were not exposed (25.6%). Same trend was observed in context of ICTC where 34% respondents who were exposed to LFP replied in affirmative against the question whether heard about ICTC as against 13.9% of those who were not exposed to LFPs. Similarly the knowledge levels in terms of blood donation and condoms were also high among the category of respondents who were exposed to LFP.

### *Conclusions*

The following key barriers were identified impacting the reach of the LFPs:

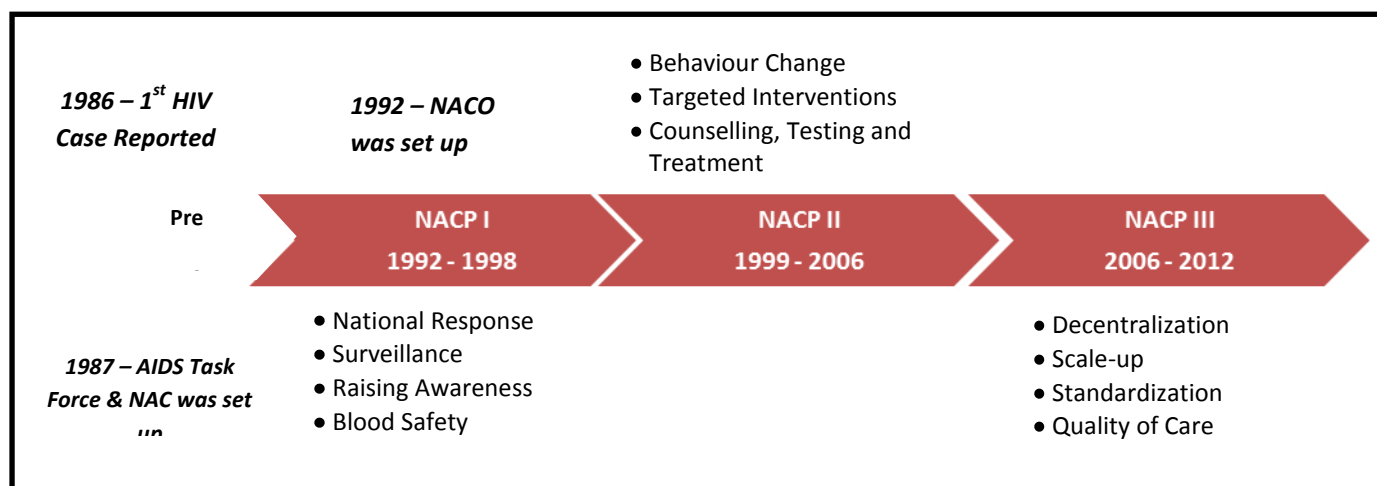
- Low viewership of national TV channel - DD and radio channel - AIR; the official broadcasters for airing the LFPs under the campaign.
- Preferences for serials and news as the genres viewed/listened to in media followed by music and comedy shows
- Low tendency among respondents to view/listen to the long duration programs related to health.

# Chapter 1 : Introduction and Background

## 1.1 About the Program

The first major step towards curtailing the spread of HIV/AIDS was taken by the GOI in 1987 by setting up of an AIDS Task force under the Indian Council of Medical Research (ICMR) and a National AIDS Committee (NAC) headed by the Secretary, Ministry of Health and Family Welfare (MOHFW). As the spread of the disease was increasing, a need was felt to curtail it with a focused approach; this led to the formation of NACO in 1992. In the same year, with the support of The World Bank<sup>1</sup>, a comprehensive programme named NACP Phase I was launched. The time log presented in Figure 1.1 provides a brief overview of the evolution of the NACP in India across the three phases:-

Figure 1.1: Overview of the Evolution of the National AIDS Control Programme in India



The key strategies and areas of focus for the NACP III program are presented here:

- Targeted interventions
- Link worker scheme
- Management of STI/reproductive tract infections (RTI)
- Condom promotion
- Blood safety
- Care, support, and treatment: ICTC and PPTCT
- Information, education, and communication (IEC) and mainstreaming
- Strategic information management

This study focusses on the LFPs. These programs, aired by NACO are aimed at spreading awareness in order to increase the knowledge and attitude about HIV/AIDS while covering the key strategies and focus areas of NACP III.

<sup>1</sup>[www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india](http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india)



## 1.2 Study Rationale

Since the inception of NACP-III in 2007, LFPs are implemented by SACS in 29 states of India. At the beginning of each year, a mass media calendar is prepared by NACO centrally highlighting the main focus areas for that particular year. Each state develops programmes in sync with this calendar to ensure synergy of messages at the state as well as national level. The themes, formats, and content for the shows are decided by each state based upon their priority and vary state by state.

Usually these programs are 15 – 30 minute episodes on HIV and AIDS issues. The objective of these programs is to raise awareness and increase favourable attitude with regard to HIV/AIDS prevention, treatment, care, and support and to address stigma and discrimination. Most of these programs have been telecast/broadcast on the public service providers for TV and radio - Doordarshan and AIR respectively. The target audiences of these programs were male and female in age-group of 18- 65 years.

Some of the formats used by NACO and SACS are:

- Phone-in programs
- Panel discussions
- Documentaries
- Drama
- Call-ins

While such programs on one hand are essential to increase the knowledge levels of the target audience in context of the issue being discussed, their evaluation on the other hand is equally important. The results of such evaluations help the implementers to understand strengths and weaknesses of the campaign. The findings from this study can also be used as a benchmark for setting targets for future campaigns. The data collected can further serve as a base to know the reach of the campaign, the comprehension levels of the key messages, likeability, and motivation post exposure to the campaign.

**The study was undertaken to assess the reach and recall of LFPs, which were implemented by NACO.**

### Geographic Coverage

As the components of this part of the campaign are primarily based on specific themes that are relevant to the states, sample respondents were selected from six states across the country. In order to ensure state selection from across the country, the states were stratified into NFHS zones. As per the National Family Health Survey (NFHS), India has been divided into six zones (Northern, Southern, Eastern, Western, Central, and North-East).

Further a matrix was created for each state based on following variables:

- (i) The number of media used
- (ii) The total number of episodes aired in the past year

One state from each zone was selected based on maximum number of media used and the maximum number of episodes being aired in last 12 months for LFP campaign.

Thus, the selected list of states arrived on the basis of the matrix is given below -

Table 1.1 *List of Sampled States*

Zones	State Selected
Northern	Jammu & Kashmir
Central	Madhya Pradesh
Eastern	Bihar
North East	Tripura
Western	Maharashtra
Southern	Kerala

### 1.3 Research Objectives

The study had the primary objective to measure the reach and recall of the LFP in the six study states of Jammu & Kashmir, Madhya Pradesh, Bihar, Tripura, and Maharashtra. The main objectives of the study were as follows:

- *To measure the reach and recall of the format, program messages, message comprehension, and when relevant, reactions to other aspects of the program/ format, including liking, relevance, and relatability*
- *To measure differences in knowledge, attitudes, and beliefs related to the themes of the campaign from the respondents exposed and non-exposed*
- *To ascertain the profile of the audience reached*

Based upon the research objectives, key findings are presented in this report. The analysis of data has been done with a view to present first a state level comparison of respondent characteristics including demographics indicators, media plans and habits. This is followed by a section on the reach and recall of the programs assessed through this study. Next, in order to ascertain the difference in knowledge, attitudes and beliefs prevalent among respondents exposed and non-exposed to the campaign, a separate section consisting of comparison between LFP exposed category of respondents and LFP non-exposed category of respondents has been included.

## Chapter 2 : Research Methodology and Study Implementation

### 2.1 Study Design

The study design included a cross-sectional household survey that was designed to capture the reach and recall of the LFPs. The episodes broadcasted by SACS under this campaign were accessed from their archives and studied in-depth.

It was understood that the format as well as the content varied across states. However, the topics covered were found to be revolving around the six thematic areas:

- (1) Sexually Transmitted Infections/ Diseases,
- (2) HIV/ AIDS,
- (3) ICTC,
- (4) PPTCT,
- (5) Blood Donation, and
- (6) Usage of condoms

The Questionnaires were designed to capture “spontaneous reach” by probing for different themes on one hand and the formats on the other hand. In order to ensure correct reach, all respondents were aided with stills of the program and audio recordings to understand if they have ever seen or heard to the programs under LFP campaign. The aids were developed by taking stills of the common features across the episodes and a few stills from different episodes for TV LFPs. Audio jingle and the opening & closing remarks of the anchor were used as aids for the radio LFPs. Finally those respondents who reported that they have seen or heard the program either at a spontaneous level or at an aided level were categorised as “exposed” to the LFP campaign.

### 2.2 Target Group

The inclusion criteria for this study were as follows:

- Both males and females
- in the age-group of 18- 65 years
- having access to either TV/ Radio

This study excluded randomly selected households in which either of the following two conditions was met:

- a) The potential respondent suffered from physical or cognitive disabilities that prevented their participation in the study, or
- b) The potential respondent did not consent to participate in the study.

## 2.3 Sampling Methodology and Sample Size

The sample size required to assess the reach and recall was computed based on the expected reach and access of all mediums (TV, radio, and digital cinemas) as 50%. As the information regarding reach of all mediums together was not available, the assumption of 50% was considered to yield the maximum sample size.

Based on the above considerations, the sample size (n) required to estimate the level of campaign reach was computed based on the following formula and key parameters:

$$n = \text{deff} \times \left\{ \frac{z^2 \times p(1-p)}{m^2} \right\} + c$$

Where, in this instance:

n = required sample size

z = confidence level at 95% (standard value of 1.96)

p = estimated reach of campaign in the project area (50% for all mediums)

m = margin of error at 5% (standard value of 0.05)

deff = design effect (considered at 1.5 for multistage sampling)

c = contingency / non-response rate (considered as 10%). Non-response would also compensate when respondents did not give consent to participate in the study.

The study was designed to provide estimates at the state level. Based on the above assumptions, the sample size per state was 634, rounded off to 660 for operational and logistical consideration. The sample of 660 per state was distributed across males and females between the age-group of 18 to 65 years.

**Table 1.2 Study sample size**

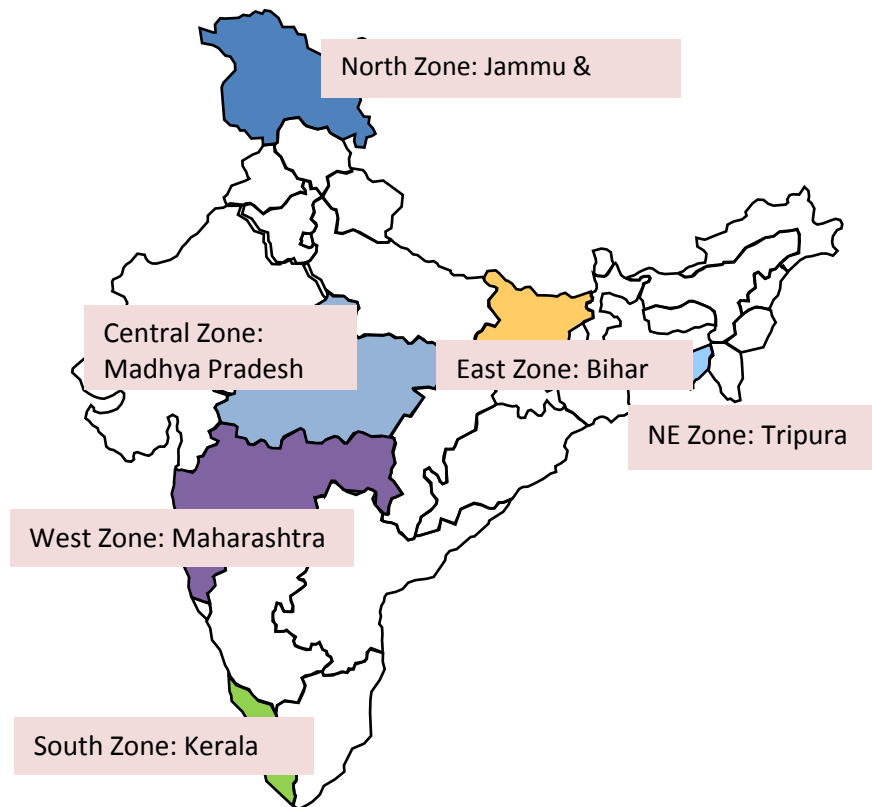
State	Sample Size	Male Sample	Female Sample
Bihar	660	330	330
Jammu & Kashmir	660	330	330
Kerala	660	330	330
Madhya Pradesh	660	330	330
Maharashtra	660	330	330
Tripura	660	330	330
<b>Total</b>	<b>3960</b>	<b>1980</b>	<b>1980</b>

## Sampling Methodology

A four staged sample selection process was utilized in this study as illustrated below:

### Step-1: Selection of States

Figure 2.2: Overview of the Evolution of the National AIDS Control Programme in India



Available information from each state in the zone was analyzed and a matrix was created for final state selection based on following parameters:

- The number of media used - if both television and radio was used then it was scored the highest followed by 'only television' and finally 'only radio'
- The total number of episodes of all media and programs telecast
- The total number of hours of telecast combined for the media used

### Period of operation & themes covered:

- Television:
  - The themes covered during the episodes aired 3-4 months prior to the study were chosen as the basis for the reach and recall study
  - All programs/episodes were studied to prepare the key messages and details to be assessed
  - In the case of multiple formats and themes, separate sections were prepared to cover the maximum information
- Radio:
  - Separate sections were created for both types of programs to cover reach and recall by program types
  - All the programs/episodes were studied to prepare the key messages and details to be assessed
  - The themes covered during the episodes aired 3-4 months prior to the study were chosen as the basis for the reach and recall study

## Step-2:

**Selection of districts:** In India, districts are categorized by Socio Cultural Regions (SCR) within the state. In each of the selected states, one district was randomly sampled from each of the SCRs with a minimum of three districts in each state.

## Step-3:

**Selection of PSUs:**The sample was spread across 30 PSUs in each state distributed across urban and rural PSUs based on population proportions. The PSUs were selected using probability proportional to size (PPS) sampling technique by using Census 2011 data. These PSUs were wards in urban areas and villages in rural areas. The distribution of PSUs across the selected districts into rural and urban category was done based on the rural and urban population proportion of the selected districts respectively. Care was taken to distribute the PSUs across districts in pairs so as to cover both male and female PSUs from each district. In order to ensure equal representation of male and female PSUs in a state, the selected PSUs were then arranged in ascending order of population and systematic random sampling technique was used to make final selection.

## Step-4:

**Sampling of the households:**This was done by generating detailed sampling frames through mapping and listing. From each PSU, 22 households were selected through this process.

## **Rural Sample**

- From the selected districts, by using Census 2011 data, a list of all the villages was drawn. As explained above, the required numbers of PSUs (villages) were selected by using PPS sampling method. Care was taken to ensure an equal distribution of PSUs among male and female categories.
- The selected rural PSUs were then categorized as segmented or non-segmented based upon the total number of households (HHs). Every PSU which had more than 150 HHs was divided into multiple segments of approximately 75 HHs each and two segments were selected randomly by using a random number table.
- A complete household listing exercise in selected segments (for segmented PSUs)/ in the entire village (for non-segmented PSUs) was done to identify the eligible HHs. All eligible HHs qualified to form the sampling frame from which the required numbers of HHs were selected by using systematic random sampling.
- For the HH listing exercise, trained investigators went to the house in selected segments of selected PSUs and after introducing themselves and the study, they collected the basic household listing information. For PSUs having less than 50 households, adjoining PSUs were clubbed together and then the process of segmentation was followed. The listing format collected information on description of

structure, name<sup>2</sup>, and address of the head of household. At the time of household listing exercise, certain details to ascertain HH eligibility were also recorded.

This information was utilized to prepare a sampling frame from which the eligible HHs were selected and approached for the interviews. Within each selected household, during the main interview, basic information related to TV and radio viewership was captured from men and women (depending upon the category of PSU) in the age group of 18-65 years. This helped in ascertaining their eligibility for getting interviewed. One respondent was subsequently selected from all the eligible members in a household for conducting final interview by using a random number table<sup>3</sup>.

The details for the household listing exercise are available in hard copies and only the serial number and eligibility number of the selected households was transferred to the main questionnaire. To ensure confidentiality, no other data from the household listing sheet was used or linked with the main questionnaire. IHBP research staff was able to access these forms for monitoring purposes and post completion of fieldwork, the forms have been safely stored with agency and shall be retained for three years.

### Urban Sample

Within the selected districts, all the municipal wards were arranged in ascending order of their population and required numbers of wards were selected using PPS sampling. Separate wards were selected for men and women respondents. Care was taken to have approximately equal number of wards in each district for coverage of male and female respondents respectively. Similar to rural areas, a complete house-listing was done in the selected segments followed by a related exercise to select eligible respondents. From each ward, 22 respondents were interviewed.

The merit of this approach was that it allowed for proper representation of the universe and kept it almost the same for male and female survey. Hence, all PSUs (rural-villages and urban-wards) had an equal probability of being selected for women's as well as for men's surveys. This approach also helped in developing appropriate estimating equations with well-defined probabilities of sampling units at different stages. There was also a logistic advantage of deploying teams of male investigators in men's PSUs and female investigators in women's PSUs. There was no possibility of any overlapping of husbands and their spouses being interviewed thereby avoiding any possible bias and non-sampling error.

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<sup>2</sup>The name of the respondent during the household listing exercise is essential to identify the eligible respondent at the time of the survey. However, the access of the respondent's information was limited only with field investigators and was handed over to IHBP team after the completion of the survey. At no stage the identity of the respondent was revealed as, in the main questionnaire we only used unique ID number.

<sup>3</sup>([www.paho.org/english/ad/dpc/nc/steps-tng-7-kish.ppt](http://www.paho.org/english/ad/dpc/nc/steps-tng-7-kish.ppt))

Table 2.1: Sample Size Distribution for LFP

Particulars	Bihar		J&K		Kerala		Madhya Pradesh		Mahara-shtra		Tripura		Total	
	P	A	P	A	P	A	P	A	P	A	P	A	P	A
No. of districts	3	3	3	3	4	4	6	6	5	5	3	3	24	24
No. of PSUs	30	30	30	30	30	30	30	30	30	30	30	30	180	180
No. of Rural PSUs	26	26	22	22	16	16	22	22	16	16	22	22	124	124
No. of Urban PSUs	4	4	8	8	14	14	8	8	14	14	8	8	56	56
<b>Gender</b>														
Male	330	330	330	299	330	329	330	330	330	316	330	327	1980	1931
Female	330	330	330	303	330	329	330	322	330	320	330	321	1980	1925
Total	660	660	660	602	660	658	660	652	660	636	660	648	3960	3856
<b>Location</b>														
Rural	572	572	484	447	352	350	484	475	352	339	484	475	2728	2658
Urban	88	88	176	155	308	308	176	177	308	297	176	173	1232	1198
<b>Total</b>	<b>660</b>	<b>660</b>	<b>660</b>	<b>602</b>	<b>660</b>	<b>658</b>	<b>660</b>	<b>652</b>	<b>660</b>	<b>636</b>	<b>660</b>	<b>648</b>	<b>3960</b>	<b>3856</b>

\* PSUs sample in each state was distributed across Urban and Rural proportionately, using PPS from Census 2011.

'P': Planned Sample ; and 'A': Achieved Sample



## 2.4 Data Collection

SRI-IMRB, a New Delhi-based research agency was hired by IHBP to carry out this study. The selection of the research agency was done through a competitive bidding process. All study operations like pre-testing of the questionnaire, field training (including research ethics), data collection, data entry, data analysis, and report writing was managed by the research agency; however IHBP researchers supervised, monitored, and coordinated the research agency's work very closely.

### Survey Instrument

Considering the key objective and the key indicators as described above, a structured close-ended questionnaire with special provision to record open-ended responses wherever required was used. The questionnaire was translated into regional languages

State Name	Language Used
Jammu & Kashmir	Hindi
Madhya Pradesh	Hindi
Bihar	Hindi
Tripura	Bengali
Maharashtra	Marathi

and a bilingual version with English followed by Hindi and other languages was put to use for data collection for each state as detailed below. The household listing questionnaire had questions on 'inclusion criteria' mentioned above.

### Pre-testing of Questionnaire

Prior to undertaking the main fieldwork, the translated versions of the questionnaire were pre-tested in real field settings. The pre-test was used to gather information on the following points:

- Flow of the questions
- Ease in understanding of the questions by the respondents
- Ease in administering the questionnaire
- Comprehensiveness in terms of information coverage
- Testing of the language used

The pre-test process involved the same process that was followed during the main data collection. However, the pre-test was done at a different location from the main survey. The pre-test was conducted with 45 men and 45 women as per the details given below.

**Table 2.2: Break-up of Pre-test Sample Size Coverage**

Pre-test Component	Number of State per category	Interviews per category	Total Interviews
Content	3	7-8 male; 7-8 female	45
Language	3	7-8 male; 7-8 female	45
<b>Total</b>			<b>90</b>

## Training

The training to the field teams were imparted in two stages. At first stage the trainers from each state were trained at a central location (Delhi) by the key Researchers from IHBP and IMRB. This training of trainers (ToT) was conducted in a workshop mode for 3 days. The trainers were briefed on the project requirements and methodology along with the Questionnaires. These trainers then conducted a 3-day training session for the listing and mapping teams and 5-day training for main field teams at the state level. IHBP researchers were present during these training sessions too to guide the field teams. The training program consisted of:

- Overview about the study objectives
- Briefing on mapping and listing methodology
- Briefing on the sampling methodology
- Research ethics, including informed consent procedures (all study staff had evidence of completion of an approved curriculum)
- Briefing on the questionnaires
- Mock interviews on study tools
- Mock practice for mapping and listing
- One day field testing

## Interviews Procedure

All interviews were one-on-one and were conducted at the respondent's household. Informed consent was obtained from the participant before the interviewer began the interview. Privacy and confidentiality of the discussion was maintained and all possible measures were taken in order to ensure that no other family members were present during the interview so as to avoid anybody's influence (bias) on the respondent's responses. In case of another's presence, the interviewer requested them to allow for respondent's privacy and ensured that no external member was present during the interview. All interviews were conducted in vernacular language and the information was coded simultaneously on the questionnaire itself. Same sex interviewers were used with respondents such that interviews with women were done by female investigators, and so forth. For every four investigators, there was one supervisor whose primary role was to supervise the performance of the investigators, and to ensure adherence to the research protocol like sampling and ethics, etc. The supervisor of each field team made at least 25% accompaniments and 20% back checks every day.

## 2.5 Data Management

### Data Scrutiny and Coding

All data entry forms were assigned a unique study identification number (study ID) to assist with data management and data entry. Before data entry each and every questionnaire was scrutinized. All coders and supervisors were involved in scrutiny and coding and received training from the systems analyst. During the scrutiny, open-ended questions, if any were coded. All questionnaires were checked to ensure that they had been assigned a study ID and that there was no identifying information for respondents recorded on the questionnaire.

### Data Entry

The data structure was developed by the agency and was reviewed by IHBP researchers prior to start of the data entry. The data entry operation was carried out using data entry and editing software - Quantum and was completed on password-protected computers. The data entry operation was initiated within seven days of the start of the fieldwork. Program-based logical checks were used to clean the data and the inconsistencies were resolved on the basis of the responses recorded in the questionnaires. The system analyst for the study as well as the core study team members closely monitored the data entry operations.

### Data Confidentiality

To avoid risks associated with the disclosure of sensitive information, every effort was made to ensure that participants' responses were kept confidential. Completed questionnaires, field notes and other study results were kept locked in a dedicated storage facility and access to these was limited to the Principal Investigator and to the data management consultant. SPSS computer files containing participant data were password protected and all personal identifiers (except study ID) were removed from analytic files. The final data set was only accessed by the local research partner agency and IHBP staff. Names were not recorded in any document and data were reported in aggregate form only. The research team was responsible for data storage after the completion of the study.

During the trainings, a propensity of sharing personal information within the participants was observed. The participants were briefed on the importance of maintaining confidentiality in context of the 'respondent information' and were cautioned not to indulge into discussing or sharing any respondent related information during the period of data collection. However, it may be possible that, despite our best efforts, confidentiality was breached. In such instances, the project staffs were instructed to immediately report the incident to the relevant coordinator, in this case, the local consultant from SRI-IMRB, who in turn would report the issue to IHBP. It was noted that during the course of entire data collection, no such incidents got reported.

## Data Analysis

In order to make the results representative for the entire population, sampling weights were applied to the data set, thus ensuring an equal selection probability for each respondent. As a multi staged sampling technique was used in the study, sampling weights were calculated corresponding to its each stage. The basis of calculation was the probability of selection of a sampling unit within that stage. Through these weights, normalized PSU wise weights were arrived at which further were applied to the data set. The percentages in the tables appearing as the part of analysis in this report have been calculated after applying the necessary weights to the raw data.

*Estimation Formula: Normalized weights (for each PSU):*

$$\hat{Y}_j = \frac{\sum \dots}{\sum \dots}$$

Steps for the calculation of multiplier based on various stages of sampling are as under:

1. Calculation of HH Multiplier:  $X_1 = 1 / (h_j / H_j)$
2. Calculation of Segment level Multiplier:  $X_2 = 1 / (s_j / S_j)$
3. Calculation of PSU Multiplier:  $X_3 = (1 / (PP_j / DR_K)) / PD_K$   
( $DU_K$  in place for urban PSUs)
4. Calculation of District level Multiplier:  $X_4 = 1 / (d_s / D_s)$
5. Calculation of Respondent Level Multiplier:  $X_5 = 1 / (r_j / R_j)$
6. Aggregate multiplier (for each PSU):  $X_j = X_1 * X_2 * X_3 * X_4 * X_5$

where:

- $h_j$  : Number of households with a complete interview in the PSU  
 $H_j$  : Number of eligible households found in the PSU  
 $s_j$  : Number of segments selected for listing  
 $S_j$  : Number of segments made in the PSU  
 $PP_j$  : PSU Population  
 $DR_K$  : District Population-Rural  
 $DU_K$  : District Population-Urban  
 $PD_K$  : Number of PSUs Selected in the district  
 $d_s$  : Number of districts selected from each SCR  
 $D_s$  : Number of Districts in the zone in which the district comes  
 $r_j$  : Number of eligible respondents with a complete interview in the PSU  
 $R_j$  : Number of eligible respondents in the PSU

## **2.6 Methodological Aberrations**

### **1. Sampling of PSUs in Jammu & Kashmir**

Similar to all other states, initially the district selection in the state of Jammu & Kashmir was based upon the total number of SCRs in the state. However, during the prelaunch phase of the study, Kashmir valley witnessed a natural calamity in form of extreme floods which disconnected the connectivity between the lower region of state and upper region including Kashmir valley. Due to this extremity and the associated security issues of Indo Pak bordering areas, we were forced to re-examine our sampling process and final district selection in Jammu & Kashmir was done from districts belonging to one SCR - North Punjab.

### **2. Unavailability of urban maps**

Directorate of Census Operation offices in every state were approached for procurement of maps of the sampled urban wards. While we were successful in procuring maps in some cases, in majority of cases the maps were unavailable. The fieldwork continued by following segmentation process as done in rural PSUs for all such cases based upon the advice received from client.

### **3. Geographical factors**

Geographical factors such as hilly terrain and scattered nature of households in Jammu & Kashmir and large size of villages in Kerala state, created a limitation to the survey. In first situation application of right hand rule became difficult while in second situation segmentation was challenging. Catering to this, in former case, teams were advised to apply serpentine rule and they performed listing exercise in selected segment by moving from one hill to the other while in latter case, panchayats maps were utilized to select wards within the selected villages and the process of random segment selection was followed.

### **4. Fieldwork constraints**

The period of fieldwork for this study clashed with the period of major Indian festivals namely Diwali and Durga Puja. Due to this, irrespective of multiple field teams visits, selected respondents were non-available in some PSUs. This lead to an overall shortfall of 3% in sample size coverage and response rate remained at 97% for this study.

## Chapter 3 : Characteristics of Survey Respondents

This chapter covers the profile of the respondents surveyed for the reach and recall study. The overall response rate for this study remained at 97%. The chapter provides details with reference to both male and female respondents accommodating for the geographical differentiation of rural and urban divide. The indicators discussed in this chapter relate to the socio-cultural aspects of the respondents in the study states.

### 3.1 Demographic Profile of Respondents

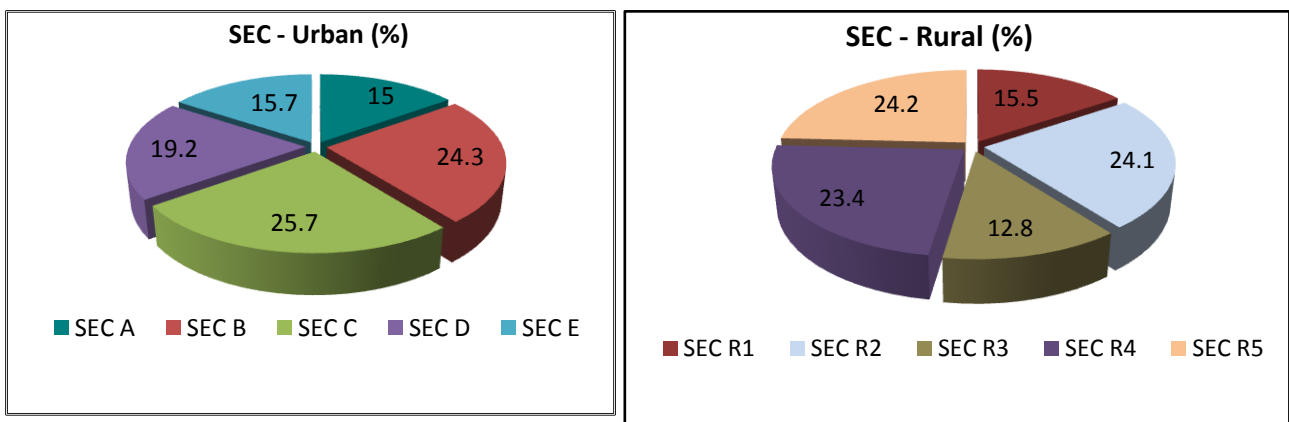
The basic demographic identifiers for characterizing the respondents in the study pertain to their age group, gender, marital status, and family composition. A snapshot of the key demographic characteristics of the respondents interviewed in the study is shown in Table 3.1 below.

**Table 3.1: Demographic Profile of Survey Respondents (Percentage of Respondents)**

Characteristics	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maharashtra	Kerala
<i>All Respondents (N)</i>	<b>3,876</b>	<b>602</b>	<b>652</b>	<b>660</b>	<b>668</b>	<b>636</b>	<b>658</b>
<b>Age Group</b>							
18-27 years	<b>23.7</b>	23.6	32.3	26.8	23.4	20.6	15.7
28-37 years	<b>30.8</b>	32.1	36.8	34.2	30.4	29.7	21.4
38-47 years	<b>24.2</b>	22.3	18.8	24.1	26.8	28.3	24.7
48-57 years	<b>14.1</b>	12.8	7.9	9.0	13.8	13.5	27.6
58+ years	<b>7.3</b>	9.2	4.2	5.9	5.7	7.9	10.7
<b>Gender</b>							
Male	<b>52.6</b>	60.1	43.6	48.6	57.3	51.0	55.5
Female	<b>47.4</b>	39.9	56.4	51.4	42.7	49.0	44.5
<b>Marital Status</b>							
Single unmarried	<b>13.1</b>	19.1	9.2	7.9	14.7	9.5	18.5
Currently Married	<b>83.7</b>	79.9	88.3	90.4	82.1	86.3	74.8
Divorced	<b>0.3</b>	0	0.2	0.0	0	0.2	1.4
Separated	<b>0.1</b>	0	0.2	0.2	0	0.0	0.0
Widowed	<b>2.6</b>	1	2.1	1.5	3.2	3.1	4.4
<b>Family Composition</b>							
Nuclear	<b>64.2</b>	53.4	49.8	70.6	71.3	50.6	88.2
Extended	<b>13.4</b>	11.7	32.2	5.0	13.2	8.6	9.7
Joint	<b>22.3</b>	34.9	18.0	24.5	15.5	40.8	2.1

Analysis of the demographic profile of the respondents showed that a higher proportion (30.8%) of respondents belonged to the 28-37 years age group. There was representation from the other age bands as well. The mean age of all respondents was around 37 years (SD=11.73), with the mean age of males being around 38 years (SD=11.86) and around 36 years for females (SD=11.51). Overall, the split between rural and urban respondents was 69:31. A majority (83.7%) of the respondents were married. Overall, almost equal proportions of male respondents (50.1%) and female respondents (49.9%) were covered under the study. However due to higher presence of eligible male respondents in a household than the female ones, the male PSUs got higher normalized weights during the process of weighing. Hence the corresponding coverage under male category post weighing came as 52.6% while that for the females declined to 47.4%.

Figure 3. 1: SEC Split (Urban) Figure 3. 2: SEC Split (Rural)



N:(All Urban Respondents): 1193

N:(All Rural Respondents): 2683

The sample was representative in terms of the socio economic class (SEC) with respondents belonging to both upper and lower classes interviewed. In urban areas, around 39.4% of the survey respondents belonged to the upper SECs (SEC A and B) and 34.9% belonged to the lower SEC (SEC D and E). In rural areas, around 15.5% of the respondents interviewed belonged to SEC R1 and 24.2% belonged to SEC R5.

### 3.2 Ethnicity and BPL Status of Respondents

Socio-cultural dimensions play an important role in shaping the attitudes and behavior of any resident population. The study captured details of caste and religion from all the respondents interviewed. Table 3.2 presents the percentage distribution of the respondents interviewed by their ethnicity and their status of having a BPL card with them.

**Table 3.2: Ethnicity and BPL Status of Survey Respondents (Percentage of Respondents)**

Characteristics	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maharashtra	Kerala
<i>All Respondents (N)</i>	<b>3,876</b>	<b>602</b>	<b>652</b>	<b>660</b>	<b>668</b>	<b>636</b>	<b>658</b>
<b>Religion</b>							
Hindu	<b>77.8</b>	59.8	80.3	92.8	78.8	84.8	68.7
Muslim	<b>15.4</b>	39.8	19.3	6.8	11.0	9.3	8.1
Christian	<b>5.7</b>	0.1	0.0	0.0	9.8	0.3	23.2
Sikh	<b>0.1</b>	0.2	0.0	0.5	0.0	0.1	0.0
Buddhist/Neo-Buddhist	<b>0.6</b>	0.0	0.0	0.0	0.3	3.5	0.0
Jain	<b>0.4</b>	0.0	0.4	0.0	0.0	2.0	0.0
<b>Caste</b>							
Other Backward Caste	<b>32.5</b>	1.5	53.2	38.7	17.2	34.9	47.7
Scheduled Caste	<b>16.5</b>	17.0	17.7	27.1	22.2	8.3	6.1
Scheduled Tribe	<b>8.3</b>	4.4	7.1	5.3	25.6	4.0	2.5
General Caste	<b>41.6</b>	77.0	20.6	28.9	32.4	50.5	43.6
<b>BPL Status</b>							
Yes	<b>33.7</b>	17.4	31.8	40.9	38.9	34.8	36.9
No	<b>64.7</b>	82.6	67.1	58.7	60.6	60.3	60.3
Don't Know	<b>1.6</b>	0	1.1	0.5	0.6	4.8	2.8

77.8% of the respondents belonged to the Hindu religion and another 15.4% were Muslims. In Kerala, close to around 68.7% of the population were Hindu and 23.2% Christians. Data from Bihar suggests that 92.8% of the interviewed respondents were Hindu and around 6.8% were Muslim. The highest proportion of Muslims, as expected, in the sample was reported in Jammu & Kashmir.

Analysis of the data by caste also revealed that the majority of respondents across states belonged to the General Caste (41.6%) and OBC (32.5%). The highest proportion of General Caste respondents were in Jammu & Kashmir (77.0%). In Kerala, the OBC respondents (47.7%) were only a little more than the General Caste respondents (43.6%). Another observation from the data revealed that around 32.4% of the respondents in the state of Bihar also belonged to the SC/ST category.

The study also captured the details of whether the household had a below poverty line (BPL) card or not. At an overall level, it was seen that 33.7% of the sample interviewed had a BPL card (24.2% urban, 43.8% rural). Looking into the variations at the state level, analysis showed that the highest proportion of BPL card holders were from Bihar (40.9%).



### 3.3 Educational Profile of the Respondents

The study collected information from all men and women interviewed about their educational qualifications. The educational profile of the respondents interviewed for the purpose of this study is shown in Table 3.3. At an overall level, around 15.4% of respondents were illiterate, close to 14.4% had completed school till Class XII, and around 20.2% were educated till Class X.

**Table 3.3: Percentage Distribution of Literacy Levels of Survey Respondents**

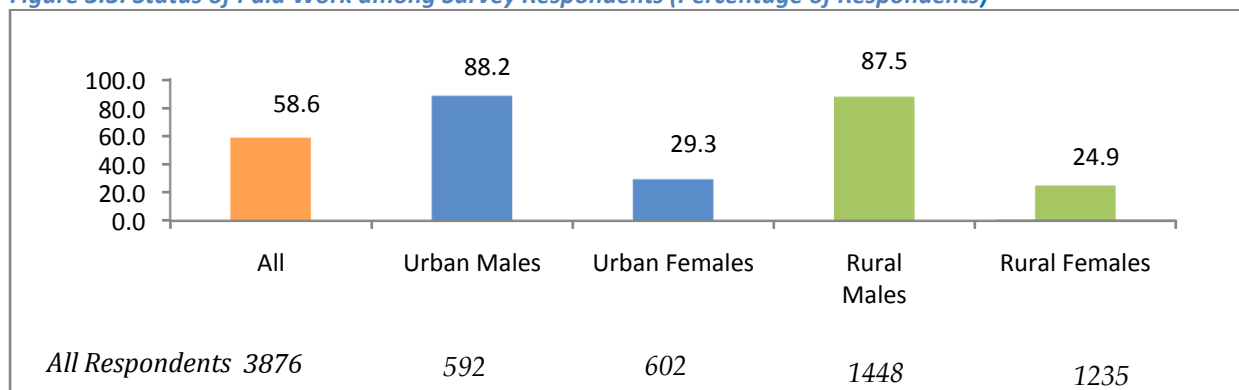
Education Level	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maha-rashtra	Kerala
<i>N (All Respondents)</i>	<i>3,876</i>	<i>602</i>	<i>652</i>	<i>660</i>	<i>668</i>	<i>636</i>	<i>658</i>
Illiterate	15.4	19.7	22.6	26.8	7.4	14.1	2.5
Literate with no formal education	4.5	0.9	9.9	3.8	4.7	4.8	2.8
Primary school (up to Class V)	16.0	11.0	23.2	8.2	24.0	14.8	14.3
Middle school (up to Class VIII)	19.0	19.1	19.4	17.2	27.9	17.0	13.4
Secondary school (up to Class X)	20.2	21.9	11.5	20.0	17.5	23.1	27.2
Senior secondary school (up to Class XII)	14.4	16.1	7.4	13.5	11.7	15.2	22.6
Graduate and above	10.4	11.4	6.1	10.5	6.5	11.0	17.2

Looking into the inter-state variations, the data revealed that the literacy rate among the respondents interviewed was the highest in Kerala (97.5%) and was lowest in the state of Bihar (73.1%). Similarly, around 17.2% respondents of Kerala were educated more than graduate, the highest among the states surveyed. The lowest percentage of graduate and above respondents was in Madhya Pradesh at around 6.1%.

### 3.4 Occupational Profile of Respondents

The study also captured the employment and occupation details of the respondents interviewed (Figure 3.3).

**Figure 3.3: Status of Paid Work among Survey Respondents (Percentage of Respondents)**



Analysis of the data revealed that about 58.6% of the respondents had worked for money in the last 12 months. The proportion of such respondents was the highest in Maharashtra (72.8%) and lowest in Madhya Pradesh (49.4%). Further analysis by gender revealed that 87.7% of males (n=2,039) and 26.3% of females (n=1,837) had worked for money in the last 12 months.

Most of the urban males were skilled workers, unskilled workers shop owners and petty traders. Rural males were mainly involved in the agricultural sector with cultivator, agricultural labor, skilled and unskilled work as their main occupation. Rural females were also mainly involved in agricultural work (~35.9%).

**Table 3.4: Occupational Profile of Survey Respondents (%)**

Characteristics	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maharashtra	Kerala
<i>All Respondents currently working for money (N)</i>	<i>2,272</i>	<i>340</i>	<i>322</i>	<i>358</i>	<i>414</i>	<i>463</i>	<i>375</i>
Unskilled Worker	<b>19.4</b>	20.3	22.4	11.1	24.6	24.7	11.3
Skilled Worker	<b>19.1</b>	14.6	17.9	10.7	29.4	15.9	24.8
Shop Owner	<b>8.5</b>	17.2	7.4	5.7	8.0	3.3	11.2
Petty Trader	<b>6.8</b>	7.3	5.3	4.8	8.1	5.9	9.0
Businessman/Industrialist	<b>1.3</b>	2.7	1.3	1.0	1.2	0.5	1.6
Self Employed Professional	<b>2.3</b>	3.3	1.2	0.8	4.3	0.5	3.5
Clerical / Salesman	<b>3.9</b>	6.7	0.9	3.0	0.7	5.1	6.9
Supervisory Level	<b>1.7</b>	3.5	0.3	2.9	1.0	0.6	2.0
Officer/ Exec Junior Level	<b>0.9</b>	0.8	1.2	0.0	1.3	0.6	1.7
Officer/Exec Mid- Senior	<b>0.9</b>	0.8	0.2	0.5	1.1	0.9	1.8
Teacher/Lecturer	<b>2.7</b>	4.3	1.6	3.5	3.2	0.7	3.6
Student	<b>1.6</b>	1.1	0.5	1.2	0.3	1.4	5.0
Agricultural Laborer	<b>13.5</b>	7.7	15.4	26.5	9.4	14.8	7.6
Cultivator	<b>14.7</b>	8.4	18.6	27.3	6.8	18.1	9.4
Servant	<b>1.0</b>	0.7	3.8	0.7	0.7	0.7	0.2
Housewife	<b>1.4</b>	0.0	1.6	0.2	0.0	5.4	0.0

Analysis of the data also revealed that close to 35% of the illiterate respondents were involved in the unskilled labor, which decreased to 4% in the case of those who had education of more than 12 years.

### 3.5 Media Exposure of Respondents

Media exposure was measured by asking respondents about the frequency (almost every day, at least once a week, less than once a week, not at all) with which they read newspapers and magazines, watched TV, or listened to the radio. A snapshot of the media habits disaggregated by gender and location is presented in Table 3.5 below.

Figure 3.4: Media Exposure (in %)

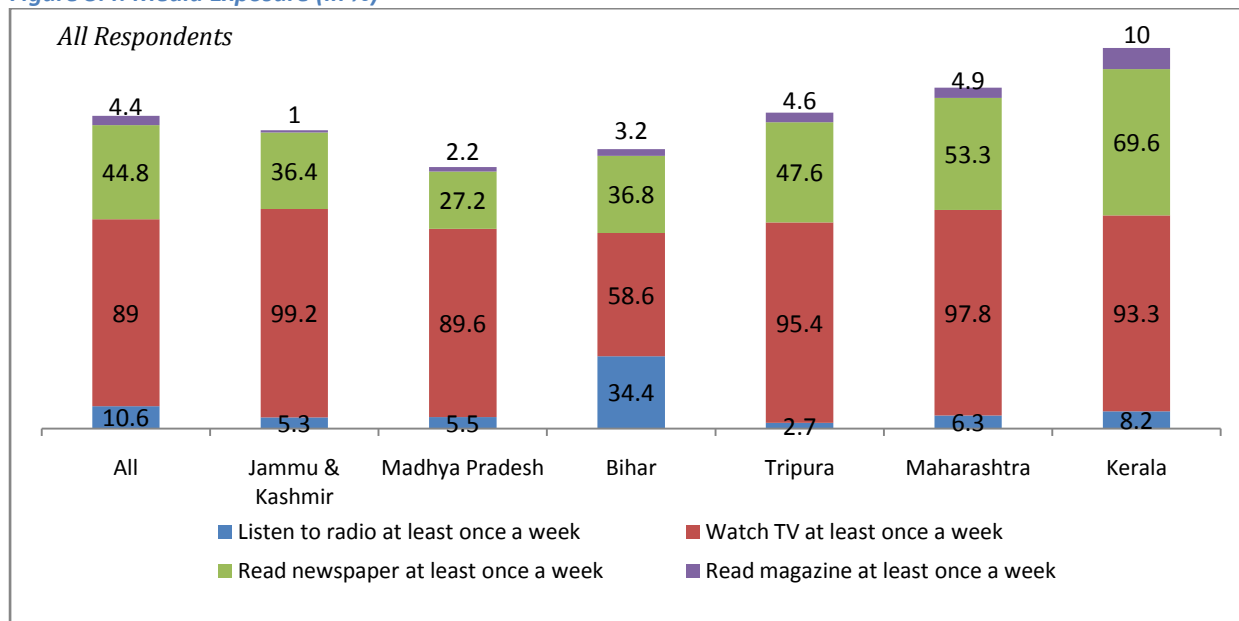


Table 3.3: Percentage Distribution of Respondents Exposed to Media by Location and Gender

	Total			Urban			Rural		
	T	M	F	T	M	F	T	M	F
<i>N (All Respondents)</i>	3,876	2,039	1,837	1,193	592	602	2,683	1,448	1,235
Listen to radio at least once a week	10.6	10.3	11.0	4.3	3.0	5.6	13.4	13.2	13.6
Watch TV at least once a week	89.0	89.6	88.4	95.9	98.0	93.8	86.0	86.2	85.8
Read newspaper at least once a week	44.8	56.0	32.4	57.0	67.4	46.7	39.4	51.4	25.4
Read magazines at least once a week	4.4	3.1	5.8	7.4	4.8	10.0	3.0	2.4	3.8

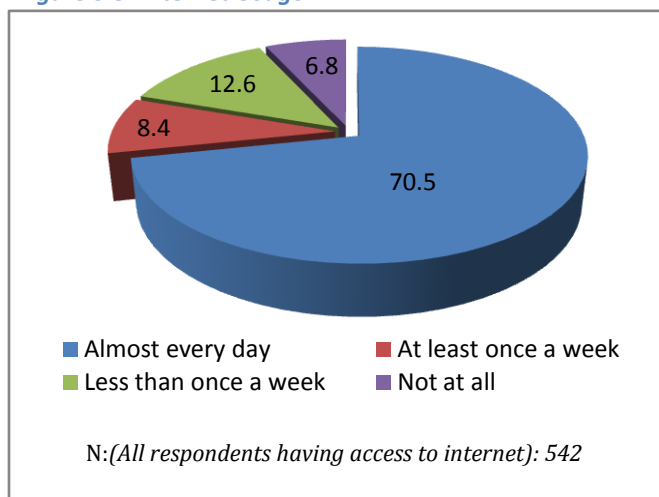
Analysis of the data revealed that the highest penetration of any regular media consumption was for TV, as 89% of respondents watched TV at least once a week, with the differentials being higher in the urban areas (95.9%) and slightly higher with urban males (98.0%) than urban females (93.8%).

At an overall level, reading magazines (around 4.4% percent) was the lowest among the various types of media exposure. A stark difference was reported for reading newspapers by gender. Around to 67.4% of males in the urban areas read a newspaper at least once a week as compared to less than half of females in urban areas (Table 3.5).

Analysis of the data by state revealed that TV viewership was highest in Jammu & Kashmir (99.2%) followed by Maharashtra (98.3%), Tripura (95.4%), Kerala (93.5%), and lowest in Bihar (59.4%). In contrast to TV viewership, regular readership of newspapers was found to be the highest in Kerala (68%) and the lowest in Madhya Pradesh (27.1%).

The usage of internet was also investigated based on these parameters but only to those who had access to internet facilities.

Figure 3.5: Internet Usage



Analysis of the data showed that around 14% of the total respondents had access to the internet. Around 6.7% of respondents had never heard about internet.

Of all respondents who had access to internet (n=542), about 78.9% reported that they used it at least once a week. The usage was marginally lower in rural areas (76.7%) when compared among the urban areas (81.1%).

The respondents were asked about mobile ownership and usage. They were also asked whether they went to watch Cinema and if yes, then how often did they go.

Table 3.4: Media exposure – Mobile & Cinema

	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maha-rashtra	Kerala
N (All Respondents)	3,876	602	652	660	668	636	658
Own Mobile	69.4	57.0	68.3	64.2	77.9	67.9	80.1
Go to Cinema	14.4	6.8	9.8	6.3	6.4	14.9	42.0

Overall, 69.4% own mobile phones. The ownership was highest among urban-male (93.2%) and lowest among rural-female (45.7%). The mobile phone owners as well as cinema-goers were high in Kerala compared to other in states with 80.1% and 42.0% respectively. Overall, the percentage of respondents who go to cinema was low (14.4%). Here too urban-males accounted for a higher proportion of cinema goers (30.9%) and the lowest category of respondents going for cinema was rural-female (4.0%).

## Media Plans and Media Habits

To further understand the media habits, the respondents were also asked about the types of genres of media consumed.

**Table 3.5: Genres/Programs Watched on TV**

	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maha-rashtra	Kerala
<i>N (Watch TV)</i>	<i>3,451</i>	<i>597</i>	<i>585</i>	<i>392</i>	<i>637</i>	<i>625</i>	<i>615</i>
News	<b>64.3</b>	85.8	41.2	62.6	64.8	57.6	72.8
Soaps/ Serials	<b>71.3</b>	84.4	81.8	71.3	64.2	82.1	45.2
Sports	<b>21.5</b>	36.0	6.4	14.8	21.1	18.8	29.0
Music	<b>31.2</b>	38.6	15.4	27.9	20.5	42.2	41.2
Reality Shows	<b>15.7</b>	9.8	7.0	5.2	11.3	12.4	44.3
Game Shows	<b>5.9</b>	4.1	1.0	0.9	5.3	4.6	17.3
Cooking Shows	<b>6.6</b>	2.1	1.8	0.2	3.0	11.7	18.4
Comedy Shows	<b>22.1</b>	19.1	14.2	5.9	6.5	23.7	57.4
Mythological Shows	<b>14.5</b>	2.1	38.3	14.9	2.1	26.3	4.4
Dance Shows	<b>12.7</b>	5.6	6.9	5.6	15.1	11.5	28.2
Horror Shows	<b>1.6</b>	0.3	0.8	0.2	0.9	3.9	2.9
Travel Shows	<b>1.5</b>	1.3	0.1	0.6	0.0	0.9	5.9
Talk Shows	<b>3.5</b>	1.4	0.3	3.3	2.5	1.2	12.3
Non-Fiction	<b>2.8</b>	0.0	7.6	0.0	0.0	7.8	0.4
Film	<b>13.9</b>	23.1	8.0	4.9	21.6	1.4	20.8

At the aggregate level, serials and news were the top genres preferred. This was followed by music and comedy shows. Some variations were observed in preferences across the study states. In Kerala, comedy shows were more preferred genres than serials. The preference toward mythological shows was higher in Madhya Pradesh and Maharashtra as compared to other study states. In Jammu and Kashmir and Kerala, the most popular genre reported was news (85.8% and 72.8% respectively) followed by soaps/serials (84.4% and 45.2% respectively). Music was comparatively the most popular in Maharashtra (42.2%) and Kerala (41.2%) as compared to the overall average of 31.2%.

Table 3.6: Genres/Program Listened to on Radio

	All	Jammu & Kashmir	Madhya Pradesh	Bihar	Tripura	Maha-rashtra	Kerala
<i>N (Listen Radio )</i>	<b>411</b>	<b>32#</b>	<b>39</b>	<b>227</b>	<b>18#</b>	<b>41</b>	<b>54</b>
News	<b>78.3</b>	64.0	49.7	86.1	67.3	62.2	83.4
Music	<b>71.2</b>	75.0	71.1	64.0	75.8	82.7	89.2
Sports broadcast	<b>3.1</b>	17.4	1.3	2.9	0.0	0.0	0.0
Call-in	<b>4.3</b>	22.9	1.4	3.3	0.0	4.3	0.8
Interviews	<b>5.7</b>	0.0	0.0	3.4	0.0	24.3	10.5
Story narration	<b>14.4</b>	4.1	12.4	18.2	0.0	28.0	0.0
Weather reports	<b>6.9</b>	10.4	5.8	7.2	7.5	8.2	2.8
Religious song	<b>1.2</b>	0.0	10.8	0.3	0.0	0.0	0.0
Agricultural news	<b>1.1</b>	0.0	6.9	0.6	0.0	0.0	0.6

# fewer observation

The news and music were the top programs listened to on radio. Almost 8 out of 10 respondents listened to news (78.3%) and 7 out of ten respondents listened to music (71.2%) on the radio. In all the study states, more people listened to music than news except Bihar, where 86.1% respondents listened to news and 64% listened to music on the radio.

## Chapter 4 Reach and Recall of the Long Format Programs

### 4.1 Long Format Programs – a State-Wise Snapshot

In every state, the LFPs aired by state SACS over a period of the last one year were covered for accessing their reach and recall. While these programs varied across states, their mode of communication remained constant – TV and radio. Apart from accessing the reach and recall of the program overall, the extent of impact created by the program on the respondents was also analyzed. Respondents were also assessed on various other parameters such as the knowledge of the main discussion themes in the program, likeability, extent of motivation and levels of relation with the program.

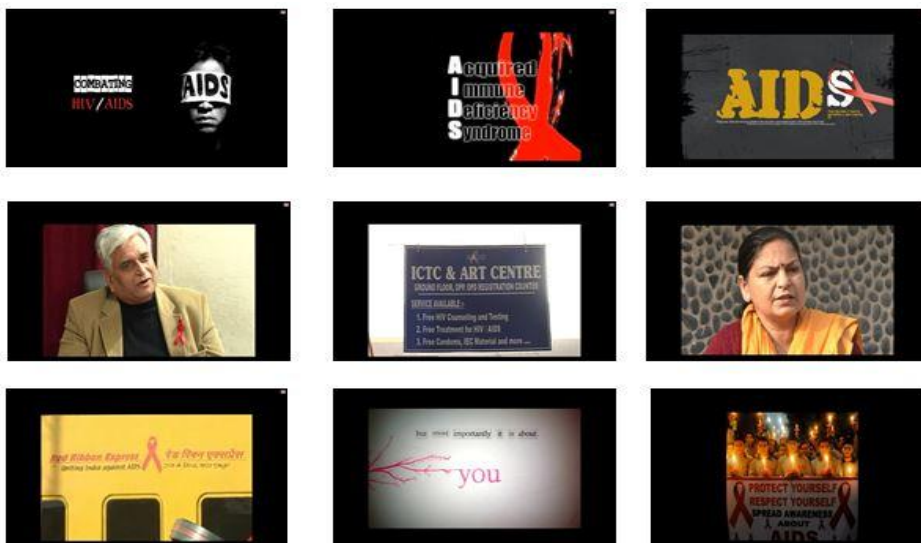
This section provides a state-specific snapshot of the LFPs covered for assessment. In order to enable the recall of the programs, visual stimuli was utilized for all the TV programs and radio jingles were used for all the radio programs.

#### State 1: Jammu & Kashmir

The LFPs in Jammu and Kashmir were aired via TV only and no program was broadcast through radio. Thus, the reach and recall assessment was conducted only for two long format TV programs – ‘Documentary on Combating HIV/AIDS’ and ‘Documentary on Blood Donation’. Different discussion points encompassing issues related to HIV/AIDS, blood donation, and STIs/STDs were included for program-related analysis.

The visual stimuli utilized for aiding the recall of programs were as follows:

#### Name of program: Documentary on Combating HIV/AIDS



## Name of program: Documentary on Blood Safety



### State 2: Madhya Pradesh

Two LFPs were aired by Madhya Pradesh's SACS - 'Aao Baat Karein' on TV and 'Zindagi Zindabad' on radio. Respondents were assessed on the various topics discussed in these programs, such as HIV/AIDS-related discussions including prevention, transmission, and treatment, vulnerability of youth to HIV/AIDS, PPTCT, sexual and reproductive rights of women, benefits of a well-planned family, and the role of the father in determining the sex of child etc. Since the formats of LFPs being assessed comprised of phone in and talk show, it allowed inclusion of discussion related to non HIV related topics as well, apart from HIV related discussions. Therefore, non HIV topics were also covered and accessed in the study. The following visual stimulus was utilized to aid the recall for *Aao Baat Karein* while the radio jingle was utilized for *Zindagi Zindabad*.



Name of program: *Aao Baat Karein*



State 3: Bihar

In Bihar, two LFPs aired by the Bihar SACS were assessed under the study. '*Jagriti*' – a live phone in was the program aired on TV while '*Kitne Door Kitne Paas*' – a story based program was broadcast on radio. Both the programs aimed at increasing the awareness of the target population in context of HIV/AIDS topics such as discussion on transmission, prevention, treatment, stigma and discrimination, role of youth in spreading awareness, STIs/STDs, and blood donation etc.

In order to aid the recall of the programs, the following visual stimulus was utilized for *Jagriti* while a radio jingle was utilized for *Kitne Door Kitne Paas*.

Name of program: *Jagriti*



**State 4: Tripura**

Similar to Jammu and Kashmir, Tripura state also did not have any LFP broadcast on radio. One long format program - 'Role of ART' which was aired on TV was covered under the study to assess the reach and recall. The key discussion points covered under the assessment were issues related to HIV/AIDS, PPTCT, STIs/STDs, and blood donation.

The following visual stimulus was utilized for aiding the recall of program.

Name of program: **Role of ART**



## State 5: Maharashtra

Maharashtra SACS aired two LFPs: 'Hello Doctor' via TV and 'Kiti Zawal Kiti Dur' via radio. Both of these programs were covered under this study to assess their reach and recall. The topics discussed in these programs spanned various issues critical to HIV/AIDS such as ICTC, ART, PLHIV, PPTCT, sexual and reproductive health rights of women, blood safety, and migrants and HIV, etc.

The following visual stimulus was utilized to aid the recall for the TV program Hello Doctor.

### Name of program: Hello Doctor



## State 6: Kerala

Three LFPs were covered under the assessment in Kerala, which were aired by the Kerala SACS. Among them, *Veettu Vishesham* was a program aired on TV while *Snehithan* and *Jyothis Sanjeevani* were broadcast on radio. Various issues discussed in these programs were HIV/AIDS, STIs/STDs, ART, blood donation, stigma and discrimination, relevance of mainstreaming activities, role of youth in spreading HIV/AIDS awareness, and women's vulnerability.

The following visual stimulus was utilized for aiding recall of *Vettu Vishesham* while radio jingles were utilized for *Snehithan* and *Jyothis Sanjeevani*.

## Name of program: Veettu Vishesham



Table 4.1: LFPs – A Snapshot

State	TV Program	Radio Program
Jammu & Kashmir	1. Documentary on Combating AIDS 2. Documentary on Blood Safety	--
Madhya Pradesh	<i>Aao Baat Karein</i>	<i>Zindagi Zindabad</i>
Bihar	<i>Jagriti</i>	<i>Kitne Paas Kitne Door</i>
Tripura	Role of ART	--
Maharashtra	Hello Doctor	<i>Kiti zawal kiti dur</i>
Kerala	<i>Veettu Vishesham</i>	1. <i>Snehithan</i> 2. <i>Jyothis Sanjeevani</i>

## 4.2 Reach of the Long Format Programs:

In order to establish the reach of the LFPs, it becomes imperative to understand the profile of the respondents surveyed on various indicators impacting the exposure to these programs. Analysis revealed that 'media exposure' and 'exposure to the TV/radio channel airing the LFPs' were two critical variables, among others affecting the reach of the programs being accessed.

Figure 4.1: Media Exposure – TV and DD Viewership; Radio and AIR Listenership

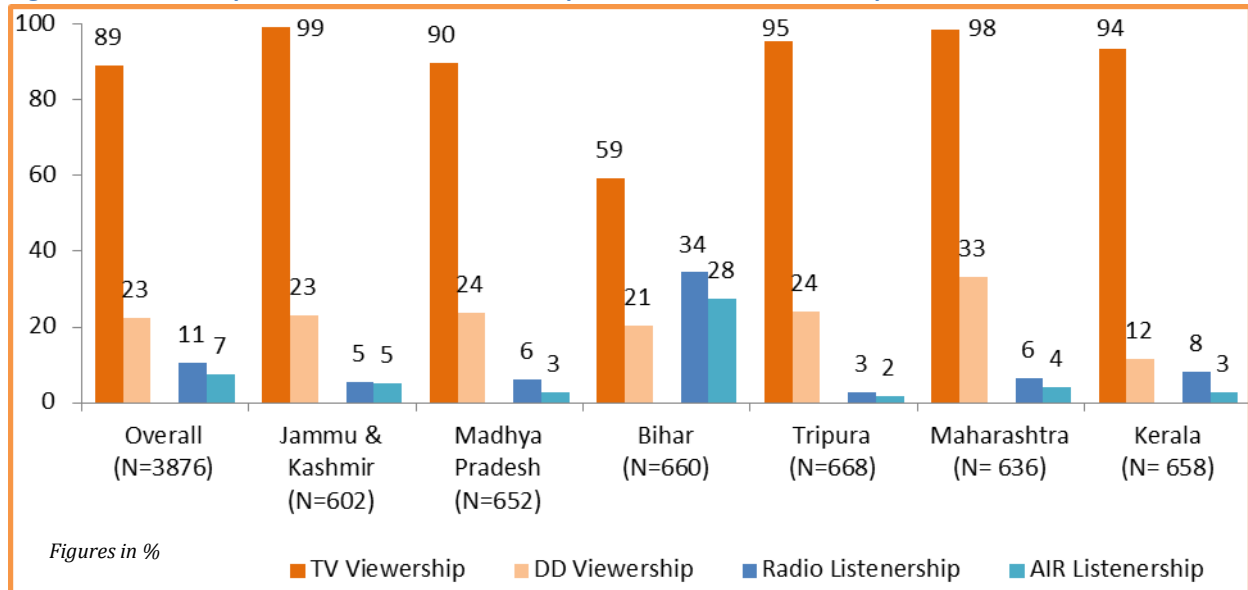


Figure 4.1 presents the proportion of the respondents who had regular exposure to TV and/or radio (i.e. the frequency of television and/or radio exposure stated was either 'almost every day' or 'at least once a week'). As can be seen, overall 89% respondents had regular TV exposure while 11% respondents had regular radio exposure. Respondents from Bihar state had the lowest exposure to TV (59%) as compared to other surveyed states. On the contrary, looking at the data corresponding to frequency of radio listenership, Bihar had most active radio listeners with 34% mentioning either almost every day listenership or at least once a week listenership. These percentages were also in line with the census 2011 data where the proportion of households having TV and radio as an asset was lowest and highest respectively in Bihar than the other surveyed states.

Since the LFPs reviewed were aired on Doordarshan (DD) channel among television and All India Radio (AIR) among radio media, the analysis of the data corresponding to the viewership and listenership of these national channels is important. The data showed that irrespective of the high proportion of respondents (89%) having a regular exposure to television, not even one-fourth reported DD viewership. In line with the low percentage reported against regular exposure to radio media (11%), the percentage of those reporting AIR channel listenership was also low at 7%. When analysed by state, respondents from Maharashtra had highest DD listenership while respondents from Bihar had highest AIR listenership.

Another variable “exposure to any long duration health program” was anticipated as critical to assessing the reach of the LFP and data corresponding to this was also captured during the survey.

Figure 4.2: LFP Campaign Exposure

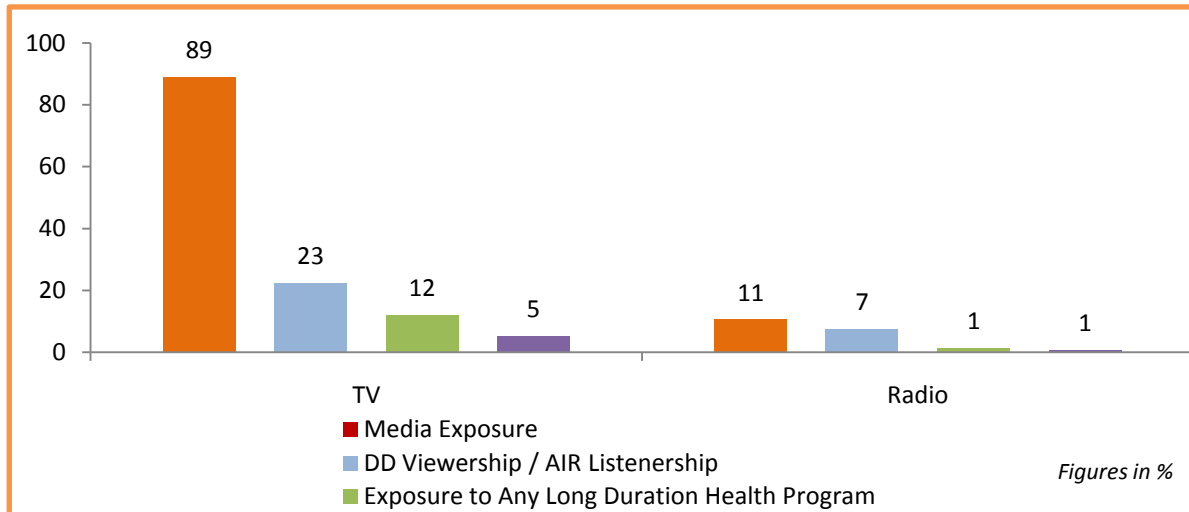


Figure 4.2 shows a comparison of all three indicators namely “media exposure”, “DD viewership/AIR listenership” and “exposure to any long duration health program” at an overall base with the respondents’ habit for watching the LFPs under the campaign reviewed. As shown above, irrespective of high levels of regular TV exposure, the tendency of respondents reporting DD viewership and AIR listenership remained low across the states. Moreover only 12% respondents overall reported exposure to any long duration health-related TV program, while the percentage of such respondents for radio programs was merely 1%. The low prevalence of watching long duration health programs among respondents impacted exposure to NACO’s LFPs as only 5% respondents reported being exposed to LFPs on TV and 1% for radio programs.

Figure 4.3: LFP Exposure by State

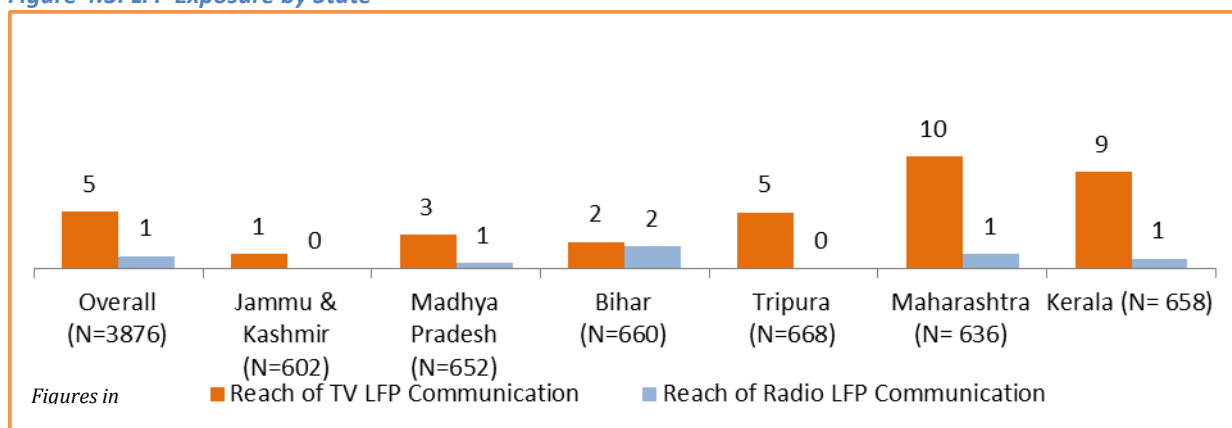


Figure 4.3 depicts exposure to NACO’s long format TV and radio programs by state. In Jammu and Kashmir and Tripura, since the assessment was done only for TV programs, the corresponding exposure to radio programs was zero.

At an overall level, as shown earlier, 5% of total respondents were exposed to long format TV programs while 1% of total respondents were exposed to the radio programs. State wise analysis of trends revealed that the reach of long format TV programs was moderately high (as compared with overall) among respondents from Maharashtra (10%) and Kerala (9%), while it was lowest among respondents from Jammu & Kashmir (1%). Overall, the reach of radio LFPs was very low across all the states.

Figure 4.4: LFP Exposure among Respondents Exposed to Media & Channel Viewers/Listeners

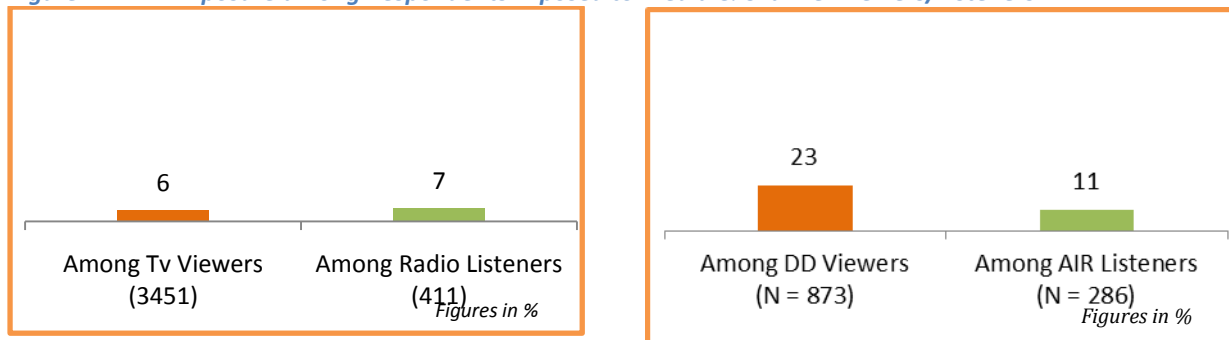
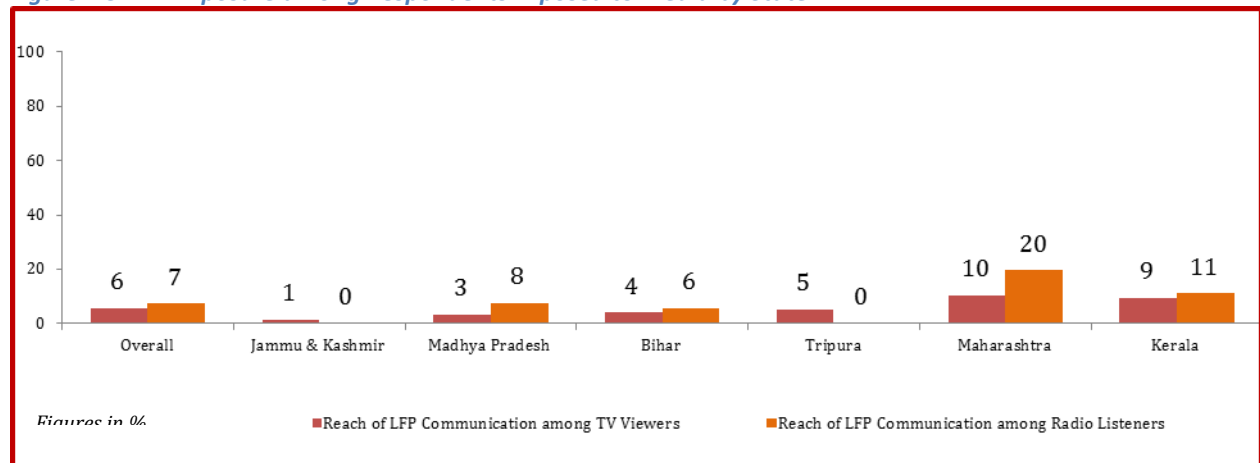


Figure 4.4 presents and analyzes the reach of LFPs by media exposure and channel viewership/listenership. Among respondents who had regular exposure to TV, the reach of LFPs was 6% for television programs and 7% for radio programs. Similar calculations revealed that close to one third (23%) of the respondents who viewed DD also were exposed to long format TV programs. Among those who were AIR listeners, 11% were exposed to a long format radio program.

Figure 4.5: LFP Exposure among Respondents Exposed to Media by State



TV Viewers	Radio Listeners	TV Viewers	Radio Listeners	TV Viewers	Radio Listeners	TV Viewers	Radio Listeners	TV Viewers	Radio Listeners	TV Viewers	Radio Listeners	TV Viewers	Radio Listeners
3452	413	597	32	584	40	392	228	638	18	625	41	616	54

Among regular TV viewers, the reach of LFPs was low at 6%, while the corresponding reach of the LFP among the respondents regularly listening to radio was 7%. Respondents from Bihar, who had the highest frequency of radio listenership, reported the lowest exposure to the LFP radio program. The highest exposure was reported by respondents from Maharashtra state. In the context of TV programs, respondents from

Maharashtra reported the highest exposure (10%) and they were closely followed by the respondents from Kerala state (9%).

In summary, media exposure for TV was very high among respondents across all states. Respondents from Maharashtra and Jammu & Kashmir were the most regular television viewers, while those from Bihar reported the lowest exposure to TV media. Irrespective of high media exposure, a low inclination to watch long duration programs along with a low penetration of DD viewers impacted the reach of LFPs for television media (6% at an overall level).

In context of the radio programs, the media exposure for radio itself was as low as 11%, which impacted the penetration of AIR listeners resulting in a low reach of 1% for the LFPs for radio media.

State analysis showed that the reach of LFPs was comparatively higher among respondents from Maharashtra and Kerala states. This trend being constant for both TV as well as radio programs

The highest percentage of respondents who reported exposure to any LFP belonged to the age bracket of 28 - 37 years (28%) followed by those within the age bracket of 18 - 27 years (26%). Further, those exposed were mainly from rural areas (55%) and were female (57%).



### 4.3 Recall of LFP Campaign Messages

Considering the low reach of the LFPs, it becomes imperative to understand the key messages of the campaign and the impact being created amongst the target respondents at an overall level. State-wise analysis of campaign elements has not been discussed in this chapter due to low base of exposed group by state.

This section highlights certain indicators relevant to understanding the recall component of these TV programs and the impact created in the minds of respondents. This includes the likeability of these programs, their perceived relevance, resulting motivation, and the extent to which target audience related with the issues shown/aired.

**Table 4.2: Topics and Messages Recalled by Respondents Exposed to the LFP TV Campaign**

Topics Recalled (all figures in %)	All Exposed to LFP TV Campaigns (N=201)
HIV/AIDS	81
Voluntary blood donation	29
STIs	16
Use of condom	14
Women's literacy	13
PPTCT	12
Key Messages Recalled	
Condoms should be utilized during sexual intercourse	13
Essentiality of removing HIV/AIDS	13
Information about protection from HIV/AIDS	10
HIV/AIDS can be transmitted if one has multiple sex partners	9
Information about treatment of HIV/AIDS	8
Awareness about the disease	8

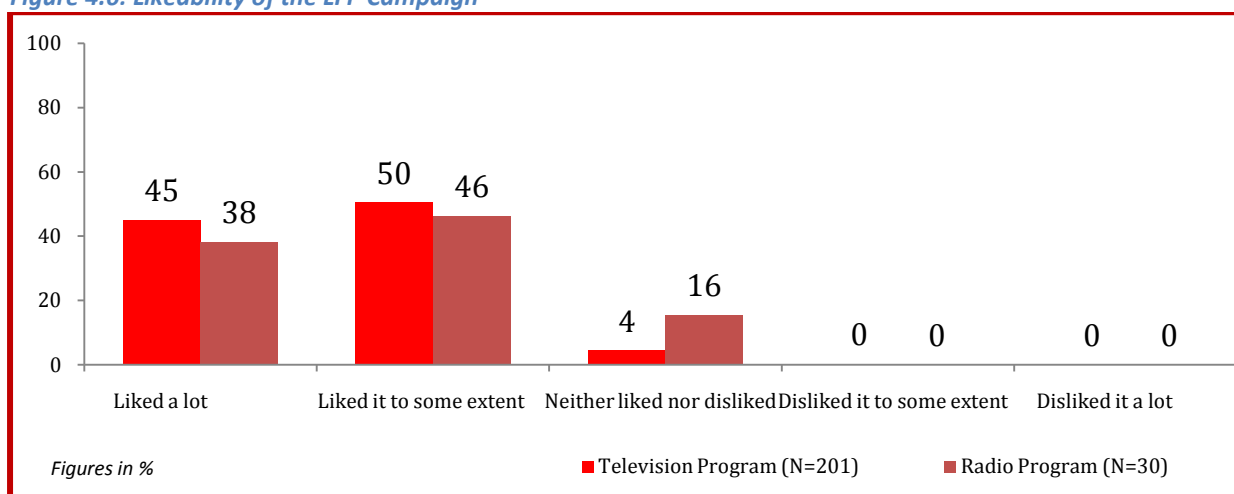
More than 4 out of five respondents who watched a NACO LFP on TV recalled that the topic discussed during the program was HIV/AIDS-related, followed by voluntary blood donation, which was recalled by close to 1/3<sup>rd</sup> of the respondents exposed. Other topics recalled consisted of STIs (16%), use of condoms (14%), women's literacy (13%), and PPTCT (12%).

Among all messages, "use of condoms," "importance of removing AIDS," and "protection for HIV/AIDS" were some of the messages recalled by the exposed respondents.

**Table 4.3: Formats of the Program Recalled by Respondents Exposed to the LFP TV and Radio Campaign**

Program Formats Recalled (all figures in %)	All Exposed to LFP TV Campaigns (N=201)	All Exposed to LFP Radio Campaigns (N=30)
Talk Show	56	61
Live Phone In	45	14
Interview Based	32	36

'Talk shows' (56%), 'live phone ins' (45%), and 'interviews' (32%) were the key program formats recalled by respondents exposed to the TV programs, whereas 'talk shows' (61%) and 'interviews' (36%) were the key formats recalled by the respondents for the radio programs. On average, seven episodes of the LFPs were watched or listened by the respondents over the period of last one year.

**Figure 4.6: Likeability of the LFP Campaign**

Irrespective of the low reach of the LFPs, those exposed primarily reported liking the programs. Nearly 95% of respondents who watched the programs on TV reported liking the programs in terms of the content, theme, and message etc. Similarly, 85% of respondents who listened to the programs on radio reported liking them. Notably, none of the respondents mentioned disliking of any kind from these programs across all the states.

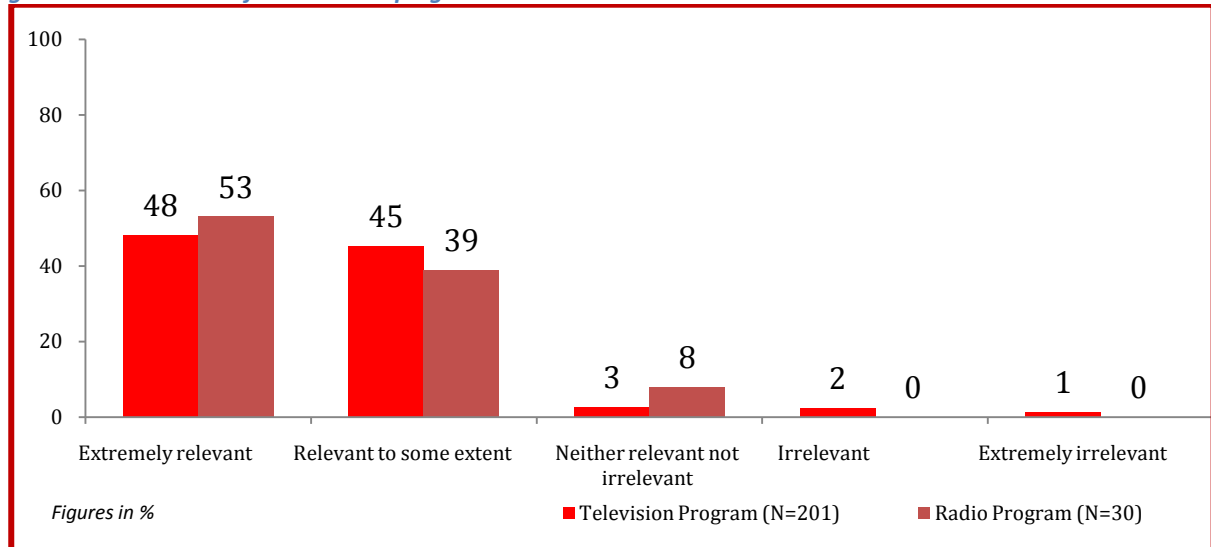
**Table 4.4: Aspects of the LFP Campaign liked by the Respondents**

Aspects of the program liked (Figures in %)	All Exposed to LFP Campaign	
	Television (N=201)	Radio (N=30)
Story	36	35
Theme	65	58
Dialogue	28	26
Songs	10	39
Characters	20	12
Messages	63	54

The general theme of the program was the most liked aspect of LFP irrespective of channel. Close to two thirds of respondents who were exposed to the TV programs mentioned it as the aspect they liked while this percentage was 60% among the

respondents who had listened to the radio programs. Other aspects participants liked were ‘messages’ (63% for TV programs and 54% for radio programs) and ‘story’ (36% for TV programs and 35% for radio programs). Respondents exposed to radio programs also highlighted likeness for the ‘songs’ adopted in the programs.

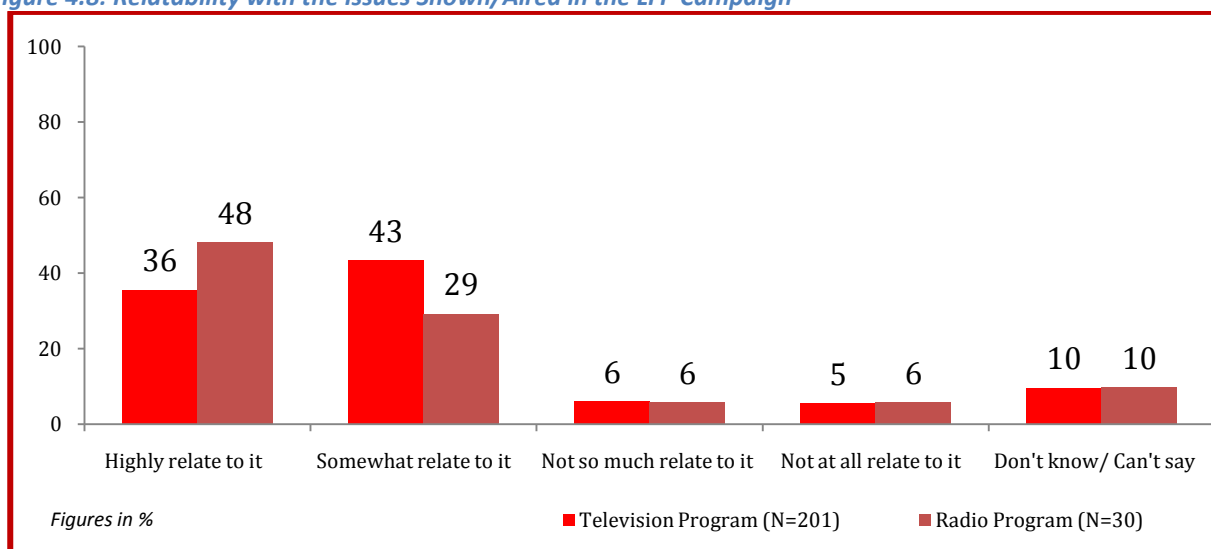
Figure 4.7: Relevance of the LFP Campaign



When the respondents were asked, how much they think that LFPs are relevant to a person of their community; - a high percentage told that they believe they were relevant. Corresponding percentages were 93% for television programs and 92% for radio programs. Very low percentages of respondents reported them as being irrelevant.

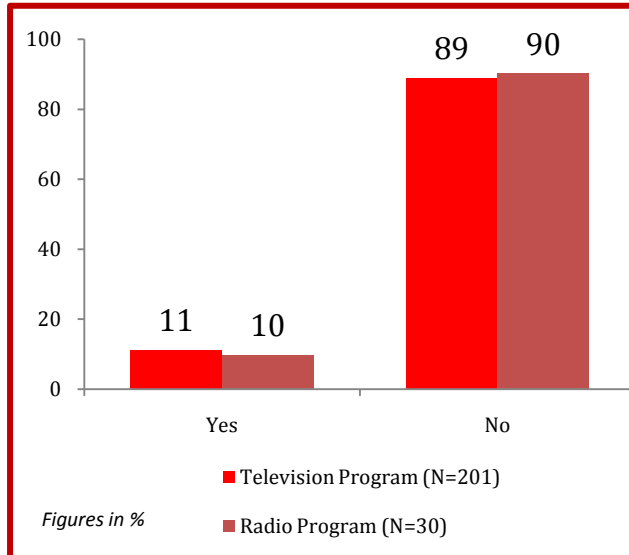
The main reasons mentioned by the respondents for the programs’ perceived relevance were that they “spread awareness about HIV/AIDS” (18%), they “informed about HIV/AIDS” (18%) and they “provided health-related information” (11%).

Figure 4.8: Relatability with the Issues Shown/Aired in the LFP Campaign



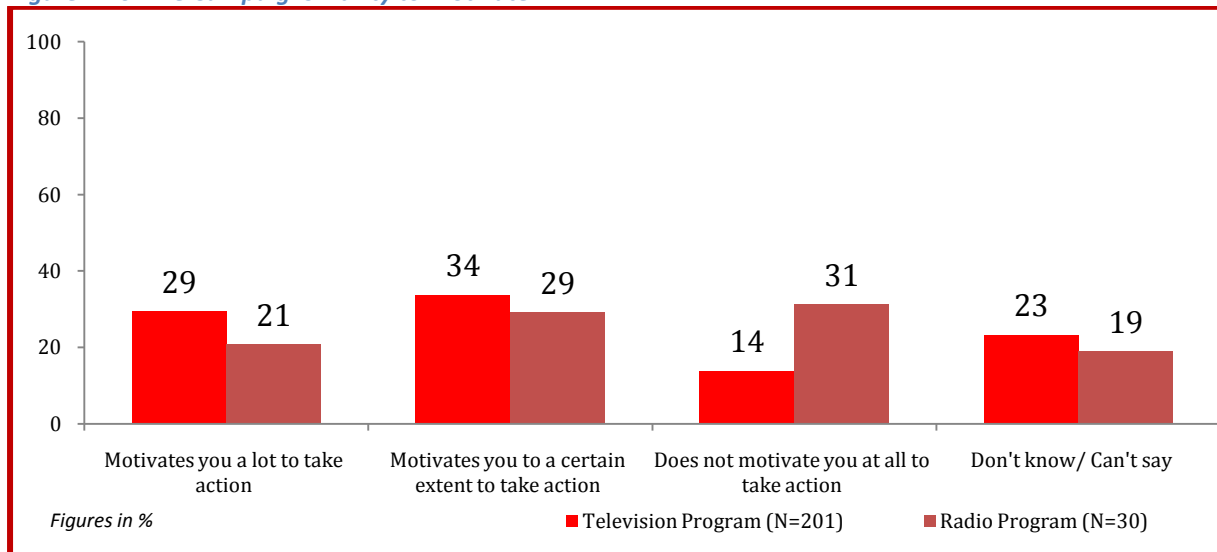
High relation to the issues shown/aired in the program was reported by respondents as between 77-79% because they “provides information by which we could keep ourselves safe” and “issues shown are critical to the society”.

**Figure 4.9: Difficulty in Understanding the Program Content**



The messages relayed through the LFPs were easy to comprehend as reported by respondents. This was evident from the percentages obtained against the question about difficulty in understanding of the program content. The majority of the respondents exposed to both the programs understood it well and reportedly did not face any difficulties in understanding the program.

**Figure 4.10: The Campaigns Ability to Motivate**



Related to motivational appeal, 29% among the TV campaign exposed group and 21% among the radio campaign exposed group felt that the campaign motivated one to take action. However, 31% of the radio campaign listeners also felt that it did not motivate them at all.

More than two thirds of respondents who were exposed to radio programs (69%) discussed the points highlighted in the program with someone while the corresponding percentage was 62% for respondents exposed to TV programs. ‘Spouse/partner’ and ‘friends’ were the key persons with whom respondents discussed the content with.

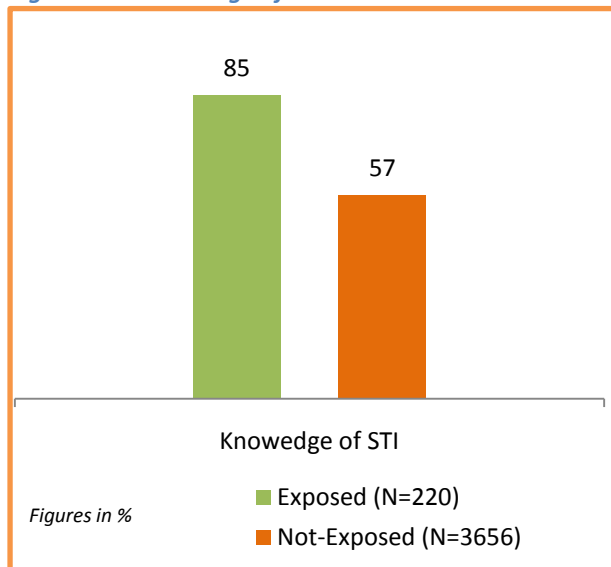
## Chapter 5 Impact of the Long Format Programs

This chapter covers the potential impact of LFPs on the respondents surveyed for the reach and recall study. The impact of LFPs on awareness, knowledge and attitudes of the respondents are given below. Each impact has been given for respondents who have been exposed to LFPs with respect to the respondents who have not been exposed to the LFPs for each of the study states; except States where the base for the exposed group is too low (<25). Significance differences have also been reported throughout this section among the respondents of these two categories at 5% significance level based upon Z-test performed.

The knowledge and attitude towards the six thematic areas among exposed and non-exposed group is being presented below.

### 5.1 Sexually Transmitted Infections/Diseases (STIs and STDs)

Figure 5.1: Knowledge of STI



When the respondents were asked whether they knew about diseases that could be transmitted through sexual intercourse, the majority of the respondents exposed to LFP (85.3%, N=220) replied in the affirmative. In contrast, a little more than half of the respondents not exposed to LFP (57.2%, N=3,656) knew STIs. In all the other states, a significant difference was observed among the respondents who were exposed to LFP compared to those who were not exposed to the same.

The respondents who knew that diseases that can be transmitted through sexual intercourse were further asked about the transmission means of STIs/STDs. The most common mode of transmission reported was multi-partner sex. This trend was same across all the study states and among the respondents who were exposed to LFP as well as those who were not-exposed. Almost equal proportion of respondents exposed to LFP (92.8%) and not exposed to LFP (90.0%) mentioned at least three correct methods of transmission of STIs/STDs. This trend was same in all the study states except Kerala.

Similarly, almost equal proportions mentioned at least one correct method of transmission of STIs/STDs among the respondents who were exposed to LFP (98.6%) and the respondents who were not exposed (97.2%). This trend was same in all the study states except Kerala.

**Table 5.1 : Diseases Transmitted through Sexual Intercourse - Knowledge**

N	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	220	3656	8#	594	23#	629	27	633	34	634	69	567	59	599
Yes	<b>85.3</b>	<b>57.2</b>		<b>45.0</b>		51.7	<b>89.8</b>	<b>44.1</b>	<b>100.0</b>	<b>78.2</b>	<b>82.2</b>	<b>51.9</b>	<b>91.4</b>	<b>71.8</b>
No	<b>14.7</b>	<b>42.8</b>		<b>55.0</b>		48.4	<b>10.2</b>	<b>55.9</b>	<b>0.0</b>	<b>21.8</b>	<b>17.8</b>	<b>48.1</b>	<b>8.6</b>	<b>28.2</b>

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

**Table 5.2 : Transmission Means of STIs/STDs - Spontaneous**

N (Respondents who knew the diseases that can be transmitted through sexual intercourse)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	187	2091	7#	267	12#	325	25	279	34	496	57	294	54	430
Multi partner sex	84.1	83.7		78.8		85.6	90.6	92.9	96.6	83.8	75.0	77.2	83.2	83.4
Sharing needles	62.2	56.7		46.2		38.5	64.0	55.8	74.3	71.2	57.8	49.8	61.2	65.8
Transfusion of untested/ unsafe blood	<b>50.4</b>	<b>40.3</b>		41.0		38.8	48.9	34.2	40.3	39.4	29.8	26.9	<b>83.9</b>	<b>55.3</b>
Infected pregnant mother to unborn child	24.4	17.7		13.9		8.9	16.7	11.8	29.9	23.5	<b>29.9</b>	<b>12.7</b>	22.6	27.1
Through Breast feeding	6.6	6.5		3.6		2.2	6.7	2.3	10.0	9.3	7.4	3.7	5.9	12.7
Through Handshaking/physical touch	3.7	2.8		0.5		1.2	0.0	0.3	12.6	10.2	0.0	0.2	0.1	0.1
Through Kissing	3.0	2.0		1.7		0.6	0.0	0.6	0.0	6.1	1.0	0.4	<b>9.3</b>	<b>0.4</b>
Through Mosquito/ Insect bite	1.4	4.3		5.5		6.9	2.8	0.7	0.0	6.7	3.1	2.9	0.4	2.3

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

**Table 5.3 : Transmission Means of STIs/STDs– Spontaneous + Prompted**

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who knew the diseases that can be transmitted through sexual intercourse)	<b>187</b>	<b>2091</b>	<b>7#</b>	<b>267</b>	<b>12#</b>	<b>325</b>	<b>25</b>	<b>279</b>	<b>34</b>	<b>496</b>	<b>57</b>	<b>294</b>	<b>54</b>	<b>430</b>
Multiple partner sex	97.7	96.9		94.3		98.7	100.0	99.2	96.6	96.1	100.0	94.4	99.2	98.3
Sharing needles	94.8	92.2		92.2		87.0	100.0	97.7	100.0	94.4	94.6	90.9	88.9	90.8
Transfusion of untested/ unsafe blood	92.1	88.3		93.3		89.6	100.0	96.2	87.7	80.1	87.3	86.3	93.6	89.9
Infected pregnant mother to unborn child	71.8	69.4		72.7		74.5	96.7	84.6	84.9	68.4	70.1	71.0	49.7	53.6
Through Breast feeding	38.3	44.7		48.7		42.0	67.8	67.8	26.2	44.0	32.6	42.7	33.1	31.4
Through Handshaking/physical touch	10.9	16.0		16.8		13.3	16.4	13.8	29.1	28.3	2.2	6.4	4.9	11.3
Through Kissing	15.6	17.0		15.5		19.2	21.2	24.1	10.5	19.3	13.3	13.6	15.9	11.3
Through Mosquito/ Insect bite	19.0	22.4		26.9		29.9	19.8	21.4	21.1	25.1	15.3	19.7	10.1	13.3

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

**Table 5.4 : Transmission Means of STIs/STDs - Knowledge**

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who knew the diseases that can be transmitted through sexual intercourse)	<b>187</b>	<b>2,091</b>	<b>7#</b>	<b>267</b>	<b>12#</b>	<b>325</b>	<b>25</b>	<b>279</b>	<b>34</b>	<b>496</b>	<b>57</b>	<b>294</b>	<b>54</b>	<b>430</b>
At least 1 correct method	100.0	98.4		96.4		100.0	100.0	99.2	100.0	98.5	100.0	95.6	100.0	99.7
At least 3 correct methods	92.8	90.0		93.0		90.1	100.0	95.8	96.6	85.0	91.1	88.8	87.8	91.0
All correct methods	33.8	38.0		41.2		34.5	67.8	66.4	21.7	34.2	29.2	40.2	25.5	23.3
At least one Misconception	29.5	35.8		44.8		36.9	31.1	31.6	33.1	50.3	25.9	26.7	20.0	21.4

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.5 : Prevention Methods from STIs/STDs - Spontaneous

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
<i>Base (Respondents who knew the diseases that can be transmitted through sexual intercourse)</i>	<i>E*</i>	<i>N**</i>	<i>E*</i>	<i>N**</i>	<i>E*</i>	<i>N**</i>	<i>E*</i>	<i>N**</i>	<i>E*</i>	<i>N**</i>	<i>E*</i>	<i>N**</i>	<i>E*</i>	<i>N**</i>
	<b>187</b>	<b>2,091</b>	<b>7#</b>	<b>267</b>	<b>12#</b>	<b>325</b>	<b>25</b>	<b>279</b>	<b>34</b>	<b>496</b>	<b>57</b>	<b>294</b>	<b>54</b>	<b>430</b>
Using condom	67.8	73.8		72.0		74.0	79.7	70.0	74.7	78.8	77.6	79.7	57.1	67.4
Using disposable needles/syringes	50.6	52.4		45.1		33.3	<b>38.7</b>	<b>65.7</b>	43.8	61.7	45.3	49.8	71.1	54.0
Avoiding sex	26.7	31.9		48.4		38.2	49.3	31.4	3.4	17.8	37.0	39.8	20.0	28.0
Having Sex with one partner only	46.8	40.8		26.4		31.9	37.2	39.1	70.7	56.2	<b>54.2</b>	<b>35.2</b>	40.2	43.5
Not wearing clothes of infected persons	7.2	4.5		6.1		1.8	0.0	0.9	<b>17.0</b>	<b>5.1</b>	1.4	0.5	13.0	9.9
STI Treatment	13.0	8.4		4.5		6.2	6.9	6.4	11.0	9.0	3.2	1.3	28.7	18.0
Cleaning sex organs with Dettol/disinfectant	6.9	7.1		3.6		3.5	0.0	0.0	0.0	15.1	0.0	0.0	23.9	12.5
Avoiding public toilets	2.5	2.6		6.1		1.5	0.0	0.2	0.0	2.3	0.0	0.0	8.7	4.8

*E\** - Exposed to LFP, *NE\*\** - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other



Table 5.6 : Prevention Methods from STIs/STDs – Spontaneous + Prompted

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who knew the diseases that can be transmitted through sexual intercourse)	187	2,091	7#	267	12#	325	25	279	34	496	57	294	54	430
Using condom	92.0	94.2		92.6		93.3	100.0	94.2	95.6	94.1	100.0	93.0	86.0	96.7
Using disposable needles/syringes	84.7	88.5		91.3		85.2	76.6	95.5	66.8	82.2	91.8	88.7	93.4	91.9
Avoiding sex	68.3	77.4		89.6		86.7	82.8	90.9	27.8	55.6	96.6	87.1	52.5	72.5
Having Sex with one partner only	93.3	88.9		87.4		87.8	93.1	93.4	100.0	88.9	96.9	91.8	83.1	85.7
Not wearing clothes of infected persons	23.9	28.8		41.5		25.8	27.2	22.6	39.6	33.5	5.2	14.1	32.4	31.6
STI Treatment	59.0	45.7		56.8		51.3	39.0	59.7	70.1	36.8	37.7	28.3	76.9	47.8
Cleaning sex organs with Dettol/disinfectant	35.4	33.7		35.6		30.1	26.3	37.2	33.4	41.4	14.6	17.7	62.5	35.1
Avoiding public toilets	19.6	19.5		26.8		17.3	31.9	21.0	14.4	20.1	5.6	8.5	30.4	22.6

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # denotes small base, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

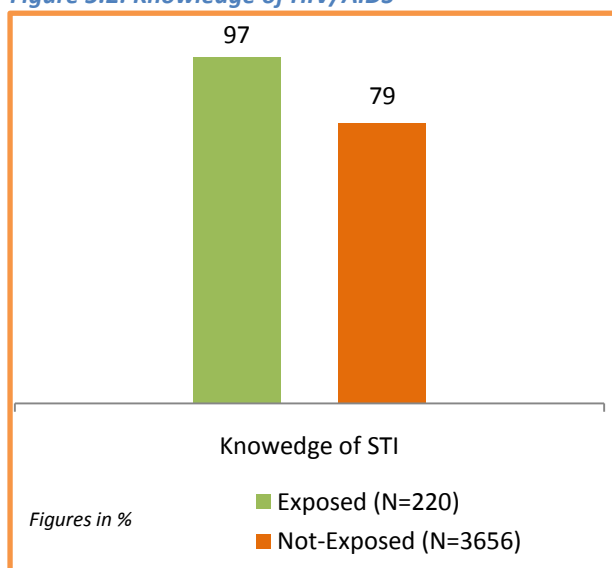
Table 5.7 : Prevention Methods of STIs/STDs - Knowledge

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who knew the diseases that can be transmitted through sexual intercourse)	187	2,091	7#	267	12#	325	25	279	34	496	57	294	54	430
At least 1 correct method	98.6	97.2		94.6		98.4	100.0	98.1	100.0	97.9	100.0	94.3	95.1	98.7
All correct methods	49.4	41.6		55.1		46.8	39.0	57.7	50.8	27.5	35.4	26.3	69.6	45.6
At least one Misconception	99.6	97.0		98.2		96.8	100.0	98.4	100.0	97.1	100.0	94.8	98.7	97.0

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

## 5.2 HIV/AIDS

Figure 5.2: Knowledge of HIV/AIDS



When asked whether they knew about HIV/AIDS, the majority of respondents exposed to LFPs (97.4%, N=220) replied in affirmative. In contrast, a little more than three-fourths of respondents not exposed to LFP (78.8%, N=3,656) knew about it.

The respondents who knew the diseases that could be transmitted through sexual intercourse were further asked about the transmission modalities of HIV/AIDS. The top transmission modes reported were multi partner sex, sharing needles, and transfusion of untested/unsafe blood. Overall, knowledge of at least three correct

methods of transmission of HIV/AIDS was almost similar among the respondents exposed to LFP (91.9%) and the ones who were not exposed (91.3%).

The common HIV prevention methods reported were - using a condom, using disposable needles/syringes, having sex with one partner only, and avoiding sex. None of the respondents, either from the exposed category or the not exposed category, were able to name all the correct HIV prevention methods. The proportion of respondents reporting at least one correct method was similar among the respondents exposed to LFP (98.0%) and the ones who were not exposed (96.1%).

When asked regarding curability and treatability of HIV/AIDS, around one-third respondents (32.7%) asserted that it is curable and more than 4 out of 5 respondents (85.9%) said that it is treatable. Higher proportions of respondents exposed to LFP replied as "Yes" against these two questions than those who were not exposed to LFP. Most of the respondents who believed that HIV/AIDS was treatable, across all the study states reported that the treatment is provided at government hospitals.

Further, the majority of respondents believed that HIV/AIDS infected individuals should be provided good medical treatment and emotional support (89.6% - exposed to LFP, 88.0% - not exposed to LFP). Significant differences were observed in the responses against the question "a healthy looking person cannot be HIV effected". Those not exposed to LFP, believed more in this statement (40.1%) than the ones who were exposed (31.0%).

Table 5.8 : HIV/AIDS - Knowledge

Base	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	220	3656	8#	594	23#	629	27	633	34	634	69	567	59	599
Heard about HIV/AIDS	97.4	78.8		75.4		67.6	96.8	68.5	100.0	94.4	96.3	79.8	96.6	87.5
Know where to get tested for HIV	55.0	31.8		30.5		40.1	65.5	27.1	42.2	29.9	63.7	39.5	41.7	24.3

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.9 : Transmission Modes of HIV/AIDS - Spontaneous

Base (Respondents who had heard about HIV/AIDS)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	214	2881	8 #	448	23#	425	26	433	34	599	67	452	57	524
Multi partner sex	87.0	82.6		78.9		86.2	97.4	85.6	96.6	81.7	77.4	80.7	89.6	83.0
Sharing needles	68.9	60.0		46.2		47.6	69.5	58.9	86.5	71.6	58.9	57.6	80.5	71.4
Transfusion of untested/ unsafe blood	46.2	43.0		47.0		44.0	45.8	34.0	38.7	39.9	20.4	32.4	88.7	59.1
Infected pregnant mother to unborn child	31.1	21.4		19.4		19.3	18.8	12.5	34.3	25.3	34.6	17.0	39.3	31.4
Through Breast feeding	9.7	8.5		4.9		2.9	9.5	5.7	5.0	12.3	2.0	4.1	21.4	17.8
Through Handshaking/physical touch	4.7	2.9		2.2		0.9	0.0	1.1	12.6	8.5	2.6	0.3	7.1	2.2
Use of public toilets	1.3	1.8		3.2		2.8	0.0	0.5	0.0	1.6	1.9	0.7	2.7	1.8
Sharing of food	3.1	1.5		0.3		3.4	3.3	0.7	2.7	3.4	1.9	0.3	1.7	0.3
Through Kissing	2.9	1.9		0.5		2.7	0.0	0.5	6.5	4.5	2.7	0.9	3.9	1.5
Through Mosquito/ Insect bite	3.1	4.5		3.2		9.4	2.6	0.3	5.4	6.9	4.7	4.2	1.9	2.9

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.10 : Transmission Modes of HIV/AIDS – Spontaneous + Prompted

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard about HIV/AIDS)	<b>214</b>	<b>2881</b>	<b>8 #</b>	<b>448</b>	<b>23#</b>	<b>425</b>	<b>26</b>	<b>433</b>	<b>34</b>	<b>599</b>	<b>67</b>	<b>452</b>	<b>57</b>	<b>524</b>
Multi partner sex	96.4	95.3		95.6		96.4	100.0	96.4	100.0	92.3	92.3	94.0	95.4	97.6
Sharing needles	<b>98.1</b>	<b>93.2</b>		94.8		90.6	100.0	95.5	100.0	93.1	96.2	93.9	98.7	91.7
Transfusion of untested/ unsafe blood	90.2	90.1		95.6		88.2	95.4	95.0	90.0	82.4	89.8	90.7	98.1	90.9
Infected pregnant mother to unborn child	78.3	72.9		78.7		77.5	<b>96.9</b>	<b>81.0</b>	77.2	71.0	80.9	77.4	74.1	55.9
Through Breast feeding	39.7	47.8		50.0		40.1	67.1	63.2	30.1	45.0	41.3	43.8	38.7	45.8
Through Handshaking/physical touch	12.8	17.2		23.6		12.6	19.8	14.3	15.5	29.7	6.6	6.3	13.4	13.1
Use of public toilets	19.0	16.1		18.2		19.4	28.8	20.1	14.1	16.3	3.7	5.2	26.4	17.5
Sharing of food	11.9	16.8		13.6		19.4	27.8	23.7	8.1	23.9	4.4	6.3	7.4	12.7
Through Kissing	15.7	20.1		15.4		22.1	24.1	25.9	10.5	27.3	15.8	13.4	23.4	15.0
Through Mosquito/ Insect bite	<b>16.8</b>	<b>24.6</b>		22.4		31.6	20.9	21.2	21.9	28.3	19.2	27.5	7.3	16.9

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.11 : Transmission Modes of HIV/AIDS - Knowledge

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard about HIV/AIDS)	<b>214</b>	<b>2881</b>	<b>8 #</b>	<b>448</b>	<b>23#</b>	<b>425</b>	<b>26</b>	<b>433</b>	<b>34</b>	<b>599</b>	<b>67</b>	<b>452</b>	<b>57</b>	<b>524</b>
At least 1 correct method	99.2	98.5		97.9		100.0	100.0	99.0	100.0	98.0	97.4	97.5	100.0	99.1
At least 3 correct methods	91.9	91.3		94.8		89.9	98.4	93.5	91.2	86.5	92.4	92.3	95.4	92.2
All correct methods	35.1	39.5		44.6		31.3	67.1	59.9	30.1	34.7	37.0	40.8	28.4	29.0
At least one Misconception	38.4	45.1		57.9		46.1	47.2	38.0	<b>36.6</b>	<b>59.0</b>	30.6	35.3	40.4	31.7

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.12 : Prevention Methods from HIV/AIDS - Spontaneous

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard about HIV/AIDS)	214	2881	8 #	448	23#	425	26	433	34	599	67	452	57	524
Using condom	74.5	70.4		73.5		70.6	67.6	64.1	<b>100.0</b>	<b>75.9</b>	76.7	69.1	70.0	67.6
Using disposable needles/syringes	52.8	52.6		43.1		41.1	42.3	59.1	<b>28.2</b>	<b>61.8</b>	45.5	48.8	76.7	57.2
Avoiding sex	29.5	34.8		46.9		37.2	47.8	32.2	8.4	24.3	50.3	48.5	9.0	24.9
Having Sex with one partner only	47.9	39.6		27.1		35.7	40.2	38.9	<b>78.2</b>	<b>52.8</b>	36.8	34.9	59.0	43.1
Not wearing clothes of infected persons	3.0	3.9		3.6		2.0	0.0	1.1	0.0	3.9	2.0	2.4	8.9	9.7
Taking ART/VRT	<b>9.5</b>	<b>3.5</b>		2.1		5.7	<b>8.6</b>	<b>0.1</b>	0.0	2.7	2.6	1.1	<b>28.8</b>	<b>8.8</b>
Treatment	<b>23.3</b>	<b>15.6</b>		7.5		10.8	<b>32.7</b>	<b>13.5</b>	31.1	19.1	11.8	12.3	35.7	26.9
Cleaning sex organs with Dettol/disinfectant	<b>9.8</b>	<b>5.4</b>		1.9		2.7	3.3	0.5	8.8	12.4	2.8	1.2	<b>26.8</b>	<b>10.3</b>
Avoiding public toilets	3.0	2.8		2.5		2.7	0.0	0.8	5.4	3.4	0.0	0.8	8.1	5.8

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.13 : Prevention Methods from HIV/AIDS – Spontaneous + Prompted

Base (Respondents who had heard about HIV/AIDS)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Using condom	93.0	89.4		89.2		89.6	96.9	91.0	100.0	89.8	93.0	83.7	89.7	92.5
Using disposable needles/syringes	<b>81.9</b>	<b>88.8</b>		94.2		83.6	<b>70.3</b>	<b>92.9</b>	<b>49.1</b>	<b>82.1</b>	92.5	91.1	90.7	91.0
Avoiding sex	<b>63.7</b>	<b>79.1</b>		92.9		84.4	86.9	90.0	<b>33.8</b>	<b>60.7</b>	89.7	90.1	<b>40.6</b>	<b>65.3</b>
Having Sex with one partner only	89.0	88.0		90.6		88.5	93.6	91.0	96.6	86.0	86.7	90.6	85.6	82.7
Not wearing clothes of infected persons	22.8	28.3		41.8		28.1	29.9	22.5	16.4	34.0	12.8	15.5	36.0	26.6
Taking ART/VRT	42.0	34.4		50.6		41.4	30.4	33.1	45.9	28.7	32.9	24.3	<b>56.1</b>	<b>31.4</b>
STI Treatment	<b>75.1</b>	<b>61.9</b>		67.3		55.6	80.1	79.3	<b>86.7</b>	<b>62.9</b>	57.5	49.6	<b>84.9</b>	<b>57.3</b>
Cleaning sex organs with Dettol/disinfectant	35.0	29.9		32.6		22.8	45.1	35.4	26.6	37.7	22.7	18.5	<b>55.3</b>	<b>29.8</b>
Avoiding public toilets	15.5	20.1		20.2		22.0	20.4	26.3	12.2	21.1	6.6	8.2	29.2	22.3

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.14 : Prevention Methods of HIV/AIDS - Knowledge

Base (Respondents who had heard about HIV/AIDS)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
At least 1 correct method	98.0	96.1		96.0		95.1	98.4	97.1	100.0	96.4	97.4	94.3	96.1	97.1
All correct methods	0.0	0.0		0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
At least one Misconception	98.2	96.9		99.6		96.7	100.0	98.1	100.0	96.4	95.5	96.6	100.0	94.7

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation

Table 5.15 : Opinion on HIV/AIDS

Base (Respondents who had heard about HIV/AIDS)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	<b>214</b>	<b>2881</b>	8 #	<b>448</b>	23#	<b>425</b>	26	<b>433</b>	34	<b>599</b>	67	<b>452</b>	57	<b>524</b>
It is curable	32.7	30.8		27.9		37.9	59.0	40.7	8.8	24.8	44.9	34.9	21.8	22.6
It is treatable	85.9	82.3		71.2		81.0	<b>91.1</b>	<b>73.1</b>	97.7	96.1	69.3	66.5	93.4	98.0
A healthy looking person cannot be HIV infected	<b>31.0</b>	<b>40.1</b>		48.6		57.3	30.8	43.5	17.0	26.7	19.6	22.9	31.8	46.2
HIV/AIDS patients should be treated just like others in the society without discrimination	59.6	65.0		56.8		75.9	79.0	79.9	65.9	70.0	46.3	44.6	53.0	62.7
Most people believe that a person who has HIV is characterless.	45.8	41.5		33.0		27.2	48.8	41.3	22.0	33.5	54.2	50.2	58.1	62.3
HIV/AIDS infected people should be provided good medical treatment and emotional support	89.6	88.0		83.6		88.0	100.0	92.3	95.8	84.3	88.8	92.3	82.5	89.0

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # denotes small base, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

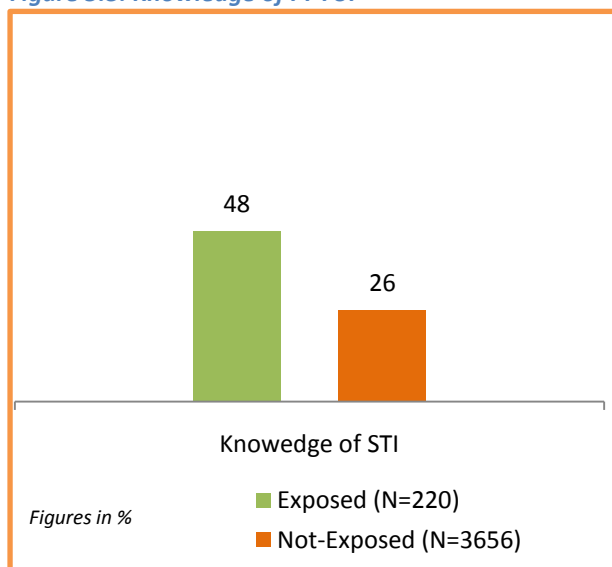
Table 5.16 : Treatment for HIV/AIDS

Base (Respondents who believe HIV/AIDS is treatable)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	<b>184</b>	<b>2370</b>	8#	<b>319</b>	20#	<b>344</b>	24#	<b>317</b>	33	<b>575</b>	46	<b>300</b>	53	<b>514</b>
Government Hospital	93.6	90.2		95.1		88.5		91.6	85.7	84.4	92.7	90.8	96.2	93.5
Private Hospital	22.9	20.9		11.6		25.1		26.7	13.3	15.9	23.3	19.9	40.1	26.3
NGO/ Trust Hospital	5.1	5.7		12.4		2.2		2.6	4.5	1.2	0.0	1.4	12.3	13.3
Ayurvedic	0.0	0.2		0.0		1.3		0.0	0.0	0.0	0.0	0.0	0.0	0.0
AIIMS	0.0	0.1		0.0		0.3		0.5	0.0	0.0	0.0	0.0	0.0	0.0

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation

### 5.3 PPTCT

Figure 5.3: Knowledge of PPTCT



When the respondents were asked whether they knew about PPTCT, almost half of the respondents exposed to LFP (47.8%, N=214) replied in the affirmative. In contrast, around one-fourth of the respondents not exposed to LFP (25.6%, N=2,881) knew about it.

The respondents who knew about PPTCT were further asked questions regarding the same. State wise analysis is presented in below table. Among all the study states, the knowledge that pregnant women should get tested for HIV was higher for the respondents exposed to LFP than the

ones who were not exposed, except in Kerala. The respective percentages were 91.8% among respondents from Jammu & Kashmir (N=45), 98.7% among those from Madhya Pradesh (N=174), 93.5% among the ones from Bihar (N=125), 89.8% among the respondents from Tripura (N=268), 88.4% among the respondents from Maharashtra (N=172) and 69.5% among those who belonged to Kerala (N=55). Significant differences in responses for this question were observed among the LFP exposed and not exposed respondents of Maharashtra and Kerala states. Further, almost all the respondents, especially the ones who were exposed to LFP knew that HIV can be transmitted from mother to her child.

Overall, the most common way of reducing the risk of HIV transmission to child from mother reported by respondents was by following doctor's advice. The proportion of respondents who were exposed to LFP reported this in higher proportion (84.4%) as compared to the ones who were not exposed to LFP (75.1%). The trend was the same with all the study states as well. In Kerala, through proper medical care was reported the highest among the respondents exposed to LFP (88.6%) in state.



Table 5.17 : Heard about PPTCT

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard about HIV/AIDS)	214	2881	8 #	448	23#	425	26	433	34	599	67	452	57	524
Yes	47.8	25.6		9.1		38.4	16.4	27.8	78.5	40.4	55.3	29.9	33.1	6.9
No	52.2	74.4		90.9		61.7	83.6	72.2	21.5	59.6	44.7	70.1	66.9	93.1

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.18 : PPTCT - Knowledge

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N*	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard about PPTCT)	102	737	4#	41	11#	163	4#	120	26	242	37	135	19#	36
Pregnant women should get tested for HIV	85.8	91.4		90.9		98.6		93.3	95.7	89.2	100.0	85.2	28.5	90.8
HIV can be transmitted from mother to her child	100.0	97.0		92.6		100.0		100.0	100.0	92.2	100.0	100.0	100.0	100.0

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.19 : Possibility of HIV Positive Pregnant Mother to Prevent Transmitting HIV to her Baby

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who knew that HIV can be transmitted from mother to her child)	102	715	4#	38	11#	163	4#	120	26	223	37	135	19#	36
Yes	86.8	92.6		88.7		92.7		89.0	100.0	95.7	82.4	89.7	83.6	99.2
No	13.2	7.5		11.3		7.3		11.0	0.0	4.3	17.6	10.3	16.4	0.8

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation

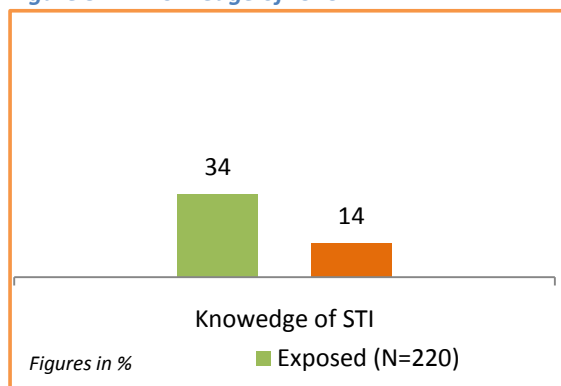
Table 5.20 : Ways of Reducing the Risk of HIV Transmission to Child from Mother

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who knew that it is possible for a HIV positive pregnant mother to prevent transmitting HIV to her baby)	89	662	4#	34	9#	151	3#	107	26	213	30#	121	16#	36
By aborting the baby	2.8	8.2		5.0		12.9		5.6	4.3	4.2	4.3	5.3	0.4	31.9
Doctor's Advice	84.4	75.1		81.7		71.6		78.3	76.0	67.7	93.5	87.1	69.6	78.2
Self-Medication	22.3	15.9		7.0		18.5		0.6	14.2	10.7	52.5	41.3	0.0	4.5
Friend's/ Relatives advice	<b>16.4</b>	<b>3.7</b>		6.6		4.7		1.0	<b>22.5</b>	<b>1.9</b>	<b>28.3</b>	7.3	0.0	3.9
Through proper medical care	40.5	39.4		56.8		77.5		43.7	23.6	19.3	26.2	21.2	<b>88.6</b>	<b>31.2</b>

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

## 5.4 ICTC

Figure 5.4: Knowledge of ICTC



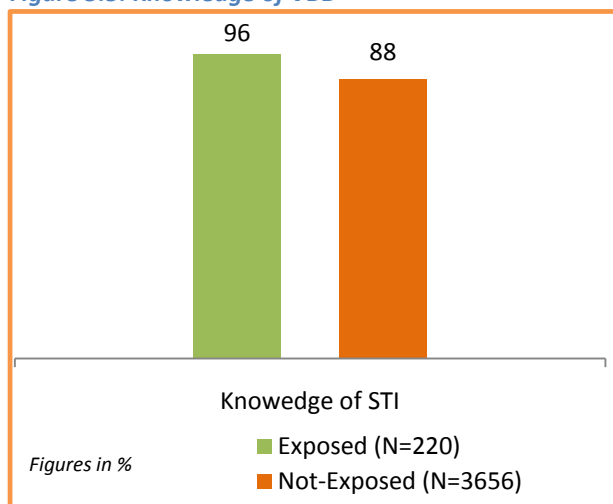
When the respondents were asked whether they knew about ICTC, 34.0% of the respondents exposed to LFP (N=220) replied in affirmative. In contrast, 13.9% of the respondents not exposed to LFP (N=3,656) knew about it. Significant difference existed among the responses of the respondents belonging to these two categories at 5% significance level.

The respondents who knew about ICTC were further asked about ICTC centres. Among all the study states, the most common use of ICTC centres reported was for HIV tests (65.9%). The next reason was 'for HIV counselling' with one third of respondents (33.1%) reporting it as one of the use of ICTC centres. If we look at state wise data, the highest percentages against these uses came from the respondents belonging to Kerala state, with the percentages being 97.1% for HIV tests and 96.3% for HIV counselling (96.3%) as reported by the respondents who were exposed to LFP.

When asked about the confidentiality of the test results of ICTC, majority of the respondents felt positive about it (80.3% - Exposed to LFP, 69.2% - Not exposed to LFP).

## 5.5 Blood Donation

Figure 5.5: Knowledge of VBD



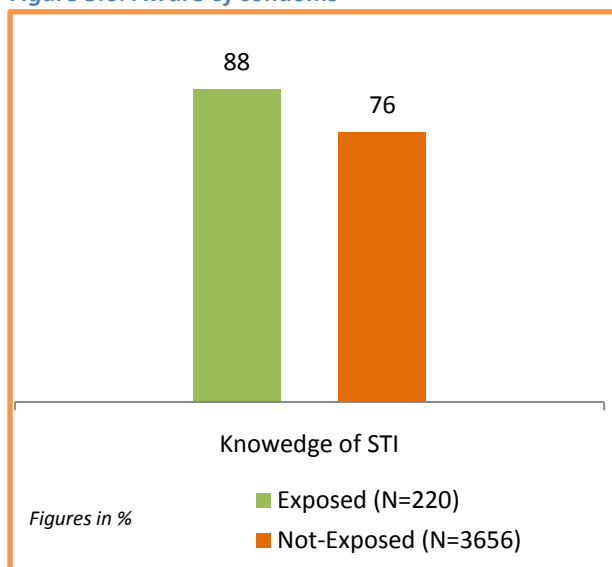
When the respondents were asked whether they knew about voluntary blood donation, 96.2% of respondents exposed to LFP (N=220) replied in affirmative and 88.3% of the respondents not exposed to LFP (N=3,656) knew about it. Overall, around half of the respondents knew about replacement blood donation and professional blood donation and no significant difference existed in the responses of those who were exposed to LFP and those who were not exposed to LFP.

When the respondents were asked that if in need, from where they'll arrange the blood, the most common responses were blood bank, closely followed by spouse/child/sibling and then friends. Government hospitals, blood banks, and blood

camps were the common choices for blood donation among the respondents. In comparison, private hospitals were not favoured in all the study states.

## 5.6 Use of Condom

Figure 5.6: Aware of condoms



When the respondents were asked whether they had heard of or seen a condom, 87.8% of respondents exposed to LFP (N=220) replied in affirmative as compared to 75.8% of the respondents not exposed to LFP (N=3,656). Significant difference existed in the responses among the respondents of these two categories at 5% significance level.

The respondents who had heard/seen a condom were asked about persons or places from where a condom can be obtained. Pharmacy/medical shop was most reported in all the states, followed by clinic/hospital. The majority of respondents reported the usage of condom to avoid pregnancy/family planning method (82.6% - exposed to LFP; 83.2% - not exposed to LFP) and HIV/AIDS prevention (72.5% - exposed to LFP; 67.2% - not exposed to LFP). The majority of respondents believed that condoms could prevent transmission of an STI/HIV (95.8% - exposed to LFP; 80.8% - not exposed to LFP).

Table 5.21 : Heard about ICTC

Base (All Respondents)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	<b>220</b>	<b>3656</b>	8#	594	23#	629	27	633	34	634	69	567	59	599
Yes	<b>34.0</b>	<b>13.9</b>		2.0		25.4	19.5	12.3	<b>50.1</b>	<b>26.6</b>	<b>31.0</b>	12.0	<b>25.6</b>	<b>3.9</b>
No	<b>66.0</b>	<b>86.1</b>		98.1		74.6	80.5	87.7	<b>49.9</b>	<b>73.5</b>	<b>69.0</b>	<b>88.0</b>	<b>74.4</b>	<b>96.1</b>

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.22 : Uses of ICTC Centers

Base (Respondents who had heard about ICTC)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	<b>75</b>	<b>509</b>	3#	12#	13#	160	5#	78	17#	168	22#	68	15#	23#
For ANC	16.1	26.9				43.6		69.9		5.7		0.8		
For HIV Tests	74.1	64.8				52.9		61.5		73.6		69.5		
For HIV Counseling	40.7	32.0				41.3		18.4		27.8		24.6		
For infant/child care/Pediatrician clinic	5.8	16.6				14.3		42.6		12.8		5.7		
For marital relationship counseling	15.8	8.9				14.8		3.6		8.4		2.8		

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.23 : Confidentiality of Test Results of ICTC

Base (Respondents who had heard about ICTC)	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
	<b>75</b>	<b>509</b>	3#	12#	13#	160	5#	78	17#	168	22#	68	15#	23#
Yes	80.3	69.2				77.7		66.9		62.6		80.2		
No	<b>2.8</b>	<b>15.6</b>				12.0		17.6		23.5		0.0		
No Response	0.3	1.1				1.6		1.2		0.8		0.0		
Don't Know/Can't Say	16.7	14.1				8.7		14.4		13.1		19.8		

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the oth

Table 5.24 : Blood Donation - Knowledge

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (All Respondents)	220	3656	8#	594	23#	629	27	633	34	634	69	567	59	599
Heard about Voluntary blood donation	96.2	88.3		90.8		76.2	90.1	87.2	100.0	96.8	92.5	84.8	100.0	93.9
Heard about Replacement blood donation	53.9	55.0		78.1		54.1	83.3	68.3	23.3	27.0	46.1	47.4	66.4	55.8
Heard about Professional blood donation	49.1	56.1		67.0		46.6	90.1	89.0	16.2	28.8	50.0	55.1	37.6	50.5

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.25 : Arrangement for Blood

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (All Respondents)	220	3656	8#	594	23#	629	27	633	34	634	69	567	59	599
Spouse/Child/Sibling (Relative)	65.2	67.7		85.3		67.4	69.9	69.4	17.8	39.0	66.7	71.1	89.3	76.2
Friends	49.5	51.4		74.1		40.2	56.5	35.4	12.7	28.6	73.1	57.0	49.6	76.6
Blood bank	66.7	57.5		64.7		35.4	66.8	42.4	92.8	78.5	63.9	59.4	47.2	65.5
Will find out from internet sources	1.9	1.3		0.6		1.8	0.0	0.4	3.9	0.8	0.7	0.4	4.1	3.6
Will buy from a blood donor	14.4	13.8		9.1		18.3	49.4	25.3	0.8	2.8	16.6	7.6	8.1	19.1
Govt hospital	6.9	2.6		0.0		9.6	12.7	3.0	2.3	1.1	2.0	0.8	5.2	0.9

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.26 : Places for Blood Donation

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (All Respondents)	<b>220</b>	<b>3656</b>	<b>8#</b>	<b>594</b>	<b>23#</b>	<b>629</b>	<b>27</b>	<b>633</b>	<b>34</b>	<b>634</b>	<b>69</b>	<b>567</b>	<b>59</b>	<b>599</b>
Blood Banks	45.3	38.2		40.5		19.8	37.5	27.9	27.3	39.3	48.6	47.3	64.6	56.1
Blood Camps	44.0	36.3		27.7		13.8	<b>36.5</b>	<b>17.4</b>	70.2	55.0	58.3	52.2	<b>31.1</b>	<b>53.4</b>
Government Hospital	<b>51.6</b>	<b>60.6</b>		76.6		76.5	76.9	66.7	29.4	49.0	41.4	42.0	51.4	51.5
Private Hospital	6.9	9.8		2.4		15.9	11.0	17.6	3.4	3.7	7.2	3.7	8.9	14.8

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.27 : Risks for Donor/Recipient

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (All Respondents)	<b>220</b>	<b>3656</b>	<b>8#</b>	<b>594</b>	<b>23#</b>	<b>629</b>	<b>27</b>	<b>633</b>	<b>34</b>	<b>634</b>	<b>69</b>	<b>567</b>	<b>59</b>	<b>599</b>
Yes, both the blood donor and recipient	<b>27.4</b>	<b>17.9</b>		12.7		20.2	40.5	24.8	<b>42.1</b>	<b>22.0</b>	<b>35.8</b>	<b>13.8</b>	10.9	12.6
Yes, only the blood donor	8.4	13.8		6.7		11.8	20.1	31.2	18.9	22.5	2.6	5.9	0.7	2.6
Yes, only the blood recipient	16.4	12.9		9.7		7.9	6.0	9.1	22.8	10.8	25.5	16.6	<b>0.3</b>	<b>24.3</b>
None	32.6	27.9		48.6		36.0	30.0	20.9	16.2	19.1	17.2	22.8	<b>55.5</b>	<b>20.7</b>

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level,  $p < 0.05$ ; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.28 : Heard / Seen Condom

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (All Respondents)	<b>220</b>	<b>3656</b>	<b>8#</b>	<b>594</b>	<b>23#</b>	<b>629</b>	<b>27</b>	<b>633</b>	<b>34</b>	<b>634</b>	<b>69</b>	<b>567</b>	<b>59</b>	<b>599</b>
Yes	<b>87.8</b>	<b>75.8</b>		70.3		76.3	<b>98.5</b>	<b>80.7</b>	100.0	85.6	<b>91.5</b>	<b>71.3</b>	65.5	69.1
No	<b>3.9</b>	<b>15.7</b>		27.6		17.7	<b>1.5</b>	<b>18.3</b>	0.0	5.4	<b>5.1</b>	<b>20.0</b>	7.3	5.7

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.29 : Places or Persons from where a Condom can be Obtained

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard / seen Condom)	<b>193</b>	<b>2770</b>	<b>8#</b>	<b>418</b>	<b>23#</b>	<b>480</b>	<b>27#</b>	<b>511</b>	<b>34</b>	<b>543</b>	<b>64</b>	<b>404</b>	<b>38</b>	<b>414</b>
Shop (General)	15.4	19.5		19.6		24.2	<b>49.2</b>	<b>27.3</b>	4.2	13.0	10.5	5.9	9.0	26.1
Pharmacy/ Medical shop	82.3	81.3		81.9		75.4	88.3	82.3	79.7	82.6	87.1	86.4	83.5	79.5
Clinic/Hospital	<b>40.7</b>	<b>50.9</b>		51.7		56.6	42.3	47.4	27.5	47.8	39.7	51.1	31.8	51.6
Family planning centre/Clinic	<b>23.5</b>	<b>11.1</b>		12.8		8.9	<b>44.0</b>	<b>20.4</b>	<b>13.7</b>	<b>2.9</b>	24.4	17.5	<b>29.9</b>	<b>5.3</b>
Peer educator/ NGO	4.9	3.0		1.5		1.2	0.0	1.8	7.8	2.4	5.3	10.4	<b>8.9</b>	<b>1.4</b>
Anganwadi worker/ VHW	16.1	13.4		1.9		30.7	27.3	20.3	12.3	6.4	12.0	17.2	0.0	2.0
Sexual partner	<b>6.8</b>	<b>2.3</b>		1.4		2.0	<b>27.4</b>	<b>1.8</b>	5.6	1.1	2.1	4.3	3.8	3.7
Condom bank/ Vending machine	<b>5.5</b>	<b>2.0</b>		1.1		0.1	0.0	3.4	0.0	0.2	11.8	5.9	8.0	1.9
Friend	<b>4.2</b>	<b>1.6</b>		0.3		0.7	<b>21.3</b>	<b>2.2</b>	3.4	1.8	2.1	4.0	0.0	0.3

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other



Table 5.30 : Condom Usage

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard / seen Condom)	<b>193</b>	<b>2770</b>	<b>8#</b>	<b>418</b>	<b>23#</b>	<b>480</b>	<b>27</b>	<b>511</b>	<b>34</b>	<b>543</b>	<b>64</b>	<b>404</b>	<b>38</b>	<b>414</b>
Avoiding pregnancy/ FP method	82.6	83.2		85.2		88.0	100.0	95.1	76.3	80.7	<b>72.0</b>	<b>84.2</b>	81.6	63.6
STI prevention	<b>29.6</b>	<b>10.7</b>		4.0		10.1	<b>41.5</b>	<b>13.7</b>	6.2	5.5	<b>33.8</b>	<b>19.3</b>	<b>49.1</b>	<b>12.9</b>
HIV/AIDS prevention	72.5	67.2		81.6		62.5	<b>85.2</b>	<b>62.9</b>	64.3	62.9	76.6	72.1	52.9	64.2

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other

Table 5.31 : Condom – Opinions and Beliefs

	All		Jammu & Kashmir		Madhya Pradesh		Bihar		Tripura		Maharashtra		Kerala	
	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**	E*	N**
Base (Respondents who had heard / seen Condom)	<b>193</b>	<b>2770</b>	<b>8#</b>	<b>418</b>	<b>23#</b>	<b>480</b>	<b>27</b>	<b>511</b>	<b>34</b>	<b>543</b>	<b>64</b>	<b>404</b>	<b>38</b>	<b>414</b>
Condom should be used for every sexual act if one has multiple sexual partners	88.8	89.9		93.0		88.8	100.0	89.9	100.0	88.0	98.0	94.6	<b>63.3</b>	<b>85.9</b>
It is necessary to use condom during sex	71.5	73.8		78.4		81.2	86.3	73.5	61.6	75.9	87.1	82.2	35.5	50.1
Condom decreases pleasure	25.2	32.5		37.3		32.5	40.5	27.5	20.0	22.7	27.8	33.7	<b>20.3</b>	<b>45.4</b>
During sex act using two condoms increases safety	45.1	40.8		41.9		46.4	<b>61.7</b>	<b>39.7</b>	39.5	27.2	64.4	65.9	18.0	27.6
Condoms can prevent from STI / HIV	<b>95.5</b>	<b>78.9</b>		83.4		77.9	<b>96.7</b>	<b>75.6</b>	<b>93.1</b>	<b>69.4</b>	<b>98.8</b>	<b>87.8</b>	87.8	83.7

E\* - Exposed to LFP, NE\*\* - Not Exposed to LFP, # fewer observation, Bold values denotes significant difference between exposed to LFP and not exposed to LFP at 5% significance level, p<0.05; Dark blue cells are representative of the category having a higher significant difference than the other



## Chapter 7: Impact of the Long Format Programs

### Conclusions and Considerations

This study was an attempt to measure the reach and recall of the LFPs in six states from different regions of India. Irrespective of a variation in the format of these programs across states, key thematic areas on which discussions were based remained almost constant across all the states. In every state, SACS was the governing body airing these programs via television and/or radio media. The public service broadcaster – Doordarshan and AIR was used for airing these programs in TV and radio respectively.

As elucidated under research findings above, the overall levels of media exposure for television media was high across states whereas the same remained low for radio media. Moreover, the penetration of DD viewers among the TV viewers was much lower. Respondents also showed a low inclination to watch long duration health programs being aired on both the media. This, along with a low penetration of DD viewers and radio listeners impacted the reach of LFPs of both the media's at overall levels.

Analysis showed that respondents exposed to LFPs possessed comparatively more knowledge, awareness, and empathy with the issues related to HIV/AIDS than those who were not exposed to LFPs.

However, given the cross-sectional nature of the study and the potential for selection biases, more conclusively attributing the effects to the program should be done cautiously. In addition, the base for exposed respondents was small.

The LFPs were also liked by those exposed to them. The issues depicted connected with the respondents and were believed to be relevant for their community by those who are exposed to them. Little difficulty in understanding program content was also one of the findings from the study.

The following key barriers were identified impacting the reach of the LFPs:

- Low viewership of national TV channel - DD and radio channel - AIR which aired these LFPs
- Low tendency among respondents to view/listen to the long duration programs related to health
- Preferences for serials and news as the genres viewed/listened to in media followed by music and comedy shows



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