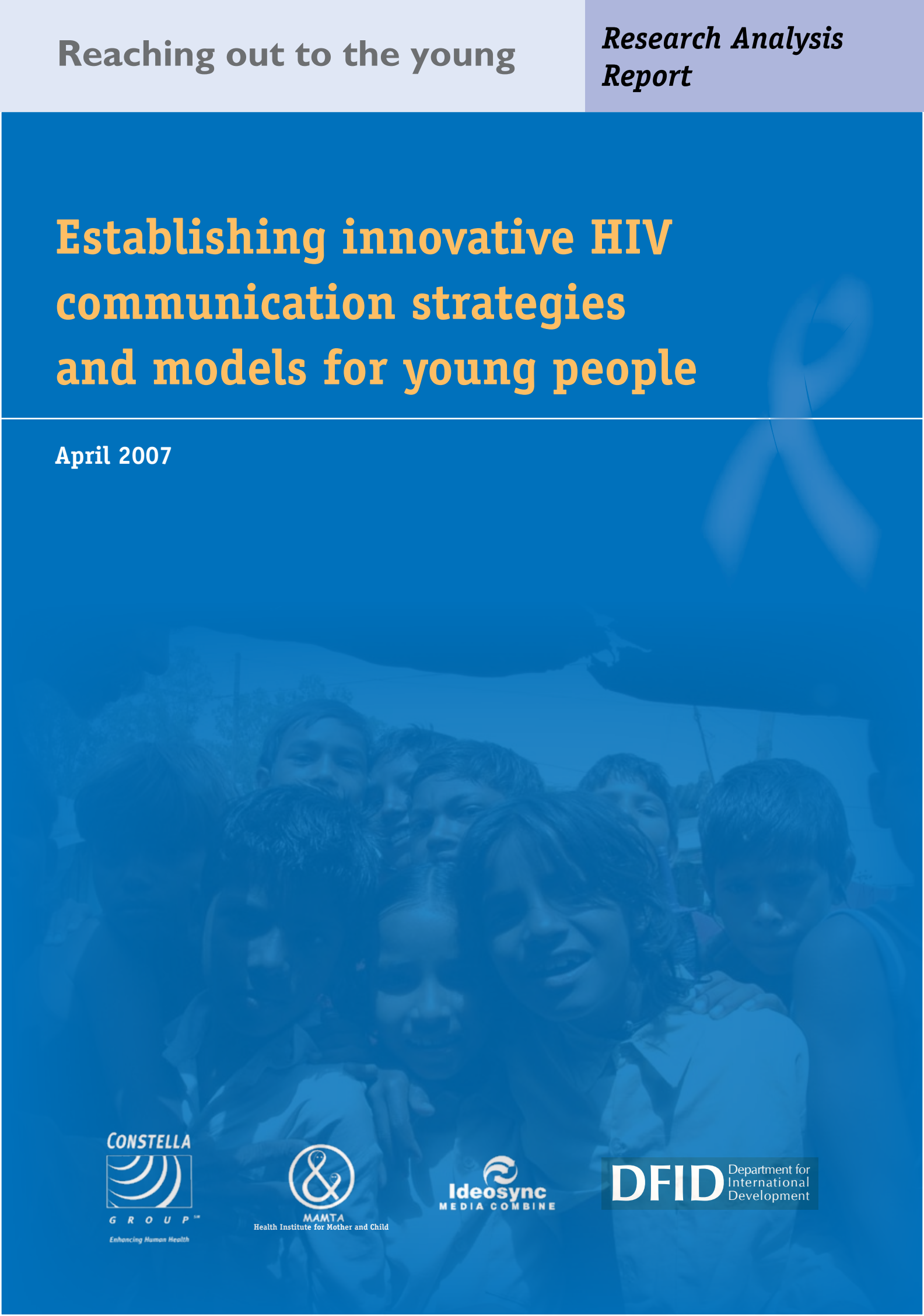
Reaching out to the young

*Research Analysis Report*

# Establishing innovative HIV communication strategies and models for young people

April 2007



CONSTELLA GROUP
Enhancing Human Health

MAMTA
Health Institute for Mother and Child

Ideosync
MEDIA COMBINE

DFID Department for International Development

# RESEARCH ANALYSIS REPORT

## Developing Innovative Communication Strategies for Young People to Address the Challenges of HIV/AIDS In India


### Consortium partners

**Constella Futures, India**
**Ideosync Media Combine**
**MAMTA Institute for Mother & Child Health**



**April 2007**

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# Foreword

In India, current available data indicates that young people will increasingly be at the center of the epidemic, both in terms of transmission and impact. It is estimated that over 35 percent of all new infections in India take place among young people below 25 years (UNAIDS, NACO). Factors that aggravate young people's vulnerability is the lack of self-risk perception, social norms that make it difficult for young people to learn about HIV/AIDS and reproductive health, and inexperience and peer pressures which easily influence them—often in ways that can increase their risk. It is extremely important for the programs to address these concerns, and use innovative models of communications. Models which not only increase awareness but also promote behavior change and encourage young people to access, prevention and care services.

It was against this backdrop that Department for International Development (DFID) commissioned a one-year project to establish 'Innovative HIV Communication Strategies and Models for Young People.' The project sought to design and develop evidence-based communication models. The project was implemented together by Constella Futures, MAMTA - Institute of Mother and Child and Ideosync Media Combine.

The research analysis document captures the methodology and the findings of the qualitative research which informed the evidence-based HIV communication strategy for young people. The document captures ten months of field-work. The focus of the report is on:

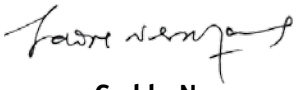
- Research methodology using peer researchers for qualitative assessment;
- Research findings and analysis; and
- Recommendations informing the development of evidenced-based HIV communication strategy

The report in its present form is a result of intensive efforts by many individuals and organizations. The process has been led by the State AIDS Control Societies of Andhra Pradesh and Uttar Pradesh. Without the support and participation of AP SACS and UP SACS this project would not have been possible. We would especially thank Dr. SP Goyal, Project Director UP SACS and Mr. Ashok Kumar, Project Director AP SACS for their personal involvement to this project.

We would also like to thank DFID for taking the lead in supporting this initiative. From the DFID-PMO we would like to thank Mr. Gordon Mortimore and Ms. Rochita Talukdar for their support and inputs to the project.

We appreciate the work undertaken by the project team for the completion of the project namely Ms. Venu Arora and Mr. N. Ramakrishnan from Ideosync Media Combine; Dr. Sunil Mehra, Dr. Suba Shankar Das and Ms. Anjali Sakhuja from MAMTA. We would also like to extend a special mention to the field partners: ARIDS, Star Youth Association, Sahara and Santoshi Mahila Abhyuday Samiti in Andhra Pradesh and AWARD and Kisan Sewa Sansthan in Uttar Pradesh who along with a team of peer researchers were instrumental in collecting the data.

We would also like to acknowledge the work of the colleagues from Constella Futures namely Ms. Shuvi Sharma, Ms. Harpreet Anand, Mr. Shaleen Rakesh and Ms. Himani Sethi who have been instrumental in bringing this project to a successful completion.



**Gadde Narayana**
Country Director, Constella Futures

# Introduction

While it is now well recognized that young people are at the center of the HIV/AIDS epidemic, there has not been enough research regarding their behaviors and the reasons behind young people's vulnerabilities. More importantly there has been very little research on the impact of current communication initiatives on prevention; and how these communication initiatives are being received and perceived by young people. Consequently, many communications programs which target youth do not lead to a significant change in risk behaviors. Given this scenario, it is imperative to develop evidence-based communication models so that these can be used to inform the next phase of the National AIDS Control Program – NACP III.

As part of this project, the consortium partners, Constella Futures, MAMTA and Ideosync Media Combine proposed a strategic Behavior Change Communication framework, which has since been validated and improved after an extensive qualitative research process with young people in Uttar Pradesh and Andhra Pradesh. Evolved, in part, from an earlier research project on young people's Right to Know (RTK) conducted by MAMTA in West Bengal and Rajasthan, this research has helped the consortium partners evolve a comprehensive communication strategy that will inform communication initiatives across the country. The consortium partners propose to develop a pilot communication project implementation based on this strategy, to be eventually scaled up to the national level.

The partners commenced the study with an extensive desk review of existing communication literature, materials and initiatives to ascertain the level of existing communication reaching young people. The findings from the desk review provided the inputs for the development of the research tools for this study, which were thoroughly pretested with young people before they were finalized. The field research itself was conducted using an innovative peer research methodology, where young people of the same or similar age groups conducted the actual research. Finally, the data generated by this process was analyzed in order to generate the final research outputs of the study.

As part of this research process, 80 Focus Group Discussions (FGDs) were undertaken with 8 sub groups divided on the basis of age, sex and marital status: For the purposes of this study, the young respondents were subdivided into age groups of 10-14, 15-19 and 20-24. 160 in-depth interviews (IDIs) were also conducted to get more detailed responses from the respondents, especially around attitudes and behavior patterns. The IDIs also included secondary stakeholders and gatekeepers whose knowledge and behavior impact those of young people: Parents, Panchayati Raj Institution members, local youth group leaders, village elders and commercial sex workers.

The project was executed by Constella Futures, in partnership with Ideosync Media Combine and MAMTA Institute of Mother and Child. Constella Futures, the lead partner, provided the overall management and technical assistance for conducting the research. MAMTA was responsible for conducting the research at the grass root level in partnership with their network partners in both states. Ideosync Media Combine provided the communication inputs (including the necessary technical expertise around behavior change communication), developed the research tools, analyzed the qualitative data, and designed the communication strategy.

# Background to Research and Desk Review

India is one among the several countries affected by a significant rise in reported HIV cases, from a few thousand in the early 1990s to around 5.2 million children and adults living with HIV/AIDS in 2005. Nearly 90% of HIV-positive individuals in India fall in the most productive age group (15–49 years), the prevalence rate being nearly 0.9% in this age bracket. It is increasingly becoming clear that the epidemic is affecting both the urban and rural areas; and that is also increasingly affecting women in the general community.

The spread of HIV within the country is as diverse as the societal patterns between its different regions, states and metropolitan areas. Our desk review reveals that the transmission route is predominantly heterosexual (85.05%), except in the North Eastern states, where injecting drug use is the main route of HIV transmission. A significant increase in injecting drug use, with drug users switching from inhalation to over-the-counter injecting drugs has occurred over the past four years. The other routes of transmission (in order of proportion) include perinatal (4.79%); infected needles and syringes (1.5%); unsafe blood and blood products (1.42%); and unspecified and other routes of transmission (6.4%).

Data from other studies researched as part of the desk review process indicate that about one-third of reported AIDS cases are among young people under the age of 30. However, it is likely many more AIDS cases within this age group go unreported. Globally, nearly 45% of all new HIV infections (about 2.4 million per year) occur among 15–24 year olds; in several settings, the rate is equal to or more than that estimated among adults. In India, the estimated percentage of young females aged 14–24 living with HIV/AIDS is 0.96% and 0.46% in high and low prevalence sites, respectively; and the estimated percentage of young men living with HIV is 0.46% and 0.20% in high and low prevalence sites, respectively. The corresponding percentage among adults globally is 0.80% (UNICEF, UNAIDS and WHO 2002).

According to the National Behavioral Surveillance Survey (BSS), sponsored by India's National AIDS Control Organization (NACO), some 3% of young, mostly unmarried males, and some 5% of young, mostly unmarried females reported experiencing such symptoms of infection (STIs or RTIs) as discharge, ulcers or sores in the 12 months preceding the survey. These proportions undoubtedly reflect considerable under-reporting (in some states not a single respondent reported any symptoms) and hint that awareness of symptoms may be limited among youth (NACO /UNICEF 2002). The qualitative research undertaken during this project confirms some of these projections and provides in depth insights to perceptions and behavior patterns of young people especially their information and communication related needs

## The Vulnerability of Young People to HIV/AIDS

One of the most plausible explanations put forward by various studies for the vulnerability of youth to HIV/AIDS, sexual and reproductive health problems is a lack of appreciation by program designers of the needs of young people in the region. Despite the fact that young people represent almost one third of India's population, their reproductive and sexual health needs are poorly understood and ill served. They may have been highlighted as a group to be addressed when policies and program proposals were written, and funds were allocated for their education, nutrition, health, and employment - but by the time these programs were actually operationalized, their needs had largely been forgotten (or addressed so poorly as to have no practical effect at all).

Young people are particularly vulnerable to HIV infection for many reasons, including age, experience (or lack thereof), state of biological and psychosocial development, and their financial dependence. Most young people have little (if any) access to health care services, or accurate information about sex or HIV/AIDS at a key time

in their lives when the vast majority of them are becoming sexually active. Equipping them with the tools they need to make safe and healthy decisions - sound knowledge and skills, access to services, a protective familial, social and legal environment - must form the backbone of the global response to the HIV/AIDS crisis if we are to tackle the spread of HIV in the long term. The evidence shows that where HIV transmission has been reduced, the greatest reductions are often seen among young people. Evidence also suggests that young people can and do change their behavior if they become more aware of HIV/AIDS and about ways to keep the virus from impacting their lives.

Young people represent a positive force in society, now and for the future. However young people today face challenges more complex than the ones previous generations faced - and often with less support. They experience puberty at younger ages, and marry and have children later than in the past. At the same time, they face significant risks related to sexual and reproductive health, and many lack the power to make informed sexual and reproductive choices. Young people also have different needs according to their stage of development and their personal circumstances: Some groups are especially vulnerable or hard to reach, and are in extra need of support. These vulnerabilities remain poorly understood and served, and it is only over the last decade that researchers and policy makers have begun to shed their traditional ambivalence to these issues. Even so, there has been little evidence generated to identify the factors that support young people's ability to ensure safe sexual and reproductive health for themselves, and to give them the autonomy to make informed and required decisions (Jejeebhoy et. al., 2003)

Health programs generally make provisions for adults and young children, but young people have largely been overlooked. Additionally, given that the position of different groups of young people's varies tremendously by age, sex, marital status, class, region and cultural context, there is a consequent need for interventions that are flexible, contextual and specific in approach to address their needs.

Gender disaggregated data for adolescents, especially, is limited in availability; and is generally available only for recent years. Such data is important to develop, as gender disparities become immediately apparent in statistics like the relative mortality rates for young men and women, particularly among young people aged 15–19 (2.5 and 1.8, respectively per 1,000 females and males) and 20–24 (3.8 and 2.7 per 1,000 respectively). (IIPS, 2000) This may be explained by the poorer reproductive health of young women at these ages. It is an important reminder that many RSH issues for young people need to be analyzed with this level of specificity – which should carry forward into the messaging developed to address the issue. More qualitative data is also needed to enable us to explore issues of gender discrimination and its linkages with reproductive behavior among young people.

There is a close association between educational attainment and age at marriage, fertility regulation and health-seeking behavior. Studies reveal that while age at marriage among illiterate women is 15 years, age at marriage among girls who have completed high school is significantly higher, at 22 years (UNFPA, 1998). Globally, women with seven or more years of education tend to marry four years later and have 2.2 fewer children than women with no schooling (UNFPA 1996).

Attention is required to address the health needs of young people by delivering on their right to health care, thus ensure that this generation of adolescents will, in turn, safeguard the health of their own children. Young people have different health risks and needs according to their age, sex and living circumstances. They may not appreciate the importance of seeking treatment when they are unwell, and often underestimate the severity of their condition. Girls are also especially vulnerable to sexual abuse, though recent studies would suggest boys' vulnerability to sexual abuse is rapidly catching up.

Adolescents often are not able to comprehend fully the extent of their exposure to risk. Societies compound young people's risk by making it difficult for them to learn about HIV/AIDS and reproductive health.

Moreover, many youth are socially inexperienced and dependent on others. Peer pressures easily influence them—often in ways that can increase their risk.

## Communicating with Young People about HIV Prevention

The desk research undertaken as part of this project also explored some of the communication interventions undertaken nationally over the last 5-7 years. The desk review revealed that while many communication campaigns were undertaken, there were very few that strategically addressed young people. Apart from the School AIDS Education program and the recently launched AEP initiative for schools - recently opposed by state governments in Maharashtra, Karnataka and Madhya Pradesh - there are few noteworthy processes or campaigns addressing young people as a specific audience. Overall, communication campaigns tend to either address adults through generalized PSAs on television and radio; or a targeted population of high risk men through campaigns like the Puliraja and Balbir Pasha campaigns (in A.P. and Mumbai, respectively); or the Bula di campaign in West Bengal. Campaigns like BBC-WST's Haath Se Haath Mila youth show or the Jawan Hoon Nadan Nahin campaign in Maharashtra are still quite rare – and even these campaigns are not addressing young people segmented by age, gender and economic variables. There are few calls to action and even fewer details of why young people are at risk provided in these campaigns. While young people have access to these messages, their particular behaviors and risk patterns are not being addressed by the messages they are receiving. Their information needs are being fulfilled either.

Adolescence and youth are a period of transition, growth, exploration, and opportunity. At the same time, adolescents typically are poorly informed about their own bodies (and about sexuality in particular) given the traditional social environment in India. As a result, they may be susceptible to unwanted pregnancies, the health risks associated with early pregnancy, unsafe abortions, STIs, and HIV. International experience shows that programs have been most successful when information and education are provided interactively and are linked to services. Most adolescents are eager to learn about reproductive health and are open to advice on how to handle personal problems. Mass-media entertainment (radio, television, music, video, film, comic books) can be a cost-effective way to communicate messages that can influence knowledge, attitudes, and behaviors - but these have to be designed with specific communication outcomes in mind. Entertainment media can reach a wide audience and can help promote communication between parents and adolescents. The mass media can be especially useful in reaching at-risk adolescents who may be illiterate, out of school, or unemployed. Personal counseling and referrals to clinic services can be integral to helping young people adopt responsible behaviors. New methodologies for participatory communication for development must be considered if we have to ensure a sustainable social change that will ensure continued safer practices and reduce HIV transmission. In this regard, local radio and television and trained local communicators can be a good way to make the communication messages locally relevant and specific for specific groups.

Campaigns like BBC-WST's Haath Se Haath Mila youth show or the Jawan Hoon Nadan Nahin campaign in Maharashtra are still quite rare – and even these campaigns are not addressing young people segmented by age, gender and economic variables.

The following are some of the gaps identified after an in-depth analysis of existing communication programs that were studied during the desk review:

- Lack of strategic focus on youth
- Youth populations seen as homogenous: Lack of segmentation of this population for directed communication
- No national focus on gatekeepers (parents and teachers) to ensure greater impact of youth initiatives
- Ongoing interventions that have a strong communication focus still lack clearly defined communication objectives, especially for adolescents or young people
- Inconsistency in messages, creating greater stigma and misconceptions - and therefore failing to convince audiences to adopt safer practices

# Research

## Significance of Research

There is already enough existing data on the prevalence of the HIV epidemic and on young people's vulnerability to HIV. However after more than 15 years of prevention focused interventions, it is time to go beyond the basic first generation messages on prevention: As later chapters of this report will show, a large proportion of young people in this country have basic information on HIV - and now need messaging on how to make use of the basic information they already have. This research has been designed specifically to get qualitative insights into the current communication ecologies of young people and look for ways to move from the first generation messages on prevention to second and third generation messaging that supports behavior change, skill development and positive choices. The study has also been timed to provide inputs to the overall strategy under NACP III (and in particular, to address issues around communicating with young people).

Most research with young people is unsuccessful in gaining intricate insights into their priorities, needs, relationship with communication media, and the messages that need to be designed to address them, because it is difficult for young people to talk openly with adult researchers. This research therefore used an innovative peer-led research design (described below) to gain this insight. Further, there are few researches designed to contribute to the development of a communication strategy. This research aims to specifically address this gap by clearly informing a comprehensive communication strategy for young people in India.

## Research Objectives

1. To explore young people's priorities, and to ascertain whether health, reproductive health and/or HIV are priority issues (Corollary: If these are not priority issues, what other issues do these issues need to be linked with to make young people perceive them as more important?)
2. To explore current HIV knowledge levels and practices among young people; as well as the impact of age, gender and socio-cultural imperatives on the risk taking behavior of young people (including determining concepts of masculinities)
3. To identify the gap between current behavior (risk patterns) of young people and desired behavior (safer practices), and the reason for this gap
4. To identify social factors that can create an enabling environment to support behavior change among young people
5. To identify social /cultural /psychological / programmatic barriers to accessing information and change in behavior among young people

## Research Methodology

### Strategic use of peer researchers for research

Young people's sexual and reproductive health is a difficult issue to discuss, especially since Indian culture does not promote open and non judgmental discussions around sexuality - and also because young people's sexuality is not recognized within the larger Indian social matrix. Given this general lack of acknowledgement of their needs, young people find it difficult to share their informational needs - and their sexual practices - with adults. This creates a challenge for those designing communication strategies to address the HIV vulnerability of young people. Adult researchers are unable to gain an insight into what young people themselves prioritize in their lives, and programs are denied an accurate understanding of the sexual dynamics of young people's lives given the limitations of the research practices followed by professional (adult) researchers. However, in the last few years, HIV program interventions with young people have used peer educators to provide information to young people on HIV prevention issues. Such programs have met with considerable success, especially in accessing young people as a constituency. The consortium therefore felt that a

similar approach to research would possibly provide better incites into current behavior patterns and practices and allow for a critical analysis of current information and programmatic needs with regard to young people's vulnerability to HIV.

## Criteria for Selection of Peer Researchers

Considering the novel use of peer researchers for the purposes of this study, and given the scale and scope of the task at hand, it was important to first develop a set of criteria to select the young people who would conduct the field research process. The final list of criteria – and the importance of each criterion – were as follows:

### 1. Should not be below 15 years of age

The target population for this research was young people between 10 and 24 years of age. Ideally the peer researchers selected should also have been of a variety of ages within the band, to successfully blend in with the different levels of maturity and experience that necessarily exist within this band. However, it quickly became evident that for research purposes, young people of age 10 or 11 or 12 would not have enough maturity to understand the concepts involved in the research process; and could therefore not be depended upon to conduct the research activities successfully. This issue was debated at the consortium partners' workshop held in New Delhi at the MAMTA office from 28-30 August. It was finally decided that all the peer researchers would be selected from the 15-24 years age group (divided into two segments - 15-19 and 20-24 - where 15-19 would be mostly unmarried and 20-24 would be mostly married.) It was also decided that the peer researchers conducting a specific FGD or IDI would be as close to the age group of the respondent(s) as possible, and would match the marital status of respondent(s) to the greatest extent possible. The peer researchers who interviewed the 10 – 14 age group, therefore, were closer to the 15 year mark than the 24 year mark.

### 2. Both male and female researchers required

IDIs and FGDs with male participants were conducted by male peer researchers. Similarly FGDs and IDIs with female participants were conducted exclusively by female peer researchers. Experience suggested that mixed gender groups would not open up during FGDs. Similarly, both genders would not discuss details of their sexual behavior with interviewers of the opposite gender.

### 3. Should be from the same districts or block but not from the respondents' village

Peer researchers were selected from the areas covered by the research study itself, in order to ensure that they spoke the same local dialects and understood local nuances of language. However, in order to ensure confidentiality, care was taken while allocating areas to the peer researchers to ensure that they were not from the same villages as the respondent. Further, if peer researchers were selected from the same villages as the respondents, there was the possibility that local village level dynamics could influence the selection of the research respondents. The active involvement of researchers or their families in local politics or dynamics could also have hampered the research process through biases.

### 4. Should have proper understanding of the local language and cultural environment

Peer researchers were expected to be representative of local culture and communities. Especially where the rural areas were concerned, city bred people would have been perceived as outsiders; and would therefore not have been able to accurately comprehend the realities and perceptions of the village communities. The selected peer researchers were therefore well versed in local dialects and had proper knowledge about the traditional, religious and social practices being followed in the research area. It was also important that the peer researchers had an interest in social service; and that he/she displayed good information seeking behavior and a willingness to learn facilitation and participation skills.

### 5. Should be open minded and dynamic enough to understand the concept of scientific social research process

The selection of peer researchers was also based on their openness to new ideas and concepts. Research processes - and especially qualitative

research processes - require the researcher to be enthusiastic and curious, and also to have the ability to ask follow-up questions to clarify and expand on issues that would otherwise not be revealed in their entirety during the IDI or FGD. This meant that care had to be taken while screening the prospective peer researchers, in order to ensure the selection of individuals who had these capabilities in some measure.

### 6. Should be open-minded regarding various social issues

Neutrality is the most important quality for qualitative researchers. The greatest risk in an approach where researchers are selected from the community is that they share the biases and stereotyped notions of the local communities, which influence the research process they undertake. Gender, masculinity and sexuality are sensitive issues and many community biases are associated them. While much of this was addressed through the training process that the peer researchers underwent, care was also taken to select researchers who were flexible towards new concepts in the first place. Some simple attitudinal questions were designed for the screening process to facilitate this aspect of the selection.

### 7. Should be able to read and write in their basic language (Hindi in U.P. and Telugu in A.P.)

Peer researchers were also selected on their ability to read and write Hindi (in U.P.) or Telugu (A.P.). It was decided that there would be no stringent educational criteria for the peer researchers due to field level exigencies. While preference was given to researchers who had cleared class 12 or at least class 10, it was decided to test their capacity to write and read through short writing exams instead of setting any academic criteria.

## Implication of the Methodology

The decision to use peer researchers to gather qualitative data entailed the capacity building of selected youth to train them in research skills, especially in the ability to conduct focus group discussions and in-depth interviews. The methodology also required the selection of peer researchers with similar demographic and socio-cultural backgrounds as the beneficiaries/respondents. Research tools were developed in partnership with select groups of young people from the areas identified for the study; and were pretested with a cross section of the beneficiary audiences.

## Challenges and Constraints of the Methodology

- Young people trained in research methodology were not professional researchers
- Challenges of implementing research with gatekeepers and other adult stakeholders using peer researchers
- Increased possibility of subjectivity and increased involvement between researcher and respondents
- High variations in the details of the data collected
- Increased time consumption
- High number of repeat focus group discussions or interviews, especially in the first phase of data collection

## Study Area

Four districts from a high prevalence state – Andhra Pradesh – and four districts from a highly vulnerable state – Uttar Pradesh were identified for data collection. With huge diversity in cultural, socio-demographic, environmental, human development, and economic indices, these two states provided a good mix of factors to test the applicability and adaptability of various communication strategies. In each of the eight districts, two blocks were identified for community-based interactive qualitative research.

## District Selection

District selection was based on the RHS/RCH Survey report of India. The indicators, in terms of access and utilization of services, and knowledge level of HIV and RTI/STI self reporting, that were used for the selection of districts were:

1. Percentage of girls marrying below age 18,
2. Percentage of births of order 3 and above,
3. Percentage of currently married women age 15-44 years knowing all five modern methods of contraception, i.e., male and female sterilization, IUD, Pills and Condom,

4. Percentage of currently married women age 15-44 years using any modern method of contraceptive,
5. Percentage of currently married women age 15-44 years having unmet need for family planning,
6. Percentage of women who receive ANC (any),
7. Percentage of women who reported knowledge of HIV/AIDS,
8. Percentage of women who had any symptoms of RTI/STI,
9. Percentage of men who reported knowledge of HIV/AIDS,
10. Percentage of men who had any symptoms of RTI/STI.

For each indicator a specific index was developed; and finally a composite index of all these ten parameters was developed for ranking of districts in each of the states. This ranking was then complemented by the NACO identified 111 high prevalence districts. Geographic distribution of the districts, representing the cultural diversity within each state, and the availability of network partner organizations with access to the concerned districts were also considered while making the final choice of the districts.

The final districts that were selected in the two states are given in the table below:

| State | District |
|---|---|
| **Andhra Pradesh** | Kadapa |
| | Karimnagar |
| | East Godavari |
| | Mahabubnagar |
| **Uttar Pradesh** | Pilibhit |
| | Aligarh |
| | Etawah |
| | Basti |

## Primary Target Population

The primary respondent group for the project and the research study were young people between the ages 10-24 years, both married and unmarried, rural and urban. For effective program deliveries, the primary group was further sub-divided into 3 subgroups by age: 10-14, 15-19 and 20-24. The male and female sub-groups were also stratified by marital status, thereby creating six major youth sub-groups studied during the course of the research.

## Secondary Population

The secondary population studied included parents, other family members, teachers and community leaders. There was an emphasis on understanding the behavioral patterns of the parents. Secondary target population also included key informants for this research - TBAs, ANMs, ICDS workers, self-help groups, NGO members, government officials, youth organizations, health service providers and local governance bodies such as the village Panchayat functionaries. It also included commercial sex workers as a population accessed by young males – and therefore as a possible source of information on their risk behaviors and attitudes.

## Sample Size

The in-depth interviews and focus group discussions were carried out with both primary and secondary target group respondents. Over all 160 in-depth interviews and 60 focus group discussions were carried out, evenly distributed between the two states and the 8 districts. There were thus 40 FGDs and 80 IDIs per state, or 10 FGDs and 20 IDIs per district.

## Research Tools

The following three primary qualitative research tools were designed and used in this study:

- FGD guideline for young people
- IDI guideline for young people
- IDI guideline for respondents from secondary population

Along with young people, influential community members, gatekeepers, and people involved in other communication programs were also incorporated in the sample. Similarly interviews with gatekeepers, influential people, and key informants were also conducted to get background information for developing a holistic understanding, and thereby to better address research objectives. FGDs were also conducted with parents, teachers and other community members. Accordingly, the IDI and FGD guidelines developed also addressed each

of these groups, with specific subsections of the guidelines directed at specific respondent groups in some cases. (IDIs with gatekeepers and key informants were conducted by workers from the local NGO partners who were supervising the research process in each district. This was decided after peer researchers experienced difficulties in engaging older community stakeholders in sensitive conversations.)

The FGDs were conducted by teams of two peer researchers, with one facilitating the discussion while other took notes on the discussion. IDIs were conducted by individual peer researchers, who took their own notes for the interview. All the FGDs and IDIs conducted were recorded on tape. The recordings were then carefully labeled and transcribed, and combined with the field notes for the corresponding interview. A qualitative research software named Nud*ist (N6) was then used for data management and analysis.

## Research Timeline

The entire research project, from start to finish, was undertaken over a period of 10 months from May 2006 – March 2007. This included the desk review process, design of research tools and methodology, selection of peer researchers and training, data collection, analysis and report writing.

Accordingly, the time table followed was as follows:

| | |
|---|---|
| Desk Review | May-July 2006 |
| Research design including design of tools | May-July 2006 |
| Selection of field partners and peer researchers | June-August 2006 |
| Pre test of research tools | August-September 2006 |
| Training of peer researchers | October 2006 |
| Refresher training of peer researchers | November 2006 |
| Data collection in the field | October-December 2006 |
| Transcription and translation | November 2006-January 2007 |
| Data Analysis and report writing | January-February 2007 |
| Design of Communication strategy | February 2007 |
| Dissemination Workshops | March 2007 |

## Constraints

This extremely tight timeline posed a challenge given the extensive scale of the project and the large sample size. The time constraints ensured that no communication models could be developed within the project timeline. The outcome of the project is therefore a comprehensive analysis report and a communication strategy document with a flexibly designed communication matrix. In order to operationalize the outcomes of the work done under this project some elements of the communication matrix will have to be developed as pilot models to enable country wide replication and adaptation.

# Key Study Outcome

## Key Research Findings: A Summary

The study has demonstrated that although knowledge of HIV/AIDS is relatively high in both boys and girls, it is comparatively higher in boys than among girls. There is a high prevalence of myths and misconceptions around sex, sexuality and HIV transmission. While many young people are able to correctly identify at least one mode of HIV transmission, most do not consider themselves at risk. The qualitative data has provided valuable insights into certain behaviors related to youth sexuality like the varied meanings of safe-sex, fears related to masturbation, and perception of individual responsibilities; and also why certain beliefs and attitudes are held and perceived differently by boys and girls. This study highlights the present needs of the young people; findings that are often corroborated by the parents, teachers and elders in their communities. This data has been generated to form a basis for planned communication strategies for young people - not just to inform and enhance levels of understanding, but also to empower them to take relevant decisions and make choices that better their life situations.

**Some of the key outcomes are as follows:**

1. Low levels of understanding around human anatomy; and consequent myths and misconceptions around masturbation, night fall, menstruation
2. Lack of information sources and empowering spaces and opportunities for discussion around sexual health issues, especially issues around growing up and bodily changes
3. Awareness levels regarding HIV are quite high - most young people have heard about HIV
4. Low levels of self risk perception regarding HIV
5. Low levels of awareness around STIs, and linkages of STIs with HIV vulnerability
6. Sexual route most commonly cited mode of HIV transmission and vertical transmission least cited.
7. Concepts around sexual transmission of HIV need to be better explored as there are indications that some of the extant communication is being misinterpreted by young people. Concepts around 'illegal sexual contact 'are very prevalent. There is no understanding or perception of serial monogamy as a risk.
8. Schools are more active in A.P. in providing information on sexual health, STIs and HIV; and many young people from A.P. have cited interactive sessions in schools as a key source of information
9. Many current messages are cited as being understood only by literate members of the community. This has been stated as a concern by young people when discussing preferred sources of information
10. Magazines have been described as important sources of information, along with the electronic media (notably TV)
11. Radio has not been used much despite its obvious advantages for HIV campaigns (especially the advantage of anonymity, reach and access for non literate audiences)
12. Condoms are associated with bad morals or multiple sexual partners and there is consequent discomfort around accessing and using condoms. Poor social acceptability of condoms leads is clearly linked to lower usage patterns
13. Lack of skills to negotiate safer sex or initiate discussions with partners has emerged clearly by its conspicuous absence in the conversations with young people

## Age Differentiated

Younger youth need more information on sexual and reproductive health issues. There is a clear apprehension associated with approaching parents for fear of being castigated. Friends are therefore seen as sources of information, but also recognized as providers of wrong information. Schools are seen by young people as a safe place to access information on sexual health. There is a demand for greater and more supportive role by teachers. The electronic media is seen as an effective source of information by the older

age groups. Television, radio and magazines are seen as effective means. However traditional community media and nukkad nataks have also been cited as effective and preferred means for communication on HIV prevention. Inter-personal communication and more spaces for interacting with trained personnel for in depth and clearer understanding on prevention have been highlighted by young people; and many community stakeholders have been listed as possible sources including teachers, local health practitioners and ANMs.

## Gender Differentiated

There is a clear divide in terms of mobility of young boys and young girls which guides their communication ecology and - consequently - their media preferences for receiving communication on HIV. Girls therefore prefer to get information from television, radio and magazines; while boys prefer outdoor interactive spaces like youth clubs and community meetings in addition to television, radio and magazines. A clear preference for interactive spaces with information providers of their own gender has also emerged from the study. Further, there is a greater interest among boys in gaining condom usage skills and in understand how condoms provide protection against HIV and STIs; whereas girls are keener to understand the modes of transmission of the HIV virus, the condom's use for family planning, and related RSH information. This

> The qualitative data has provided valuable insights into certain behaviors related to youth sexuality like the varied meanings of safe-sex, fears related to masturbation, and perception of individual responsibilities; and also why certain beliefs and attitudes are held and perceived differently by boys and girls.

clearly indicates the need for a gendered design for communication initiatives.

## Note for Communication Strategy

This research reveals that while there is awareness on HIV and its transmission, and much is credited to ongoing campaigns, there is also an increasing gap between awareness and practice. This clearly suggests the need for moving to second and third generation communication by prioritizing:

1. Behavior change and skill based communication
2. Integrating mass media with interactive strategies
3. Enhancing spaces for greater inter-personal communication (IPC)
4. Designing innovative participatory communication initiatives using community media, and including community radio and community video
5. Designing age specific and gendered communication frameworks and activities

# Research Results and Analysis

## Reproductive and Sexual Health Issues

The research findings indicate fairly low levels of understanding of sexuality and sexual health related issues among young people, especially in the 15-19 age groups in both Uttar Pradesh and Andhra Pradesh. In particular, there is confusion regarding understanding of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) among most young people interviewed. This stems from an incomplete understanding of the human anatomy and a lack of knowledge about their bodies. Young people from urban areas had a slightly better understanding of these issues than their rural counterparts; and this urban-rural contrast in levels of understanding is more pronounced among women than in men: Educated, married and urban women had a much greater awareness and understanding level about reproductive and sexual health issues than their counterparts in rural areas. Most rural women and girls reported lack of cleanliness of the genitals as the main reason for sexual health problems. According to an educated unmarried female respondent from rural Andhra Pradesh: *"I do not know any thing because I am unmarried, but as I am educated I can tell you that some ladies wipe the wetness on their sexual organs soon after intercourse and some women don't follow healthy habits - I think that is why reproductive problems happen."*

Many respondents believed a lack of education and exposure were the primary reasons for lack of knowledge around sexual issues. Some also spoke of child marriage and sexual relations at an early age as the main causes for sexual health problems among women. According to an educated male from rural Uttar Pradesh,

> *"Child marriage and sexual relations at younger age are the main cause (of sexual health problems)".*

### Issues around menstruation

Though most girls from rural areas reported various traditional practices around their monthly menstrual cycle, girls from better educated families - especially those whose parents were educated - reported fewer restrictive practices during their periods. Traditional beliefs and practices - such as not taking a bath for five days or keeping utensils separate for the menstruating girl - were more pronounced in rural contexts than in the urban contexts. There is also a strong caste-wise variation that has emerged in the study as far as these traditional practices are concerned, with more stringent regulations and myths around the menstruating girls 'purity' (and consequent exclusion from religious ceremonies) among specific castes and sects. This has been observed in both Uttar Pradesh and Andhra Pradesh. To quote a male respondent from rural Uttar Pradesh:

> *"Here it exists only among Brahmins. In Brahmin families, ladies are not allowed to come into the kitchen when they are menstruating."*

Some of the common practices reported included exclusion from the house during meals, exclusion from participating in religious ceremonies or regular daily prayers, and the avoidance of a daily bath during the menstrual period. While some of these practices may cause psychological anxiety among growing girls, the practice of not bathing is an unhealthy practice that often leads to infections. These practices have also been reported from respondents of both states.

According to a female from rural Andhra Pradesh: "Yes, these types of practices are there when girls go through that time in the month. Especially the Kapus and OC communities make the girls sit outside the main house all through the five days. Their utensils for food will be separate. Menstruating girls will not be allowed to touch anyone. This is how things are in our village. As soon as the five day menstruation is over, the girl is asked to bathe. While they are menstruating they are considered 'maila' and, turmeric water is sprinkled everywhere. They are not allowed to use oil for the head, or go to temples. They are not even allowed to offer prayers inside the house nor are they allowed to touch anything near the prayer room.

It is clear from the in depth interviews that many practices around girls' menstrual cycle cause much of their regular routine to be disrupted; and that some of these practices are quite discriminatory and segregatory in nature. One of the respondents recounted how she was told by older women in the family that

> *"At this time (when I am menstruating) I should not use any makeup or perfume and should not go out of the house. I should hide from people and must not participate in any religious ceremonies."*

A few girls also reported that, during menstruation, girls in their area were not allowed to cook in the house. According to an unmarried female from rural Uttar Pradesh,

> *"We are not allowed to perform Puja. (A menstruating girl) is not allowed to cook."*

Some instances of active discrimination are also reported around the regular monthly cycle. According to a female from rural Uttar Pradesh: *"Well, I have a friend who is not allowed to sleep on the bed during this time; she has a separate dirty mat to sleep on. She does not go to the kitchen. Her utensils are separated. She eats the food sitting outside the house. During this time everyone behaves with her like she was a beggar. Mostly this happens among Aggarwals and Jainis – they hang a cloth to cover the household deity so that God may not see her in this dirty (state). I do not like these practices – I do not believe in these things. But when it has to be done in the family one cannot refuse."*

Similar practices have also been reported among Muslim women. To quote a female respondent from rural Uttar Pradesh: *"They do not offer namaz, do not read Kuraan and do not go to the religious places for worship etc. This thing is considered dirty and unholy".*

The concept of avoiding sexual relations during a woman's menstrual cycle seems to have much support among people. While respondents were unable to give any coherent arguments for their beliefs, many of the practices are favored by social norms and cultural or traditional perceptions. According to a male respondent form Uttar Pradesh, *"The person who does not consider the condition of the women, whether her M.C. has started or not... this is not right. It is the duty of the man that he should not have any contact with the lady for a week if she is suffering from MC, he should not ask her for anything. Because there is much bleeding at that time any physical contact with the woman will result in some damage inside her. Since there is bleeding if any pressure is put at that time, then many diseases may develop and sometimes due to pressure her uterus gets damaged and operation may be necessary."*

This clearly shows a lack of understanding of the human anatomy and the normal processes of the human body. Lack of understanding around the menstrual cycle causes many myths and misconceptions to take root. Some unhygienic practices, especially those that propagate avoidance of bathing during menstruation, can lead to infection and can be quite dangerous for a girl's health. To quote a health practitioner from a rural area in Uttar Pradesh: *"Now-a-days this discriminatory treatment is meted out only by uneducated persons. Only uneducated families follow such traditional practices like not allowing the girls to take a bath for five days. Patients come to our clinic, with bad smell from their bodies and when we ask the young girls why they have not taken a bath they tell us about all this. Educated persons keep cleanliness."*

It is evident from the study that, while such practices are rampant in rural areas - and especially in families where family elders have lower educational levels - these practices find less credence in many urban areas and among more educated families. Most educated girls spoken to as part of this research did not believe in the validity of these practices. While some form of celebration or traditional ritual is practiced around menarche in both Uttar Pradesh and Andhra Pradesh, there were some responses from young girls that lead us to believe that the process of change in the understanding of these cultural practices is very slow. According to a female from rural Andhra

Pradesh, *"At the time when a girl is going through MC the body needs rest. So all these traditional practices of the elders actually were a way to give rest to the girl. But now many new things have been added and some of them are bad. But actually these are so we can get some rest during this time. Even now, especially in Brahmin families we can see this kind of tradition being followed. But in many educated families if a girl gets her menstrual cycle we will not get to know, nobody will tell it out side also. Some people have a small celebration when MC begins but without bringing it to anybody's notice. Many of these are blind beliefs."*

### Perceived sexual health problems among males

Among boys the most common and prevalent misconceptions are around masturbation. This is also an area of maximum concern and anxiety for boys, much of which is not addressed. Boys in rural areas, particularly those with lower levels of education and those who were unmarried had much higher levels of myths and misconceptions. One of the interview respondents from Andhra Pradesh reported a fear of weakness as a consequence of masturbation:

> *"Energy reduces when having masturbation. I masturbate 5 times a day and I feel some weakness in my body".*

There seem to be some initiatives and information sources in Andhra Pradesh that talk about masturbation as a safe sexual practice, and this seems to have provided some sense of understanding that there is no harm in practicing masturbation. A male respondent from rural Andhra Pradesh said: *"A lot of information we get from Samaram. He is an expert doctor. Just we have to follow what he says. I am telling you freely, we did not generally know about these things. Many boys masturbate to get pleasure. We have to satisfy ourselves and we do not need women also. But sometimes I worry that because I masturbate, may be some serious problem will happen to me and may be I can never have relation with women at all. But Samaram said that there is no harm in masturbation. However, many times among friends these doubts are always there".*

However it is disheartening to find that local doctors interviewed under this study also had misconceptions around nightfall and masturbation. One respondent talked about providing local herbal medication for curing 'nightfall' (nocturnal emissions). Nightfall is perceived as a sexual health problem, and young men are approaching local health providers for treatment. According to a local health practitioner from rural Uttar Pradesh:

> *"Many boys come to me for treatment They have nightfall problems and many masturbate a lot. I give them a grass (herb) and tell them that if you take it, then there will be no nightfall. I have prepared very good medicine for nightfall."*

### Sexual and reproductive health information needs

Young people are the key determinants of the future course of the HIV epidemic. The behaviors they adopt now, and those that they maintain throughout their lives, will determine the direction of the epidemic for decades to come. Youth behavior, in turn, will always depend on the information they have, and their ability to make choices and decisions based on their understanding of this information.

Most of the young people spoken to agreed that they had many unanswered questions; and that they often discussed these issues with their friends. Some of the issues they seek information on - as cited by respondents from both states - included:

- Sexual organs and their functions
- Menstruation
- Changes in the body while growing up
- Sexually transmitted diseases
- Masturbation
- How does reproduction happen
- How to maintain sexual and reproductive health

In both the states most young people are currently getting information from the following sources: **Friends, Books, magazines, newspapers, friends who are slightly older than them, married friends, and relatives.** The study clearly shows a high demand for information on sex and sexuality among young people, especially in the 15-24 age groups.

The research also shows that most young people are hesitant (if not downright afraid) to discuss their concerns around sexual issues with their elders, due to their fear of being castigated by them. One respondent from U.P. said: *"I cannot talk to my parents, and definitely not to my father. So sometimes I talk with my aunt. But mostly (I) cannot talk to (my) elders."* Another young male said: *"I have not discussed any of this with my parents or with my teacher. I have only discussed it with my friends; and after that I have not discussed these things with anyone. It is not possible to tell an older person that I masturbate, or if I have questions about sex. With friends I can talk about this matter. But how can I talk to my mother or father or guruji about such things?"*

On the other hand, some parents opine that there is a need to educate young people by providing them information about reproductive and sexual health, keeping their future safety in mind. According to a parent: *"To ensure that these problems don't happen in children and young people, first we have to make them aware. Knowledge should be provided so that people may come to know about it. People who take it lightly may face a big problem after sometime. Whether it is my child or yours, if they are at a certain age the same things apply to all. My only advice is that full information may be provided to all young people."*

However, there seems to be no understanding or concurrence among parents on the fact that the act of providing this information is also a part of their responsibility towards their children. (Conceivably, one possible obstacle that prevents parents from taking on this role is that many of the parents are themselves unaware about the issues in point; and are not equipped with the correct or complete information.)

Discussions with health professionals during the study revealed a strong gender bias, and a large gap in understanding these issues; especially the need to address gender inequality with regard to sexuality and sexual health issues. In the villages, the local health worker or ANM or *anganwadi* workers are all women; and so girls get an opportunity to talk to them (at least as regards their concerns around menstruation). There are no parallel systems that provide a safe environment for boys to discuss their anxieties with older, better informed individuals: There are no accessible male health worker figures in the village that boys can approach for assistance. According to a female health worker in rural Uttar Pradesh: *"Boys are influenced by the atmosphere in the village. If there is a boy, then he is hesitant to (talk to) me; but if there is a girl she talks me with comfort. Perhaps this is the general attitude in the village. They think that girls should be kept in the boundary of the home. Earlier girls were not allowed to talk to anyone but slowly things are changing. Many families let their girls come to the center and I can talk to them; and many also send them to school for education… and they are being given opportunities to develop."*

The boys' hesitation in discussing sexual health problems with their parents even persists, to an extent, among educated married youth. To quote a married male respondent from rural Uttar Pradesh: *"I don't think I can discuss these issues in my family. I cannot talk like this to my wife or to my parents. If at all, maybe, I can approach my doctor if I have a sexual problem; but if I have any questions I don't talk to anyone."*

The situation in terms of access to information from parents is similar in Andhra Pradesh. To quote one of the male respondents from A.P.:

> *"Even if we ask (our) parents, they don't tell so much. They scold us, and then it becomes very uncomfortable for us so it is better not to ask."*

According to another young male, *"With parents I can never be free, as they will think all wrong things about me. I am always uncomfortable. I never speak to them freely on these issues, I think even if I ask them something they will not tell me."*

Other sources of information on sexual and reproductive health issues mentioned by respondents included television, newspapers, and articles in weekly magazines. However, the primary source of information continues to be the young people's peer groups. The extent of the information they are receiving is not sufficient, and this is evident to many of the young people, who would like to find an

older and reliable person who could be a source of information. At present, however, there are no such readily accessible sources, since an environment where parents or health workers can be friendly sources of information for young boys or girls has not yet been created. Almost all the youth surveyed expressed a preference for receiving information on reproductive and sexual health from parents and siblings, schoolteachers, community elders, and health professionals.

### Reasons for not seeking information

The study also indicated several reasons why young people are unable to seek the information they need. The reasons cited varied from feelings of guilt about their own curiosity regarding sexuality to misconceptions around masturbation or nightfall. This feeling of guilt often becomes a closed loop, leading to a reduced ability to seek information, and creating a consequent lack of information that creates even more misconceptions to feel guilty about. Additional reasons cited were the lack of information seeking skills (**"How should I ask about this issue?")** and the fear of parents' and elders' disapproval **("What will they say?")**. Respondents often cited parents' uncooperative and unhelpful attitudes, and the unfriendly and inaccessible attitudes of teachers.

This resistance to providing sexual health information to young people is corroborated by adults and parents when they talk about their distrust of ongoing sexuality education classes in schools. A parent from Andhra Pradesh stated: *"Yes, information can be given; but this has to be done carefully. Nowadays all these surveys, meetings and education on sex and changes in the adolescent age, and HIV are happening - but they give details that we should not give to young as it takes the young people in the wrong path. Young people misinterpret all this information and are spoiling themselves, in my opinion. The matter is not taken in perspective of our tradition and culture. Young people can be made aware of the changes in their body and in their future; but when they are exposed to 'sexual connected' classes in their class in the name of the 'health education', it is not good."*

### Sources of information

Along with friends and local medical practitioners - quacks or qualified medical and health professionals - the electronic media (radio or television) are major sources of information for many young people. This is especially true of Andhra Pradesh: In Uttar Pradesh, *anganwadi* workers and ANMs were cited more often that TV and radio as the key sources of information on sexuality and reproduction, as revealed by the following table:

| Andhra Pradesh | Uttar Pradesh |
|---|---|
| Friends | Friends |
| TV channels TV9, MAA | Anganwadi workers |
| Siblings (Brothers and sisters) | ANM |
| Doctors | Health centers |
| ANM | Radio |
| Radio | TV |
| Sex books | Sister in-laws |
| Articles in magazines | Spouse |

Magazines were specifically quoted as sources of information, as they carried agony aunt columns and columns where doctors respond to reader questions. These columns appear to be quite popular among young people. There is also a strong desire to remain anonymous, and a need for confidentiality while accessing responses to one's questions around sexuality; a fact attested to be a respondent who actually preferred to not go to the qualified local doctor:

> *"We will not ask the doctor, because our parents will know (if we do) this. Then we meet Samaram (famous sexologist in A.P.) secretly".*

### Attitudes towards sexuality related issues

Regarding attitudes towards sexual health problems, almost all the young people interviewed, irrespective of their educational backgrounds, felt that these were personal issues, not to be spoken about openly and freely. Some of the study respondents felt that these issues can only be shared with health providers and friends. To quote a male respondent:

> *"They discuss the necessary things. They never discuss their personal things. They are afraid that if they discuss with elders what will the elders say? Elders may think that he is experimenting sexually or has a sex disease."*

As previously noted, age and marital status does not greatly impact the respondents' hesitation to discuss these issues; or the perception that sexuality is a matter of secrecy and privacy. However, it must be noted that younger unmarried young people were more clearly afraid of sharing these issues with parents.

### Perceptions around ongoing messaging

Young people acknowledged having come across and being exposed to some messages on sexual and reproductive health through a variety of sources.

Overall this study shows that young people feel that the information they get through these messages is not detailed enough; and that they often find it difficult to understand the messages in their entirety. According to one respondent from rural Uttar Pradesh, commenting on his experience watching a TV advertisement: *"I am also young, and among groups of young people such curiosity is always there. There is all this information and I also get it, but it is not enough. All the information is given only in symbols, and not clearly or in detail. They will talk about black and white color, and just write Condom - and what does that mean? We don't understand. Now when I am 24, I can understand a little more; but when I was 16 or 18, like other younger boys, this kind of short message did not give me full answers. Some advertisement will come in the paper or on TV, and they give a number but what do we understand by that?"*

As a large part of the information reaching young people in both states came through friends of the same age, many young people interviewed as part of the study felt that the information they got in this manner was not enough. According to an educated male from a rural area in Uttar Pradesh,

*"No, we cannot say it is sufficient. There is so much information, which is still not available to the people. People do not even understand about it. There are so many evils in the society so it cannot be said that this information is sufficient. Had this information been sufficient, then these diseases would not have taken place. Some people are aware but it cannot be said that these are sufficient."*

Many of the respondents also felt that information sourced from friends and peers could, in fact, be quite incorrect, as their friends also had access to the same sources of information as themselves - and were therefore likely to know no more than themselves.

Many young people interviewed regularly accessed agony aunt columns in magazines; and the information given by these columns was widely perceived to be more detailed and satisfactory. The information on sexual health given by these articles – especially the articles by doctors - is also perceived as easily understandable, as reported by youth in Andhra Pradesh. The messages through the regular columns in daily news papers (such as ***Vasundhara*** in ***Eenadu*** and ***Cheli*** in ***Vaartha)*** were seen as providing sufficient information on reproductive and sexual health, as reported in a focus group discussion with girls from Andhra Pradesh.

Young people felt that most current campaigns (and related messaging) are centered on HIV prevention and condom promotion; and that there were relatively few messages on sexuality and sexual health on the electronic media. They also opined that this information would be more effective if it was provided in group meetings; especially group meetings with friends. The following were some suggestions that emerged around how sexual health information could best be provided to young people:

- The messages should be clear and easily understandable
- Should be presented in a manner that the messages are also understood by young people who are not literate
- Information should be provided through group meetings and gatherings
- Should be in the local dialects and languages
- Parents should also be given this information so that they can respond to the needs of their children
- Wall hoardings and local media may be used

Respondents felt that messages should be polite and should be in local dialects – a point stressed by several young people as well as by members of the secondary population that participated in this study - so that the youth could understand the information clearly. To quote an educated rural male, *"Sex means*

*you must talk in a language that they can understand. Now we have the village language - if you talk to them in such a high manner of politeness they may or may not understand but you must speak to them in a polite manner. The information should be provided to parents, as they are the key person in transferring the information to their children. Mostly the mothers provide all such information to the girls and in similar the fathers also should provide to the boys."*

> *According to a parent from rural Andhra Pradesh: "We can gather the information based on the situation, based on their relationship with their parents mostly they get through their friends; but getting information from parents may be correct. In my opinion girl can know from the mother and boys from his father."*

Another strategy suggested from Uttar Pradesh is the involvement of the teachers, parents, health professionals, and village politicians in awareness campaigns on sexual health. To quote a respondent: *"Parents, brothers, sisters, elders of village, pradhan, doctor and teachers should come forward for this campaign on sexual health".* Giving messages through health providers at the village level is perceived as a successful strategy to educate the rural youth on sexual health. According to a respondent: *"If any health center is established in the village then the compounder or nurses can be posted in the center, and they can provide such kind of information."*

## STIs and HIV

### STI awareness

A majority of the young people from both the states had heard of sexually transmitted infections (STIs). However, most of the young people did not have detailed information about STIs. Additionally, a majority of the young people who had heard of STIs could not name any specific STIs: They simply clubbed a broad range of symptoms under the term STI. As one female of 15-19 age group from Uttar Pradesh said:

> *"I have heard but I don't know about it."*

It must be noted that the English term 'STI' itself is rarely understood in either state; neither are the formal equivalents in Telugu and Hindi. In Andhra Pradesh, sexually transmitted infections are popularly referred to as ***sukha rogalu*** *or* ***gupta rogalu***, and in Uttar Pradesh as ***gupt rog, youn rog*** *and* ***dhat*** (the last term, a reference to the passing of semen or white prostatic secretions with urine, mistakenly identified as a disease). Most young adults perceived STIs as something transmitted through unsafe sexual relations. Only a few young people were aware of the names of different types of STIs and of these, the most common STIs mentioned were leucorrhea, gonorrhea, and syphilis, apart from HIV.

The research reveals this lack of detailed information among the respondents, which is the primary cause of many different kinds of misconceptions around STIs. One young male in the 20 to 24 age group from Uttar Pradesh linked STIs with an increase in the size of the kidney:

> *"There are many types of sexual diseases. I think as a result (the size of a) man's kidney increases."*

Responses from both the states suggest that females had more awareness about STIs than males. Most frequent STI mentioned by females was leucorrhea. As one female of age group of 20-24 from Uttar Pradesh mentioned:

> *"White discharge from vagina, pain in lower abdomen."*

Most of the young people aged 10-14 from both the states were not aware about STIs at all.

If we compare the responses from both the states, arguably young people from Uttar Pradesh are more aware about STIs than the young people from Andhra Pradesh. One young male in the 20 to 24 age group from Uttar Pradesh said:

> *"These are venereal diseases, eruptions appear and pustules appear over (the) penis."*

One female of the 20-24 age group from Uttar Pradesh mentioned: *"Become – blister, wound, swelling in*

*organs, pain in abdomen."* One participant of a girls' group from the 15-19 age group from Andhra Pradesh, on the other hand, shared her thoughts thus: *"We might have heard about it; if it comes we don't know what happens and how it comes."*

### Sources of information on STIs

Most of the young people from both the states mentioned multiple sources of information for STIs. Television was the most common source for receiving information about STIs according to young people from both the states. *"I listen from TV and I also learnt a little through one speech given at our college,"*

said a young female of age group 20-24 from Andhra Pradesh. Another female of age group 15-19 from Uttar Pradesh said:

> *"In TV etc., in which they have this very short announcement."*

After TV, schools and health providers were the next common sources of providing information about STIs. Schools were important sources of information about STIs **only** in Andhra Pradesh. One female of age group 15-19, from Andhra Pradesh, mentioned that she got to know about STIs:

> *"From newspapers, by watching TV and from our college."*

All these responses indicate clearly the important role that educational institutions are playing in providing this information to young people in Andhra Pradesh. The same does not hold true in the context of Uttar Pradesh, where health centers and health providers are seen as the main sources of information; and which are currently playing an important role in how young people are accessing information on STIs. One young male in the 20-24 age group from Uttar Pradesh said:

> *"One ANM came to our village one time, then I heard this conversation about such diseases. She was telling all our village women about this."*

One girl in the 15-19 age group mentioned:

> *"Most of the people in our village go to consult a doctor only then they find out about these diseases."*

Other sources of information regarding STIs that were cited by various respondents included **radio, newspapers, magazines, friends, posters** and **street play**s. Only two young girls from Uttar Pradesh mentioned the role of **family** in providing information about STIs. Newspapers and magazines play a more important role in providing information about STIs in Uttar Pradesh than they do in Andhra Pradesh. One boy of age group 15-19 from Uttar Pradesh noted:

> *"I read it in magazines, the heading was 'Yaun Rog.' "*

Similarly participants in a male group (Age 20-24) from Uttar Pradesh said:

> *"We get it from TV, radio, newspapers etc.. But everybody can't read as there are very few literate people in this area."*

Radio seems to have been under utilized for communicating with young people as compared to other sources like TV and newspapers in both the states, especially in Andhra Pradesh. Friends also play important roles in providing information on such issues as one boy of age group 15-19 from Uttar Pradesh shared:

> *"Friends - especially those who have already suffered from any STI - do tell us about it. That is how I got to know about these diseases"*

Posters and wall writing were also seen as important sources of information about STIs: As one male of age group 20-24 from Uttar Pradesh put it, *"Yes I know about STIs. These are secret diseases, and there are so many advertisements written on the walls; and I have also read in the papers. They call it 'dhat rog' and there are contact details of various doctors you can meet to get a cure."*

If we examine the responses across genders, then it becomes clear that most women get their information from television, while most of the males get their information from local health providers/ local quacks or schools. One reason behind this finding may be the fact that males generally go outside and females spend most of the time inside the home. A major source of information for the females of age group 15-19 in both the states was television; however, friends, magazines and health providers were the main sources of STI information for boys of the same age group. (Having said that, television was viewed as a more important source of information on STIs by young boys and men in Uttar Pradesh than in Andhra Pradesh.) Street plays were important sources of such information in Andhra Pradesh.

The following is a listing of the various sources of information on STIs cited by various respondents:

- Advertisements in television
- Posters and wall hoardings
- Friends
- Newspapers/Magazines
- Elders/close relatives of their families
- Elders in the community
- Awareness campaigns such as ASHA, and popular advertisements such as Puliraja, and messages from celebrities, especially from film stars and cricketers

A disturbing aspect that emerged from the research is that many young people learn about STIs only after they come to know that they are suffering from it. To quote a respondent from rural Uttar Pradesh:

> *"I came to know about sexually transmitted infections when I was infected."*

Knowledge about the curability of these infections varied considerably across the respondents. To quote a respondent from rural A.P.:

> *"There are no fears about these STDs. Medicines are available in Government hospitals and also in private hospitals. But the medicines have to be used by both the wife and the husband. Boys and girls who are in education period should not be sexually active but if they are, they should use Nirodh. But sometimes medicines may not give good result so it is better to prevent."*

## HIV awareness

Raising awareness about HIV/AIDS has been the key strategy to address the challenge of HIV across the world and in India. 'Information is protection' has been the slogan of most of the HIV campaigns. Numerous interventions have been focused on raising the awareness of general population about HIV/AIDS, since the first appearance of the virus. The Behavioral Sentinel Surveillance Survey (2001) and BBC-WST baseline study (2005) have proved that awareness about HIV/AIDS has gone up in India: According to the BBC-WST study, about 85% of the population had heard of HIV/AIDS. Again, according to theses baseline studies, awareness was higher in males and in urban populations.

This research study shows that awareness of HIV/ AIDS is, indeed, high among young people. Correct and complete knowledge on its transmission and prevention, however, is still low. The responses of the young people who took part in this research process suggest that a majority of the young people from both the states, across genders and age groups had heard of HIV/AIDS. Many respondents, especially from A.P., felt that HIV/AIDS is a dangerous disease; and that most of the populations in rural areas are aware about its modes of transmission. But the continued high prevalence of the virus in A.P. villages seems to negate this perception.

Most young people have heard the name of the virus and the syndrome. One participant of the focus group discussion for girls in the 15–19 bracket from Andhra Pradesh was able to clearly give a definition of HIV:

> *"Acquired Immune Deficiency Syndrome and Human Immune Virus".*

Very few participants and only females said: *"I haven't heard about it (participant of a girls group of age group 20-24 from Andhra Pradesh)"* or *"No. I have not heard about this HIV. Today is the first time I am hearing about it from you." (Participant of a girls group of age group 15-19 from Uttar Pradesh).*

Among women, those belonging to socially and economically backward groups were comparatively less aware of HIV and AIDS, and of how to avoid contracting the infection. Lack of exposure to local meetings and awareness campaigns within the community, along with restrictions from the family members (especially on their mobility) results in young women being less informed about HIV and issues around it.

### Sources of information on HIV

Most young people from both the states indicated more than one source of information for HIV/AIDS. Among rural populations, the most commonly cited sources of information were radio and television. In addition to these, various awareness initiatives being implemented in the villages were also cited as sources, including posters, banners, skits, or one-to-one talks by ANMs, anganwadi workers, and doctors. Newspapers, talks in schools or health centers, films, youth club activities, and rallies were also cited by some of the respondents. According to a few key informants, young men get more information as they are more educated and also travel to cities where the advertisements on HIV/AIDS are more prominent; as opposed to women who mostly stay at home and have fewer opportunities to gain access to various sources of information. It is also evident from the study that youth are seeking messages mainly from their friends.

Various sources were cited in different combinations in most of the responses. However, television was the most common source of HIV/ AIDS information, as is clearly mentioned in the responses from both the states. A majority of the young people said that they had heard about HIV/AIDS through advertisement on television. Apart from advertisement several TV programs were also mentioned as important sources of information in this regard. One girl of age group 15-19 from Uttar Pradesh mentioned:

> *"Yes I have heard about AIDS. On TV there is a serial called 'Vijay'. I saw the serial one time and they were talking about HIV."*

**Schools/teachers** came after television as the most cited source of information; however, this source was commonly cited only by the young people of Andhra Pradesh: Very few young people from Uttar Pradesh mentioned that they had received information about HIV/AIDS from their schools or teachers. One female of age group 20-24 from Andhra Pradesh shared:

> *"When I was in class X, a teacher came to our school and conducted a session separately for boys and for girls. That time they talked about AIDS. That is when I came to know about this disease."*

**Newspapers** found third place and **radio** received fourth place in the list. It is worth mentioning here that radio was cited more commonly as a source of HIV information by young people in Uttar Pradesh. **Health centers/health providers** and **peers** came next to radio.

If we analyze the responses of young people from both the states, and club TV and radio under the general head ***'electronic media',*** then the findings from both the states suggest that the role of electronic media in providing information about HIV/AIDS is greater in Uttar Pradesh than Andhra Pradesh. On the other hand, if we club health providers/centers, schools/teachers and AIDS campaigns into a single head, and call it (say) ***'grassroots interventions',*** then findings from both the states suggest that role of grassroots level interventions in providing information about HIV/AIDS to young people has been crucial in Andhra Pradesh, but only partially so in Uttar Pradesh. (The notable exception has been health providers/health centers, which were deemed equally important in both the states.) To quote an unmarried female respondent aged 19 years and a graduate from Uttar Pradesh:

> *"Yes I do know about HIV, the women from mahila mandal come here and there are teenage girls who come to the center. Mothers play an important role in this. Parents must inform their children about these issues. In my home there is my sister- in- law, and my mother is there, so I talk to them about this. The young girls are here so if they talk in the microphones about AIDS then they keep listening and this way they too get informed."*

Responses of young people suggest differences in the preferences and roles of various sources in providing HIV information across both the genders. **Television** was the most common source of providing HIV information to young females from all age groups in both the states; however, only one third of the total young people who got HIV information from **radio** were females. This finding indicates that radio provided HIV information largely to the males of both the states, rather than to females. Another finding suggests that role of **friends and peer** group is more important in providing information to young females than young males in both the states, especially in Andhra Pradesh. N**ewspapers** are more important in providing information to young males than young females; however, the role of **magazines and books** are more important to young females than young males in both the states.

Among other sources of information on HIV, some respondents revealed that they accessed information from family members like sisters- in- law or elder sisters. One female graduate aged 20 from an urban area of Karimnagar district (A.P.) said:

> *"We will discuss with our sisters and mothers and with other people about the person who is suffering with this. We will say among ourselves that – "do you know about this she is having that disease."*

Another young female respondent from Uttar Pradesh said:

> *"I asked from papa but he told that when the real time comes, then he will tell."*

Some of these responses reveal that inter personal communication on HIV is limited, though young people are seeking greater clarity through personal interactions with elder members of the family or community.

There are no major differences in the role of various sources in providing information about HIV/AIDS across different age groups, with a few small exceptions: **Newspapers** were mentioned as a more important source of information about HIV/AIDS by young people of age group 20-24 (and especially by males of this age group) than by respondents from the other age groups. Similarly **health providers** and **health centers** were seen as more important sources of such information by this age group than by the others. **Television** was seen as a slightly more important source for HIV information to young people of age group 15-19 – especially by females of this age group. The role of **teachers** was more important to young people of age group 10-14 - especially to boys of this age group - than young people of the other age groups.

### Knowledge about HIV

Many young people who were aware of HIV/AIDS had heard about its modes of transmission and ways to protect against the virus, apart from the fact that HIV infection has no cure: *"HIV. There is no medicine for HIV as far as I know. If we get into sexual contacts with such a person we will be affected. This happens only through sex. If we use his plate, his blanket, touch his cheeks, talk - we will not get HIV. Only through sex AIDS is affected."*

(Male; age group- 20-24, Andhra Pradesh). Responses of the majority of the young people from both the genders and states in all three age groups indicate that knowledge about major transmission routes of HIV, safe sex and the use of condom as a protective measure are quite common. One female participant from Andhra Pradesh (age group 20-24) explained what she understood about HIV transmission: *"For example if my husband goes to a girl and participates in intercourse with that girl and if that girl has AIDS my husband can also get AIDS. Through him we can also get it. When we get the disease we can go to the doctor and tell them that itching is there, doctor explains it clearly."*

This finding corroborates the finding of the National BSS among General Population (2001), which also indicated that three out of every four respondents were aware that HIV/AIDS is transmitted through sexual contact.

While many respondents were also aware of other methods of transmission – see below – the majority

stressed on sexual contacts as being most responsible for the spread of HIV/AIDS.

> *"In general, HIV is transmitted by using shaving blades, syringes, and blood transfusion but 90% of it spreads by illegal sexual contacts" said one young male from A.P. (age group 20-24).*

There was no gender-wise or age-wise trend evident in the responses of young people in this regard. But the statement quoted is also representative of the fact that, while there is awareness around HIV, there is also incomplete knowledge about the virus, and many myths and misconceptions regarding HIV and AIDS.

Transfusion of infected blood and reuse of syringes were other commonly mentioned reasons for the spread of HIV. One girl from U.P. said:

> *"HIV spreads through unprotected sex, use of contaminated needles and transfusion of infected blood." (Female, 20-24, U.P.)*

Awareness of infection through transfusion of infected blood and re-use of syringes was slightly higher in Andhra Pradesh than in Uttar Pradesh. Once again, however, the statements made by many young people from both the states reflects their misconceptions regarding these two routes of infection, as is discussed later in this report.

Very few young people from both the states mentioned vertical transmission of infection from infected mother to child. A majority of the young people (across both the states) who knew about mother to child transmission were women in the age group 20-24. Awareness about this route of transmission was higher in Uttar Pradesh than in Andhra Pradesh. One female of age group 20-24 from Uttar Pradesh said:

> *"HIV spreads through unprotected sex, use of contaminated needles and transfusion of infected blood. Also an infected mother can pass the virus (on) to her child."*

The responses of the young people from both the states tend to endorse the findings of the BBC-WST baseline study, which indicated that the potential of mother-to-child transmission was less known to the respondents across the country.

### Sexual contact and social norms

The responses of many young people from both the states reflected their knowledge as well as their misconceptions, gender biases, and the prevalence of normative gender and sexual stereotypes. Their responses also force us to think about the term 'sexual relations', and the sociocultural context this term must be addressed within. 'Sexual contacts' are seen by young people as the major reason for the spread of HIV; however, the terms and phrases used to indicate this were also indicative of a perceived linkage between HIV/AIDS and socially unacceptable sexual contacts.

> *"HIV happens to people due to illegal sexual contact"*

(male, 20-24, A.P.) was the most commonly quoted reason for the spread of HIV by young people of all age groups and genders in both the states. A female of age group 20-24 from Andhra Pradesh defined this as:

> *"HIV is transmitted by participating in sex with different girls."*

Another girl of age group 15-19 from the same state further defined it as:

> *"Those who have unacceptable relations."*

One girl of age group 15-19 from Andhra Pradesh shared her perception about sexual relation and HIV infection in following words: *"HIV is transmitted though sexual relations. It may be that both people have been together for long. But it is mostly in teen age when young people make sexual relations in a bad way. It is said that relationship should be always between husband and wife so if relations are made with other people then, this problem occurs."*

Some young people, especially from Uttar Pradesh pointed toward 'unprotected sex' as a reason for spreading HIV:

*"It spreads mostly because of unprotected sexual contact" (Male laborer, Uttar Pradesh).*

Another boy of age group 15-19 from Uttar Pradesh said:

*"HIV spreads by unsafe sexual relation".*

One unmarried girl of age group, 15-19 from U.P. described it as: *"the unsafe sex"* and *"sex without condom".* However, the overwhelming responses around "illegal" sexual contact shows that perception of risk to HIV within marriage is minimal, and that extramarital, pre-marital and multi-partner sex are seen as the primary point of exposure.

Apart from using phrases like 'unprotected sex' or 'illegal sex', many boys associated the spread of HIV to men's relationship with girls and blamed girls/ women for the spread of HIV. A participant of boys group said:

*"Most of the time AIDS is transmitted by girls. If a girl is having such a desire they look for boys. They try many ways to woo the boys by going with them, going to their home; they try all means so that boys get attracted to them. But it is not good for boys and girls to do like this because this is how HIV spreads." (Boys group, 15-19, A.P.).*

Access to safe community environment for discussion around HIV and RSH issues

It is clearly evident from the study that there is a great need for accurate information if young people are to be able to make informed choices and appropriate decision. Most young people are approaching the following groups for their information needs on sexual health and HIV:

- Friends of the same age group
- Friends of older age groups
- Relatives
- Siblings, parents and in-laws
- Elders in the community and teachers

However, responses also indicate that while the groups above are mentioned as sources of information, adults (consciously or unconsciously) tend to discourage openness on these issues, and obstruct the establishment of an environment where young people can feel confident of asking their questions without fear of being castigated or labeled as immoral.

## Discussion with Parents and Close Relatives

Most responses show parents' unwillingness to initiate or encourage a discussion on HIV with young people. Many young people reported that discussion on HIV with parents and elderly relatives did not address issues like modes of transmission or preventive measures, as parents were unwilling to talk about sex or condoms. Most young people reported that these discussions with older people concentrated more on discriminatory practices and fear of HIV positive people. In the case of young girls, most of them depend on their sisters and sister in-laws or peers for information - and parents do not seem to constitute a supportive source of information at all. Girls tend to discuss these matters with older married peers and women members of the family who may be slightly older than themselves. Among young boys, the situation is worse as their only source of information is their peers. Some boys reported discussing these issues with older 'more experienced' friends, to get better and clearer information. The research clearly shows that almost all young boys feel comfortable discussing sex, sexuality and HIV issues only with their friends; so there needs to be a concerted effort to evolve informed peer groups to address young boys, and to evolve other innovative strategies to address young people in the prevention programs. For young girls, some suggestions that emerged from the community included using *Dwaraka* groups and *Mahila Mangal Dals* in order to create increased access to correct information. A 19 year old unmarried female graduate respondent from Uttar Pradesh talked about her experiences at the Mahila Mangal Dal, where she provides information to the village girls: *"In the Mahila Mangal Dal we talk about this issue. Sometimes teenage girls also accompany the older women and I think this should be encouraged. We ask the mothers to play a role in taking this information to their daughters as parents must inform their children about these things. In my*

*home there is my sister-in- law and my mother and I talk to them about this also. The young girls are here so if (we) talk on the microphones about AIDS then they keep listening and this way they too get informed".*

It is also vital to note that there is a perceived gender disparity in how young people compare and consider their sources of information. According to a married 25 year old woman from a rural area near Etawah, Uttar Pradesh:

> *"It is easy for boys to discuss these things with their friends. They go out a lot and no one will question them."*

### Discussion with teachers

The role of teachers in providing information related to HIV/AIDS and RSH issues are seen as critical by most respondents. A few responses even seemed to indicate the presence of ongoing school activities on HIV prevention. One respondent, for example, indicated that teachers in their village make announcement using local folk forms like 'dandora' to deliver these messages in schools:

> *"The school has a program for information dissemination using the "dandora". This works well in our village." (Anganwadi worker, Kadapa district, Andhra Pradesh).*

Several respondents indicated that teachers are seen as reliable and credible sources of information, and that *"the general public will obey the teachers and trust them."* To quote a 24-year-old married male from Uttar Pradesh: *"Yes, (young people) are satisfied with these sources, they have much faith in these sources… when anyone has faith on somebody, suppose that, you are my best friend, and I am asking you something, whatever you will tell me, I will believe that you are telling me truth. When a teacher tells something, the students think that he is telling the truth."*

Another unmarried female from a rural area in Andhra Pradesh says:

> *"He (Dorayya – the local teacher) conveys any type of subject in depth."*

This faith in teachers and their ability to give correct information suggests that prevention programs must address teachers as a key population - and that the programs must ensure that they are well trained and correctly informed before they are made responsible for conveying prevention information within their local communities.

It must be kept in mind, however, that there were also responses from young people that indicated a lack of access to teachers in order to discuss these issues.

### Misconceptions about HIV

Many reports and studies suggest that young people are highly vulnerable to HIV infection because they are not aware of the factors that place them at risk; that young lack the information and skills needed to engage in safer sex behavior; and that they have misconceptions about HIV transmission. The disaggregated data from the National Behavioral Surveillance Survey (2001) indicates that while 85% of young adults (age 15-24 years) had heard about HIV, only 54.8% knew at least two modes of transmission correctly. More than 72% harbored misconceptions regarding the transmission of the infection. 52% reported using a condom on the last casual sex episode, but only 34% reported consistent condom use for casual sex. This formative research also revealed that a large number of respondents from both states had multiple misconceptions, especially regarding the spread of HIV/AIDS.

The most common misunderstanding that has emerged from our study is that HIV is a result of 'illegal' sex or more sex - or simply sex. The concept of unprotected sex is unclear among most young people. Therefore sex within marriage seems to be considered safe, whether protected or unprotected.

Some of the other misconceptions highlighted by this study are around using/sharing shaving blades, blood transfusions, and using/sharing syringes and needles. Again, in all three of these cases, the concept of how the infection is transmitted seems unclear to many young people: Many responses indicate that young people think that getting a shave at a barbershop is risky or simply getting a blood transfusion is risky. The in-depth interviews reveal

that while there is information, it is incomplete or only partly understood by many young people. Most of these common misconceptions seem to be arising due to miscommunication of the messages associated with condom social marketing projects and AIDS campaigns. For example, the message 'HIV spreads through unprotected sex' seems to have been perceived as 'HIV spreads through just having sex, or due to more sex.' Similarly messages like 'HIV spreads through transfusion of infected blood', seem to be misunderstood on occasion as 'HIV spreads through blood transfusions' by some of the respondents.

These examples clearly point to the limitation of a purely mass communication-based approach. Mass communication - especially slogan and PSA based campaigns - can do a good job of creating basic awareness, but need to be supplemented with more intensive community-based activities that foster a clear grasp of the messages. Participatory communication initiatives can bridge this gap. Responses like:

*"AIDS can spread when a male and female participates in sex"*

(One participant, boys group, 10-14, A.P.),

*"If a girl is beautiful then having desire to participate in sex causes HIV" (Boy, 10-14, A.P.), and "Don't do marriage when you are adolescent and don't do love with girls & don't go outside with unknown person"*

(Boy, 10-14, A.P.) are some examples of incomplete messages reaching young people through various channels of communication. Such misinterpretation of messages is also responsible for the prevalence of high levels of stigma and discrimination against positive people, and an infringement of their rights to live normal life.

The following table presents a sample of responses that indicate some misconceptions:

| Misconception | Quotes |
|---|---|
| HIV can spread by getting a shave at a saloon | *"Through the syringes, due to roaming in brothels, or getting shave in the saloon, and due to blades, people get AIDS."* (Boys, 15-19, Andhra Pradesh) |
| HIV can spread just by using blades | *"Through sexual contacts, by needles and shaving blades."* (Girl, 15-19, Andhra Pradesh) |
| HIV can spread by blood transfusion | *"In general, HIV (infection happens because of) using shaving blade, syringes, blood transfusion 90% illegal sexual contacts."* (Male , 20-24, Andhra Pradesh) |
| Through touching blood | *"If AIDS patient's blood touches a person he also gets AIDS definitely."* (Male, 20-24, Andhra, Pradesh) |
| HIV can spread by using syringes | *"It is transmitted by participating in sex, using syringe by using injections"* (Unmarried boy, 15-19, A P). |
| HIV can spread by kissing | *"If someone kisses another person then AIDS will come. If men and women meet then AIDS will come."* (Boy, 15-19, A.P.) |
| HIV can be caused by nail scratches | *"AIDS can happen if you get scratched by AIDS patient. It is also caused by sexual relation with men. We should not talk to men."* (A participant of female group of 20-24 from Aligarh, U.P.) |
| STI causes AIDS | *"I think that STI is cause of getting AIDS."* (Girl, 15-19, A.P.) |
| It spreads through eating together or touching | *"It spreads through eating together, sitting together and by shaking hands it can be spread."* (One boy, 15-19, U.P.)<br><br>*"We get AIDS by wearing their clothes, by sharing toilets, by using their plates."* (A girl, 10-14, A.P.) |

| Misconception | Quotes |
|---|---|
| Through mosquito bite | *"Through mosquito also and from other states. Lorry drivers are going to other states like Madras. Where they get AIDS from them it spread here."* (A female, 20-24, A.P.) |
| Bodies of dead positive people spread infection | *"After his death, he was taken after normal rituals and buried, he was not burnt. He was consigned in the river after tying stones etc. around his neck. He might have been eaten by fishes- and (if) we eat fishes, then how we can be safe? He was consigned in the river fearing that if he is burnt, then his germs may spread over in the atmosphere and may enter in the body of other persons."* (Male, 20-24, U.P.) |
| Positive people's blood turns black | *"His blood had turned black so it was clear that he died with AIDS"* (Unmarried young male, 20-24, U.P.) |

# Condoms

## Awareness, Sources and Brands

Most young people from both the states have heard about condoms. Only a few young people did not know about condoms, and these respondents were mostly female. The mass media were reported as the major source of providing information about condoms. Within the mass media, the electronic media were identified as the principal source of information, followed by the print media. Most of the participants had heard about condoms on television.

> *"I saw this (condoms) in TV 'Detective Vijay' in serial and Om Puri was telling about AIDS,"*

said a male from the 15 to 19 age group in Uttar Pradesh. Radio was the other important source of information about condoms.

In the print media, newspapers are reported in both the states as important sources of information on condoms, with wall hoardings reported as an additional important source of information on condoms specifically by respondents from Andhra Pradesh. Health professionals, *Anganwadi* workers, sessions in school, street plays and community programs by voluntary organizations were reported as sources of information regarding condoms only in Andhra Pradesh.

Information on condoms in Uttar Pradesh seems to be largely restricted to the mass media: Advertisements such as *'helmet for head and condom for life'* and a few programs like *'bindas bol'* are commonly reported as sources of information. Some young people mentioned seeing messages near medical stores.

However, young people in Uttar Pradesh seem to have more information on condom brands than their counterparts in Andhra Pradesh. **Nirodh** was the most recalled brand in both the states. One female participant from 10 to 14 age group in Andhra Pradesh said:

> *"We (have) heard the word NIRODH. But we don't have any more information about it."*

One male participant in the 15 to 19 age group from Uttar Pradesh said:

> *"Deluxe Nirodh is what we remember most. There are many other types."*

Other brands that were named by respondents included *'Masti', 'Kohinoor', and 'Zaroor'. 'Deluxe Nirodh* was recalled as distinct from *'Nirodh'* by a majority of the young people. A few young people also mentioned *'Kamasutra', 'Ustad', 'Thrill', 'Sahaj', and 'Rakshak".* Most of the secondary population respondents mentioned *'Nirodh and 'Masti'.*

Young people of the 20–24 were more aware about condom brands, especially in Uttar Pradesh. It is worth noting that female respondents from this age group were as aware about condom brands as their male counterparts in Uttar Pradesh; but that females from the same age group in Andhra Pradesh did not have much information about condom brands.

### General notions about condoms

A large proportion of the respondents from both states were of the opinion that condoms were useful for protection against infections as well as in providing contraception for family planning. However, according to a majority of young people from both states, society has negative notions about condoms. As a young male from the 20–24 age group (A.P.) put it:

> *"People have a bad opinion - they look at it as if it is bad thing. But in the present society it is compulsory to use it. Now it is common knowledge about condoms - that we must use it. It is compulsory…I don't know how many people use it in their own life."*

Young females in the 20-24 age group in Andhra Pradesh were also aware that condom gives protection against infections. One young female of that age group from Andhra Pradesh said:

*"I feel that using condoms, no diseases come. HIV, AIDS etc don't come."*

The same young female further associated the condom with family planning:

*"Also there will be gap between children if condom is used."*

Many female respondents of the same age group in Uttar Pradesh also felt that condoms were useful, though society had negative notions about condoms in general. One female from this group in Uttar Pradesh said: *"All people do not have a positive perception about condoms. But some find them useful."*

These negative notions were associated with a lack of information by most young people who participated in this study. Talking about sex and other associated issues is taboo in most traditional societies, including India – and information and discussion about condoms is therefore associated with the same taboo by many sections of society. One female of Uttar Pradesh from the 15-19 age group noted:

*"In the village there is no question of any of us buying or selling condoms. What will people say if they get to know someone has bought a condom?"*

These negative notions around condom use are linked to moral issues, and therefore buying of condoms becomes taboo as well. As one young female of Andhra Pradesh from the 15-19 age group says: *"I have heard that those who buy condoms, they use it to maintain legal and illegal sexual relationships. I have heard this one thing."*

Some responses indicated that knowledge about condoms and its use is justified only after a person is married. If, therefore, young people talk about such issues before marriage, they are castigated – so much so, in fact, that many young people felt that they could not discuss details about condom use even *after* marriage. A young male from the 15-19 age group in U.P. reveals his frustration with this situation:

*"Our friends are not married. And nobody tells us about this (condoms)."*

Young people from Andhra Pradesh also acknowledged that people have negative opinion about condoms in the villages: *"In our village they will have negative thoughts about condoms. If someone will go to buy they will think wrong of him,"* said one young male in the 20-24 age group.

However young people from both the states agreed that attitudes toward condoms were changing in society, in tandem with increasing levels of awareness and education.

*"Previously there was no proper education among the people but nowadays many people know the important of condoms and are using it."*

said one young male from Andhra Pradesh. According to an adult male respondent from Andhra Pradesh; *"If they (young people) want to use a condom, they can't go and buy. Because they feel that other people will think ill of them. I am in medical field. So I can ask easily and buy. But generally, for young people or other people in the village we still have to build a lot of understanding before they are able to freely buy condoms."*

To quote another response from an unmarried 19-year-old female from rural Andhra Pradesh: *"In our community, generally, people will wonder why this person is using condoms. I want to use condoms for my personal use, (but) I will not be able to go and ask for it by name…I will be afraid of what people will think about me. They may misunderstand why I want to use (it)."*

The evidence from the research therefore shows that many respondents feel that they would not able to buy condoms freely without fear of suspicion. A 35-year-old married post graduate male respondent from rural area of Karimnagar district, Andhra Pradesh said, "There is no proper awareness about condoms, so many people are not prepared to buy directly or from government hospitals. In olden days they did not use (condoms) for family planning, they used to have

three, four, five children. Now they are ready to buy hot drinks and cigarettes freely but not condoms."

Some respondents also talked about the lack of pleasure during condom use as one of the reasons that many young men prefer not to use condoms. To quote a response from a 30-year-old married village pradhan, from a rural area of Uttar Pradesh: *"Well, a lot of people say that unless skin touches skin there is no pleasure, so the condom should not be used. And a lot of people don't even know about condoms, in the tribal areas especially. In the city, everyone knows."*

Some respondents reported condom use during menstruation. To quote a response of a 20 year old unmarried female from Aligarh from Uttar Pradesh:

> *"Condom can be used during M.C. or to avoid conception."*

Though the use of condom is widely reported among sex workers, sometimes customers demand sex without a condom, especially with young CSWs. Since many clients of sex workers are young themselves, this highlights the high risk taking behaviors practiced by young people. According to a female sex worker, Kadapa district, Andhra Pradesh: *"Many unmarried boys come to us. They are looking for young girls. If she insists on condoms, they get angry. We have to satisfy the customer so he pays us. We have no other use of the customer …one young girl can take four boys in a day…some use condoms, some don't. What can we do?"*

### Reasons for not using condom

Lack of satisfaction during sexual intercourse, lack of awareness about condoms, and 'a feeling of dirtiness' are some of the reasons reported for not using condoms. The urge to earn more money is also a barrier for sex workers to actively promote condom use. According to a young 16 year old boy from a rural area of Karimnagar district, Andhra Pradesh: *"Some say that by using Nirodh we won't get satisfied, the way we have sex naturally. For getting satisfied they don't use this, and by not using this they get AIDS. But we are confused what is better…getting satisfaction or not?"*

Another male of age 24 years, a post graduate from a rural area of Mahabubnagar, Andhra Pradesh, says, *"We don't know all these (things). If we come to know of a girl who has come there, we go, enjoy and come back. We don't know about condoms. We don't use. We have no time, no money."*

Many respondents also reported that when young people have sex with someone known to them they very often do not use condoms. According to an unmarried 19 year old male:

> *"My friends do without condom with near and dear relatives etc., with those who they have fallen in love. Like this with known person, with someone you love there will be no problem."*

Paradoxically, while most respondents knew that non-usage of condoms could expose them to HIV, this was tempered by a (mistaken) notion that sex with known people was safe and did not necessarily require condom use. Detailed conversations with respondents reveals a high rate of sexual activity, as well as a high prevalence of STIs, which tells its own tale. According to a married 35 year old male from a rural area In Kadapa district, Andhra Pradesh: *"We know that if we wear a condom the disease may not come. When Amala and I went to work here and there, he started getting pus from his penis, and he suffered a lot. Later he went to the doctor; even then it did not get fully cured. We have Buggabvanka village here, gents go there to enjoy harlot, prostitute and pay Rs 300, Rs 400 to them."*

## Availability of Condoms

Easy access to condoms is of utmost importance if young people are to be able to successfully protect themselves from the virus. Even if condoms are available in the community, their accessibility may become an issue for young people due to social restrictions on their purchase/acquisition. Young people in this study cited hospitals, medical shops, general stores and health professionals (such as ANMs and doctors) as places where condoms are available. In Andhra Pradesh, condom availability seems to be much higher: Many young people mentioned that condoms were easily available at the village panchayats, vending boxes at market areas, highway roads, pan shops, ration shops,

lorry centers, NGOs, red-light areas and crowded places. Women volunteers were also cited by many young people from rural Andhra Pradesh. Market places are mentioned as a source of condoms in both the states.

The availability of condoms at STD clinics is reported in Andhra Pradesh, while these were reported only in private clinics in Uttar Pradesh. The primary health centers in Andhra Pradesh and *anganwadi* workers in Uttar Pradesh were also mentioned as sources of condoms.

Non-availability of the condoms was also mentioned as an issue in the rural areas of both states, but this seems to be much greater problem in Uttar Pradesh than in Andhra Pradesh. To narrate a response of a young married male from rural Uttar Pradesh:

> *"It is almost impossible to get condoms in the village. These relations happen always in a hurry, so it is difficult to think at that time and no one is able to use condoms at that time."*

To quote another respondent from a rural area of Mahabubnagar district, Andhra Pradesh, who talks about having to go far to get a condom:

> *"It could be available in Wanaparthy. Here they are not available in the village".*

According to another male interviewee from rural Andhra Pradesh: *"There is a primary health center in the village next to ours. There is a lady there. In the beginning, only she used to supply (condoms). When these condoms were with her nobody used to collect them from her. So she asked me to help in distribution. She even asked me to collect the names of those who take (condoms) from me. But I told her that if we ask the names they might misunderstand, they wouldn't even come forward to collect. From that time onward she gives them to me, and I distribute to those who want it".*

This also indicates the need for a gendered design to HIV prevention initiatives. It is clear from several responses that women and girls will be more comfortable talking to girls and young men will talk about and access condoms only from men.

The various sources of condoms mentioned are:

| Andhra Pradesh | Uttar Pradesh |
|---|---|
| Medical shop | Market |
| Government hospitals | Anganwadi center |
| Hospitals | Hospital |
| Health workers | Health center |
| Vending boxes in main places | Medical store |
| Streets, roads, stalls | Husband brings |
| Open markets | Private shops |
| Sites of sex workers | Private clinics |
| Primary health center | ANM |
| Highway roads junctions | General stores |
| Pan shops | ANM distribution |
| Crowded places | Doctors |
| General stores | |
| Village panchayat | |
| Ration shops (public distribution system) | |
| Red light areas | |
| Markets | |
| Lorry centers | |
| NGOs | |
| Women volunteers | |
| STD clinics | |
| Distribution by health workers | |

## Role of Condoms

Three main reasons for condom use were mentioned by most young people from both the states: Protection against HIV and STIs, family planning and avoiding unwanted pregnancies. The majority of the responses from Andhra Pradesh pointed towards the use of condoms as protection against HIV and STIs. As one young male from the 20-24 age group said: *"We know that by using condom HIV will not come. We have come (to know) through paper statement, advertisement and through friends that if there is any sexual intercourse then we have to use condom."*

However, a few young people - mostly females - also indicated family planning as the primary use for condoms, apart from protection against infection. One young female from Andhra Pradesh (20 to 24 years) stated: *"Disease will not spread from one person to another. More gap between child and child.*

*Chances for children to be healthier due to the gap between child and child. By using condoms during sex, if they have got disease, disease will not come from one person to another person."*

Responses from Uttar Pradesh, on the other hand, revealed a balance between using condoms as a protection against HIV and for its role in family planning. As one boy from the 15-19 age group noted:

> *"There is no danger of HIV. No sexual diseases and no pregnancy will take place (if one uses condoms)."*

As previously noted in this report, one key difference between responses from the two states was that many young people from Uttar Pradesh linked the use of condoms with pre-marital sex, sex outside wedlock or 'illegal' sexual relations. One young boy of age group from 15 to 19 said: *"The persons who are not married and making sex-relation with others use condom."* Similarly one participant from the boys group (10 to 14 years) linked HIV infection, use of condoms and 'illegal' relations in the following words: *"In wrong relation - 'galat sambandh karne par'- use condom otherwise you will suffer from HIV/AIDS."*

If we club the responses of the males and females from both the states, the majority of females tend to see the condom in a dual role, as a means of protection as well as a family planning measure. However, males from both the states primarily focus on its role as a protective measure against HIV and STIs. One participant from the boys group (10 to 14 years) from Andhra Pradesh said:

> *"By using the condoms, it will be useful to eradicate HIV to a maximum extent."*

> *Another young male from the 20-24 age group, from Uttar Pradesh said: "Yes, I know that with the use of condoms AIDS does not spread."*

However, if we examine the responses of young females then it becomes clear that they stress equally on its role of creating a gap between children, apart from providing protection against HIV and STIs. One female from the 20-24 age group, from Uttar Pradesh, shared her opinion about the use of condoms: *"So that pregnancy cannot occur, and if any boy or girl is infected, this infection should not increase. Condom is (a) very simple (option)."* Another young female of the same age group from Andhra Pradesh expressed her opinion about condoms in these words: *"Condoms are used to prevent HIV, AIDS etc. If condoms are used, HIV, AIDS will not come. Sexual diseases don't come. Also, you can space child birth and have proper gap between children."*

A closer examination of the responses of the young males highlights their fear of acquiring infections during sex, especially if condoms are not used when having sex with someone with whom they are not familiar. One young boy from the 15-19 age group in Uttar Pradesh said, revealingly: This statement has broader implications regarding how HIV messages are understood, given that there seem to be some misguided perceptions around who to use a condom with – and whom not to use it with.

> *"Because if (we) don't know about that. If we, don't know about the person with whom we want to have intercourse that (he/she) has any disease or not. So, we use condom."*

# Stigma & Discrimination

## Existence of Stigma and Discrimination

This chapter explores some important dimensions of the existing discrimination against people living with HIV/AIDS (PLHAs). With the increase in the number of HIV infections - and, indeed, the number of awareness building programs - people's attitudes and behavior toward infected persons have been changing over a period of time. Most of the youth interviewed revealed that the discrimination against HIV/AIDS infected people has been changing in the past few years. The various programs promoting awareness on stigma and discrimination, myths and misconceptions and modes of transmission and prevention have contributed a vital role in reducing the existing discrimination.

Sadly, though discrimination against HIV positive people seems to have gone down somewhat during this time, our study reveals the continued and widespread existence of discrimination against infected persons, especially by their own family members: Discrimination against PLHAs was widely reported in rural areas by both, the primary respondents (youth) as well as the secondary respondents (stake holders). This discrimination is often multi-dimensional in nature, resulting in a severe impact on the PLHAs, as well as other members of their households. (The specific experiences vary from individual to individual, as does the intensity of the impact.)

The observed modes of discrimination against HIV/AIDS are briefly discussed under the following heads:

- Discrimination at family level
- Discrimination at society level
- Variations in discrimination
- Discrimination among children
- Discrimination at health care centers
- Discrimination in marriage
- Discrimination against the community leaders and social activists
- Discrimination at the place of work
- Discrimination at community organizations in rural areas
- Discrimination against the family members
- Discrimination by family members
- Discrimination against females

Various strategies have been proposed by the respondents themselves on how stigma can be further reduced. Some of these are listed below:

- Group interactions with persons living with HIV/AIDS
- Direct interaction with the youth in the rural communities
- Increasing literacy levels of the rural population
- Local canvassing using influential messages
- Increasing awareness on various transmission modes of HIV/AIDS
- Influential messages through radio and other media
- Wider publicity for existing messages
- Increase knowledge about HIV/AIDS
- Educating people regarding HIV/AIDS
- Promoting sympathetic approach
- Educating parents of the youth
- Messages should focus on the ways of avoiding risks
- Providing relevant information through older generation

A majority of the responses from young people in both states reveal the presence of discrimination in some form or the other against positive people.

> *"They were discriminated. They put HIV+ people away, they asked not to go with them," Said a female of age group 20-24 from Andhra Pradesh.*

Other women of same age group and same state expressed their feelings in following words: *"But if it is in our village, AIDS-infected person is banned and kept at the last place of the village. Without keeping any relationship with them, not even allowing them to come nearer, our villagers will blame them continuously…keeping them at the end of the village, these things are done generally."*

Similar experiences were also expressed from Uttar

Pradesh: "People think ill about them, and they feel that they are spreading HIV. People living in far flung areas even hate and despise them," said a woman of age group 20-24 from Uttar Pradesh.

The most common forms of stigma and discrimination against positive people, according to young people from both the states, include **rejection, blame, hate, mental and physical abuse,** and **restrictions on their interaction with other villagers.** One woman (20-24) from Uttar Pradesh said:

> *"Yes. Not only that, they will not even allow him/her to take water from the community tap or even to stand in front of their house."*

According to a girl of age group 20-24 from Andhra Pradesh, the most common forms of discrimination included:

> *"…Keeping them away, not to go with them, don't share any thing etc."*

Another girl of the same age group and same state shared her experience about a positive patient: "Yes, I also saw, seeing the AIDS patient discrimination," she says, and explains: *"AIDS is caught due to the wife of the patient and that is why he is seen with discrimination and is not respected. Also due to fear the patient is kept away."* The same girl concludes by saying: *"They are tortured with words and also they are seen as untouchables."*

One boy of age group 15-19, from Uttar Pradesh, shared his experiences about the insensitivity of the society toward positive people in the following words:

> *"They think that he (will) die soon, he (should) go, and he (should be) finish(ed)… (people) hate him."*

Responses of young people suggest that the sexual taboos attached to HIV ensure that HIV positive people are looked down upon and blamed for the overall epidemic.

> *"People see him as if he has done some mistake and keep him away,"*

said a young man of age group 20-24 from Andhra Pradesh. One girl from Uttar Pradesh (15-19) clarified the motivations behind such discrimination:

> *"They will say that he or she is characterless."*
> *"People think that the person must have had illicit sexual relations,"*

said a young man (20-24) from Uttar Pradesh. One woman of age group 20-24 shared her experience of discrimination against a positive person: *"We ban them… locality people cannot allow him to talk with anyone and ban him from meeting others, because again he can make relations with others."*

A few young people accepted that girls and women are more vulnerable to such stigma and discrimination in society.

Most responses indicated that community elders were responsible for propagating such discriminatory behavior and encouraging stigma against positive people. As a boy from Uttar Pradesh (15-19) shared:

> *"Elders press them to live away from them, or they live away from him (the PLHA)."*

However, many young people, especially from Uttar Pradesh, revealed a hidden stigmatization of HIV in the form of their own fear of getting the infection - the same boy from Uttar Pradesh expressed his own fear of positive people thus: Such fear sometimes manifests itself in the form of violent restrictions against positive people for utilizing public facilities: *"We will not, let him take water from the well but we will let him take water from the hand pump"* said another boy from U.P. (15-19). These responses indicate that despite improved levels of awareness, the lack of understanding on how exactly the virus transmits leads to much of the stigmatization of positive people in society.

> *"When we know that he is suffering from HIV AIDS we ourselves make enough distance from him because we have some fear of diseases."*

# Information Needs

The majority of the young people interviewed, from all three age groups and from both states and genders, were of the opinion that correct information about prevention and spread of HIV should be given to young people in order to address their HIV information needs. One participant in a boys' group (15-19) from Uttar Pradesh said:

> *"This knowledge should be given - that to have safety, use condom at the time of sexual intercourse and (if) refer (sic) the blood of one another then it checked."*

A participant in an FGD with a male vulnerable group from Pilibhit district of Uttar Pradesh shared this opinion:

> *"They should be informed about the manner in which this disease spreads and how to protect oneself from the disease."*

Information about using condoms in the context of avoiding HIV infection came next in the list of issues about which information should be given to young people. One participant of a girls group (15-19) from Andhra Pradesh said: *"What (information) should we give, madam? In spite of their knowledge they are doing mistakes - what should we give? In my village, one woman is making mistakes in spite of knowledge. They should use Nirodh and should prevent it."*

This clearly points to the need for second generation skill building messages. The need to give young people information about RSH, on avoiding risky behaviors and unprotected sex, on the need to avoid infected needles were the areas highlighted by young people who participated in the study. Other issues which were listed by the young people included: Information about safe blood transfusion, information regarding stigma reduction, and information about mother to child transmission.

If we compare the responses of young people from Andhra Pradesh and those from Uttar Pradesh, a slight state-wise difference in the HIV communication needs of young people becomes evident. The responses from young people in Andhra Pradesh suggest that they feel a greater need for communication regarding the use of condoms, and on avoiding risk behavior. One female of age group 20-24 from Andhra Pradesh said: *"That is: (How to) avoid moving like that and don't have sexual relationships. About AIDS, one to have sexual relationship with one only. Not to move with more men or women."*

A participant of a girls group (15-19) from Andhra Pradesh pointed out the need for communication on avoiding risky behavior in the following words: *"Yes, protected sex with wife only. We should follow Lord Sri Rama in this regard. They should not get bad habits like alcohol, cigarettes, drugs, we should follow and let all follow."*

However young people from Uttar Pradesh focused more on the need for providing information regarding prevention and the spread of HIV. One male from the 20-24 age group from Uttar Pradesh said:

> *"As per our knowledge related to AIDS, we should not keep sexual relationship. Nirodh should be used compulsory for sexual intercourse."*

One female of the same age group from Uttar Pradesh stressed the need for information regarding

> *"How to avoid AIDS? How is it prevented? How to avoid it?"*

Responses from the young people in Uttar Pradesh also suggested the need for communication on condoms as a protective measure against HIV/AIDS. One male of age group 20-24 from Uttar Pradesh suggested that appropriate information should be given to young people so that they should use condom while indulging in sex; that young people should use condoms as a contraceptive as well; and that they should avoid using used needles. **It seems**

**from the in-depth evaluation of the responses that in Andhra Pradesh young people are now looking for more skill based communication.**

**An age-wise analysis** of the responses from both the states also shows us the different types of communication and information needs of young people from the different age group categories. Responses from boys of the 10-14 age group highlighted their need for information regarding RSH; the spread/transmission of HIV; and the use of condoms, in that order. Participants in a boys group discussion for 10-14 year olds focused on the need for providing RSH information to young people:

> *"At last, you can tell me that what knowledge should there be among young people about sex. Reproduction (breeding) health and HIV/AIDS."*

Most of the young people of age group 15-19 years stressed more on HIV prevention, use of condom and information regarding spread of HIV. One member of a boys group (15-19) from Uttar Pradesh said: *"This knowledge should be given that to have own safety, use condom at the time of sexual intercourse and (if) refer the blood of one another then it (should be) checked."*

On the other hand, most of the people from the 20-24 age group reversed the priority order to focus on condom use, information regarding RSH, and – finally - information regarding prevention. One male from the 20-24 age group from Andhra Pradesh said: *"As per our knowledge related to AIDS we should not keep sexual relationship. Nirodh should be used compulsory for sexual intercourse. Blood and needles should be used only after testing."*

One female of the same age group from Andhra Pradesh pointed that: *"The information relating to sexual health and HIV/AIDS should be provided by means of speech through TV. Don't have the illegal sexual contacts, don't share blades, use the blood of the same group."*

(The last part of that statement, it may be noted, also points to a confusion between infected blood and blood groups.)

**A gender-wise** analysis reveals that most of the males in both states expressed a need for information regarding the condom, while females from both the states tended to stress a need for information about modes of HIV transmission. Most of the females of the 15-19 age group from Andhra Pradesh stressed the need for information regarding RSH, condom use, and on avoiding risky behavior. However, females of the same age group from Uttar Pradesh stressed the need for information regarding the prevention of HIV transmission. Most of the males from the 20-24 age group in Uttar Pradesh expressed a need for information regarding modes of transmission (especially a better understanding of how HIV transmits through the sharing of needles); females of the same age group from both states, on the other hand, expressed a need for more information about infection caused by blood transfusion. Many of the females from Andhra Pradesh in the 20-24 age group also focused on the need of information regarding RSH; while girls in the 15-19 age group from the same state focused more on need for information to reduce misconceptions and stigma. Boys of the 10–14 age group from Uttar Pradesh tended to stress the need for information on RSH, along with information on the spread and prevention of HIV. Girls from the same age group from Uttar Pradesh tended to stress their need for information on reducing misconceptions about HIV/AIDS. As one of these girls said:

> *"We should know that (HIV infection) does not happen by cut, by mosquito, by touch …that HIV don't attach by touch."*

The information being provided by others in the community is evidently not satisfying the local community at any level. One of the focus group discussions with parents explores the question of whether medical personnel provide people adequate information:

> *"No they do not provide complete information," said many of the parents. "They only provide partial information."*

There is also evidence that the information being provided to the community workers is incomplete, and that it does not fulfill the needs of young people

in particular. Another focus group discussion with females reveals: *"While providing information about AIDS, they do not tell openly that condom should be used to protect from AIDS. They do not provide information about protecting oneself from the disease. They tell only about the disease."*

A need to provide detailed, specific and precise information related to the HIV/AIDS has also been expressed: According to a married male of 31 years, *"All this (information) that HIV/AIDS is related with sex, or that there is danger of HIV by using wrong type of needles.. Such kind of information, we want to know in detail."*

Though messages on these issues and priority areas are being spread through a number of programs and campaigns are being conducted by government and civil society based organizations, there is a demand that the information be given through government personnel, which seems to be a deciding influence for many rural people. A farmer, 30 years of age, in a rural area opines: *"If Government sends any person, then we will also get information and will try to teach the people about that. Because there is our welfare in it. We will try to make the persons understand so that it does not spread".*

There is also a perceived need to educate people about child marriages, and the opinion that this information could be clubbed along with the HIV/AIDS related information. According to an unmarried 20 year old male:

> *"To remain safe against HIV, they should be given this message, make safe sexual relations…check population and child marriage."*

There is also demand for messages which are simple and easily absorbed, and which educates people about HIV/AIDS issues in layman terms. According to a young boy: *"This information - how it happens, how it can be avoided - if (one) has very detailed information, then (one) will think, (one) can escape. Messages can be (of) any (kind), but it depends on the understanding. (Otherwise) we can make a lot of messages, (but) no one is following."*

## HIV Information Needs

Young people from all the districts and areas surveyed expressed a need for information HIV and various aspects of the infection.

The respondents suggested a variety of key points to be kept I mind where this information was concerned:

- Messages should be in easily understandable language
- Messages should be provided through some organizations working at grassroots level
- Messages should be part of academic curriculum in schools, and should be delivered by the teachers
- Messages should highlight protective measures against HIV; and these messages should be passed through mainly close family members and relatives.
- People should be educated on issues around stigma and discrimination through small gatherings in the communities
- Young people should be educated on these issues in school
- Concentrate on talking to young people. Steps should be taken to ensure the availability of places (and spaces) where the young people can feel comfortable (and can clear their doubts and questions)
- Once the literate people are educated on these issues, they can pass this information on to illiterate people
- Programs on condom promotion should concentrate on rural areas
- Migrants from rural areas, and vendors along the highways should be involved in such programs.

The demand for more holistic information packages through television has been evinced by many of the respondents. There is also a specific demand for programs by medical and health professionals. To quote a male respondent from Uttar Pradesh, working in the army:

> *"There should be (such) topics in academic education, or I told you, specialist doctors should be called. One day in a week."*

The necessity for educating people on early marriage, pre-marital sexual relations, interpersonal communication, and the need to discuss sensitive issues with elders is widely expressed by respondents from the rural areas of both states. According to an unmarried female respondent a rural area in Uttar Pradesh: *"We ought (to) completely use education - if we get any information from anywhere we should complete it. We must talk open-mindedly with our elder brothers, sisters, friends, and others. We should not make (sexual) relations without any knowledge. We should make sexual relation only after marriage, (so that) which love and (mutual faith) increases between the two of them. Use the condom and tablets with your husband. It is the best. According to me if you have any physical problem talk about it at the home or with a doctor. It is best to take advice and treat it. By (taking a) bad step you can think your life (is) in great danger."*

There is also a demand for a broad-spectrum program by the government, which educates every segment of the population on HIV/AIDS issues. According to a 30 year old male respondent from Uttar Pradesh (educated up to intermediate):

> *"The government should implement programs in such a way that each and every household (should) be targeted - to provide education related to HIV/AIDS issues".*

The 'compulsory-HIV-education-for-all' approach was also suggested by some respondents. According to a young educated male from an urban area of Uttar Pradesh: *"Unless a policy is implemented, (where) each house is targeted and (in) every village, people go and explain, I don't think everyone will understand."*

While knowledge that HIV infection has no cure is widespread, there is a deeply inadequate understanding of care and treatment options, especially with regard to ARVs and access to treatment. The focus group discussion with unmarried males in rural areas of Uttar Pradesh threw up this statement: *"We are unmarried, we all are bachelors - we wish that we should be told about AIDS... it is very dangerous. We have heard on TV, radio that there is no treatment of AIDS. I read in a newspaper there is a hospital in America but we cannot go there. We do not have so much money. Information should be available in our village so that we can safeguard ourselves against AIDS."*

## Effective Medium for Providing Information on HIV/AIDS to Young People

Most of the responses from the primary and secondary population mentioned the role of the mass media, interpersonal channels of communication, and folk media in informing people about HIV/AIDS. Almost all the young people from both the states suggested the concurrent use of more than one medium for the distribution of HIV related information to young people. The same media were mentioned in different combinations across age groups, genders and states. A majority of the responses of young people from both the states indicated a preference for the electronic media, especially television, as the most effective medium for passing information on HIV/AIDS to young people. A girl from the 15 – 19 age group in Andhra Pradesh said: *"TV is very convenient to everyone. So many people have come to know in their houses; there is no need for them to go outside. It is better to give through TV. If everyone goes it will be nice but no one will have patience to listen to it."*

One participant in a girls group of the same age from Uttar Pradesh offered this opinion:

> *"Propagate this by TV and radio, so people hear and (take) precautions."*

The next highest preference among young people after the electronic media was for **interpersonal communication** (including group meetings and house to house contact programs). Within this, the respondents highlighted the role of peer groups, teachers and health providers. A truck driver from Pilibhit district of Uttar Pradesh suggested: *"The ideal course is that you people should visit and provide information. Publicity should be given through newspapers. You should keep in touch with the public, keep them informed. The boys of the village could also inform us."*

One girl from the 15-19 age group in Andhra Pradesh pointed out the need for interpersonal communication in providing information: *"If you want all the people to know, I feel the message should (go) through newspapers, nurses from village hospitals, through anganwadi, (and) teachers. Training should be given to anganwadis, teachers and employees of the Gram Panchayat. These trained people should go to every house in the village and spread the message."*

The next highest preference was for the print medium, including magazines, newspapers and books. A girl from the 15-19 age group in Andhra Pradesh said that she would like to get information *"through EENADU (Telugu Daily newspaper)"*. Another girl from the same age group and state pointed out the importance of the print medium in providing information about HIV/AIDS:

> *"Madam…books are good. Books are main… because through books personally we can know more and study more. In TV we won't know more. Through TV not much is known; even it is known no one will watch."*

This also indicates that television messages, by themselves, are seen as unable to provide detailed information: A clear need is being voiced here for the supplementary awareness campaigns through channels of communication that allow for greater participation, interaction and in-depth understanding regarding the virus and its transmission.

Many participants from both the states also mentioned folk media as a means of receiving HIV/AIDS information. A boy from the 15-19 age group in Uttar Pradesh expressed his opinion about the effectiveness of folk media in providing information regarding HIV/AIDS to people, especially those who are illiterate: "Illiterate people should be given knowledge by 'nautanki' and dramas."

Another young man of the 20-24 age group, also from Uttar Pradesh, said: *"Information about AIDS is mandatory. For this nukkad natak, folk tales or big programs could be organized, high level meetings could be conducted and all the persons could be mobilized. We should get proper information at a proper time i.e. young age so that we don't get inflicted by this fatal disease. We should be able to lead a successful life and reach our goal."*

A state-wise analysis of the responses indicates toward the popularity and importance of television in providing information regarding HIV/AIDS in both the states. There are many TV programs spreading information about HIV/AIDS in recent times; and as mentioned earlier in this report, young people have received a fair amount of information about HIV/AIDS through these programs. One girl of age group 15-19 from Uttar Pradesh noted:

> *"Yes, in TV a serial is telecast, "Vijay", in that I have heard (about HIV)."*

Responses from both the states suggest that many TV spots and advertisements being broadcast on different channels have played important role in educating young people about HIV/AIDS. Many young people from both the sates said that they would like to get such information through: *"Advertisements on TV and Radio"* (participant in a young male FGD, 20-24, Uttar Pradesh). If we consider the frequency of specific source of HIV information mentioned in the responses of young people then it will become clear that newspapers and magazine were quoted as the second most important sources of information in both the states.

> *"People are becoming conscious. We have television in the villages and people also read newspapers," said a female of age group 20-24 from Uttar Pradesh.*

Radio was the third most preferred medium of receiving information on HIV among young people in Uttar Pradesh:

> *"TV and radio and by the health workers" says a female from the 20 – 24 year age group in Uttar Pradesh.*

However, it is worth noting that though radio figured in the list of preferred media in Andhra Pradesh, it was not as high on the list among young people there as it was among young people in Uttar Pradesh.

A range of different media and channels for providing information regarding HIV and AIDS were mentioned in the responses of young people from both the states. The principal ones suggested are in the table given below.

A gender-wise analysis of the preferred medium for receiving HIV information suggests that, overall, females prefer TV, newspapers and radio as the primary media of choice, while males prefer TV, radio, interpersonal communication, and community/folk media. Specifically, female respondents from Andhra Pradesh preferred TV, interpersonal communication and newspapers; while female respondents from Uttar Pradesh preferred TV, newspapers/magazines and radio. Similarly, male respondents from Andhra Pradesh preferred TV, newspapers and interpersonal communication; while male respondents from Uttar Pradesh preferred TV, radio and interpersonal communication.

An age-wise analysis of the responses revealed that young people of the 10-14 year age group from both the states preferred newspapers, TV and radio - in that order - for accessing information on HIV. Females of this age group from both the states mentioned newspapers/magazines as their most preferred medium. [*"In TV and in newspaper,"* said one; and *"Through Newspapers,"* said another participant of the same girls group (10-15) in Andhra Pradesh.] Radio was mentioned by the girls in Uttar Pradesh as their favorite medium of getting HIV related information. [One participant in a girls' group from Uttar Pradesh noted that she had heard about HIV on her *"Baja (radio)"*, while another quoted radio along with TV: *"Give (information) through – TV, radio."* All the participants of the same group collectively quoted radio with TV.] Boys of the same group from both the states mentioned TV as the most important medium for HIV information. One participant in a 10 – 14 boys group from Uttar Pradesh suggested other media in tandem with TV for passing on information on HIV and stigma reduction: *"Yes, (HIV & stigma) can be reduced (through) book, radio, TV, mobile."*

Young people of the 15-19 age group from both the states mentioned TV, newspapers and interpersonal communication as the best media to give information on HIV to young people. *"...(use) TV channel - in between the cricket match ...in the form of advertisement,"* suggested a boy of this age group from Andhra Pradesh. Other boys of the same age group from Andhra Pradesh suggested: *"If we want to prevent (HIV) we can prevent through information: First they should educate high school people by introducing AIDS information into the syllabus. They should conduct the class separately for boys and girls. In the same way they should educate about AIDS at villages. They should even tell at CEC center there it consists of 15 – 40 age people, they should show through TVs."*

| Andhra Pradesh | Uttar Pradesh |
|---|---|
| Television (ETV) | Television |
| Newspapers/ magazines | Newspapers/magazines |
| Door-to-door campaign/group meetings/camps | Radio |
| Street play/ drama /puppet show/Dandora | Health provider |
| Radio | Door to door campaign |
| Teachers/ schools/ syllabus | Street play/drama/puppet show |
| Posters/ banners/ wall writing | Door-to-door campaign/group meetings/camps/ chaupal |
| Health providers | Peer group |
| Family members / mother | Posters/ banners/ |
| NGOs | Teachers/ education |

This clearly shows the need for greater interactivity and a desire for schools and teachers to play a larger role in providing information. Many of the 15- 19 year old male respondents from Uttar Pradesh expressed a preference for street plays/drama as the next best choice after TV. One boy of this age group from Uttar Pradesh said: *"Like, by organizing camps, by playing street plays, by organizing fairs, and by organizing meeting etc. information should be given to the youths so that they get the whole information. In our society youths should have whole information about it (HIV)."*

Girls of this age group from both the states mentioned newspapers/ magazines as their preferred medium in both the states. *"Through EENADU (Telugu Daily newspaper),"* suggested a girl of the same age group from Andhra Pradesh. Another girl of the same age group from Andhra Pradesh shared her opinion about books and magazines:

> *"Madam…books are good. Books are main… madam. Because through books personally we can know more and study more. In TV we won't know more."*

Television was the second most frequently quoted medium of information in the responses of young female of this age group in both the states, with radio a close third in Uttar Pradesh, especially for the girls. *"And if it is broadcast on radio, then we will hear on radio"* said a girl of this age group from Uttar Pradesh.

Young people of age group 20-24 from both the states mentioned TV and interpersonal communication (through AIDS campaigns and health service providers) as their most preferred medium of getting HIV related information. TV was frequently mentioned by the females of this age group in both the states; with face to face contact with health providers mentioned as the second most preferred medium of HIV information in both the states. For males, the interpersonal component was the preferred medium of information, even though TV did play an important part. One young man of this age group from Andhra Pradesh shared his opinion in the following words: *"In our community, to reduce this we have Nirodh. Other organizations should come and organize the programs which can (make) aware the elder person and they will suggest the Nirodh should be used. Publicity means through this program or through direct interaction; in this way if we tell then it will be clear to them. It will be nice if we tell in this way".*

Another male of the same age group from Uttar Pradesh pointed out the need for providing *'proper information'* at the *'proper time and place'* in the following words: *"Information about AIDS is mandatory. We should get proper information at a proper time i.e. young age so that we don't get inflicted by this fatal disease. We should be able to lead a successful life and reach our goal."*

# Inputs For Communication Strategy

The different preferences that emerged with regard to a possible strategy for communication on HIV and RSH related issues can be summed up as follows:

## Peer Oriented Programs

- Peers share a social and cultural identity and therefore act as credible information sources to each other, and also as a means to involving more young people in the programs
- Peer programs should work towards increasing the participation of young girls and women
- Such programs should reach the marginalized population who do not access formal institutions
- Cultural relevance and acceptance should be considered

## Motivating the Youth through Youth Networks (Yuvak Mandals)

- Involvement of adults and other elderly people in the community along with the young people, to create a dialogue and a shared space for discussion
- Strengthen existing youth networks
- Promote social norms supportive of a positive approach to HIV
- Behavior change activities should be promoted in the rural communities with wider involvement of youth associations (yuvak mandals)
- Develop effective and specific programs directed towards reducing the sexual risk-taking behaviors

## Youth Networks or Mandals

- Form youth mandals and mahila mandals through which the information can be disseminated through direct interaction with the members
- Involve these youth and mahila mandals extensively in awareness and outreach programs at the grassroots level
- Create a counseling session program for group members, conducted by health professionals
- Address individual risk factors and issues related to sexual health

Many of the stakeholders - such as teachers, panchayat members, health practitioners and parents - were of the opinion that education on HIV/AIDS, reproductive and sexual health should be widely promoted both in rural and urban areas.

- Give information on the risks of substance abuse (such as alcohol, tobacco consumption and drug use) and the consequences for one's health.
- Emphasize and develop health services and information transmission in non-clinical settings: This will attract youth, and reduces visits to formal health facilities
- Programs should be more effectively focused on young men than for young women, as the men are more mobile in nature and therefore more vulnerable to HIV infection

Many of the stakeholders - such as teachers, panchayat members, health practitioners and parents - were of the opinion that education on HIV/AIDS, reproductive and sexual health should be widely promoted both in rural and urban areas. They also felt that urban youth already have a much greater exposure to mass media, and can access information on HIV through a greater variety of sources compared to rural youth; and that there should therefore be a concerted effort to provide direct educational materials to youth in rural area.

Accordingly, some of the strategies suggested by the stakeholders to address rural youth are mentioned below:

- School based education programs
- Education through mass media and entertainment channels such as cinemas and documentaries
- Educating through local folk media
- Involving youth as representatives and leaders
- Involving young celebrities
- Education on condom use, coupled with condom promotion campaigns
- Developing life skills education programs to support decision making skills and generate local employment

There is a huge demand to impart RSH and HIV related education to young people at school level, possibly as a part of the official syllabus, in both states. Similarly, the stakeholders recommended the development and extensive distribution of programs made exclusively for youth on HIV/AIDS and sexual health.

The demand for health and life skills education for young people emerges from virtually every aspect of this study, and from every group of respondents covered, as there is a popular view that such an education most effectively shapes young people's attitudes and behaviors, and reduces their vulnerabilities. Many respondents recommended that these programs could also be conducted through youth centers, and that the programs should be gender sensitive and very participatory. The need for life skills education to be an integrated part of this process was seen as vital, especially with a view to addressing peer pressure (which encourages and influence risky behavior among youth) and to developing negotiation skills in order to equip young people with the ability to refuse unsafe or unwanted sexual contact.

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Some health practitioner respondents also felt a focus on young married or single male migrants - often extremely vulnerable due to their potential involvement with multiple sexual partners and commercial sex workers would be useful.

Involving girls and women in advocacy and awareness programs

One of the key gaps identified by this study is the necessity for including women and girls in outreach, awareness and skill-building programs on HIV. This is especially important given their relative lack of exposure (vis-à-vis young males) to extant messaging; as well as their lack of decision making power.

It is also increasingly clear that mothers are not very visible as part of the awareness generation process, a fact that highlights the need to involve them in educational programs. Safe and supportive home, school and community environments greatly increase the ability of young girls to protect themselves against HIV/AIDS and sexual health problems. As a step towards this, peer supportive networks and friendships would greatly help the girls in gaining information about reproductive and sexual health within a comfortable personal space; and programs to support the development of such networks among girls are strongly called for at the grassroots levels communities. In order to create freedom of expression and give mobility to young girls, community leaders, village elders, parents and teachers need to be engaged with information, knowledge and skills that empower them to create such a supportive environment. The development - and involvement of - trusted role models and respected teachers would also greatly enhance skill building among young girls, and increase their ability to access information on HIV and RSH, and thereby protect themselves. The involvement of boys, with a view to encouraging them to be more respectful toward girls and women, would also support the creation of such an empowering environment.

Many of the respondents also suggested the development of HIV related programs at the work place, as a large proportion of the young people covered by this study – men and women both – were involved in earning their keep from a very young age. The working youth and secondary stake holders participating in this study suggested that workplace programs would be useful because:

- Many young people are found at different employment settings in the first place, making it a good way to reach young people
- It can reach school dropouts and youth who cannot be accessed in general community, but who may be employed
- The environment may be more familiar, possibly contributing to greater receptivity to new ideas and information

- The workplace can often be a more convenient place to address sensitive issues than a village or home environment
- Programs are already accessing high risk workplaces anyway (truckers, migrants and commercial sex workers)
- Workplaces often offer a more systematic setting for the conveying of prevention and risk reduction messages

## Involving Parents, Siblings and Relatives

Many of the young people reported seeking information on various sensitive issues from close members of the family, but were thwarted due to due to the exigencies of their different social and cultural settings. But the preference for receiving information through this channel continues to remain high, as evidenced by earlier sections of this report.

In the previous section, we have already dwelt on the importance of involving mothers and empowering women in awareness and skill building programs. It is also important to remember that other members of the family can also play an important role, and should be sensitized and empowered to assist in the process of making young people less vulnerable to HIV.

Many of the respondents noted that:

- Young people continue to seek information from trusted adults
- Parents can contribute to a supportive and healthy environment for young people, if they are open and friendly
- Positive relationships between youth and adults provide safety not only from HIV and other sexually transmitted infections, but also in other areas of life
- Youth learn from and respect adults, especially parents, so adults should set positive examples by practicing safe behaviors
- They sought the participation of their adult family members in programs related to health and HIV/AIDS

Together, these points build a powerful case for the development of communication tools, strategies and programs to address families as units; as well as enlist family elders as pivots on which to base communication and programs directed at young people.

# Limitations and Challenges

By and large, the study generated a massive bank of useful data and offered a plethora of useful insights into young people, their communication needs on HIV and RSH, their preferences, their levels of information exposure and their attitudes towards HIV, risk behavior and sexuality.

It must be recorded, however, that the timeframe and the innovative methodology developed for the study posed a few challenges to the successful execution of the process, as detailed below:

## Training Peer Researchers

It was important to use young people as researchers in order to pilot an innovative methodology that would present insights into the thinking and behavior patterns of young people. This did pose a challenge in that the peer researchers needed orientation and training - not just in being able to comfortably and confidently use qualitative research techniques like in-depth interviews and focus group discussions, or in having a sensitive conversation with their peers - but also in understanding HIV and its transmission, and the risks that young people face. It was important to ensure that, as peer researchers, the young people conducting the research were able to confidently lead a conversation. Almost all the peer researchers were selected from the community; most had minimal research and social development background. However, the training workshops organized in both the states were quite successful in transforming the raw young boys and girls, mostly from rural backgrounds, into field researchers.

While this provided various insights it also limited the research in some ways: An analysis of the transcripts revealed that richer data could have emerged if the peer researchers had undergone a longer and more intensive training process. The peer research approach, however, did benefit the overall research process by effectively taking the process into community life in a way which would never have been possible through traditional research approaches involving adult researchers.

## Selection of the Districts

Four districts in a high prevalence state (Andhra Pradesh) and four districts in a low prevalence/ highly vulnerable state (Uttar Pradesh) were selected in this study for data collection. In most cases the districts and blocks selected represent a socio-economic/demographic/geographic cross section of the two states. However, given certain geographical limitations, urban centers in both the states were not comprehensively covered during the segmentation process: Although four urban blocks were identified in both the states (2 in U.P. and 2 in A.P.), research findings revealed that these blocks did not differ in any significant manner from the rural blocks in their overall communication ecology. Since cities like Lucknow, Kanpur, and Hyderabad were not part of the study, the research is limited in its outcomes and unable to draw true urban-rural contrasts or similarities. This limitation influenced the data to the extent that researchers could not find any specific urban-rural pattern in the responses from both the states. Responses of the young people of urban blocks in both the states were not significantly different.

## Capturing Perception of Young People of Age Group 10-14

Originally, in-depth interviews were planned with all the three age categories of young people. However, during the course of the research process, the field researchers felt it was difficult to conduct in-depth interviews with the 10-14 age group, as ten-year-olds find it difficult to sit and provide detailed information across a relatively lengthy period of time (the average IDI took between 45 minutes and 90 minutes). A new technique or tools would have been required to conduct detailed interviews with this age group. The team therefore decided to only conduct focus group discussions with the 10-14 year olds: In a group environment, peer researchers were able to gather enough information regarding the communication needs and preferences of this age group. However, from the research point of view, this limited the scope of analysis as the type

of data which could be collected through in-depth interviews could not be collected through focus group discussions.

## Transcription and Translation

The transcription and translation of the 240 IDIs and FGDs in a very short time frame was a major challenge in this research process. IDIs and FGDs were conducted by peer researchers in the local languages. These had to be completely transcribed in the local language/ dialect and then translated into English to enable researchers to use qualitative analysis software. There was an inevitable loss of information during this extremely complex process. While the research process made best use of available materials, the depth of expression, perceptions and experiences of the young people and the secondary population in their local languages could perhaps have been better analyzed if the timeframe of this research study was longer.

## Analysis of Process

One of the most challenging tasks in this research was to analyze a data set of 160 in-depth interviews and 80 focus group interviews. All the 240 documents were coded under 269 codes. Further all the 269 codes were analyzed according to 32 variables and sub-variables based on age, gender, marital status, urban, rural and state-wise categories. Thousands of responses were closely studied, counted, recounted, coded and decoded during this rigorous analysis process. Along with the strict time frame, the sheer variety and scope of the information posed a challenge to the successful execution of the study. The dataset was vast and required much more time for a complete and comprehensive analysis to be possible; and continued analysis of the data is likely to throw up even greater insights and interlinkages as time goes by.