

Establishing innovative HIV communication strategies and models for young people

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REACHING OUT TO THE YOUNG

Establishing Innovative HIV Communication Strategies and Models for Young People

Strategy Document

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Foreword

In India, current available data indicate that young people will increasingly be at the center of the HIV epidemic, both in terms of transmission and impact. It is estimated that over 35% 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, inexperience and peer pressures which easily influence them — often in ways that can increase their risk. It is extremely important for HIV prevention and care programs to address these concerns, and use innovative models of communication, models that 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 the 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 strategy document provides a detailed outline of the communication needs of youth; key messages, approaches and channels for reaching them.

The focus of the strategy is on:

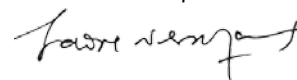
- A situational analysis of the youth based on the research findings
- Strategic elements for an HIV communication strategy for the youth
- The way forward for stakeholders to adapt the strategy

The strategy in its present form is the result of intensive efforts by many individuals and organizations. The process was started 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. S.P. Goyal, Project Director UP SACS and Mr. Ashok Kumar, Project Director AP SACS for their personal involvement in this project.

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

We appreciate the work undertaken for the completion of the project by the project team comprising of Ms. Venu Arora, Mr. N. Ramakrishnan and Mr. Avanish Kumar from Ideosync Media Combine; Dr. Sunil Mehra, Dr. Suba Shankar Das and Ms. Anjali Sakhuja from MAMTA. We would also like to specially mention 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 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

Chapter 1: Introduction

1.1 Context and Need for Strategy

There are an estimated 300 million young people in India today representing almost one-third (31 %) of the total population. However, they are referred to in varying ways and the terminologies used are often confusing and overlapping. The term 'adolescent' is often used to refer to young people between 10 and 19 years of age, 'teenagers' refers to those between 13 and 19 years and the term 'young people' or 'youth' is sometimes used to refer to people up to 25 years of age. For the purpose of this strategy we are using the terms 'youth' and 'young people', which refer to people between the ages of 10 and 24 years. This includes 'early adolescence' (10-14 years), middle adolescence (15-19 years) and young adults (20-24 years).

India's vast and diverse socio-cultural and economic composition ensures that young people here, more than anywhere else, are not a homogenous group. They come from varying economic backgrounds from the very rich to the very poor; they could be migrants; school going or drop outs, on the street taking drugs and being sexually abused, or at home protected or abused; groups with special needs; married and unmarried; parents; and those who live in rural and urban settings. The group also includes young people who may have been sexually exploited; those who are disabled; or those in conflict with the law. Given the different realities of today's youth, depending on their environment and upbringing, it is important to address them as a group with complex needs that cannot be met by one homogeneous communication strategy or message. Therefore, segmenting the youth target audience into specific groups and delineating the

most effective way of addressing each through strategic communication efforts has been the aim of this project.

Youth is a time of a transition from childhood to adulthood, marked by profound physical, psychological and behavioral changes. The onset of puberty and initiation of sexual behavior usually occurs in this phase. This is also the age when consequences for one's actions and responsible behavior patterns and norms can be impressed upon young minds. Thus young people need an environment that is non-judgmental and allows for safe exploration, while providing access to correct information to help protect them from diseases and risk-taking behavior. Some of the factors that impact their overall sexual health include the environment in which they live and grow and the quality of their relationships with their families, community and peer groups. Gender inequality, early marriage, early pregnancy, and the consequences of such social and cultural practices are largely responsible for the poor sexual and reproductive health status of young people. An unsupportive environment can cause problems, with a long-term impact on the lives of the youth.

Studies have shown that youth are typically poorly informed about their own bodies and about sexuality in particular, given the traditional social environment in India that does not promote open and healthy discussions on the issue. This puts young people at risk of unwanted pregnancies, health risks associated with early pregnancy, unsafe abortions, STIs, and HIV. In the present context the HIV/AIDS situation for the youth is

very serious in the country, owing to factors such as lack of access to accurate and personalized HIV information and prevention services, social and economic imperatives that lead to risky sexual behavior and substance abuse. Most important, young people seem to have a sense of invincibility given their youth and health and have an extremely low self-risk perception.

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. The entertainment media can reach a wide audience and can help promote communication between parents and adolescents. 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. It is now acknowledged that comprehensive communication strategies aimed at specific target audiences must include multiple media channels.

1.2 Existing Communication Initiatives for Young People Addressing HIV Vulnerability

HIV prevention among young people has been the focus of many programs initiated by the Government of India, non-governmental agencies, institutions and community groups. However, a critical look at the campaigns suggests that there are very few that incorporate a consistent communication strategy to address young people in a strategic way. Apart from

the School AIDS Education program and the recently launched Adolescent Education Program 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 public service announcements (PSAs) as on television and radio; or a targeted population of high-risk men through campaigns like the '*Puliraja and Balbir Pasha*' campaigns (in AP and Mumbai, respectively); or the '*Bula di*' campaign in West Bengal. Campaigns like BBC-WST's '*Haath Se Haath Milaa*' youth show or the '*Jawan Hoon Nadan Nahin*' campaign in Maharashtra are still quite rare - and even these campaigns do not address young people segmented by age, gender and economic variables. There are not enough calls to action and fewer details of why young people are at risk 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 not being fulfilled.

Provided below is an overview of some of the main programs that have addressed young people

1. School AIDS Education Program, India

The National AIDS Control Organisation (NACO) in partnership with the Department of Education has taken the lead and mobilized the entire school system for HIV prevention. A multisectoral approach embedded within the 'Right to Know' for Young People has been developed by NACO to reduce vulnerability and reinforce existing positive behavior among young people. The strategy adopted has important implications for working with young people. Special features of the program include:

- Sustained and continuous coverage of grades IX and XI in all schools (28 million young people) with minimum core content on HIV;
- A rapid scaling up; development of technical support and capacity for implementation; special advocacy sessions with local administrators, parents and community;
- Information provided directly to young people with 'space' created for them to discuss sensitive issues such as sexual health.

The program highlighted the fact that large-scale coverage for young people is feasible and the demand for sexual and reproductive health information among young people is very high. However, the sustainability of the program hinges on the technical capacity at the school levels to implement and sustain the program as well as the scope for integration of the program into regular school curricula and ownership by the Department of Education. Building on the lessons learned, it has been suggested that HIV/AIDS education be integrated into regular school curricula and the coverage be expanded to include vulnerable, out-of-school young people.

2. Programs by the Department of Youth Affairs and Sports

- 'Universities Talk AIDS' under the National Service Scheme, which reaches colleges and university students throughout the country
- 'Villages Talk AIDS' under the Nehru Yuvak Kendra Sangathan (NYKS)
- HIV/AIDS integrated with training programs for volunteers under the National Service Volunteer Scheme
- Scheme for assistance to Youth Clubs and the scheme for financial assistance for promotion of youth activities and training will also include HIV/AIDS training/awareness activities.

3. Electronic media campaigns and HIV prevention, Ministry of Information and Broadcasting

Prasar Bharati, the broadcasting corporation of India has in the past several years incorporated HIV/AIDS campaigns in its national broadcasts both on All India Radio (AIR) and on Doordarshan. AIR broadcasts NACO-sponsored programs every week. '*Jeevan Hai Anmol*' is aired on the primary channel and the Vividh Bharati stations of AIR. The State AIDS Control Societies are enlisted to provide field-level inputs and to highlight issues of significance relating to HIV/AIDS which are woven into the radio programs. There have been many public service announcements woven into sponsored song and entertainment programs. The 'Let's Talk AIDS' program, broadcast on Delhi's AIR FM Rainbow is another example of collaboration among NACO, AIR and civil society organizations reaching out through radio.

One of the longest high-profile campaigns has been part of the British Broadcasting Corporation World Service Trust (BBC-WST)-NACO-Prasar Bharati collaboration. The project utilized the Education-Entertainment (E-E) approach to design a five-year electronic media campaign. BBC-WST, NACO, Doordarshan and All India Radio joined hands in October 2001, for a national collaborative entertainment-education project to increase HIV/AIDS awareness among the Indian populace. The project was supported by DFID-India, and formally commenced in 2002. Initially, this project was launched in three Hindi-speaking states – Uttar Pradesh, Rajasthan and Delhi – but later Haryana and Uttarakhand were also included in the coverage area. This project had the following components:

4. The Ministry of Youth Affairs and Sports

The ministry, in consultation with NACO has prepared a five-year plan and action agenda called YUVA

Example of Electronic

Jasoos Vijay

An interactive half-hour detective TV drama series, which airs three times a week. The '*Jasoos Vijay*' television drama is designed to raise awareness among the rural masses on HIV/AIDS. Apart from the HIV/AIDS issue, this popular drama addresses a broad range of other social and developmental issues, as well as those of concern to rural audiences using an entertaining and interactive drama format. Issues of gender-based discrimination and violence, superstitions and 'quacks' have been covered in the series.

Additionally, *Jasoos Vijay* has been portrayed as HIV positive, allowing the program to address issues of the care, treatment and support to those living with the virus. This concept has given very effective space to propagate against stigma, apart from prevention. The first season revealed Vijay's positive status; the second season ended with Vijay and his love interest, Gauri, joined in holy matrimony; and the third season begins with their living happily and responsibly with each other. With reportedly over 70,000 viewer responses, *Jasoos Vijay* is currently on air for the third season.

Haath Se Haath Milaa

A weekly TV-reality/road show for young people, '*Haath Se Haath Milaa*' is a television series produced under the campaign, and targeted at the same states as the *Jasoos Vijay* series. The specific objective of this program at the initial stage was to create an unbroken human chain of 80 young people, *humsafars* ('fellow travellers'), joining their hands to raise awareness and to participate actively in the fight against AIDS. Traveling in two separate caravan-style buses, one for boys and the other for girls, the group journeyed through five Indian states and picked two young people from each of the different villages and towns they visited, to carry on the work of spreading HIV awareness. *Humsafars* came from various backgrounds and different walks of life: these included *paan-walas*, boatmen, tailors, taxi drivers, mothers, and housewives. The young *humsafars* joined the group/chain, often facing strong opposition from their families, relatives and sometimes from the entire community or village. Some of the *humsafars* were HIV positive and the program provided them a platform to voice their feelings and thoughts as well as to take part in creating awareness about prevention of HIV/AIDS.

Media Campaigns

TV and Radio Spots

As part of the campaign, BBC-WST also produced TV and radio spots aimed at raising awareness about HIV/AIDS and other related issues. Many of these spots featured key condom-promotion messages developed through an extensive research and pre-testing process.

Regional TV Spots

Approximately 18 regional TV spots were produced for Lucknow, Jaipur and Delhi regional Doordarshan centers. The corresponding regional languages and cultural contexts featured prominently in the spots, and were effectively incorporated in the production of these spots, e.g. the '*Kajri*' spot for Uttar Pradesh depicted the lively enthusiasm associated with the '*Kajri*' songs of Uttar Pradesh, while the folk dances of Rajasthan were depicted in regional spots to be broadcast in Rajasthan.

However, a major criticism of these spots has been that most of them were placed in an urban context while they were, in actual fact, specifically targeted towards rural viewers.

National TV Spots

These TV spots were focused on various themes associated with HIV/AIDS: the spot titled '*Archnd*', for example, focused on reducing stigma associated with being an HIV positive person, while '*Factory*' focused on the human rights of People living with HIV/AIDS (PLHA) at the workplace in addition to addressing stigma. '*Circus*' highlighted the risk associated with unprotected sex, and '*Kaun Banega Sachcha Saathi?*' was based on the popular TV show *Kaun Banega Crorepati?* The national TV spots were well received by the public and were reportedly quite successful in raising the awareness among targeted audiences.

Chat Chowk

A weekly radio-phone-in show on All India Radio, which invites audience members to talk about sex, sexuality and HIV/AIDS, *Chat Chowk* features two young hosts and a sexual expert in the discussion. The discussion takes a non-judgmental attitude for the specific purpose of attracting a wide cross-section of young people from diverse social and cultural backgrounds.

– Youth Unite for Victory on AIDS. YUVA envisages reaching out to adolescents and youth in all parts of the country to ensure that by 2010 all young people have accurate information, skills and access to HIV prevention services/facilities in a conducive, safe and supportive environment. The target is to cover 50% of young people by 2007, 65% by 2008, 75% by 2009 and 90% by 2010 and sustain the momentum through mainstreaming. These goals are proposed to be achieved through involvement of all youth volunteer networks in the country, the youth NGOs, youth clubs and youth development centers and through integration of HIV issues in all programs of the ministry. The key to the success of this program will be the training provided for use of the YUVA modules and the capacity of the volunteers who will work with the modules to reach out to young people.

5. *TARU* Project, Bihar, India

Project *Taru* is an Entertainment - Education (E-E) project supported by outreach activity in four districts in Bihar. The project revolves around a radio soap opera titled *Taru*, based on the life of a 21 year old woman who resists cultural norms and pursues further education. The program was aired twice a week in Bihar, Jharkhand, Madhya Pradesh and Chhattisgarh states from February 2002 to February 2003. This program focused on gender discrimination and stereotypical norms of a gendered society, and their implication on women's health and the overall development of women.

The *Taru* project was the result of a collaborative intervention between Population Communications International, New York, USA; Ohio University, USA; AIR; The Center for Media Studies, New Delhi and *Janani* in Bihar. The on-ground partnership with *Janani*, an NGO working in the area of reproductive health, was a unique feature of *Taru*: *Janani* trains village-based rural health providers (Rural Medical

The Entertainment-Education (E-E) strategy should not be limited to mass media such as TV, radio and music but can be advanced and supported through local folk media, art, and photography.

Practitioners) and their wives in a three-day crash course on reproductive health. Following this, the NGO designates these couples as village-level service providers in the 30,000 villages where it works.

Intensive use of mass media – including folk performances dramatizing the *Taru* storyline, posters, banners, wall paintings – were applied as part of the publicity program a few weeks before *Taru* went on air in February 2002. Some lessons learnt were:

- The E-E strategy should not be limited to mass media such as TV, radio and music but can be advanced and supported through local folk media, art and photography.
- Pre-program publicity and priming helps to build early listenership.
- Listeners' groups result in audiences coming together and spur dialogue and discussion about the messages they hear.
- E-E interventions need a ground-based service delivery partner for effective behavior change communication (BCC). The presence of *Janani* on the ground to support the listener groups and the program content was a vital link in the *Taru* implementation process.
- E-E intervention can successfully integrate inter-sectoral partnerships to widen its reach, provide services and monitor and evaluate its impact.
- There is a great need for formative and summative research for effective BCC-based project interventions and the learning from such interventions. Process documentation allows easy adaptation of successful models.

6. AASHA Campaign

The AASHA (AIDS Awareness and Sustained Holistic Action) campaign started in July 2005 was an intensive one month-long campaign. AASHA focused on promoting AIDS awareness, strengthening service delivery, and increasing demand for HIV/AIDS-related services by engaging all sectors of society, from government agencies to individuals and families. The main goal of the campaign was to deliver prevention messages to every home in Andhra Pradesh.

Rural area strategy

In the villages the campaign was designed to be led by the village committee. The trained AASHA volunteers were expected to facilitate the implementation of the program with support from the *mandal* team. The campaign broadly involved two strategies at the village level – an exclusive, intensive awareness campaign on one day of the campaign month; and continuous awareness activities through media, IEC display and interpersonal communication during the entire month.

Urban area strategy

The urban area strategy under AASHA-II focused on ensuring that awareness activities were undertaken in all wards in the project operational areas during the campaign month. (The ward was selected as the basic intervention area unit to ensure that slum dwellers, informal sector workers, construction workers, etc were covered by the program). The core team was also expected to identify areas with highly migratory populations, and to take up special programs to increase their awareness. Extra attention was also provided for employees of the transport sector and sanitation staff.

In the formal sector the aim of AASHA-II was to mainstream HIV/AIDS awareness programs in the industries and private companies. Interventions in

industries were facilitated by the Confederation of Indian Industry (CII). The AASHA-II campaign also envisaged the display of IEC material at locations visited frequently by the youth, such as malls, music shops, and coffee shops. Simultaneously, peer educators-based awareness programs were to be conducted at cinema theaters, market yards, bus stands, railway stations, parks, tourist spots, and taxi stands.

Experience from the field indicated a high level of ambiguity in the general population with regard to the acronyms of the different service points such as Prevention of Parent to Child Transmission (PPTCT), Voluntary Counseling and Testing Centers (VCTC) and Sexually Transmitted Infections (STIs). In order to ensure recognition of these service-delivery units, the program envisaged a common brand name – **AASHA Clinic** - to be used for all HIV/STI-related service units in Andhra Pradesh.

1.3 Gaps in the Existing Communication Programs

The desk review and preliminary analysis of research data helped to identify some gaps in the current communication program strategies. Some of these included:

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

7. Little integration of mass awareness programs and electronic media campaigns with support and skills building in the field to enable adaptation of this material to the folk or local media

1.4 Need for Innovative Models for HIV Communication and the Process Involved in Developing Them

With this background and based on current available data, limited as it is, it is clear that innovation and strategic thought are needed in designing a new and comprehensive communication strategy for young people. Existing statistics indicate that young people will continue to remain at the center of the epidemic, both in terms of transmission and impact. It is estimated that over 35% of all new infections in India take place among young people below 25 years (UNAIDS, NACO). Thus, highlighting the need to develop models of communication that not merely increase awareness on issues of sexual health and HIV prevention, but also provides linkages and information on the services available. There is also a need to better comprehend the information needs of young people in the different segments and address these information needs creatively and consistently over a long period of time.

This brings to the forefront the important need to develop an HIV communication strategy, which correlates information and services, primary and secondary target audiences, varied channels of communication and the media and the different yet consistent messages that will help equip young people with the tools they need to make safe and healthy decisions. It is to address this gap, and with this background understanding, that Constella Futures in partnership with MAMTA and Ideosync Media Combine have been working to develop innovative models for HIV communication.

The communication strategy designed under this project is based on the evidence from the extensive

qualitative research undertaken in the states of Andhra Pradesh and Uttar Pradesh. The research was designed and conducted in partnership with young peer researchers and thus it provides an accurate and detailed basis for this communication strategy design. The strategy provided below can be utilized by national and local bodies to direct their communication responses to the different audience segments within the larger youth focus. The strategy is designed to inform youth-focused communication initiatives within the national response to HIV prevention.

1.5 Process of Developing the Strategy

The strategy is based on an understanding of behavior change communication and development communication for social change. It is also entirely based on the analysis of primary data from the extensive qualitative research conducted by the consortium in Andhra Pradesh and Uttar Pradesh. An initial matrix of target audiences, needs, barriers and communication messages and channels was drawn up prior to the research. This matrix was based on existing knowledge regarding young people and their needs and the comprehensive desk review conducted by the consortium partners. Post-research, the matrix was validated and revised based on findings from the research undertaken in Andhra Pradesh and Uttar Pradesh. To provide a more holistic socio-cultural context to the matrix design, findings of the 'Right to Know' campaign conducted by MAMTA and UNICEF in West Bengal and Rajasthan were also analyzed and included. This provided a large canvas of different cultures, socio-economic environments, human development indices, and findings that ensure that the communication matrix developed is adaptable and replicable. The strategy explained in the following chapters is derived from this communication matrix and based on the communication needs expressed by young people during the research process.

Chapter II: Youth Segmentation

As discussed in the earlier chapter, young people represent a multifaceted segment of society with special communication needs at different times of their lives. In order to develop a communication strategy for young people, it is important to address their diverse socio-cultural and economic backgrounds as well as different needs based on their different age groups and gender. The communication strategy developed as a part of this project addresses these concerns and provides a coherent segmentation by age, gender and marital status to make the messages more targeted, suitable and responsive to the needs of young people.

2.1 Youth – A Heterogeneous Entity

Youth today represents a multi-dimensional cross-section of society. This group, characterized by its curious nature, experimental attitude, and lack of exposure to the ways of the world, is easily impressionable, and hence highly vulnerable to the environment and people around them. Representing over one-third of India's population, youth are often classified as one homogenous group in programs and projects related to young people. However, youth are not homogenous; rather, they represent a whole of many diverse parts that may be broken up into sex, age, socio-economic status, education, location, family structure, etc. The life of a young boy in rural India may be markedly different from the life of a boy of the same age living in an Indian metropolis. Similarly, the experiences of a girl from a village who marries young and has a child at the age of eighteen are very different from those of a school going girl from a middle-class family in an Indian city who will eventually attend college,

marry and have children later in life. Gender also plays a significant role, and boys and girls in India are subject to different realities. Hence, the environment they live in, their peer groups, their families, their social status and income all play an important function in shaping young people's behaviors and lifestyles. These inter-dependent factors linked with their young age, inexperience, their biological and psychosocial development during adolescence, financial dependence, and social taboos that prevent them from accessing correct and relevant information, exacerbate young people's vulnerability. It is therefore important while designing a communication strategy for young people to appropriately segment them into smaller groups whose information needs and access points as well as points of reference and contexts are similar. Messages designed within segmented audiences are better understood and more successful in addressing concerns.

2.2 Situational Analysis

(1) Environment

The environment may be understood as the overall space where young people live, work, play, socialize, make friends, and spend most of their time. This shapes their behavior patterns and who they are as individuals. School, home, the street or the park where they engage with one another are all examples of different environments that young people may encounter during the course of a day, and each different place has the potential to influence them and their lives. Thus, the environment acts as a key factor in controlling a young person's behavior. Often it is the environment that generates peer pressures

that may lead to high-risk behaviors such as smoking, drinking, and unsafe sexual contact. Apart from this everyday social environment, the overall economic environment also impacts behavior patterns. Poverty and lack of access to resources may prevent health-seeking behavior. Cultural environments that promote masculine ideals and create gender barriers for open conversations between married partners form another barrier to HIV prevention and shape the behavioral patterns of young people. Thus the particular environment, within which different segments of young people grow up, plays a crucial role in determining their practices. Communication strategies therefore need to address these overall environments to make them conducive for supporting HIV prevention.

(2) Peer groups

Interaction with peers is an important part of adolescent development. Peer groups are members in the community that form the social circle of a particular young person. These are mostly groups of young people of the same gender and age. However, many times peer groups include one or two members who may be slightly older or slightly younger. The reasons for these variations in age groups are multifold. Making and keeping friends represents an important facet of growing up and is sometimes the most important concern for young people. Belonging to a particular peer group and identifying with the priorities of that

Peer groups become important sources of information around sexual issues and with no external resources to authenticate the quality of information; this peer information is also often a source of misguidance, generation of myths and misconception.

group becomes important during adolescence. The peer group provides a vital medium for learning about the world, social interactions, relationships and one's own self. Peer groups can play a positive as well as negative influence on young people. Positive elements of belonging to peer groups include developing a sense of belonging, increased self-confidence, security, practice in engaging with other young people of the same and opposite sex, a way to meet new people, and friendships that provide emotional support and influence decision-making about life. However, negative peer pressure can be damaging to young people. In such cases, peer pressure may lead to low self-esteem and experimentation in high-risk behavior without understanding the consequences of the actions.

Peer groups also may change over time. A young girl who played with boys when she was little may no longer interact with them as she undergoes physical changes in her body during puberty. Similarly, as young people grow older, their interest in members of the opposite sex increases and they seek opportunities to interact with the opposite sex. Also, curiosity about sex and sexuality engenders conversation around these issues within peer groups. Peer groups become important sources of information about sexual issues with no other sources to authenticate the quality of information, which could perpetrate misinformation and become a source of misguidance, and generation of myths and misconceptions. Many young people have been found to base their behaviors and beliefs on what they heard from friends in their peer groups, much of which was false, unsubstantiated and incorrect information.

(3) Family

Adolescence marks an important phase of self-discovery for young people and parents play an important role in shaping the attitudes and behavior

of their children. Research shows that parent-child relationships have a noticeable impact on adolescent behavior and social development. In addition, with changing times, joint families, nuclear families, orthodox families, new generation families all coexist in India and are in continuous flux between traditions and the adoption of modern life. Thus families are subject to social pressures that in turn have an impact on young people within the family. Since socialization of young people starts at home, family members are capable of playing a critical role in shaping behaviors and attitudes of young people. Furthermore, the reality of low-income families is quite different from that of middle-income and higher-income families and these socio-economic pressures also impact the behavior, activities, and attitudes of the youth.

(4) Income

The financial condition of a family has an impact on the introduction of young people to external influences resulting from a working scenario. A family with financial constraints may send their children to work at a young age to meet the basic needs of the family. In some cases, low-income families may not send their children to school due to economic pressures. Stepping out of the house at a young age, especially into the work environment, exposes young people to information that they may or may not be ready to assimilate. In addition, extra income generated by them may lead to experimentation. Incidents of smoking or chewing tobacco are very high in 15-19 year old earning boys. Access to new environments and people may also lead to high-risk behavior related to drinking, smoking and sexual activity, especially in cases where peer pressure forces them to flaunt newly acquired wealth. Exposure to hazardous work environments at a young age may lead to sexual exploitation and abuse of young people.

It is important to look at each age group separately and connectedly with the entire continuum of growth so as to enable communicators to address the physical, psychological and information needs of young people in the different age groups.

Our social and cultural environment does not allow for a discussion of abuse that many young boys and girls undergo at the risk of physical infection and emotional trauma. These realities need to be understood before communication strategies are designed and implemented.

2.3 Age and Gender Analysis

The onset of puberty is a powerful moment marked with physical and psychological changes and a time when age and gender play an important role in defining youth. The behavior of young people varies quite significantly on the basis of gender and age groups; therefore, referring to the youth as one standard group is misleading. Through the course of their journey from adolescence to adulthood, the youth are exposed to diverse forces. It is important to look at each age group separately and connectedly with the entire continuum of growth so as to enable communicators to address the physical, psychological and information needs of young people in the different age groups. Using the research as a basis for the purpose of this strategy, the youth category has been broken up into the following distinct age groups.

Age 10-14 years

The age group of 10-14 years is marked by the onset of puberty. This period of adolescence is a time of physical and social transition from childhood to adulthood and represents a period of insecurity, self-discovery, and curiosity about one's body

among boys and girls. Unsure about changes within their bodies and often unable to discuss this with parents, young children within this age group seek information from available sources. Their knowledge is usually incomplete and incorrect as it is culled from their peers or older members of their peer group who themselves do not have access to the right information. It is critical to provide this vulnerable age group with comprehensive and correct information about their body and hygienic practices to deal with these changes.

Age 15-19 years

Having already gone through puberty, this age group is marked by young adulthood and the social pressures of growing up related to marriage, career, and the uncertain future. Curiosity related to sex and sexuality is heightened and most often, questions about attraction to the opposite sex, menstruation and masturbation remain unanswered. Information sources such as the television, radio, newspapers and magazines provide information and influence their lifestyle; images of sex in movies and on television again act to increase curiosity about sex but do not provide complete answers about how and why. These detailed inputs can only be supported through interpersonal communication with trained and well-informed facilitators.

Age 20-24 years

This is the age group that represents overlapping sub-groups of young adults, both married and unmarried as well as parents. Among males, this time-period focuses on family, employment, and financial concerns. These financial concerns often take the men outside of the house for work. Females within this age group are mostly married and have often entered motherhood. In most cases, women are still not completely comfortable with their bodies and the changes within them, and have no self-risk perception about acquiring STI/HIV from the husband. Mass media messages about condom use and safe sex serve to provide only half the information and do not necessarily lead to behavior change or increased perception of risk. Interpersonal communication coupled with mass media messages would be a useful way to reach this highly vulnerable segment of youth.

Summary

There is no one face of youth as each young person is his/her own unique individual influenced by various socioeconomic, cultural and traditional factors as well as age, gender and the environment. As there are different people in different places, with different mindsets, communication messages have to be focused and targeted.

Chapter III: Strategy Focus

This chapter attempts to list key frames of reference for the communication strategy structure. These will be helpful in designing communication material and the overall communication plan.

3.1 Increasing the Spiral of Information Based on Age Segregation

Information needs can be segregated on the basis of age. Although there will always be overlapping needs, in order to impact behavior, getting the correct facts at an early age is important. The increasing spiral of information methodology relies on the fact that the same groups of young people are taken through an affirmative process of learning whereby they are provided with age-specific information cross-referentially as they grow up. Unfortunately, in the past communication messages have been aimed at young adults of say, 20 years, promoting condom use when the target group did not even fully comprehend their own body anatomy. Abstinence messages are directed at 15 year olds in school when they do not understand sex and therefore are unable to make sense of a message promoting abstinence. The increasing spiral of information framework necessitates that

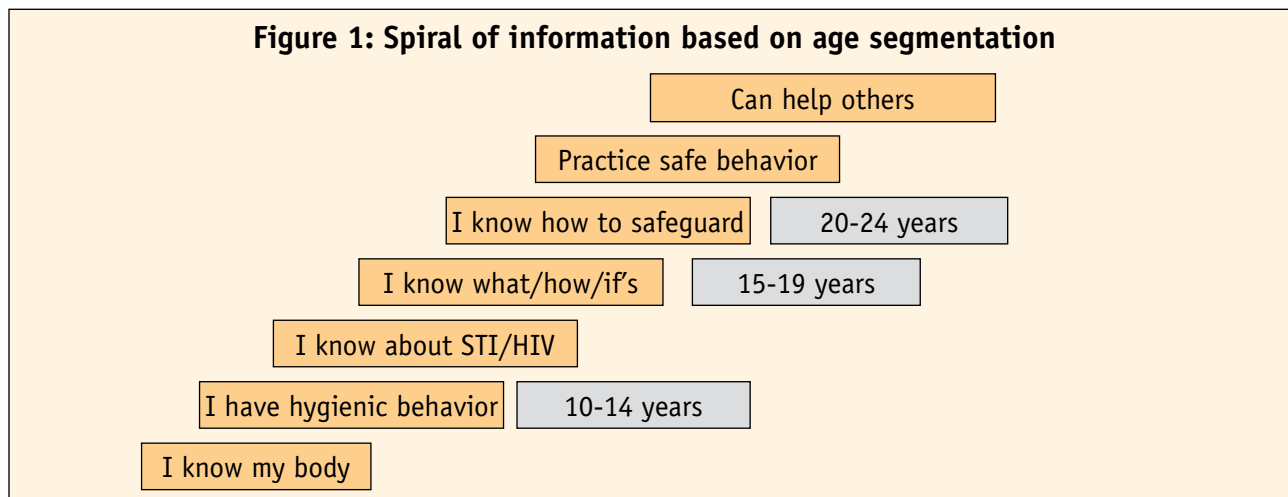
all young people of a particular age group have the basic information desirable and required in that age group, thereby ensuring that prevention messages are contextualized and well understood.

Key areas of information focus within the different age groups are:

Age 10-14 years

This is the age of rapid physical changes when young people need to be reassured about these changes and why they happen. Knowledge about basic body anatomy and the physiological and hormonal changes that take place during puberty need to be the basis of the information provided at this age. Both boys and girls should have access to the same information. Research has shown that young women remain unaware regarding the anatomy of young boys and vice versa and this lack of knowledge continues till many of them get married and sometimes even after marriage. Puberty is the right time to initiate a discussion around body changes and if done in a non-judgmental fashion, this information creates the foundation for understanding HIV prevention messages.

Figure 1: Spiral of information based on age segmentation



Puberty is also the time when young boys and girls feel insecure and there needs to be an environment where different growth rates are acknowledged as normal. Additionally, young people feel the beginnings of attraction towards the opposite sex and questions relating to menstruation and masturbation arise. These need to be responded to in a non-judgmental manner providing explanations related to sexual desires and bodily changes. Since this is a time of rapid change and all young people grow up differently, it is also important that no messages create the idea of only one pattern of growing up as being considered normal. Focus on hygienic behavior, tolerance of differences and understanding basic facts around bodily functions should remain the focus of information and communication messages to this age group.

As young people grow and move into their teens (15-19 years) their information needs change. Gender roles become predominant and young men and women feel pressured to respond to these social structures. Assertion of masculine identities and absence of discussion about gender inequalities may lead young men to try and exhibit supposed acts of bravado and 'manliness', which may include eve-teasing and acts exhibiting dominance over girls and women. Women in turn may feel compelled to accept the male advances to gain acceptance. Thoughts of marriage, love, and vulnerability lead them to situations where basic knowledge about sex, sexual organs, emotions and controls need to be established. Knowledge about STIs, their symptoms and syndromic management needs to be well understood. Explanation of HIV/AIDS, its mode of transmission, effect on the human body, social impact in terms of stigma, etc. needs to be addressed. This is also an age when a lot of experimentation takes place and there is a need to focus on life skills-based messages and information that allow young people to understand

the consequences of their actions. As they grow up to be adults (20-24 years), their knowledge about matters related to sex and sexuality needs to be complete so that they not only protect themselves but also help society in building an informed enabling environment for better health. They need to fully comprehend responsibilities within sexual relationships and the need to protect themselves and their families from STIs and HIV.

3.2 Cross-cutting Themes of Gender and Masculinity

While India may have made certain gains in the area of gender equality, there is still much that needs to be done for Indian society to become gender equitable. As far as the risk to HIV is concerned, gender-based discrimination continues to be an exacerbating force that is guiding the epidemic. Gender, therefore remains a cross-cutting thematic focus for all communication campaigns and messages designed for the different age groups of young people. At each age group and socio-economic level, gender plays a part in different and varying ways and will need to be addressed within that specific context so as not to further promote gender bias. For example, in the younger age groups, research shows that many young girls in rural areas stop going to school after puberty. This is directly related to fears about their virginity and moral concerns within the community. Limited mobility results in limited access to information for these girls, and, therefore, greater vulnerability in the future to the HIV epidemic.

Gender-based discrimination continues to be an exacerbating force that is guiding the epidemic. Gender therefore remains a cross-cutting thematic focus for all communication campaigns and messages designed for the different age groups of young people.

Similarly, while efforts have been made to increase the participation of women in decision-making at the family and community levels, in terms of sexual decision-making and ability to negotiate condom use within relationships, this decision-making capacity is still limited.

In all our communication efforts we need to be alert and vigilant that we do not inadvertently create any gender bias. It is important that stereotypical images of 'girls only doing household jobs' and 'boys going for education' or 'girls being fed less than boys' should not be encouraged. The IPC efforts should be undertaken in gender-desegregated groups so that women understand their bodies better and can discuss issues important to them.

Men also have limited information about STI/HIV. They may have heard about it but have very low self-risk perception. Men need to be involved in understanding how gender operates in society, thereby creating conditions for both young men and women to lead healthy sexual lives. HIV prevention communication therefore needs to address gender on a cross-cutting basis and ensure that all messages are gender sensitive and promote gender equity.

3.3 Cross-cutting Themes of Stigma Reduction

Stigma and discrimination are by-products of misinterpreted communication. Direct linkages to out-of-home sex, not being faithful to one partner, visiting commercial sex workers (CSW) have all emerged out of the communication efforts made to educate people about HIV transmission routes. The tendency to link HIV transmission to only sexual behavior, rather than focusing on all possible routes of transmission, creates greater environments for stigma to exist in society. Intolerance towards alternate sexual identities and practices exacerbates

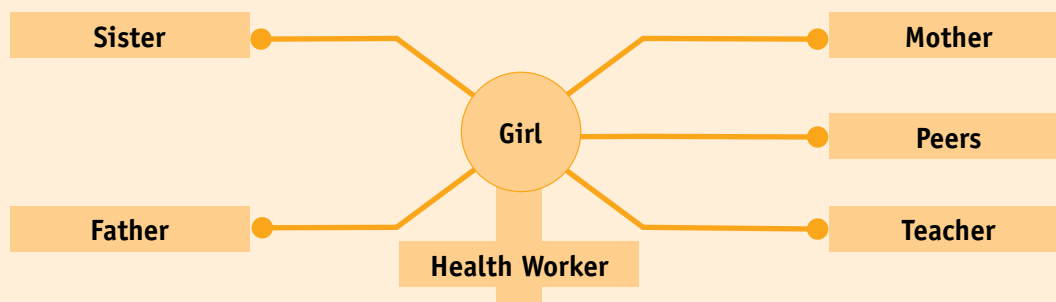
stigma. Greater involvement of people living with HIV (GIPA) has long been discussed as a key to successfully mitigating stigma in society. Stigma also exists because most people have no experience of everyday interaction with a positive person. Generally there are no first hand experiences of dealing with HIV positive friends. At times, media messages about HIV propel stigma leading young people to talk about the disease as something that affects others with limited understanding of self-risk. Hence media campaigns require conscious analysis to ensure that messages are not perpetuating the stigma they are trying to dispel.

Earlier experiences with stigmatized communicable diseases like leprosy and tuberculosis have revealed that curability increases social acceptance. Therefore facilities for managing and providing anti-retroviral therapy (ART) need to be emphasized in order to help create an environment where more people are willing to be tested for HIV and avail of ARTs. The direct connection of sex and STIs with the HIV epidemic is the main reason for such stigmatizing behavior in society. Communication needs to work towards normalizing the concept of sex and sexuality among young people and creating a non-moralistic and non-judgmental framework for conveying safer sexual messages in order to create campaigns that refrain from reinforcing stigma.

3.4 Increased Focus on Secondary Stakeholders

Most communication programs in the past have focused on the primary stakeholders. However, current work on communication for social change acknowledges that individual behavior is guided by social structures and environment. No individual lives in isolation and social supports are very important. As most of the information flow happens from peers or the immediate sub-set, focus on secondary

Figure 2: Secondary stakeholders influencing young people's behavior



stakeholders is very important. Different people play different roles in the life of the primary stakeholders especially if the primary stakeholders are young people. Key secondary stakeholders must be equipped to respond to accept the knowledge being imparted and participate in the information-gathering processes. New information will generate more questions and it is the identified key secondary stakeholders who are accessible to, and likely to be approached by the primary target groups. For the different age groups of young people, this communication strategy suggests different critical secondary stakeholders who play the most important role as conduits of information and access. For example, for the 10-14 year olds the parents and teachers are the most critical secondary stakeholders.

In Figure 2, it is evident that a girl's access to information and life choices are dependent on people who play a critical role in her everyday life. If the girl is the primary stakeholder then the people around her will form the ring of secondary stakeholders. A teacher can provide her with technical and up to date information, and, with the help of visual aids and in the environment of learning, can impart complete and correct knowledge. She can also act as a check on behavior. She can act as a link between the service provider (health worker) and the mother.

The mother herself needs to be well informed and know about her child's information needs and be able to fulfill these. The father is generally the provider, the financial resource and decision-maker on the young person's mobility. Older siblings also play an important role in providing information and being role-models for younger siblings.

The above factors highlight the need for a communication campaign which involves secondary stakeholders and encourages them to play a proactive and supporting role in making young people understand the issues related to growing-up.

3.5 Increased Focus on Interpersonal Communication (IPC)

An increased focus on IPC is being suggested as part of this communication strategy, so as to enhance the effectiveness of ongoing and new mass media campaigns. The formative research undertaken clearly indicated a demand for more details on HIV prevention and care. Young people voiced their inability to fully comprehend abstinence or safe sex messages that they had seen on television or heard on radio in the absence of one-to-one communication with trusted facilitators who could explain the details of the messages. This lacuna could also be due to the fact the electronic media campaigns are often not

focused on segments of young people and therefore have more generic messages that are acceptable to a much larger audience. The message is, therefore, very often lost on the most vulnerable segments of young people that most communication campaigns wish to address.

However, this increased focus on IPC will need two key inputs:

- intensive training and capacity building of facilitators leading IPC initiatives
- better and more focused IPC materials

Therefore, communication programs aiming to use interpersonal communication need to ensure that facilitators leading the interpersonal communication initiatives at the grassroots level are well trained and fully informed of the issue, have access to appropriate materials for the appropriate audience segments they will address, and have been trained in the use of these materials.

Chapter IV: Behavior Change

Two decades of HIV/AIDS prevention efforts have shown that the HIV epidemic presents unique challenges in terms of behavior change and requires innovative methods to address them. In this chapter, based on the findings of the qualitative research, the consortium team has tried to evolve a usable strategy matrix that takes the core principles of behavior change communications and the new thinking on communication for social change (CSC) to come up with a stratified and targeted approach for preventing the spread of HIV among young people.

The strategy will be useful as it is based on problem analysis, segmentation of youth groups, existing levels of knowledge, psychological and economic barriers, service utilization and other relevant social and environmental factors that impact individual behavior. The strategy suggests:

1. The communication approach for different categories of youth
2. Secondary audiences and approaches for addressing them
3. Content for the different communications
4. Channels for communication

4.1 Understanding BCC and CSC

To start with, it would be useful to define BCC as a concept: Behavior change communication is an interactive process of molding social and individual attitudes and behavior through the provision of information and ideas in the form of persuasive and contextual messages. These messages should ideally be presented in the form of comprehensible, relevant and segmented communication products that can be used by (and within) the communities being addressed by the communication intervention.

It is worth noting that BCC goes beyond the mere provision of information. Knowledge of a problem and awareness of the issues concerned are by themselves only the foundation for behavior change, and do not constitute behavior change communication by themselves - especially when issues such as HIV are concerned. The closer the behavior in question is to issues of personal spaces, self identity and moral/ethical societal and personal structures, the more difficult it is to ask for a change in the behavior.

Thus, BCC must be seen as a process rather than a one-time intervention. An individual passes through a series of stages or steps in a thought process before she/he accepts that the change in behavior carries definite advantages for him/her (see figure 3). Guiding the individual - and thereby the community she/he belongs to - through these steps successfully is the process of behavior change communication. Successful BCC implementations require a systematic assessment of the stage the individual is at, followed by a careful articulation of an argument or incentive in favor of changing the behavior and nudging the individual along to the next step.

The process of behavior change

The process of behavior change can be seen as a progression through five distinct mental states on the part of the individual. The essence of BCC or behavior change communication, correspondingly, is to assist the individual in making the transition from each stage to the next, till the desired change in behavior is permanent and a regular part of the individual's life. These five stages - in the sequence of progression - are as follows:

- Knowledge

- Approval
- Intention
- Practice and
- Advocacy

In order to carry an individual through this process of self-realizations and change, it is necessary to offer a series of well planned and logical arguments and messages that inform the individual and allow him or her to make the leap from one stage to another. Finding the correct stimulus at a particular point in time has to be correlated with:

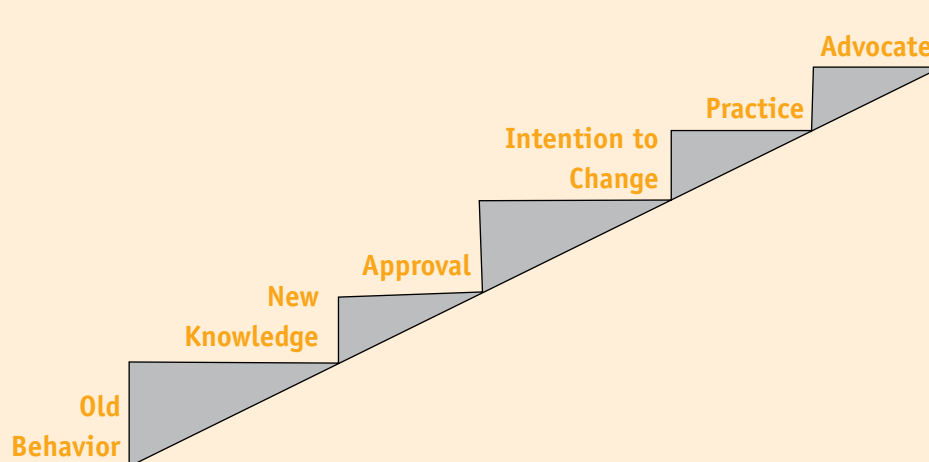
1. An analysis of the stage at which the individual is currently placed; and
2. An assessment of the appropriate stimulus that will suit the mental make up and context of the individual in question. This identification has been an important focus of the research and based on the research findings young people have been segmented and placed at appropriate points in this behavior change continuum. The communication strategy matrix presented later in this chapter allows users to follow this logic when designing prevention communication interventions.

Broadly, these stimuli that promote behavior change can be categorized into 6 types:

1. Rational stimuli (e.g. appeals to reason, justice, fairness)
2. Emotional stimuli (e.g. patriotic appeals, the chance to earn praise)
3. Skills (the chance to learn a new skill or capability which is perceived as useful)
4. Family and personal networks (motivation due to blood ties or friendship)
5. Social structures (motivation on account of belonging to a specific club, or society or structures like labor unions and welfare associations)
6. Physical stimuli (physical gratification, income, wealth generation)

When translating this theory of change, it is important to remember that before individuals and communities can reduce their level of risk or change their behavior, they must understand basic facts about HIV/AIDS, adopt key attitudes, learn a set of skills, and be given access to appropriate commodities and services. The environment also needs to support this change in individual behaviors

Figure 3: Behavior change stairs: Adopted version of Johns Hopkins behavior change stairs



and the maintenance of safe behavior (including abstinence), and seeking appropriate treatment for prevention, care, and support.

Therefore the new understanding around Communication for social change (CSC) has been adopted while designing this communication strategy. The theory of CSC suggests that social change supports individual behavior change and in order to make social change possible, the process of communication must be interactive and involve the beneficiary communities. Some practitioners of CSC believe that community-created content in fact is more effective in bringing about social change.

However, as health messages need to be technically grounded in factual information, there has to be a new overall communication design for addressing behavior change for health results, especially for HIV prevention, while simultaneously encouraging participation and aiming to achieve outcomes for social change without which behavior change would not be sustainable. In creating this communication strategy matrix, the consortium partners have decided to combine the two approaches: Behavior change communication and communication for social change in order to achieve these broader goals for enhancing HIV prevention efforts with young people.

This combined approach sets the tone, offers insights on the AIDS epidemic, and encourages society to confront cultural values and practices that may

This communication strategy combines two approaches: behavior change communication and communication for social change in order to achieve broader goal of enhancing HIV prevention efforts with young people.

contribute to risk for HIV infection. Effective BCC and CSC is vital to setting the tone for participatory, responsible interventions.

The communication strategy proposed aims to:

- Increase knowledge
- Stimulate community dialogue
- Promote essential attitude change
- Reduce stigma and discrimination
- Create demand for information and services
- Advocate for appropriate HIV/AIDS policies and laws
- Promote services for prevention, care and support
- Improve skills and self-efficacy

The advantage of this approach is that working groups or program partners can choose the age and area where their expertise lies, instead of adopting a general information dissemination module. This functioning will allow for the development of communication themes around the age and lifestyle of the primary and secondary stakeholders. This would lead to programmatic efforts that cater to specific needs with measurable results.

4.2 Objective

It is important that a strategy should have clearly crafted objective for it to be successful. It should be designed with specific results in mind. The research analysis provided data on current priorities of young people, current behaviors and practices and the existing gaps, current attitudes of secondary stakeholders and the extent to which local environments allowed for young people to gain accurate information about sexual and reproductive health issues. Using the results of the research, this communication strategy aspires to provide NGOs and program staff with a framework to help design targeted and more focused communication

intervention initiatives aimed at young people. The strategy addresses issues in an age specific manner keeping the gender dimensions of our society in mind not just in designing the messages but also in suggesting the channels appropriate for disseminating those messages. The communication strategy is also focused on addressing secondary stakeholders in order to address the social environment that is currently creating a barrier for young people to practice desirable behaviors - simple behaviors like seeking information on sexuality before experimenting etc. are difficult for young people to practice as community adults do not approve of, or are unable to provide relevant information. Most of all the strategy is actionable and enables users to create their own communication design using the framework that the strategy presents.

The strategy is therefore:

- Age specific
- Addresses the gender dynamic in society
- Addresses the social environment
- Actionable

The Table on page 26 presents the Communication Matrix based in the findings of the qualitative research and suggests the strategy.

4.3 Strategy for HIV Communication

10-14 years boys/girls

What information levels, attitudes and behaviors have been identified as needing change?

In the youngest age group of 10-14 years, both boys and girls were found to have poor knowledge about their own anatomy. While many had heard of HIV, there was no context within which the HIV prevention information could be understood. This gap in understanding is a matter of concern as they

grow up to be young adults and promote myths and misconceptions about HIV based on their limited knowledge and exposure. This strategy strongly recommends addressing the information gap among young people.

Key information needs identified

- Information about sexual and reproductive anatomy of the human body
- Information around reproductive organs, changes during puberty and reasons for this change
- Information around physiological changes and hormonal activity during adolescence
- Menstruation and menstrual hygiene
- Masturbation and nightfall concerns among boys and hygiene
- Clear and succinct knowledge about HIV and routes of transmission

Existing attitudes

Both young boys and girls did not really perceive the need to know about their anatomy and, if they did, many felt this was not approved of by society. Their own curiosity around the issue was therefore marred by feelings of guilt and an unwillingness to be open about their questions. A second important component as far as behaviors and attitudes of the youngest age group are concerned is their feelings of inadequacy and lack of self efficacy. This is also very largely guided by the social environment and the attitudes of other adult stakeholders around them.

Attitudinal and behavioral shift required

- Increased self efficacy
- Increased openness regarding seeking information
- Greater perception of the importance of reproductive health information
- Reductions in feelings of guilt around curiosity about sex, sexuality and reproductive processes

Table 1:

Communication Matrix for 10-14 year old Girls

Audience Profile	Goals/Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication Framework	Activities
				Internal	External				
10-14 year old girls	Increased knowledge around basic anatomy and changes during puberty to create a framework within which HIV prevention messages can be understood.	Low levels of knowledge around bodily changes; Misconceptions around menstruation and poor hygienic practices/traditional beliefs; Low levels of knowledge about pubertal changes in boys.	Use menstruation awareness as a means of introduction to reproductive and sexual health; Better hygienic practices during menstruation reduced RTI/UTI rates.	Does not understand need for sexual health issues.	Taboo to discuss sex, sexuality and sexual health; Access to right information; Right environment to discuss; Easy to comprehend, relevant messages; Lack of opportunities for normal interaction between girls and boys, social inhibitions with respect to adolescent sexuality.	Interpersonal communication to the target groups; Identified secondary stakeholders are mothers, peers, teachers and community health workers; Personalized material for the PSH.	Primary Stakeholders - Pride in Growing Up; Mothers (SSH) - You are the first person your daughter looks to for information. Inform yourself so you can inform her; Teachers (SSH) - School is the best place to know about our bodies and how to remain healthy. Sex education should become part of regular school curricula; Peers (SSH) - Seek information from credible sources. If you learn about your body now you will be able to take the right decisions when the time comes.	Approach - Friendly; Appeal - You have the right to know; Context - Lead healthy life; Content - Body, Nutrition and Hygiene; Source - Credible; Changes in body, reasons for change, changes in emotions, accepting changes, good habits, hygiene myths, myths and misconceptions, ask - right person.	Working through existing adolescent groups (or create if not already mobilized) at village/colony level for facilitated discussions conducted by trained facilitators using specifically designed IPC materials; Facilitated sexuality education sessions with young people in gender segregated groups; Poster campaigns designed to increase participation of communities in creating an environment; Sensitization and skill building of parents to address issues of adolescents; Skill building of teachers and community health workers on addressing issues of adolescents; Special campaign and training program with mothers.
	Increased knowledge around HIV transmission routes.	Young people have heard about HIV but unclear about all routes of transmission.	Clear knowledge about HIV and routes of transmission; Early understanding of opposite sex leading to better understanding of HIV risk in later years.						
	Increased levels of self efficacy and information seeking behavior.	Low levels of self efficacy.							

Communication Matrix for 10-14 year old Boys

Audience Profile	Goals/ Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication Framework	Activities
				Internal	External				
10-14 year old boys	Increased knowledge around basic anatomy and changes during puberty to create a framework within which HIV prevention messages can be understood.	Low levels of knowledge around bodily changes; Misconceptions around menstruation and poor hygienic practices/traditional beliefs; Low Levels of knowledge about pubertal changes in opposite sex.	Increased awareness about pubertal changes.	Increased awareness about pubertal changes.	Taboo to discuss sex, sexuality and sexual health; Access to right information; Right environment to discuss; Easy to comprehend, relevant messages; Lack of opportunities for normal interaction between girls and boys, social inhibitions with respect to adolescent sexuality.	Interpersonal communication to the target groups; Identified secondary stakeholders are fathers, peers, teachers and community health workers; Personalized material for the PSH.	Primary Stakeholders - Pride in Growing Up; Fathers (SSH) - You are the first person your son looks to for information. Inform yourself so you can inform him; Teachers (SSH) - School is the best place to know about our bodies and how to remain healthy. Sex education should become part of regular school curricula; Peers (SSH) - Seek information from credible sources. If you learn about your body now you will be able to take the right decisions when the time comes.	Approach - Friendly; Appeal - You have the right to know; Context - Lead healthy life; Content - Body, Nutrition and Hygiene; Source - Credible; Changes in body, reasons for change, changes in emotions, accepting changes, good habits, hygiene musts, myths and misconceptions, ask - right person.	Working through existing adolescent groups (or create if not already mobilized) at village/colony level for facilitated discussions conducted by trained facilitators using specifically designed IPC materials; Facilitated Sexuality Education sessions with young people in gender segregated groups; Poster campaigns designed to increase participation of communities in creating an environment; Sensitization and skill building of parents to address issues of adolescents; Skill Building of teachers and community health workers on addressing issues of adolescents; Special campaign and training program with fathers.
	Increased knowledge around HIV transmission routes.	Young people have heard about HIV but unclear about all routes of transmission.	Clear knowledge about HIV and routes of transmission; Early understanding of opposite sex leading to better understanding of HIV risk in later years.	Clear knowledge about HIV and routes of transmission; Early understanding of opposite sex leading to better understanding of HIV risk in later years.					
	Increased levels of self efficacy and information seeking behavior.	Low levels of self efficacy; High levels of peer pressure around masculinity.	Low levels of self efficacy; High levels of peer pressure around masculinity.	Low levels of self efficacy; High levels of peer pressure around masculinity.	Low levels of self efficacy; High levels of peer pressure around masculinity.				

Communication Matrix for 15-19 year old Unmarried Girls

Audience Profile	Goals/Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication Framework	Activities
				Internal	External				
15-19 year/ girls/ unmarried	Increased knowledge of the body.	Very little or no knowledge around self; body or safer sex; Incomplete understanding around sex, pregnancy, contraception, abortion.	Seek information about physical and mental change during puberty.	Lack of self efficacy, shyness	Lack of sources of correct communication/ information; Sex and sexuality is a taboo; Girl's mobility controlled thereby curtailing opportunities for information sharing; Community perceptions around STI/RTI suggest promiscuity, 'immoral' behavior; Low importance to girls' needs, education, information needs.	IPC most appropriate to reach this group; Mass media needed to supplement IPC; Identified secondary stakeholders (SSH) are mothers and peers; Capacity building for PSH.	PSH- Why Shy!- Its my life; Mother (SSH) - Today's girls will be mother's tomorrow. They need to have the resource to manage a healthy family. Their biggest resource is correct information; Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV. (Join the young peoples club in your village/listen to radio programs/TV programs); 'Bhabhi'/'Sister-in-law (SSH) - Younger unmarried girls can turn to you for information about sex, marriage, and reproductive health. Keep yourself informed so that you can help them.	Approach - Confident you; Appeal - Be in control; Context - One life, live with care; Content - Sex and sexuality; Source - Credible; Me and my body; sex and sexuality; my habits and behavior; hygiene musts; HIV/ AIDS/ STD; Myths and misconceptions; Ask-right person; What is HIV/AIDS; what it does to the human body; How to safeguard one self - VCTC/ABC; My right to question - partner, friend, doctor.	Peer education model for one on one information sharing; Extensive training for young people as peers, use of accurate, well produced peer education kits and materials; Establish young people's clubs that discuss a range of issues pertinent to young girls including HIV, create IPC training materials, Extensive training workshops for facilitators/peers who lead the young people's clubs. Link the young people clubs to ongoing mass media long term interactive campaigns through dramas and quiz shows; Mass Media: Create PSAs that call for young girls to join the adolescent clubs/ visit youth friendly service centers; Establish youth and community lead community radio in every district that allows for participation of young girls as media peer leaders; Media campaigns around 'Bhabhi' or newly married role models; Use popular magazine like Griha Shobha, Saras Sati, Saheli to carry ongoing stories about positive living, HIV prevention etc; Creation and promotion of youth friendly services at STI clinics, VCTC centers and government hospitals via advocacy campaigns; Create access to and promote availability of condoms and contraceptives to young people
	Have increased knowledge on STI and HIV and actively seek information on the topics.	Incorrect and incomplete information on HIV and AIDS, linkage between STI and HIV vulnerability; No treatment seeking in case of STI.	Knowledge about safe sex; Knowledge about STI and HIV; Increased conversation with peers about HIV and safer sex; Seek medical help from competent medical practitioners.	Lack of correct information; Girl's mobility controlled thereby curtailing opportunities for information sharing; Community perceptions around STI/RTI suggest promiscuity, 'immoral' behavior; Low importance to girls' needs, education, information needs.	Capacity building for PSH.	Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV. (Join the young peoples club in your village/listen to radio programs/TV programs); 'Bhabhi'/'Sister-in-law (SSH) - Younger unmarried girls can turn to you for information about sex, marriage, and reproductive health. Keep yourself informed so that you can help them.	Approach - Confident you; Appeal - Be in control; Context - One life, live with care; Content - Sex and sexuality; Source - Credible; Me and my body; sex and sexuality; my habits and behavior; hygiene musts; HIV/ AIDS/ STD; Myths and misconceptions; Ask-right person; What is HIV/AIDS; what it does to the human body; How to safeguard one self - VCTC/ABC; My right to question - partner, friend, doctor.	Peer education model for one on one information sharing; Extensive training for young people as peers, use of accurate, well produced peer education kits and materials; Establish young people's clubs that discuss a range of issues pertinent to young girls including HIV, create IPC training materials, Extensive training workshops for facilitators/peers who lead the young people's clubs. Link the young people clubs to ongoing mass media long term interactive campaigns through dramas and quiz shows; Mass Media: Create PSAs that call for young girls to join the adolescent clubs/ visit youth friendly service centers; Establish youth and community lead community radio in every district that allows for participation of young girls as media peer leaders; Media campaigns around 'Bhabhi' or newly married role models; Use popular magazine like Griha Shobha, Saras Sati, Saheli to carry ongoing stories about positive living, HIV prevention etc; Creation and promotion of youth friendly services at STI clinics, VCTC centers and government hospitals via advocacy campaigns; Create access to and promote availability of condoms and contraceptives to young people	
	Understand and practice hygiene musts.	Lack of negotiation skills; Early marriage and garna practices; Limited information on HIV testing facilities or process; Condoms linked to birth spacing.	Practice hygiene. Postponement of sexual debut, have negotiation skills; Early recognition of STI symptoms.	Lack of self efficacy, shyness	Lack of correct information; Girl's mobility controlled thereby curtailing opportunities for information sharing; Community perceptions around STI/RTI suggest promiscuity, 'immoral' behavior; Low importance to girls' needs, education, information needs.	Capacity building for PSH.	Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV. (Join the young peoples club in your village/listen to radio programs/TV programs); 'Bhabhi'/'Sister-in-law (SSH) - Younger unmarried girls can turn to you for information about sex, marriage, and reproductive health. Keep yourself informed so that you can help them.	Approach - Confident you; Appeal - Be in control; Context - One life, live with care; Content - Sex and sexuality; Source - Credible; Me and my body; sex and sexuality; my habits and behavior; hygiene musts; HIV/ AIDS/ STD; Myths and misconceptions; Ask-right person; What is HIV/AIDS; what it does to the human body; How to safeguard one self - VCTC/ABC; My right to question - partner, friend, doctor.	Peer education model for one on one information sharing; Extensive training for young people as peers, use of accurate, well produced peer education kits and materials; Establish young people's clubs that discuss a range of issues pertinent to young girls including HIV, create IPC training materials, Extensive training workshops for facilitators/peers who lead the young people's clubs. Link the young people clubs to ongoing mass media long term interactive campaigns through dramas and quiz shows; Mass Media: Create PSAs that call for young girls to join the adolescent clubs/ visit youth friendly service centers; Establish youth and community lead community radio in every district that allows for participation of young girls as media peer leaders; Media campaigns around 'Bhabhi' or newly married role models; Use popular magazine like Griha Shobha, Saras Sati, Saheli to carry ongoing stories about positive living, HIV prevention etc; Creation and promotion of youth friendly services at STI clinics, VCTC centers and government hospitals via advocacy campaigns; Create access to and promote availability of condoms and contraceptives to young people
Increased self risk perception.			Understand that she can also be at risk and practice safer sexual behavior.						Peer education model for one on one information sharing; Extensive training for young people as peers, use of accurate, well produced peer education kits and materials; Establish young people's clubs that discuss a range of issues pertinent to young girls including HIV, create IPC training materials, Extensive training workshops for facilitators/peers who lead the young people's clubs. Link the young people clubs to ongoing mass media long term interactive campaigns through dramas and quiz shows; Mass Media: Create PSAs that call for young girls to join the adolescent clubs/ visit youth friendly service centers; Establish youth and community lead community radio in every district that allows for participation of young girls as media peer leaders; Media campaigns around 'Bhabhi' or newly married role models; Use popular magazine like Griha Shobha, Saras Sati, Saheli to carry ongoing stories about positive living, HIV prevention etc; Creation and promotion of youth friendly services at STI clinics, VCTC centers and government hospitals via advocacy campaigns; Create access to and promote availability of condoms and contraceptives to young people

Communication Matrix for 15-19 year old Unmarried Boys

Audience Profile	Goals/ Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication Framework	Activities	
				Internal	External					
15-19 year/ boys/ unmarried	Increased knowledge of the body.	Very little or no knowledge around self, body or safer sex.	Increased information seeking behavior; Seek information about physical and mental change during puberty.	Unquestioning trust in information provided by peers; Lack of perceived need for information; Inhibitions to discuss sexual health issues outside peers, exchange of incomplete information among peers, lack of sources of correct communication/ information.	Few sources of correct information other than peers who often become sources for miscommunication; Social pressures to conform to male stereotypes and masculine identities creating pressure among young boys to experiment and gain sexual experience; Community perceptions around STI/RTI suggest 'immoral' behavior; Sex is a taboo.	Role of mass media will be only to generate a social mobilization of raising issues, getting people to talk, making subject relevant. IPC will detail it and present it in RIGHT and Relevant way; Identified secondary stakeholders (SSH) are fathers and peers; Capacity building for PSH.	PSH- Why Shy! It's my life; Older sibling, cousins, and friends (SSH) - Today's boys will be fathers and leaders of tomorrow. They need to have the resource to manage a healthy family and work life. Their biggest resource is correct information and education; Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV. (Join the young people's club in your village/ listen to radio programs/TV programs).	Approach - Confident you; Appeal - Be in control; Context - One life, live with care; Content - Sex and sexuality; Source - Credible; Changes in body, reasons for change, changes in emotions, accepting changes, good habits, hygiene musts, myths and misconceptions, ask - right person.	Establish young people's clubs that discuss a range of issues pertinent to young boys including HIV, create IPC training materials; Establish youth and community lead community radio in every district that allows for participation of young boys as media peer leaders; Peer education model for one on one information sharing; Extensive training for young people as peers, use of accurate, well produced peer education kits and materials; Use of community radio models to create community based content through youth participation; Use of community radio as a viable alternate career opportunity to create community media leaders -use of existing youth club structures like Nehru Yuva Kendra etc.; Mass Media: Create PSAs that call for boys to join the Yuva clubs (Nehru Yuva Kendra's can play key role)/visit youth friendly service centers; Long running radio soap opera's especially for young men linked to career goals etc that also discuss gender stereotypes and HIV prevention issues; Use local video parlours and other hang out places for young men as points where condoms, material on HIV prevention is available; Media campaigns around 'the concept of the 'Real Man' as responsible towards his life and the life of his partner; Media campaigns on HIV linked to content on careers and job opportunities; Creation and promotion of youth friendly services at STI clinics, VCTC centers and government hospitals; Create access to and promote availability of condoms and contraceptives to young people; Advocacy with community leaders and parents to support avenues for correct information on sexuality for young boys.	
	Have increased knowledge on STI and HIV and actively seek information on the topics.	Some information on testing facilities but incomplete knowledge around VCTC and confidential testing practices; Low levels of knowledge around STIs and treatment; Misconceptions around STIs.	Early recognition of STI symptoms; Knowledge about safe sex; Knowledge about STI and HIV; Increased conversation with peers about HIV and safer sex; seek medical help from competent medical practitioners.							
	Understand and practice hygiene musts.	Actively seek protection of self from HIV.	Some Knowledge of Condom and HIV but lack of correct condom use; Lack of skills to procure/purchase condoms; Treatment seeking from local 'jhola chhaap' or quacks.	Increased treatment seeking behavior from competent medical practitioners.						
Increased self risk perception.	Self risk perception very low; High levels of peer pressure around issues of masculinity, sexual prowess; High levels of casual sexual encounters and experimentation especially with sex workers.	Changed beliefs around manhood and manliness, reduced risk taking behavior; Practice safer sexual practices; Postponement of sexual debut.								

Communication Matrix for 15-19 year old Married Girls

Audience Profile	Goals/ Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication Framework	Activities	
				Internal	External					
15-19 year old married girls	Increased self risk perception.		Understand that she can also be at risk and practice safe sexual behavior.	Young age as compared to partner; Lack of self efficacy; Lack of complete information on sex, sexuality, sexual health, and HIV; Lack of self risk perception.	Social and cultural barriers to raising such issues within the family.	Role of mass media will be only to generate a social mobilization of raising issues, getting people to talk, making subject relevant. IPC will detail it and present it in RIGHT and Relevant way ; Identified secondary stakeholders (SSH) are husbands, mothers/ mothers-in-law and peers; Capacity building for PSH.	PSH - Why Shy: It's my Life; Husband (SSH) - You can have open communication about sexual health and contraception with your partner; Mother/ mother-in-law (SSH) - Today's girls will be mother's tomorrow. They need to have the resource to manage a healthy family. Their biggest resource is correct information. Young daughter-in-law and son must know about HIV. It is a question of their future. Encourage them to seek information and practice safe sex; Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV. (Join the young peoples club in your village/listen to radio programs/TV programs); "Bhabhi"/ Sister-in-law (SSH) - Younger married girls can turn to you for information about sex, marriage, and reproductive health. Keep yourself informed so that you can help them.	Approach - Confident you; Appeal - Be in control; Context - One life, live with care; Content - Sex and sexuality; Source - Credible; Me and my body, sex and sexuality; my habits and behavior; hygiene musts; HIV/ AIDS/ STD; Myths and misconceptions; Ask-right person; What is HIV/ AIDS; what it does to the human body; How to safeguard one self - VCTC/ ABC; My right to question - partner, friend, doctor; How am I at risk; Right to live healthy - confidence to talk to each other- Symptoms and signals; My rights to question - partner- doctor; How to safeguard self and family.	Build credibility of networks; Create training programs for Rural health practitioners and local quacks; PSAs around risk within marriage and promoting conversation with partners; Advocacy with in laws of young girls.	
	Increased knowledge of the body; Increased understanding around safer sexual practices.	Lack of knowledge around contraception and low contraceptive use.	Complete information and understanding around pregnancy, contraception and HIV prevention; Understanding around STI and linkage with HIV vulnerability; Seeks information about physical and mental change during puberty.							
	Complete and correct understanding of HIV, routes of transmission, difference between HIV and AIDS, linkages between STI and HIV vulnerability.	Some knowledge around HIV and prevention but incomplete and inconsistent; Low treatment seeking behavior for STIs.	Knows and understands the routes of HIV transmission.							
	Increased skills to discuss issues with partner and negotiate condom use.	Lack of skills to discuss HIV prevention with partner.	Discusses HIV vulnerability issues with partner and negotiate condom use.							
Increased reporting of STIs and treatment seeking from competent medical practitioners.	Lack of knowledge around VCTC facilities or process.	Discusses HIV counseling and testing issues with partner; Increased HIV testing behavior for self and partner.								

Communication Matrix for 20-24 year old Married Men

Audience Profile	Goals/ Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication Framework	Activities	
				Internal	External					
20-24 year old married men	Increased conversation around HIV risk.	None or limited conversation between couples on HIV risk issues.	Increased conversation and prevention within married couples.	Lack of skills to discuss HIV and sexual health with partners; Lack of complete information on HIV transmission and prevention; Stigma related to HIV - perceived as only a sexually transmitted infection and a deadly disease.	No role models for young couples around conversations around HIV.	Role of mass media will be only to generate a social mobilization of raising issues, getting people to talk, and making subject relevant. IPC will detail it and present it in RIGHT and Relevant way; Identified secondary stakeholders (SSH) are wives and peers; Capacity building for PSH.	PSH: I am aware! HIV is around!; Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV; Wife (SSH) - You can have open communication about sexual health and contraception with your partner.	Approach - Implant self-risk. Appeal - Only you can. Context - Safe sex. Content - Careful and concern.	Campaign with young married men around concept of Responsible husband encouraging young men to discuss issues on HIV with their wives; IPC: Create Peer couples that provide access to intimate conversations on condom use, contraception and HIV; Mass media Campaigns addressing couples jointly through PSAs and programs on radio and television directed at couples.	
	Increased understanding around STI and linkage with HIV vulnerability.	Very low usage of condoms within marriage.	Increased use of condoms within marriage.							
	Increased levels of treatment seeking behavior for STIs by couples.	Low levels of reporting and treatment seeking for STIs jointly by couples.	Increased treatment seeking behavior for STI.							
	Increased testing for HIV.		Increased voluntary counseling and testing for HIV by young couples.							
	Increased understanding around positive living.	High level of stigma against HIV.	Reduced stigma around the infection and against those infected.							

Communication Matrix for 20-24 year old Married Girls

Audience Profile	Goals/ Objectives	Current KAP/ Behavior	Desired KAP/ Behavior	Barriers and Gaps		Communication Strategy Proposed	Key Communication Proposition	Communication framework	Activities	
				Internal	External					
20-24 year old married girls	Increased conversation among married couples around HIV risk and contraception.	None or limited conversation between couples on HIV risk issues.	Increased conversation on HIV risk and prevention within married couples.	Lack of skills to discuss HIV and sexual health with partners; Lack of complete information on HIV transmission and prevention; Stigma related to HIV - perceived as only a sexually transmitted infection and a deadly disease.	No role models for young couples around conversations around HIV.	Role of mass media will be only to generate a social mobilization of raising issues, talk, and making subject relevant. IPC will detail it and present it in RIGHT and Relevant way; Identified secondary stakeholders (SSH) are husbands and peers; Capacity building for PSH.	PSH: I am aware! HIV is around; Peer (SSH) - You can learn to make the right choices if you have the complete information about HIV. (Join the young people's club in your village/listen to radio program/TV program); Husband (SSH) - You can have open communication about sexual health and contraception with your partner.	Approach - Implant self-risk. Appeal - Only you can. Context - Safe sex. Content - Careful and - Credible.	HIV education and information to be integrated with safe motherhood and family planning programs; Campaign with young married men around concept of Responsible husband encouraging young men to discuss issues on HIV with their wives; IPC: Create Peer couples that provide access to intimate conversations on condom use, contraception, maternal health, pregnancy and HIV; Mass media Campaigns addressing couples jointly through PSAs and programs on radio and television directed at couples.	
	Increased understanding around STI and linkage with HIV vulnerability.	Very low usage of condoms within marriage.	Increased use of condoms within marriage.							
	Increased levels of treatment seeking behavior for STIs by couples.	Low levels of reporting and treatment seeking for STI jointly by couples.	Increased treatment seeking behavior for STI.							
	Increased testing for HIV.	High level of stigma against HIV.	Increased voluntary counseling and testing for HIV by young couples.							
	Increased understanding around positive living.		Reduced stigma around the infection and against those infected.							

Key secondary stakeholder populations and their attitudes

Parents and teachers are the key secondary stakeholders that have the most influence over the 10-14 year age group. Research shows that there are gaps in information among parents as well as teachers on issues pertaining to sex and sexuality. Furthermore, they are ambivalent about imparting this information and do not have the skills to provide information to young people related to anatomy, bodily changes, masturbation etc. Adults are unsure whether this information is beneficial or harmful to young people. While they clearly believe that young people should have information on protecting themselves against HIV, background information that helps the understanding of safer sex messages and practices is not perceived by adults as important. Research revealed that young people who had proactive teachers in school were not only better informed, but they also had more confidence in themselves, were keen to seek information, and were less guilty about their curiosities.

Proposed communication strategy for change

While key messages and campaign ideas are provided in the next chapter, a cohesive Interpersonal Communication (IPC) strategy is proposed to encourage parents and school teachers to create an environment where young people can learn about sexual and reproductive health issues, in particular addressing the information needs listed above. The strategy proposes an increased focus on creating interactive IPC materials to be used in group activities in schools and communities and greater training and capacity building of the key adult stakeholders who impact young people namely parents and teachers. For young girls, their mothers are usually considered the first point of information seeking while for boys, their fathers are seen as the ideal first point of contact. However, young people during the research

process felt that parents are not forthcoming about providing information regarding sex and sexuality and are often ill-equipped to provide accurate information. A more focused activity to build capacity of parents to be supportive of the needs of young people is proposed in this strategy. It is also proposed that active community discussion spaces are created that encourage positive interaction among young boys and girls that encourage a healthy learning environment – these could be spaces for '*kishor*' and '*kishori*' clubs, time allocation for young people within anganwadi activities, regular school based sessions etc. It is also proposed that adult learning and training sessions be initiated to enhance capacity of teachers and parents to respond appropriately to this growing need for information among young people.

The strategy also proposes a mass media campaign using both print and electronic media creating positive role models for adults who encourage and promote such information seeking behavior among young people as well as equip themselves with accurate information in order to assist young people.

15-19 years boys and girls

What information levels, attitudes and behaviors have been identified as needing change?

Research findings reveals that basic awareness on HIV/AIDS exists but knowledge about the virus, its effect on human body, and transmission routes is limited. Traditional knowledge with misconceptions also add to unhygienic practices and inaccurate information. In addition, the link between STI transmission and HIV is poorly understood by the young people in this age group.

The evidence also suggests that this is the age group where gender separation is found. Various social

factors prevent young boys and girls from interacting in a healthy way. There is plenty of discussion among same sex peers on sex and sexuality but there are limited opportunities for discussion on a common platform. Work with young people has shown that transition into adulthood often translates into an urge to mix with the opposite sex that may be accompanied by shyness. Exposure levels are higher than before and they possess a better understanding of sex and sexuality. However, they seek further information on these matters and because of social constraints, do so in a secretive manner, which is often misinterpreted by parents and teachers as perverted behavior.

The key outcome of the research with this age group shows prevalence of many myths and misconceptions around changes in the body during adolescence as well as incomplete and misinformation about sex and sexuality. Many young people especially boys discuss sexual experimentation with their peers. Many young girls in rural areas get married at this age, but possess limited information on sex, contraception, conception, pregnancy and abortion issues. While young people in this age group recognize the need for information, they have limited resources for accessing correct information.

Young people in this age group depend largely on their peers for information. There is shame attached to issues of sexuality which prevents them from accessing information and treatment. A lot of young people in this age group recognize HIV as a risk, and none of them perceive themselves as being at risk.

Among young men there is a sense of bravado and invincibility that is linked to their perception of manhood and masculinity. These false perceptions, very often supported by social constructs around being a man or being a woman, contribute to high-risk behavior.

The communication directed towards this category of youth should aim to bridge the information gap and provide them with the confidence to seek information for better and healthy living.

Key information needs identified

The following are the information areas that must be covered by communications designed to address this age group:

- Information on anatomy and physiological and emotional changes during puberty and adolescence
- Information about sex and reproduction
- Pregnancy, contraception and abortion
- HIV and modes of transmission
- HIV and linkages with STIs
- HIV's impact on the human body
- Voluntary counseling testing
- Right to question:
 - Partner
 - Friend
 - Doctor
- Risk practices and use of condom for both birth spacing and HIV protection
- Abstinence/being faithful and condom use (ABC)
- Correct and complete knowledge about condoms and their use
- Information designed to increase self risk perception
- Stigma and discrimination

Existing attitudes

Shyness is very common in this age group, especially among girls. Among boys there is a reliance on their peers for all information. The concept of masculinity plays a large part in boys' attitudes of invincibility and bravado that encourages them to take sexual and other health risks due to peer pressure. Lack of negotiating skills with peers or partners and

very low self-risk perceptions, especially within relationships, are some of the key existing attitudes that need change.

Attitudinal and behavioral shift required

Much of the shift needed for this age group is in their attitudes and behavior as gender based attitudes and inequalities start to form during this age. Social structures encourage these perceptions, denying girls the freedom to access information and encouraging boys to take unnecessary risks to prove their masculinity. The concept of masculinity encompasses the perceived right to tease or dominate over women and girls, and this can lead to undesirable behaviors under peer pressure.

The concept of masculinity plays a large part in boys' attitudes of invincibility and bravado that encourages them to take sexual and other health risks due to peer pressure.

The communication for this age group, therefore, has to work not just to increase levels of awareness and information but focus on creating social change in perceptions that have for many years been part of Indian patriarchal culture. Communication must be designed to create role models that differ from the current perception of gender defined roles and status.

Key secondary stakeholder populations and their attitudes

The following are the critical stakeholders that impact this age group:

Parents: Parents' attitudes, especially towards girls in this age group, are extremely restrictive. The mobility and information access points for young girls in the 15-19 year age group are severely limited. Additionally, parents also inform larger community

attitudes towards information on sex and sexuality, and STIs. STIs are often linked to promiscuity and compromised morals, thereby driving many young boys with possible STI symptoms underground and restricting service accessing behaviors.

Peers: Peers are the single largest influencing stakeholders for the 15-19 year age group, especially boys.

Anganwadi workers and health care workers including local Registered Medical Practitioners (RMPs):

The attitudes of local *anganwadi's* and RMPs are restricted by limited training and capacity. These stakeholders are accessed by young people for much of their sexual health related information and form important sources of information and advice.

Older siblings and relatives in the family like *bhabhi's* or younger aunts: For young girls of this age older siblings and '*bhabhi*' play a large role.

Proposed communication strategy for change

Given the considerable influence of peers, the strategy suggests an increased focus on training of peer group leaders and establishing youth clubs for boys and girls. This would mean an increased focus on inter personal communication. Training of peer educators will include production of innovative and good quality one-to-one discussion kits for peers. Long term electronic media campaigns with an entertainment-education approach can be designed – using the drama or serial format and featuring key stakeholders like *bhabhi's* or older brothers/*chacha*, cast as the desired role models. These campaigns could use both television and radio. PSA campaigns encouraging parents of young people to be supportive of their questioning about sex and sexuality related issues can be useful.

Increased and more detailed communication packages on HIV related information that go beyond modes of transmission and increase self-risk perception of young people are required. Young people should be engaged in media activity like using community radio (recently licensed by the Government) developing content on responsible behavior, gender equity and treatment seeking practices.

15-19 year old married girls

Within this age category there is also a large subgroup comprising of married girls. This subgroup requires additional information and support. Married girls in this age category need information on sex, on delaying conception, preventing teenage pregnancy, marriage and family health education. This becomes extremely important since many women are not aware that they represent a growing at-risk population. An emphasis on skill building related to discussing pertinent topics on sex and sexuality with their partner is required.

Information needs identified

- Understanding self-risk factors
- Skills to talk to partner confidently
- STI symptoms and treatment related information
- Pregnancy, contraception and abortion related information
- Right to question
 - Partner
 - Doctor
- HIV, transmission route and role of condoms in prevention

Communication strategy for change

- IPC (supplemented with mass media) as most appropriate means to reach this group; same age group relatives are seen as role models and information providers

- Identified secondary stakeholders (SSH)
 - Mothers
 - Mothers in law
 - Husbands
 - Local anganwadi workers need to be trained to be more sensitive to the needs of young adolescent married girls.
- Both IPC and mass media need to be used to enhance capacity of young married girls to talk to their partners about STIs, HIV prevention and other issues
- Communication campaigns promoting husbands as positive role models can be designed
- A positive and supportive role of young men towards their spouses can be emphasized.

Age group 20-24 years

Information levels, attitudes and behaviors identified as needing change

Most young people in this age group are married or about to be married. Most girls may already be mothers and are adjusting to new roles in a new family. While they may possess basic information on HIV, there is very low-self risk perception and consequently extremely low condom usage. Most married couples use condoms for family planning and when they have completed their families, most adopt permanent contraceptive methods and thereafter don't feel the need to use condoms. Since they do not perceive any risk from HIV, condom usage drops.

Additionally, since information on physical anatomy and reproductive and sexual organs is also low, there are many myths and misconceptions about these issues, and treatment seeking behaviors for STIs is low. Among women, awareness on HIV/AIDS is extremely low barely extending beyond just the name. The "why" and "how" remain unknown.

The communication strategy needs to instill self-risk perception and make this group aware that HIV is around. Additionally, and most importantly, conversation between partners needs to increase in order to enable them as couples to protect themselves and their families.

Key information needs identified

Detailed information about the following must be part of a communication strategy for this age group:

- The body anatomy particularly in relation to reproductive organs and their functions
- HIV, modes of transmission and prevention
- STIs prevention and treatment
- Myths and misconceptions around pregnancy, contraception and abortion
- HIV stigma and discrimination
- Voluntary counseling and testing facilities and importance of testing for HIV

Key secondary stakeholder population identified and their attitudes

Family members, peers, and other married couples are the key influencers of young married couples in this age group. Most community elders, in-laws and senior members in the family have limited information on HIV or STIs and do not approve of open conversation between newly married couples or spouses. Traditionally conversations between husband and wives on these issues are not supported. All communication addressing the 20-24 years age group needs to be designed towards creating healthy conversation between spouses, and the willingness to adopt healthy practices together.

Behaviors needing change in secondary stakeholders

Secondary stakeholders should allow children to access information and resources. Mothers need

to allow their girls to speak their minds. Leader in society including religious leaders can contribute to establishing a conducive environment as they are widely heard and accepted, and are in position to influence change faster.

Proposed Communication Strategy for change

- Increased and more detailed awareness on HIV modes of transmission and role of condoms for prevention. This can be done using electronic and print mass media as well as interpersonal communication
- Mass media campaigns that create role models for young couples and allow for open conversation among spouses for greater health seeking behavior.
- Interpersonal communication used to encourage secondary stakeholders to support young married people in seeking HIV counseling and testing as well as adopt safer sexual practices
- Campaigns for young men that create responsible young adult male role models where concepts of masculinity and the 'Real Man' are seen as being gender sensitive
- Interpersonal communication that encourages discussion among groups, especially for young married women to enhance their capacity and build skills for initiating conversation within the family and with the spouse

4.4 Evaluation Strategy

Individual communication programs designed using the above communication strategy must include a framework for evaluation. Increasingly participatory and qualitative evaluation strategies are emerging as the most useful for communication initiatives. Evaluation should be ongoing and not designed to assess knowledge, attitudes and practices at the end of the project. Social change created through participation and evaluation

of any communication initiative should also involve participatory appraisal and impact assessment methodologies.

No program is successful without a review at every stage. A continuous and conscious process of monitoring allows program managers to change programs to better serve the needs expressed by the beneficiaries. While communication programs are hard to measure in the short term except for reach, clarity of the messages and the communication should be the primary indicators for success.

Efforts need to be measured in terms of:

Cost of reach: The number of people reached through a particular communication needs to justify the costs incurred by the program. This would also decide the scalability of the program. Since this strategy

promotes involving stakeholders in the creation of content after adequate training, there should also be a measure of sustainability that can be assessed as the program progresses.

What changes will it bring in the society?

Awareness levels and in-depth knowledge must be researched by independent evaluators. The number of people with old and new knowledge and reported shifts in attitudes and behaviors should be measured by research conducted before and after the implementation of the communication program.

Community involvement and change: Stakeholders must assess the communications reaching them and define how much they have learnt or done due to the knowledge and skills received as part of the communication initiative.

Chapter V: Messaging and Campaign Ideas

The consortium partners would encourage users to explore permutations and combinations presented in the communication strategy matrix to come up with a suitable communication campaigns according to individual focus areas. The smaller the focus and the more targeted the population, the better the results of the communication initiative. It is therefore recommended that no generalized messages be developed to cover the entire youth population. Additionally, while the title of this chapter indicates messages, we would encourage communicators to move from top-down messaging to creating discourse and dialogue with youth. Some of the communication ideas presented below encourage the creation of such opportunities within the community.

This initiative is based on research amongst young people in three main age categories in urban and rural areas. However, if the young people being addressed are in high-risk situations like sex work, are on the

streets, are physically or mentally challenged, or are living in extremely remote areas, this strategy and the suggested communication designing would need to be considerably modified.

The following suggestions are designed to inspire greater creative thought and discussion amongst communicators and participants from the community to enable a robust dialogue that will help create an enabling environment that supports change at the community level.

10-14 Years

Key campaign idea:

The biggest gap identified during the research and as elaborated in the previous chapters is that neither the key secondary stakeholders – parents and teachers nor the primary target group – young people in 10-14 year age group - considered it important to have complete information about their anatomy and

10-14 years	Boys	Girls	Secondary stakeholders
Key campaign hook	PRIDE IN GROWING UP		
Key messaging	I am proud to be a growing boy and I know how my body is changing. Do you?	I am proud to be a growing girl and I know how my body is changing. Do you?	<p>Teacher: Growing children have many questions and as a teacher I am proud I don't dismiss the awkward ones.</p> <p>Be a good teacher. Respond to questions about puberty and adolescence.</p> <p>Mother: When my daughter asks me those difficult questions I am proud to be able to answer them well. Don't be afraid. Learn how to tell your children about the changes during puberty and adolescence.</p> <p>Father: When my son asks me those tough questions I am proud I can respond to him confidently. Be a good father and learn about the changes your son goes through during puberty and adolescence</p>
Call to action	Pick up the information booklet at your school, anganwadi center		

reproductive health. Further, there is shame attached to asking questions about growing up. The messages and campaign ideas proposed under this strategy, therefore, are aimed at reducing this sense of shame and creating a need for, and approval of, information dissemination about puberty, adolescence and the changing anatomy.

Supplementary Campaign materials:

***'I am a proud teenager'* Booklet for 10-14 year olds:** This booklet would cover information on sexual and reproductive anatomy; physical and psychosocial changes during puberty and adolescence; nutrition and hygiene. The booklet may also address issues of gender equality and gender roles as well as negotiation with parents and authority figures. It could also contain the basics of HIV and commonly-held myths and misconceptions. If it does, then the HIV basic booklet described below would not be necessary.

The booklet would be designed in simple language with good illustrations. It would be targeted at young people, ideally be pocket-sized, and be made available in the local language. The same booklet would contain materials for both boys and girls. Posters, hoardings and PSAs that are part of the campaign discussed above, may announce the availability of this material and locations for ready access.

***'I am a proud parent/teacher'* Booklet for Parents/Teachers:** The information in this booklet would offer parents an opportunity to learn about the changes their young children go through during puberty and adolescence. This is to enable parents to learn in detail, not just about the changes, but how to respond to various questions asked by young people. The booklet may include mock conversation segments to enable parents and teachers to practice conversations with young people. It may also include preferable responses to any behaviors or activity

undertaken by young people. This could range from sexual exploration and masturbation. Parents and teachers need to learn how to cope with such situations without being morally judgmental. Posters, hoardings and PSAs that are part of the campaign may announce the availability of this material so people can obtain it and increase their knowledge.

Radio series for mothers: Many parents, especially mothers in rural areas are uneducated. Many of them are extremely busy in household and field work. This campaign design therefore suggests a long-term radio program series directed at mothers so that they understand the need for talking to their young growing children about their changing anatomy and the reasons for menstruation, sexual attraction, etc. The radio program must have detailed information for mothers and how they can discuss the issue with their daughters. It could be a chat show that also includes success stories of how mothers were able to respond to questions posed by their growing daughters. The program could also include a section with an expert or a doctor. A radio program is suggested to overcome issues of illiteracy, electricity shortage and mobility. Additionally, women can listen to the program while attending to household work rather than having to sit in front of the television.

IPC materials: Research shows that interpersonal communication channels are most successful with this age group. The communication campaign design therefore recommends creation of tool kits that can be used as part of the interactive sessions conducted by school teachers or *anganwadi* workers or any other trained facilitator. This would require not only the creation of these materials but also an elaborate and well-planned training program to train the facilitators who would use these materials with young people. The materials could include interactive life skill board or floor games, flip charts, flash cards,

suggested theatre activities and a guidebook. There is already a great deal of such material available, much of which has been documented as part of the secondary desk review undertaken by this project. Some of the agencies where different communication material is available are: NACO, UNICEF, Population Services International, Project Concern International, TARSHI, MAMTA, BBC World Service Trust, Family Health International, Kaiser Foundation, Johns Hopkins University, HLPPT, Ideosync Media Combine, Thought shop Foundation, CINI etc.

Content of IPC materials

To build on the proposition discussed above, the content of an IPC tool kit may include information on:

- Changes in the body and mind during puberty and adolescence
- Reasons for this change and accepting the changes
- Emotional and psychosocial changes including feelings of attraction and love
- Nutrition and hygiene
- Myths and misconceptions about growing-up issues, especially menstruation, masturbation, nightfall
- HIV basics and modes of transmission
- Gender equality issues
- Negotiation skills

HIV specific message for 10-14 year olds

The basic premise behind an information campaign for 10-14 year olds on HIV is to familiarize young people with the concept of HIV. The campaign must therefore be worded in a manner to fill the information gaps found during research:

1. Create a campaign with key message that enables the young reader/listener to differentiate between HIV and AIDS.
2. Talk about AIDS as a condition rather than a dreaded disease.

3. Create slogans that promote positive living with HIV rather than HIV as a dangerous disease.
4. The message needs to focus on the fact that anyone can be vulnerable if she/he does not have complete and proper information and the skills to protect himself/herself. This will reduce stigma against high-risk populations (namely, truckers and sex workers) who are currently seen as transmitter of HIV and therefore stigmatized.
5. Additional emphasis must be given to all routes of transmission rather than primarily focusing on the sexual mode of transmission so as to reduce the moral stigma against positive people. This is also because 10-14 year olds do not have a complete understanding of sex and messages around abstinence or safer sexual practices may not make sense to them.

HIV information Key campaign hook for 10-14 year olds

I know about HIV and how it's transmitted. Do you? Knowledge is protection.

The above campaign can be on local electronic media –television and radio PSAs, local wall posters and drawings, hoardings, etc but must be supplemented by a call to action.

Call to action: *Pick up the information booklet at your school, anganwadi center*

Key information focus: Four modes of transmission

Additional campaign materials: The basic HIV booklet that discusses modes of transmission of HIV and provides correct information on commonly held myths and misconceptions. This book should be designed in simple language with illustrations as a read-it-yourself material for 10-14 year

olds. This could be combined with the booklet described earlier or could be specific stand alone HIV material.

15-19 Years

Key campaign idea: 'It's my life and I can live it responsibly!'

The main campaign idea is to instill a sense of responsibility and active information-seeking behavior among the 15-19 year old boys and girls. If this campaign key idea is used, it needs to have a linked service that offers greater and more detailed information. The linked service could be a youth helpline, youth club where information on HIV is part of regular club activities that allow for dialogue

and sharing, or even a detailed booklet that is easily available at public outlets.

Main messages:

15-19 year old boys: Research shows that boys in this age group are strongly influenced by peers and role models. The campaign idea suggests creation of a role model as part of the campaign. The following role model campaigns are suggested:

Role model of the real man: The real man (*asli mard*) is one who does not tease girls; who has the correct information about HIV; who is not afraid to ask for information; who does not take risks; who is gender sensitive and shares emotions and concerns

15-19 years	Boys	Girls	Married Girls	Secondary stakeholders
Key campaign hook	'It's my life and I can live it responsibly!'	It's my life. Why be shy		
Key messaging	'Be your own hero'. 'Take Control'		My husband has promised to be faithful. We know he can bring HIV into the family if he is not careful	<p>Peer: A real friend is one who does not persuade his group to take unnecessary risks; who does not promote smoking drinking or experimenting with sex; are you a real friend?</p> <p>Bhabhi: I must learn to talk to her about HIV and STIs. It is the right thing to do. If I don't, who will?</p> <p>Mother: My daughter will not marry young. I must protect her from HIV till she has the confidence and skills to protect herself</p> <p>Husband: I am supportive of my young wife. She has the right to be safe from HIV and I am responsible to ensure her safety.</p> <p>Mother-in-law: I don't know much about HIV but my young daughter-in-law should. Staying safe from HIV is her right.</p> <p>Registered Medical Practitioner: I am a responsible RMP. I do not give false cures or wrong information.</p>
Call to action	Pick up the resource booklet, join the local youth club, visit the local STI clinic			

with his partner; who is willing to wait for marriage before having sex, etc.

All these can be campaign stringers or become part of a series of PSAs in the electronic and print media. The campaign slogan for the real man could also be around the image of a hero with slogans like **'Be your own hero'. 'Take Control'**. This campaign of role models supports the idea of not being easily swayed by peer pressure.

Role model of the real friend: Since friends and peers are the strongest influencers, especially for boys in this age group, one of the suggested campaign role models is that of a friend. *A real friend is one who does not persuade his group to take unnecessary risks; who does not promote smoking drinking or experimenting with sex; are you a real friend?*

Role model for abstinence: Research also shows that having a career is one of the most important issues for young people. The campaign can also be designed around a series of messages that ask young people to concentrate on their careers and delay sex. Similar campaigns can be run in urban areas for both boys and girls where young girls also aspire to a career.

Call to action: The above campaign must be linked with the service delivery and interpersonal communication activities that help build greater community dialogue and positive action on the ground. If *yuva* and *yuvati* clubs are established, as suggested below, the campaign materials must call on young people to join their local club. If a community radio has been set up and young media leaders are being trained, the campaign PSAs and posters must inspire young people to join the community radio teams. All communication would be incomplete for this age group unless there is

a call for action, either to pick up the resource booklet, to join the local youth club, to visit the local STI clinic, etc.

15-19 Year Old Girls

The approach for young girls in this age group needs to be slightly modified given that not only are they less influenced by their peers in comparison to boys, but their mobility is highly curtailed, especially in rural areas. Their main source of information and role model therefore is either an older sibling or close relative of the same gender, e.g. a *bhabhi* or older sister. Research shows that a large number of girls in both urban and rural areas enjoy watching television soap operas. The two campaign strategy ideas therefore proposed are:

1. Encouragement to overcome shyness: ***"It's my life. Why be shy?"***

Similar to the key campaign hook idea for boys, this campaign hook must be linked to local services offered at the anganwadi center or through the establishment of *yuvati* clubs. This is to ensure that the mass campaign allows the girls to access more information through IPC activities.

2. **Electronic mass media:** Creation of a long-standing television soap opera or radio chat show that discusses risks to HIV infection especially for young women, even within what they consider monogamous married relationships. The soap opera must be created along the popular entertainment-education approach and must promote conversations with spouses, skills to negotiate safer sexual practices and an in-depth understanding of how the virus spreads and its modes of transmission. The soap opera must also link STIs and risk to HIV. Since most young girls in this age group, at least in peri urban, small town and rural India

are getting ready to get married; the soap opera could be titled '*Shaadi ke baad*'. While this will create mass appeal and immediately draw young audiences, the content must be designed to **reverse** the gender dynamics that exacerbate the vulnerability of young girls to HIV.

3. **Mass media campaign around a *bhabhi* role model:** A skill-based campaign that encourages older siblings and married relatives of young girls to equip themselves with information on HIV and STIs and educate their younger siblings. *I must learn to talk to her about HIV and STIs. It is the right thing to do. If I don't, who will?* This campaign should also be aimed at creating an environment that encourages young girls to ask questions and equip themselves with the information they need for a healthy sexual life after marriage.

Secondary stakeholder population: The key message for the secondary stakeholder population for young girls in this age group would be to the parents to promote delaying the marriage of their daughter. Protection from HIV can be used as a good motivation to delay marriage.

Role model of a parent: *My daughter will not marry young. I must protect her from HIV till she has the confidence and skills to protect herself.*

Key information for boys and girls in this age group, primarily through IPC activities:

- Details about sex and sexual intercourse in order to help increase understanding around abstinence and condom usage
- Details of HIV (all transmission routes, differences between HIV and AIDS, effects of the virus on the body, understanding what exchange of body fluids means;
- VCTC (counseling, details about virus testing and window period)

- Positive living, positive role models of people living with HIV, and stigma reduction
- STIs (details of symptoms and treatment, linkage between STIs and HIV)
- Gender equitable roles and responsibilities of young married men
- Additional information on pregnancy, contraception, condom use, abortion

The above information must be included in the peer educators' toolkit or simple handout booklets that young people can read by themselves. The booklets need to be in local languages.

Community radio

Community radio is an excellent tool to involve poor and disadvantaged people in a dialogue on issues that impact their lives. It has already been seen that behavior change is not possible unless communities acknowledge the validity of new behaviors and are able to create an environment that sustains them. Community radio not only gives a voice to local communities but enables the conversion of messages into active dialogue. This communication strategy therefore recommends involvement of young people, especially youth in the 15-19 year age group in local community radio activities; training them as youth media leaders and encouraging them to make programs on how young people are vulnerable to HIV or around issues that concern them most, including reproductive and sexual health. This will be an innovative way of combining broadcast media with interpersonal communication that would enhance the advantages of both these forms of communication for optimum results. The community radio efforts for HIV prevention would involve training groups of young people as youth media leaders with skills in designing and producing audio content. They would also need to be trained on the various issues about HIV including virus transmission, gender, vulnerability of

young people, myths, misconceptions and other HIV and sexual health-related information details. There have been excellent stories of such efforts with young people reaping enormous benefits in terms of creating an enabling environment within which young people are able to ask questions without fear of castigation or moral chastisement. Examples like the *Saathi Sanga Man Ka Kura* radio program in Nepal supported by the UNICEF and now established under Equal Access Nepal is one such successful initiative.

Interpersonal communication for secondary stakeholders:

One of the most important components of any communication strategy is the engagement of the primary audiences in a continued dialogue and discussion on the issue and to create an environment that is conducive to learning through a process of sharing and debating ideas. The concept of youth clubs is not a new one; however, there needs to be sustained effort in dovetailing youth club activities with young people's priorities and include skill building, vocational training and livelihood skills into efforts aimed at HIV prevention. Additionally, if *Yuva* and *Yuvati* clubs function around ongoing communication programs like a long running television or radio series, it allows young people a point of discussion and debate and inspires greater participation at the club level. The establishment of such clubs would also require creation of IPC communication materials to be used to train club members on various issues. These could include a peer education toolkit that has interactive board games, cards, or suggested community activities that the club can undertake at the village or colony level. Strategic training and training materials, *Yuva* and *Yuvati* clubs and peer education models are also important. It is essential that the IPC material include not just information on sexual and reproductive health but also other materials of interest to 15-19

year olds. The material should also have a guide on how a local *Yuva* club should be set up with simple management and structure guidelines that will allow such clubs to gain local recognition and evolve a sense of formality and identity.

Local Rural Medical Practitioners (RMPs): One of the key secondary stakeholders identified for 15-19 year old boys are the local RMPs who do not necessarily have adequate information about HIV but become de facto conduits for information to young boys, often offering remedies for non-existent ailments. It is important to generate communication and training materials for local RMPs to help them improve their knowledge levels about HIV. Mass media campaigns using posters and wall writings could be used for influencing RMPs to be responsible: *I am a responsible RMP. I do not give false cures or wrong information.*

Local magazine agony aunt columns: Another important source of information for young girls and boys in this age group are agony aunt columns in popular local language magazines. Many such columns also propagate myths and misconceptions. This communication strategy proposes creating an advocacy campaign for editors of such magazines to be vigilant about the information carried in their agony aunt columns. Additionally, a simple true or false frequently asked questions booklet could be supplied to all writers of such columns so they are able to provide correct guidance to their readers.

15-19 Year Old Married Girls

The information and communication needs of young married girls are guided by their increased vulnerability within marriage and lack of negotiation skills. The communication strategy therefore proposes two additional communication designs over and

above what has been suggested for the 15-19 year old unmarried girls:

Addressing their increased risk through creating greater self-risk perception: Research shows that young girls do not think of themselves as being at risk since all the HIV prevention messages talk about being faithful to one partner. In the Indian context a large number of women in marriages are monogamous and hence do not perceive themselves at risk. Empowering women to talk about this issue with their spouses will help in reducing their vulnerability to the virus. Mass media campaigns, especially on television and radio through PSAs or long-standing soap operas that encourage young women to consider risk situations are suggested strategies. Two suggested campaigns are:

PSA-based campaign directed at young married girls: *“My husband has promised to be faithful. We know he can bring HIV into the family if he is not careful.”*

This could be on PSAs on electronic as well as in the print media but must also include a call to action, inviting young girls to visit the local VCTC for counseling and testing.

Another important issue that married girls in this age group need to deal with is treatment seeking for STIs. A PSA campaign inspiring greater treatment-seeking behavior followed by availability of services would strengthen the response to HIV prevention as well as help audiences make the connection between the presence of STIs and greater vulnerability to HIV.

“I know the symptoms of STI and as soon as I noticed them in my husband we went to the nearest STI clinic. You can be proactive too.”

Cure STI early and protect your family from HIV.

Secondary stakeholders: The key stakeholders identified for this group are the husband and the mother-in-law. These two members of a young girl’s family not only control her access to information but are also responsible for regulating her decision-making abilities.

A campaign creating positive role models for the mother-in-law and the husband may help a young married girl have more status in the family:

For husband: *I am supportive of my young wife. She has the right to be safe from HIV and I am responsible to ensure her safety.*

For mother-in-law: *I don’t know much about HIV but my young daughter-in-law should. Staying safe from HIV is her right.*

Supplementary materials: Short concise booklets giving names, symptoms and cures of most common STIs as well as details on why the presence of STI increases risk to HIV should be available at STI clinics and at local *paan* shops for husbands to take. These booklets should also include detailed information on HIV, routes of transmission, VCTC facilities and ART. This material is also useful for the next age group of married 20-24 year old young people.

20-24 Years

Key campaign idea: *The Future is in our hands*

The proposition gives a sense of control and an ability to guide one’s own safety. Additionally, it addresses both men and women simultaneously as young couples.

The main aim of such a campaign is to increase conversation about HIV and risk among young married couples. Since couples like to see themselves as planning for their future, this communication proposition includes conversation about HIV within their larger

20-24 years	Boys	Girls	Secondary stakeholders
Key campaign hook	The Future is in our hands		
Key messaging	Role model couple: We talk about everything including HIV and how to keep safe. That's what good marriage is all about		
Call to action	Visit the nearest VCTC center for more information/meet the peer couple in their locality/obtain the HIV booklet from their nearest chemist		

economic and family goals bringing the health of the other spouse onto center-stage of that planning. This proposition can be used in designing electronic mass media spots and PSA or hoardings and posters.

Role model couple: Creation of role model couples is suggested as another campaign idea:

“We talk about everything including HIV and how to keep safe. That’s what good marriage is all about.”

All mass media PSA campaigns must as a rule have a call to action - asking couples to visit the nearest VCTC center for more information or to meet the peer couple in their locality or to obtain the HIV booklet from their nearest chemist.

Television and radio talk shows about couples:

The entertainment-education approach needs to be used while creating a series of chat shows directed at married couples. Both radio and television may be used to create an entertaining show about how couples negotiate and solve issues. Many of the episodes should be devoted to HIV and include the experiences of positive couples. The shows should also create role-model couples who are able to talk openly about their fears and the need for their spouses to remain faithful, couples who negotiated to go to the VCTC centers and get tested, etc.

IPC - Peer couples: It is important to have an IPC component to the mass media campaign addressing

young married couples. This IPC intervention effort should be directed at training young couples on discussing HIV as an issue with other couples. Their training should include talking to other couples about negotiation for safe sexual practices and using counseling and testing facilities. The trained couples should have detailed information on HIV and about services available in their villages, towns. This new concept is being suggested as many couples in small towns engage in kitty-party activities or some kind of couple savings groups schemes, and whether the peer couples are alone or present at such meetings, as a couple their role should be to start a discussion on HIV and risk and create greater discussion and awareness about the VCTCs.

Supplementary campaign material:

A short, concise and well-written booklet for adults titled *“Everything you wanted to know about HIV”*. This booklet should be available at local chemists and book stores. It should be tastefully illustrated and detailed in its approach to HIV. The following information content must be included in it:

- HIV and modes of transmission
- How the virus acts on the body
- Difference between HIV and AIDS
- STIs and linked HIV risk
- STI symptoms and treatment
- HIV tests and benefits of testing
- Voluntary counseling and testing process and services

- HIV treatment and drugs
- Myths and misconceptions

The above communication campaign ideas are by no means exhaustive or directives. They are designed as a starting point for communicators to begin the process of using this communication strategy while developing HIV interventions in the field. Some

materials are already available, many others can be locally created, and it is our advice to all users of this strategy to take the time to involve communities in the pre-testing of all communication designs and materials. They must also involve communication, behavior change and HIV experts at some stage of the process for appropriate training programs.

Chapter VI: Integrated Mass Media and IPC Model

6.1 Behavior Change Communication and Participatory Methodologies for Social Change

It is now widely recognized that the perception of self-risk and vulnerability to HIV is the first step towards adopting behavior change. This is difficult in a region where, based on the dollar-a-day benchmark, 40% of the world's poor reside. In India, like elsewhere in South Asia, social and economic vulnerabilities lie at the root of extensive commercial sex, population movements (cross-border/rural-urban migration) and trafficking, which fuel the HIV/AIDS epidemic. Under the UNAIDS Communications Framework for HIV/AIDS: A New Direction published in December 1999, it was concluded that:

“Based on a review of the literature and of experiences in the field, most current theories and models [of HIV communication programming] did not provide an adequate foundation on which to develop communications interventions for HIV/AIDS in the regions...”

Chief among the weaknesses identified were that:

The simple, linear relationship between individual knowledge and action, which underpinned many earlier interventions, does not take into account the variation among the political, socio-economic and cultural contexts that prevail in the regions. External decision-making processes that cater to rigid, narrowly focused and short-term interests tend to overlook the benefits of long-term, internally derived, broad-based solutions. There is an assumption that decisions about HIV/AIDS prevention are based on rational, volitional thinking with no regard for more true-to-life emotional

responses to engaging in sexual behavior. There is an assumption that creating awareness through media campaigns will necessarily lead to behavior change. There is an assumption that a simple strategy designed to trigger once-in-a-lifetime behavior, such as immunization, would be adequate for changing and maintaining complex, life-long behaviors, such as consistent condom use. There is a nearly exclusive focus on condom promotion to the exclusion of the need to address the importance and centrality of social contexts, including government policy, socio-economic status, culture, gender relations and spirituality. Approaches based on traditional family planning and population program strategies tend to target HIV/AIDS prevention to women, so that women, rather than men, are encouraged to initiate the use of condoms.

Despite recognizing these limitations, in practice isolated, top-down information dissemination seems to be the preferred communication framework adopted by most programs. Messages reading “I care, do you? Let’s join hands against HIV/AIDS” dot the region.

There are several stories of HIV-positive people who, despite having heard of HIV, did not know how to protect themselves and tested positive, and only then recognized HIV as a real threat to themselves. Very often the refrain of young people and others who hear about HIV through such top-down slogans/messages is that they know about the infection but that they themselves are not vulnerable because ‘the virus is either not prevalent in their region’ or that they are educated and from ‘good’ families, etc. This sense of false immunity clearly indicates the failure

of our communication strategies which therefore need to move away from top-down messaging that does not allow reflection or self-risk perception to a communication strategy that generates debate and community dialogue, which will allow audiences to think at length and with greater involvement. Communication strategies need to be redirected so that they give prominence to the creation of communication environments which encourage interpersonal communication, dialogue and debate, and which focus as much on providing a voice to those most affected by HIV as they do on educating through messages. The evidence increasingly suggests that only when people become truly engaged in discussions and talk about HIV, does real individual and social change come about.

Vulnerability to HIV is greatly exacerbated by gender and other inequalities, and any attempt to overcome such health issues without tackling the underlying causes represents only a superficial solution. Messages about HIV/AIDS prevention, international campaigns on HIV/AIDS and men or HIV/AIDS and stigma are valuable, but are insufficient when divorced from approaches that respond to the underlying structural issues. Rather, there is an urgent need for supporting interventions that facilitate communication on HIV/AIDS in a manner that adapts and responds to the inequalities within each setting.

Communication strategies need to be redirected so that they give prominence to the creation of communication environments which encourage interpersonal communication, dialogue and debate, and which focus as much on providing a voice to those most affected by HIV as they do on educating them through messages.

Sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication. Communication for social change should be empowering, horizontal (versus top-down), give a voice to the previously unheard members of the community, and be biased towards local content and ownership. Communities should be the agents of their own change. Emphasis should shift from persuasion and the transmission of information from outside technical experts to dialogue, debate and negotiation on issues that resonate with members of the community. Emphasis on outcomes should go beyond individual behavior to social norms, policies, culture and the supporting environment.

The strategy detailed in this document therefore gives an equal if not greater emphasis to activities that create opportunities for community dialogue and interpersonal communication. The strategy also details how mass media can be used in a manner that is more participatory than top-down. The introduction and use of community electronic media including community video and radio can play a key role in ensuring such long-term and sustained involvement of community members in the creation of communication content.

It is also essential that all mass media campaigns be accompanied opportunities for access to more detailed and comprehensive information. The research undertaken by this consortium clearly indicates that while we have succeeded in creating awareness through the aggressive HIV campaigns conducted over the last five years, young people are still unclear about details and therefore unsure of how to protect themselves. They have heard about HIV but their information beyond that is at best hazy, incomplete and full of misconceptions. The communication strategy detailed above therefore addresses social attitudes that stigmatize discussion on sex while simultaneously

providing opportunities for dialogue and information sharing within communities especially in environments that are friendly to young people. This is also one of the reasons why key secondary stakeholders are considered such an important element of the communication strategy detailed above. The emphasis is less on individual behavior change and more on an environment that will support and encourage that behavior change to take place. Participation is the key to the creation of such environments and the strategy proposed does not envisage participation as passive or merely the presence of the audience but active roles for the user groups in the communication process, as learners, peer educators, content creators, youth club members, active social influencers, etc.

6.2 Strategic use of Radio and Television: Suggested Integrated Communication where Mass Communication is Linked with IPC

It is now well known in communication studies that interactivity is the key to the success of any communication. Traditionally, mass media is a one-way communication tool. However, the entertainment industry has increasingly found various means to make mass media interactive, using other technologies in combination with the broadcast programs. There are phone-in shows, online polls, mobile video technologies, live coverage and many other ways to help audiences participate and involve themselves with the mass media. However, HIV communications have yet to use this structure and the new technology model to create an interactive forum. The communication strategy proposed has therefore created two focus areas – the focus for community media where audiences are involved directly in the content creation activities through community radio and community video, and that of integrating mass media with interactive IPC. This could be done in two ways:

1. Integrate mobile telephone technology with mass media campaigns where every program's call to action involves listeners to call in with their queries, suggestions, stories, etc. Programs inspire young people to form clubs, provides stories of success and role models for young people to emulate, re-broadcast programs which have been successful in the interactive process thus creating an interactive loop for audiences to feel part of the ongoing communication.
2. Create trained community media leaders who inform and create content directly at the community level, involve HIV-positive people in this process as experts on the various issues on HIV, giving them not only a voice but a place of honor in the community. Thus they fight stigma not through slogans but through action.

The use of the radio has also been limited in India thus far, especially for development and for HIV prevention despite the fact that the All India radio signal covers 95% of the total Indian population. Radio programs can help communities to access useful health information, promote behavioral change and widen access to health services. While TV signals are often confined to urban areas and electricity remains a challenge to television viewing in rural areas, the radio is seen as a permanent and mobile information provider. A significant expansion of radio-based interventions for health at the national and community levels must be encouraged. In other parts of the world, particularly in Africa and Latin America, radio is showing that it can be a cheap and effective means of providing health information and stimulating both community dialogue and national debate on health policy issues.

Communicators need to work with communities to understand the epidemiological, behavioral and risk-taking factors that drive disease and ill

health and design communication products that build on this knowledge.

The consortium argues for:

- popular radio formats such as soap operas and mini-dramas that support and create community dialogue on health issues
- radio listening clubs and distribution of radios in order to encourage communal listening
- building partnerships between specialist health NGOs, UN bodies and health ministries to develop accessible information
- establishing health information 'clearinghouses' or 'content banks' for health broadcasting/mass media that can be accessed through Internet or CD-ROM and which contain information, scripts, audio clips and radio production guidance
- training radio station staff in broadcasting for health issues and methods.

Both radio and television programs should be made interactive and participatory and linked to on-the-ground IPC activities as suggested in the communication strategy in order to enhance the impact of the communication campaigns.

6.3 Use of Print Media

The use of print media for communication has to be extremely strategic as it caters only to a literate audience. However, new experiments in pictorial print media have managed to go beyond the literacy limitation. Pictorial storytelling, comic books that are entirely picture based with no writing, flash cards for out-of-school or street-based young people have proved to be extremely useful resources. Once again the emphasis on developing content needs to be participatory. In the print media it is easier to fall into the 'expert says' trap and create campaigns from within office settings without extensive contribution

and involvement of the young people whom the campaign is addressing. Some of the ways in which print media can be made interactive is through creating wall newspapers where young people contribute to the content creation activity. Involving editors of local language newspapers to create spaces for young HIV-positive people to anonymously share their stories and experiences could be another way of creating interactive spaces within the print media.

National mainstream newspapers cover a lot of social and sexually implicit materials but do not address HIV vulnerability with the same vigor. The national print media is widely read by educated urban young audiences and influence a lot of what they know and believe in. Editors therefore need to ensure that question-answer columns and information spaces for interaction on HIV are regularly made available in the mainstream media where young people have the opportunity to anonymously ask and get responses to their questions.

New technologies: While much of this document has been dedicated to traditional media largely because a large proportion of India's young still live in small towns and rural areas, the communication strategy would be incomplete without the mention of possibilities to use new media technologies for reaching young people. The mobile phone, Internet, gaming and other new mix

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media technologies are becoming available to a large population in India extremely rapidly. Young people also have an avid interest in learning and accessing these new technologies. Using these new media and the high levels of interest that young people have in learning and accessing the new media could go a long way in creating innovative channels for dissemination of HIV information, as

well as creating new platforms for dialogue where face-to-face interaction may not be required. The consortium and the authors of this document encourage the users of this communication strategy, especially those intending to work with urban youth, to incorporate the use of the Internet and mobile phones as channels for interactivity and communication on HIV.

Conclusion

The most effective responses to HIV/AIDS are those that emerge from within societies; and they tend to be long term, complex and difficult to evaluate. Although communication programs are difficult to evaluate in the first place, they can be effective only if they are participatory and not top-down. Since it has been recognized that measuring behavior change is not possible over a short span, many stakeholders and communication leaders are currently working on models for impact assessment and evaluations of innovative communication initiatives that create dialogue and community action, which have longer term but success oriented implications.

However, the lack of adequate indicators should not detract from the proven efficacy of more participatory content creation and communication strategies and integrated mass media and IPC models. Only through changed practice will we be able to evolve better and more replicable models that create greater impact for HIV prevention.

Changes in behavior have happened when information is passed between people, rather than been directed at them. It is often argued that mass media campaigns are not effective in directly changing individual sexual behavior, and this is sometimes true. However, the media is critical in stimulating public debate and dialogue, and in challenging the kind of long-established social norms that prevent more widespread changes in behavior. In 2001, a major meeting of donor, multilateral and international communication organizations and practitioners came together in Nicaragua for

the Communication for Development Roundtable organized in part by the Panos Institute (with UNFPA, UNESCO and the Rockefeller Foundation). The conclusion of the meeting was summarized in its final declaration:

“Existing HIV/AIDS communication strategies have proved inadequate in containing and mitigating the effects of the epidemic. For example, they have often:

- treated people as objects of change rather than the agents of their own change;
- focused exclusively on a few individual behaviors rather than also addressing social norms, policies, culture and supportive environments;
- conveyed information from technical experts rather than sensitively placing accurate information into dialogue and debate;
- tried to persuade people to do something, rather than negotiate the best way forward in a partnership process.

Progress in slowing the epidemic will require a multi-sectoral response and use of communication to tackle the behaviors related to the spread of the epidemic and to address its causes (inequality, prejudice, poverty, social and political exclusion, discrimination, particularly against women).”

These are the gaps that the communication strategy presented as part of this document has tried to address. We hope that users of this document will go beyond the suggested framework and innovate, based on the principles guiding the entire work presented here.

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