COMMUNITY NEEDS ASSESSMENT ON HIV/AIDS IN MIZORAM

Report of the Research Project Submitted to Mizoram State AIDS Control Society (MSACS)

CENTRE FOR PEACE AND DEVELOPMENT (CPD)

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ABBREVIATION

AIDS	:	Acquired Immuno Deficiency Syndrome
BBEC	:	Bible Believing Evangelical Church
BC	:	Behavioural Change
BCM	:	Baptist Church Of Mizoram
CBO	:	Community Based Organisation
CNA	:	Community Need Assessment
CSW	:	Commercial Sex Worker
EFCI	:	Evangelical Free Church Of India
FGD	:	Focus Group Discussion
HIV	:	Human Immuno Virus
ICMR	:	Indian Council Of Medical Research
IDU	:	Injecting Drug User
IEC	:	Information Education And Communication
IKK	:	Isua Krista Kohhran
LIKBK	:	Lairam Isua Krista Baptist Kohhran
MHIP	:	Mizo Hmeichhe Insuihkhawm Pawl
MSACS	:	Mizoram State Aids Control Society
MUP	:	Mizo Upa Pawl
MZP	:	Mizo Zirlai Pawl
NGO	:	Non-Governmental Organization
NICD	:	National Institute Of Child Development
OD	:	Over Dose
PPTC	:	Prevention Of Parents To Child Transmission

RD	:	Rural Development
SA	:	Salvation Army
SDA:	:	Seventh Day Adventist
SNEP	:	Syringe Needle Exchange Programme
STD	:	Sexually Transmitted Disease
UNODC-CHARCA	:	United Nations Office On Drug And Crime- Coordinated Hiv/Aids Response Through Capacity Building And Awareness
UPC	:	United Pentecostal Church
YMA	:	Young Mizo Association
ZDU	:	Zoram Drivers Union

COMMUNITY NEED ASSESMENT ON HIV/AIDS

I. Introduction

The study *Community Needs Assessment on HIV/AIDS* was conducted throughout the state of Mizoram. The purpose of the study is to assess the needs of community in terms of information and communication for HIV/AIDS prevention. The study assesses the existing communication materials, and evaluates the effectiveness of the present strategies for HIV/AIDS prevention by assessing the level of awareness on the part of the community at large. Finally it attempts to suggest systematic ways and strategies for information dissemination for prevention of AIDS through awareness generation and attitudinal and behavioural change.

Objectives

The objectives of the study are- to assess variations in the levels of public awareness on HIV/AIDS, to analyze the social distance between general public and people living with HIV/AIDS (PLWHA), to identify the effectiveness of various channels of communication especially the existing IEC materials provided by MSACS, to find out the public preference of channels of communication for dissemination of information on HIV/AIDS, to suggest strategies of communication for promoting enabling environment.

II. Methodology

Both Qualitative and quantitative approach was used. The qualitative data were collected through focus group discussions (FGD) with youth, women, and community leaders, people working in the field of HIV/AIDS while the quantitative data was collected with field survey with structured interview schedule from the sample.

Sampling

A multi-stage stratified random sampling procedure was followed in the study. At all levels a proportionate stratified of random sampling into rural and urban areas has been attempted. All the eight districts of the state of Mizoram were chosen as the focus of the study. One representative block in each district was chosen on the basis of female literacy. The block with female literacy closer to the district female literacy was considered as representative block of a particular district.

The villages and urban localities were again chosen on the basis of female literacy, same procedure as selection of blocks. In each village and urban locality sample household list acquired from the VCP were selected on the basis of systematic random sampling.

Tools of Data Collection

The tools used in the collection of primary data are the structured interview schedule and Focus Group Discussion Guide.

The structured interview schedule was administered by 16 trained field investigators. The schedule covered information on the demographic social and economic profile of the respondents, public awareness on HIV/AIDS, Beliefs and Misconceptions on HIV/AIDS, Social Distance with PLWHA, Exposure to Communication Channels and People's Preference on Communication channels.

Focus group discussion was carried out to obtain qualitative data and a guide was used. Two FGDs were used one for the leaders of NGOs and personnel working in the field and another for the community leaders, women and youth.

III. Review of Literature

In chapter II, the available literature on HIV/AIDS was presented on local, national and international basis. The review of literature was presented in a manner that study conducted by research teams, scholars etc are reviewed and research gaps are highlighted in the context of Mizoram. Besides, any information on HIV/AIDS published in the mass media is presented and the Information Education and Communication materials prepared by the Mizoram State AIDS Control Society were also analysed.

IV. FOCUS GROUP DISCUSSION WITH PERSONNEL IN THE FIELD OF HIV/ AIDS

A number of FGDs were organized with the leaders of NGOs and other personnel working in the field of HIV/AIDS. All together, there were 98 participants. The focus group with this particular group greatly focuses on IEC materials, obstacles for Behaviour change and also on new suggestion for strategy in HIV/AIDS education and awareness.

All the participants in all the districts have shared in unison that the people are not reading them and are now considered as boring by most of the general population. Most of the NGOs do not have a monitoring mechanism for the dissemination of their IEC written materials. IEC pictures are mainly imported and thus show pictures of non-Mizo people. It was suggested that IEC have to be written and pictures given according to the culture and tradition of the people. It was shared that updating the IEC materials is needed. Awareness campaigns according to the group do not reach the people who needed it most. Due to fear of being stigmatized, it is difficult for a person to go out and buy or take condoms. The Church was not playing active part in providing sex education, prevention and care of HIV/AIDS too.

Regarding the cases of HIV/AIDS, it was shared that the medical workers and those who are working in the hospitals do not maintain confidentiality. It was shared that people do not have access to condom nor do they have adequate training on prevention of HIV/AIDS.

Suggestions

In the light of the Focus Group Discussion a number of suggestions are put forth like- House to house awareness campaign, modification of the contents and strategy of awareness campaign, establishment of youth Red-Ribbon club, more focus on rural areas, focus on migrant population, condom promotion, VCTC to be made more people friendly, Mobile Testing Centre, Sensitizing Church Elders and Leaders, Awareness campaigns through CBOs such as YMA, IEC Written Materials shall be Gender specific, Cultural and regional age specific.

Regarding IEC-Media, the suggestion was that the advertisement that has to be given out should be tested first. Each and every worker in all districts should be given the theme for advertisement. It should be only after the acceptance of the workers in such unit that the advertisement should be given out.

V. RESULTS OF FOCUS GROUP DISCUSSIONS

5.1. COMMUNITY LEADERS

The results of the Focus Group Discussion may be summarized briefly. The awareness level of community leaders on HIV/AIDS is at a reasonable extent. All the

modes of transmission such as sexual contact, sharing of needle and syringes, mother to child, blood transfusion were well recognised but still hold certain myths and misconceptions like HIV/AIDS can be spread by living and sharing together, people with fewer blood cells, three interrelated processes of liberalisation and secularisation of Mizo social structure, weakening family ties, and increased mobility of women were perceived by the leaders as responsible for spread of HIV/AIDS in Mizoram.

Suggestions and recommendations

In the light of the Focus group Discussion many suggestions were put forth like- Isolation of PLWHA, publishing the names of PLWHA, promoting enabling environment, employment opportunities for youth, isolation of high risk group and restriction of their mobility, setting up of Drop-in centres and AIDS Cell under the purview of NGOs, Compulsory Blood Test**,** Condom distribution**,** Syringe Needle Exchange, distribution of gloves for the Community Leaders for preparing the dead corpse, active involvement of the church, networking and cooperation among various organizations-Govt. and non-government, Promoting Cultural Ethos and Values, Channels of Communication to be more systematic and beneficial for the grass root level**,** Education in School on HIV/AIDS.

5.2 WOMEN

Focus Group discussion with women was conducted in all the districts. The participants were 185 in numbers. The results can be summarized as under: Although there are several myths and misconceptions with regard to the mode of transmission, all the routes of transmission of HIV/AIDS have been well recognized.

There are many myths and misconceptions like- HIV/AIDS can be spread through mosquito and leeches bite, Sharing Toilet, Smoking Cigarette**,** As easy to Infect as Common Cold**,** Kissing and Oral Sex**,** Women have High Blood Pressure and vulnerable to this disease**,** Indirect Infection During Menstruation.

Among the reasons for HIV/AIDS infection as discussed women are- vulnerability of women (which is because of insincerity of male partner), Mobility and Freedom of Men in the Society HIV/AIDS Associated with immoral Character HIV/AIDS is spread by Mobile Workers-truckers, Contractors etc**,** Accident or Carelessness etc. It was shared that those infected persons are mostly seen to be drug and alcohol abusers, sex workers, persons of loose character etc and are seen to reap what they sowed.

Suggestions

Many suggestions and recommendations as put forth by the women members in the Focus Group Discussion may summarized as- Publication of Names of PLHA**,** Isolation of PLHA**,** adopting Positive and Humanitarian Attitudes towards PLWHA, Role of women to be emphasised in generating awareness on HIV/AIDS, Family Education**,** Promoting Condom**,** Family Counselling**,** women centred Awareness programme

5.3 YOUTH

The youth share the various modes of communication of HIV/AIDS in the group discussions and they are more familiar to the transmission of the disease though there are

some myths and misconception like mosquito bite, sweat and perspiration**,** kissing etc can spread it.

The factors responsible for the rapid spread of HIV/AIDS as discussed by the youth are- Lack of Sex Education at the grass root level and the community at large, indulgence in loose behaviour like pre-marital sex, exposure to pornographic movies and pictures, unprotected sex, Mass and Electronic Media Impact**,** Generation Gap direct impact on family**,** Excessive Freedom and Lack of Recreation Facilities**,** Lack of Employment**,** Prevalence of Traditional Values on Sex among Male Youth, Negligence and Ignorance of youth by Parents.

Many suggestions are put forth for preventing the further spread of HIV/AIDS like- Education to Parents on Parenting Skills- restructuring of Mizo family system*,* Sex Education**,** Condom Promotion-more accessible to the masses to avoid unsafe sex.

VI. RESULTS : CONCLUSION AND SUGGESTION

Here the findings and results of the core study conducted through structured interview schedule can be summarized as under:

The profile of respondents has been discussed on the basis of demographic characteristics of the respondents like gender, age group, locality and educational status of the respondents are discussed. As a whole male population constitutes higher number. This over all patterns was invariably observed in the cases of all the districts

Age of the respondents has been classified into four age groups viz. Adolescent (13-18), Youth (18-35), Middle (35-60) and aged (60 and above). Youth group constitutes highest number followed by Middle age. Regarding locality of the respondents it is classified into rural and urban locality. On the whole more than one half of the respondents live in urban settlement. As regard the educational status of the respondents again it was classified into six levels viz. Illiterate, Primary (1-4), Middle (5-7), High School (8-10), HSSLC (11-12) and College and above. It was observed that almost all the respondents are literates. But most of the respondents had not gone beyond high school.

For understanding of social structural basis of respondents, analysis of social structural characteristics of respondent's viz., sub tribe, type of clan and denomination has been attempted. Religious Denomination professed by the respondent has been classified into twelve categories viz, Presbyterian, Baptist, United Pentecostal Church, The Salvation Army etc. Presbyterian Church is the largest denomination in Mizoram and Baptist is the second largest denomination, which is also highlighted by the result.

The respondents belong to different Sub- tribe viz, Lusei, Lai, Hmar, Ralte, Paihte, Mara, Pang, Gangte, Kuki, Non-Mizo and Bru. Majority of the respondents belong to Lusei sub-tribe, followed by Lai and Hmar.

Economic characteristics of the respondents have been measured in terms of type of occupation and level of household income. The occupation of the respondents is classified into nine items and it was found that most of the respondents are cultivators, which is followed by Government service and Businessperson. The annual income of the respondent has been classified into four categories viz. Less than 24000, Rs 24000-48000, Rs 48000-100000 and Above 100000. Most of the respondents are with income of Rs 48000-10000.

The awareness of the respondents on HIV/AIDS was measured in terms of four dimensions. The result indicates that the most of the respondents have knowledge on

AIDS and *HIV* but majority of the respondent does not know the difference between HIV and AIDS and the problematic of no cure. Regarding the Symptoms of HIV/AIDS again the result indicates that most of respondent do aware of both the symptoms.

Regarding the mode of transmission the result indicates that most of respondents have knowledge on all the modes of transmission. Regarding the prevention of HIV/AIDS three items are selected on the basis of which the awareness of the respondents is assessed. The result reveals that most respondents are aware of the ways of preventing *AIDS/HIV*.

Regarding myths and misconception the result indicates that there are many myths and misconception among the majority of the respondents and a strong dislikes and excessive fear to PLWHA is found. The result indicates that there is substantial social distance between the infected and non-infected people and the respondents are anxious that they would get infected from PLWHA

The level of exposure of the respondents to mass media was measured. The results on the mass media exposure show that all these modern mass media channels of communication- Doordarshan, Local/Cable TV, Radio, Printed media are very popular among the masses.

More than two third of the respondent shared that using condom during sex is one method of family planning. More than one half shared that it is against their religious belief. More than two third shared that it is useful for preventing the spread of HIV/AIDS.

To find out the respondents' preference of Communication Channels for knowing about the HIV/AIDS, the respondents were asked to rank the channels of information on the basis of their preference. Interestingly of the 17 channels ranked interpersonal channels like peer or project worker, health center worker, were most preferred and secured the top two positions while group channels- church meetings and YMA meetings obtained the third and fourth positions respectively.

6.10. Suggestions and Recommendations

On the basis of the result many suggestions may be put forth. It is suggested that awareness and training workshops be extensively be carried out. Mobile blood-testing facility, Training of trainers like Locality Based Educators/ Peer Educators/family counselor, media-interface or training programme at periodic interval, emphasis on parents-children relationship, enhancing the parenting skill, establishment of Red Ribbon Club in the schools and among the youth, New IEC material for adults and young people, Monitoring mechanism, Separate printed IEC for Positive people, Comics for children, attractive signboard and hoarding with a picture, a more informative and attractive book on HIV/AIDS to clarify misconception, updated IEC material, Newsletter, Coordination with the local cable distributors and Doordarshan, careful study of radio message, Condom vending machine for easy access, research and documentation, more emphasis on the role of the church, the need to address linguistic and ethnic minorities.

CHAPTER I

Introduction

The present study attempts to assess the Community's needs on HIV/ AIDS in the Mizoram as a whole with special focus on communication channels.

The purpose of the present study is to assess the needs of community in terms of information and communication for HIV/AIDS prevention. The study assesses the existing communication materials, and evaluates the effectiveness of the present strategies for HIV/AIDS prevention by assessing the level of awareness on the part of the community at large. Finally attempts to suggest systematic ways and strategies for information dissemination for prevention of AIDS through awareness generation and attitudinal and behavioural change.

Objectives

1. To assess variations in the levels of public awareness on HIV/AIDS in Mizoram across districts, age groups and gender.
2. To analyse the social distance between general public and people living with HIV/AIDS (PLWHA) across districts, age groups and gender.
3. To identify the effectiveness of various channels of communication especially the existing communication materials on HIV/AIDS provided by MSACS
4. To find out the public preference of channels of communication for dissemination of information on HIV/AIDS
5. To suggest strategies of communication for promoting enabling environment.

Methodology

Both Qualitative and quantitative approach was used for the study. The qualitative data were collected through focus group discussions (FGD) with youth, women, and community leaders, people working in the field of HIV/AIDS while the quantitative data was collected with field survey with structured interview schedule from the sample.

Sampling

Using the Primary Census 2001, the age group under 14 years was cut down and the total population was calculated so that the study will be conducted reaching 1% of the whole Mizoram population. A multi stage stratified random sampling procedure was followed in the present study. The various stages involved are choice of districts, choice of blocks, choice of localities, and selection of respondents. At all this levels a proportionate stratified of random sampling into rural and urban areas has

been attempted. The sample size of each district, its rural and urban areas were decided according to the proportion of their population to total population of the state in rural and urban areas.

Selection of Districts

The first stage is choice of districts. All the eight districts of the state of Mizoram viz. Aizawl, Lunglei, Saiha, Champhai, Kolasib, Serchip, Mamit, and Lawngtlai were chosen as the focus of the study was on the inter district variation in the levels of awareness and social distance.

Selection of Blocks

The next stage is selection of blocks. One representative block in each of the districts was chosen on the basis of female literacy. The block with female literacy closer to the district female literacy was considered as representative block of a particular district.

Selection of Rural and Urban Localities

The third stage is choice of villages and urban localities. According to the rural and urban sub sample size of each of the district the number of villages and urban localities were decided. The villages and urban localities were again chosen on the basis of female literacy. The villages and urban localities having female literacy closer to the district rural and urban female literacy respectively were chosen as representative ones.

Selection of Households and Respondents

In each of the village and urban locality household list was acquired from the VCP, and the sample households were selected on the basis of systematic random sampling. In each of the household, all members of the family above the age of 14 years were administered the structure interview schedule by the trained investigators.

Conceptual and Operational Frame Work

Public Awareness on AIDS/HIV/STD (PAAIDS)

PAAIDS is conceptualised into four dimensions viz., nature of AIDS **(NAIDS),** Symptoms **(SAIDS),** Sources of Infection **(SIAIDS),** Preventive Measures **(PMAIDS).** These dimensions were measured in terms of a set of binary (yes/no) indicators. Simple average score of the indicators in each of dimension forms the dimensional indices and the simple average of the dimensional indices constitutes the overall index of public awareness on AIDS (PAAIDSI).

Social Distance with PLHA measured in terms of a set of items that could be indicative of distances. Eleven questions were thus put forth to assess the level of social distance.

Perceptions Related to Condom was also measured in terms of binary (yes/no) indicators.

Communication channel and exposure to each channel as well as preference of communication channel for information was explored.

Tools of Data Collection

The tools used in the collection of primary data are the structured interview schedule and Focus Group Discussion Guide.

Structured Interview Schedule

The structured interview schedule was developed and was administered by 16 trained field investigators. The schedule covered information on the demographic social and economic profile of the respondents, public awareness on HIV/AIDS, Beliefs and Misconceptions on HIV/AIDS, Social Distance with PLWHA, Exposure to Communication Channels and People's Preference on Communication channels (please see appendix).

Focus Group Discussion Guides (FGDGs)

Focus group discussion was carried out to obtain qualitative data and a guide was used to structure the discussion. Two FGDGs were used one for the leaders of NGOs and personnel working in the field and another for the community leaders, women and youth. The first FGDG focussed on assessment of IEC materials and modes and channels of communication while the second focussed on awareness, and perception of reasons for spread of HIV/AIDS in Mizoram and strategies of combating.

In all the district capitals one FGD was held with leaders of NGOs and personnel working in the field of HIV/AIDS prevention and care. In each of the districts, a focus group discussion was held with community leaders, women and youth one group each of the urban wards and villages

Chapter Scheme

The report of the study has been organised into seven chapters. The first chapter presented the introduction of the study. In the second chapter review of literature is presented. The third chapter presents the setting of the study. Reflections of the grassroots agents and workers are presented in the chapter four. The fifth

chapter is devoted to present the discussion on public awareness on HIV/AIDS, Social Distance and Communication. In the sixth chapter the perception of community leaders, women and youth on HIV/AIDS is presented. The seventh chapter presents the conclusions and suggestions of the present study.

CHAPTER II

REVIEW OF LITERATURE

The Mizoram State AIDS Control Society (2005) held that prevalence of HIV infection in Mizoram was concentrated to injecting drug users initially which was however, decreased due to the rigorous implementation of harm reduction strategies and the trend of transmission has shifted to sexual mode. The trend indicates that transmission of HIV through sexual route is on the rise. Besides, the increased incidence rate infection, HIV spread has shifted from high-risk group to low risk groups and from urban to rural areas. It was found that the rate of infection (abscess) among IDUs was decreased from 35.6% to 4% because of Needle Syringe Exchange Programme and the rate of HIV infection as well. Risk Reduction Programme has decreased HIV cases amongst IDUs by 50%. Nevertheless, free distribution of condom by NGOs and medical professionals as well as condom sold through social marketing has made significant progress in the prevention of HIV/AIDS. However, convincing the clients of commercial sex workers and high-risk group about the importance of condoms as a means for preventing the HIV still remains as a great challenge.

Lalthansangi (2003) conducted a study on communication need assessment and after thorough analysis of the present communication channels on HIV/AIDS/STDs recommended that proper mapping of areas and target groups should be made prior to dissemination of communication materials/information and suitable training of persons in charge of information dissemination should be made mandatory. She further suggested that communication approaches and materials should be designed separately for different

groups based on age, profession, area etc and homogeneity of focus in the approach and materials used for each group.

Futures Group MAMTA Ideosync Media Combine (2006) conducted a study on HIV communication strategies for young people and highlighted that one third of the India's population constitutes the most productive young people and 35% of reported AIDS cases in the country are from the 15-24 age group. The vulnerability of young people are highlighted as young people are more vulnerable to HIV infection because of lack knowledge and awareness, have risk taking behaviour and lack the necessary skills to protect themselves. The task of communicating gets further complex as often the populations to be addressed cannot be reached by means of conventional media channels. Communication is a necessary but insufficient tool, for preventing, augmenting cares and support programmes for HIV/AIDS. Further India's fast changing economic and socio-cultural realities have placed this critical age group at cultural crossroads of traditional socialization and non-traditional cultural and economic imagery. The exposure at different cultural patterns and models within a traditional environment puts the adolescent group in a unique situation that requires special skills and information to guide their growth and development.

Gupta, Weiss and Mane (1996) analysed the factors which contributing to young women to risk and opine that the social pressure to remain a virgin could contribute in a number of ways to the risks of STI and HIV which young women face. According to them in some contexts, young women may engage in risky sexual practices, such as anal sex, as means of protecting their virginity

Gracious Thomas, N.P. Sinha, Johnson Thomas (1997) [i] pointed out that understanding the way how HIV spreads is important in order to draw up any plan of action for the prevention and control of HIV/AIDS in any society. Understanding facts about AIDS, signs and symptoms of AIDS, type of blood test for HIV, who should get tested for HIV/AIDS, existing treatment options for the disease, route of transmission alone will not serve the purpose unless and until individuals, expert, and social and health organizations take adequate steps to prevent and control the spread of this disease. It was further stressed that open and frank approach to the problems caused by HIV/AIDS which can be materialized through appropriate policy measures which is possible only through social action, community organization and empirical research on delicate issues like the sexual behavioural pattern.

Radhika Ramasubbaan and Bhanwar Rishyasringa (2005) emphasized that HIV/AIDS can be prevented through self-conscious knowledge and the power of individual and collective action i.e. correct and consistent use of condoms, prompt treatment of sexually transmitted infections and reproductive tract infection, using blood that has tested safe abnd adhering to universal precautions (ensuring the sterility of all invasive medical instruments including injection needles (and needles of drug users), consistent use of protective clothing in hospitals where necessary and careful disposal of wastes contaminated by pus, blood and body secretion). Of these condom use has the potential of widest impact, since sexual intercourse is the commonest behavior through which infection occur.

Govind Srivastava (1989) is of the view that the changing pattern of life has resulted in certain derogatory advances in human scenario. One of its major components is the promiscuity and unnatural sexual practices including homosexual act and bestiality. The promiscuity is on the increase because of more social freedom, easy availability of contraceptive devices and abortion facilities, prostitution and frequent travels to anonymous places that removes social stigmas. Thus, in escaping this dreaded scourge, the first and foremost step is to re-establish the dishevelled threads of social conduct and regain the old moral values like avoiding multiple sexual practices, sex with stranger, homosexuality etc. this will go a long way in controlling the transmission of the disease.

TBL Jaiswal (1992) stressed that method of sex and AIDS education must be adopted to the population and may vary considerably according to the cognitive and emotional attitudes of the people towards AIDS patients depending on country, states, culture, beliefs and customs. Education based on the knowledge available can be carried out by mass information media, such as radio, TV, newspaper, magazine, books, posters, photograph, organizing exhibition and by personal method like personal interviews. Broad and large-scale education programme about AIDS are needed so that every one should know method of protect oneself and others.

Local Newspapers

In making assessment of communication channel on HIV/ AIDS and its related matters two Daily Newspapers are chosen purposively viz, Vanglaini and Tawrhbawm Daily Newspaper. The information regarding HIV/AIDS in the two newspapers are studied and kept properly for further reference. Let us briefly highlight the information contained in these two newspapers.

a) Tawrhbawm daily newspaper

Tawrhbawm Daily Newspaper is one of the oldest and widely –distributed newspaper in Mizoram. The information found in this newspaper regarding HIV/AIDS is usually news items and special report on entertainment column. The news items covered include local, nation wide as well as international. The local news items consists of special report on Seminar on Prevention of Parents to Child Transmission (PPTCT) organized by World Vision (India) CARE at RD Conference Hall, Aizawl. (August 23, 2006). HIV/AIDS and Career Awareness Campaign organized by MZP and a book on AIDS published by the MZP and released by Chief Secretary is featured as headlines (Sept.5, 7,28 2006 issue). Besides, in the entertainment column special report on special event and contribution made by popular persons are featured like popular singer. The contribution of Johan H. Lalmalsawma, Gospel singer for HIV/AIDS prevention was covered interestingly.

Regarding nation-wide coverage the current condition of the country and the number of newly infected are highlighted. It reports that there were 4.9 million people who got infected during 2005.

(b) Vanglaini Daily Newspaper

Vanglaini Daily Newspaper is one of the most widely distributed and most popular Newspapers in Mizoram. The information regarding HIV/AIDS contained/published in this Newspaper includes Editorial, news about HIV/AIDS in the news column as well as special column for youth.

The news items covered in this newspaper include local, nation as well as international affairs. The local news on HIV/AIDS is briefly highlighted here. On 2nd

Sept. 2006 it was reported that The Mizo Zirlai Pawl (MZP) organized HIV/AIDS Awareness campaign among Higher Secondary School students at Saitual. Apart from AIDS Awareness, Career Awareness programme was also conducted at Saitual village (2nd Sept.2006). The HIV/AIDS Awareness cum Career Guidance programme was highlighted on 7th September Issue. It was also mentioned that the MZP published a book on HIV/AIDS titled '*AIDS DORAL A HRANG LUA E* ' was formally released by the Chief Secretary of Mizoram in his office. It highlights the detail programme thereon.(Sept.7, 2006).

On 23rd September, training for Community Based Organisation leaders on HIV/AIDS organized by Mizoram State AIDS Control Society at State Guest House inaugurated by Honourable Health Minister Pu. R.Tlanghmingthanga was highlighted in the news column. The detail programme was also presented.

On 3rd November, it reports that the Convergence Meeting organized jointly by Mizoram Social Defence & Rehabilitation Board, Mizoram State AIDS Control Society and UNODC-CHARCA at Social Welfare Conference Hall on Drug Abuse and HIV/AIDS. The function and Programme was presented in detail.

On 4th November, it reports the visit by Presbyterian Church of Wales members to Mizoram to collaborate Govt. of Mizoram against HIV/AIDS dilemma. It was mentioned that eight members of Presbyterian Church of Wales, who are highly educated and technically trained on HIV/AIDS issue visited Mizoram to adopt more effective measures to fight this disease. The non Government Organizations and Synod Social Front attended the training programme conducted by the said party at PR

Conference Hall 1 & II. The training was focused on HIV/AIDS and Alcohol and Substance Abuse (4th Nov.2006).

On 11th November 2006, it was headlined that the Honourable Health Minister' talk to media persons at his office Chamber. It was mentioned that the Minister gave a report on North East State Health Ministers' Meet on National Rural Health Mission. The Minister highlighted that the rate of AIDS infection in Mizoram was gradually decreased as the result of effective measures taken by MSACS, NGOs and Churches.

On 11th November, it highlighted the formal talk between Health Minister and the visiting teams from Presbyterian Church of Wales. It was also reported that the agreement was signed between the parties to combat the problems of HIV/AIDS in Mizoram.

MSACS IEC Written Materials (2006)

Some of the pamphlets and Booklets published by the Mizoram state AIDS Control Society for distribution to the general masses are studied and reviewed properly and are briefly highlighted:

a) PAMPHLET: Some of the significant information contains in the Pamphlet/ Leaflet are:

1.***Nature and historical background of HIV/AIDS:*** AIDS is an abbreviation of incurable and life killing disease i.e. Acquired Immuno Deficiency Syndrome. HIV is the causing virus of AIDS. HIV is classified into HIV-I and HIV-II. These two are the causing factor of AIDS. There is no medicine for curing/healing AIDS and is still a life-

killing disease and prevention is the only way of curing. The symptom of HIV/AIDS may not be detected even up to 10 years.

HIV/AIDS was discovered in the year 1981 in USA. During this time it was also found in Africa. In 1986 it was confirmed that there were AIDS patient and gradually the incidence of HIV/AIDS was more and more alarming and every day and every year the incidence of this world alarming disease is higher and higher.

It was found that a chance of infecting HIV/AIDS is higher among women than men. As there is no medicine for healing the infected are treated with Antiretroviral treatment for strengthening immune system.

2. How HIV/AIDS spread and does not spread: HIV/AIDS is spread through unsafe/unprotected sex, Using unclean syringe/exchange of syringe with others, Blood transfusion, mother to her baby etc.

3. HIV/AIDS does not spread by- living together, shaking hands, Kissing, Sneeze/ cough, Sharing of utensils, Swimming, Hugging, Mosquito bite etc

Symptoms of HIV/AIDS: Diarrhoea, fever, and loss of weight etc

(a) *Preventive measures:* Using condom, usage of clean and safe syringe, receiving only safe blood, having one faithful partner etc.

(b) *Myth and misconception about HIV/AIDS:* Many people hold prejudices and assumptions as well as misconception and false beliefs regarding HIV/AIDS. Those people having HIV/AIDS are socially deprived of their rights and looked down upon. Some people treat them, as untouchables and their welfare and well-being are never taken into consideration. These people need love; care and affection as well as they are worthy

of living in this world as other people. They should have an equal footing and enjoy life to the greatest possible extent.

b) BOOKLET: The booklet published by MSACS can be classified into different components viz, Testimony of HIV/AIDS patient, Guidebook on how to manage dead body (corpse) of HIV/AIDS patient.

a. ***Testimony*****:** This small book contains an autobiography of one woman living with HIV/AIDS who has passed away on June 10, 2004. It was published with the aim of encouraging those who are living with HIV/AIDS in Mizoram. The book was published with the consent of the person before she died. It gives the real image of life's struggles by other people having HIV/AIDS. Besides, it is believed that this book will give real impetus and hope for others who are fighting with HIV/AIDS. She got infected when she was only 14 years of age and was the first one who publicly confessed her and faced her problem hopefully and fruitfully despite her mental trauma. She led her life in a difficult circumstance and encountered so many problems. But she hopefully strived hard and dedicated her whole life for fighting HIV/AIDS. It will really serve as well wisher and encouragement for those people living with HIV/AIDS in Mizoram.

b. Guide book: This small guidebook contains significant information on how to manage dead body of HIV/AIDS affected patient. This guidebook was published with a view to generate public awareness and clarifying misconception and wrong belief regarding HIV/AIDS. It tries to eradicate false belief and unnecessary fear always developed by the masses regarding this disease especially the management of corpse of HIV/AIDS dead body.

It says that HIV/AIDS is indeed a dangerous and easily infective but it is not necessary to develop excessive fear. It points out the guidelines for managing dead body of HIV/AIDS as prepared by Indian Medical Association (IMA). Some important features of the guiding principle are as follows:

b.1. Management *of corpse:* It suggests not packing the corpse with polythene as even this is not so safe but it should be optional. It also says that covering the whole face of the dead body without the consent of the family member is human right violation and this should be avoided. If the dead body discharges water or pus from the orifice, the orifice should be covered with cotton but not covering the head. Hurting the feeling of the dead person's family should be avoided as far as possible while managing the dead body of HIV/AIDS patient.

b.2. *Preparation of coffin and burying of the dead body:* The coffin should be prepared carefully and the entire hole/orifice should be covered entirely and excretion of water or puss should be avoided. The dead body should be put in the coffin immediately but the face should not be covered, as the relatives may want to see him/her for the last time. The funeral function and process should be same as usual as long as possible.

The apparels and dead person's belongings should be washed and cleaned and dried so that it is safe. The unwanted should be put to fire. The blood stained or water/pus on the floor or any particular place should be washed and cleaned with bleach, Lysol and phenol codex water and after that it should be washed with water again.

The book stresses care and systematic way but to avoid unnecessary fear and false belief regarding the management of dead body. Many people strictly cling to misconception and follow wrong belief. It tries to eradicate these kind of misconception held by the public. It gives clear information and valuable guidelines for the public regarding the management of dead body of HIV/AIDS patient. While managing corpse proper care should be taken not to get infection and attention should be given not to hurt the feelings of dead person's relatives.

B.3.Drug *addiction and HIV/AIDS:* This small book contains significant information about Drug addiction and its consequences. It briefs out the meaning, causes, physical as well as psychological problems caused by drug addiction. It clearly points out the social stigma and mental trauma faced by the addicted. There are many causes of drug addiction according to it. Let us briefly point out some of the causes:

a) Hereditary

b) Moral degradation/inquisitive mind during adolescence period

c) Addictive medical treatment

d) Lack of family and social control

e) Complication Management: It gives significant information about Overdose (OD) and its management, abscess and ulcer.

The second part of this book is devoted to HIV/AIDS, its nature, causes, how does it spread and its prevention. Besides, it gives valuable information about HIV/AIDS and Drug addiction. Regarding the management of complication it suggests harm reduction and counselling approach.

The literature on HIV/AIDS provides an understanding of geographic, demographic, social and economic aspects of HIV/AIDS. Yet, a few research gaps have been found. The major research gap is that a few studies were attempted in the context of Northeast India especially Mizoram where the prevalence of HIV/AIDS is deeply rooted in social and economic aspects. The present study tries to fill this research gap.

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[i] Gracious Thomas, N.P. Sinha, Johnson Thomas (1997) AIDS Social Work and Law, Jaipur & New Delhi: Rawat Publication.

CHAPTER III

THE SETTING:

DRUG AND SUBSTANCE ABUSE PROBLEM IN MIZORAM

The state of Mizoram lies in the North Eastern corner of India between Tripura and Bangladesh in the West, Myanmar in the East and South, Assam and Manipur in the North. The State has an area of 21,087 Sq.Km. The geographical location of Mizoram is characterized by undulating terrain of unformed rocks, which are of likely steep to moderate slope with about 5% of gentle slope. The entire population of the state is about 8.9 lakhs according to Census 2001, 46% of who live in urban areas.

The drug and substance abuse problem in Mizo society probably started as a spill over of the international drug trafficking. The State shares two long international borders, one with Myanmar (404 Kms) and the "Golden Triangle" in the east and with Bangladesh (318 Kms.) in the west. The geographical location of the state provides an easy route for trafficking of Heroin. Being adjacent to the "Golden Triangle" Mizoram is one of the drug trafficking routes from the Golden Triangle to India and elsewhere. Drug abuse has become a very rampant problem among the youth with the initial drug of abuse being heroin.

The Mizo tribe is of a descendents of the Sino-Tibeto Burmese race, which is divided into different sub-tribes like Lusei, Hmar, Lai, Mara, Paihte etc. The Mizo society is a close-knitted relationship bound and homogeneous in tongues and cultural centric. The major spoken language is Mizo, though there are many dialects spoken in particular sections of the community. Apart from the indigenous tribes other non- Mizo tribes like Chakma, Bru, etc are also found in the state.

Over the past decades, Mizo society has undergone radical changes brought by local insurgency led by the revolutionary Mizo National Front and on the reach of development resulting in free communication and movement of the people inside and outside the states as well as across the Indo-Myanmar border. After two decades of the insurgency since 1966, a remarkable Peace Accord was signed between the Mizo National Front and the Union Government in the year 1987 since then the land acquired full-fledged state-hood. Because of easy money from the Central government the Mizo society has been undergoing rapid transition and developmental changes even till today. Due to the influence of modernization and westernisation the Mizo society has undergone tremendous changes and many social problems, which were never found and foreign to the land, become unwelcome guests, and have been deeply rooted in the Mizo society.

Before 1978, the social evils like drug addiction and substance abuse were not much known even though it cannot be said that there was no such problem. However, after half a decade the first overdose death case due to heroin injection was witnessed when a young man of age 24 died due to overdose of heroin in the year 1984. Since then there was a noticeable rise in the growth of substance abusing population and heroin, Proxyvon, cough syrup, sedatives, Nitrozepam and volatile are of the preferred drugs of choice. Injecting gained popularity among the drug using community since the year 1988 and the first overdose death of smasmoproxyvon was witnessed this year itself.

The introduction of proproxyphene in the form of Spasmo proxyvon in the market since 1988 was gaining popularity amongst the youth, which quickly superseded the demand of heroin. Accordingly, after two decades the overdose death of heroin was less compare to spasmoproxyvon and the death of heroin was only 1 in 2006 whereas the

death of spasmoproxyvon was 132. Simultaneously, oral intake of sedatives, cough syrup and volatiles also increased reasonably. Since the drug users were injecting proxyvon, a high incidence of abscess was marked because of lack of syringe and sharing needle with each other. The over all death case of substance abuse from 1984 to 2007 is 1103 of which heroin death case is 58, whereas spasmo proxyvon 1028 and 17 other substances like Diazepam, dendrite, ganja, peptica, cough syrup and alcohol. Anyway, the rate of overdose death is reduced to a great extent because of rigorous initiative adopted to put down substance abuse (The Mizoram Liquor Total Prohibition Act) which is a join venture of The Young Mizo Association, the biggest and strongest organisation in Mizoram and Excise and Narcotics and Police department. The overdose death of sasmoproxyvon was 20 in 2006 and 34 in 2005, which was really a reasonable decrease while in 2003 the overdose death of spasmoproxyvon and related substances is 137. It is likely to say that substance abuse is decreased year by year and the mode of HIV/AIDS transmission is also shifted to sexual mode of transmission.

HIV infection was just detected in Mizoram in the year 1990 by ICMR/NICD. The survey also showed that almost 90% of the injecting drug users were sharing needles and syringes without adequate cleaning. However, over the last four years, prevalence of HIV infection among the IDU community has somewhat decreased, which is because of the introduction of Syringe Needle Exchange Programme and the trend has shifted to sexual mode of transmission, and this problem presents a formidable challenge and needs to be addressed systematically for not only medical personnel but also for the community at large. Prostitution was almost unknown before 1960s. Following the onset of insurgency in the state, the people had to live in extreme poverty with very limited

available mode of earning livelihood. At the same time, many Indian Army personnel were sent to subdue the local insurgency. Therefore, on the background of poverty on one hand and sudden influx of men away from home, prostitution became one mode of earning livelihood. The insurgency and its consequences degraded the peaceful, innocent and simple Mizo moral values and as a result, many social evils, which were hardly found in the past, became popular. Commercial sex work has started operating in Mizo society for sometime but there are no organized brothels in Mizoram. There are a number of illegal joints from where female sex workers operate. In around 1980, one of the first efforts to put down prostitution in Mizoram was carried out by the Salvation Army named "Slum Operation". It was documented in the record of "Slum Operation" carried out by the Salvation Army that there were many places like restaurant, tavern, etc where female sex workers operated in one particular locality called Atta lane, now Bazar Bungkawn, Dawrpui. Since then, commercial sex work has been one mode of earning livelihood even until today.

Though the first HIV/AIDS case was detected in Mizoram in 1990, the disease started becoming an alarming siren for the whole state. During October, 1990-January 1991 164 blood samples were tested (102-IDUs, 31 CSWs /STD, 6 Blood donors and 64-others) and 9 were found positive, and all were all IDUs. This period was the time when the injection of spasmo proxyvon gained immense popularity among the drug using community. In1992 the first Over Dose death case was found in Mizoram and the sharing of injecting equipments also popular among the drug injecting community. During February 1991-December 1992, 3294 blood (166-IDUs, 292-CSWs/ STDs, 2520 Blood donors and 316- others) were tested out of 15 positive case 11 were IDUs and 4 CSWs.

During January, 1993-September 1993 out of the test of 3066 bloods 3 positive cases were found from donors. However, cases detected from blood donors were not subjected to confirmatory test as per the rule of the Government.

During October 1993-September 1994, out of 4 perinatal tests 3 cases were detected. Increasingly sexually risk group are tested since 1997 the number of detected positive case also multiplies and eventually surpass IDU transmission in 2003. Where the cumulative total of HIV transmission through sexual route was after four years, 497. In addition, out of this unlike the drug using community 55% were females and male accounting for 45%. The vulnerability of women and the need to address women issue is on the stage. A statistic is cited in the ensuing page:

Table 1 Trends i HIV/AIDS in Mizoram

Year	No. Of Blood tested	HIV+ Cases	AIDS Cases	No. of death Cases
1990-91	294	15	0	0
1992	204	5	0	0
1993	917	16	3	2
1994	641	17	1	1
1995	456	12	0	0
1996	366	18	4	4
1997	364	14	2	2
1998	292	31	2	2
1999	801	28	0	0
2000	547	41	5	2
2001	2,294	63	2	1
2002	2,434	195	9	3
2003	3,810	222	21	12

2004	6,343	410	59	30

Source: Care Mizoram 2006

CHAPTER IV

EXISTING INFORMATION EDUCATION AND COMMUNICATION STRATEGIES: GRASS ROOT REFLECTIONS

A number of FGDs were organized with the leaders of NGOs and other personals working in the field of HIV/AIDS. All together, there were 98 participants. In places where there are NGOs, the participants were consists of persons working in the field of HIV/AIDS prevention having direct link with MSACS. In other district capitals where there are no proper NGO funded by MSACS, there were community leaders who had for time and time again involve themselves in HIV/AIDS education and awareness campaigns. The focus group with this particular group greatly focuses on IEC materials, obstacles for Behaviour change and also on new suggestion for strategy in HIV/AIDS education and awareness.

4.1 Written Materials

For all the NGOs participating in the discussions the sole source of IEC material is the MSACS. However, there are some NGOs who develop their own IEC materials in different languages according to their own projects. Even for them MSACS is the main source of IEC material.

All the participants in all the districts have shared in unison that the people are not reading them and are now considered as boring by most of the general population. One person has observed that eighty per cent of the IEC written materials is not being read by the people.

4.1.1 IEC Distribution and Monitoring Mechanism

Most of the NGOs do not have a monitoring mechanism for the dissemination of their IEC written materials. Some of the NGOs has shared that they did not even count the numbers of IEC that they get from MSACS nor do they know what age group or persons have benefit from the distribution.

Mainly the peer educators and other staff do the dissemination of IEC when awareness is being imparted in different settings. It was also observed that untrained persons who do not even know the contents of IEC materials that they are distributing do sometimes dissemination of IEC materials. This was considered as wastage and a suggestion for more training in the field of IEC written materials was given.

As such, the group members in all districts could not tell whether the IEC materials distributed are being read or not. It was also shared that there is difficulty is monitoring the distribution. Only one participant of the NGO shared that they have a practice of giving guidelines every week before disseminating the IEC materials. However, the effectiveness of it is still a question as monitoring the written materials is difficult.

4.1.2 Content, Quality and Quantity of the IEC Written Material

The quality of the paper, the contents and the style of writing were also discussed in great detail. Some of the important highlights were:

4.1.3 Imported Pictures in IEC

IEC pictures are mainly imported and thus show pictures of non-Mizo people. The group shows concern in this and highlighted that the feeling that we usually get is

that this is not our problem. It was suggested that IEC have to be written and pictures given according to the culture and tradition of the people.

4.1.4. Written Materials are not attractive

The paper quality, colours are also considered as an important indicator for effective IEC written materials. Most of the members suggested that the IEC are not good enough and the quality of the paper is not up to the mark. In this respect, the present generation youth and the taste for better and sophisticated materials were also pointed out as one important reason for making quality IEC written materials whether in pamphlets or in hoardings.

4.1.5. Content

The contents of IEC especially pamphlets were discussed. It was felt by many that the written materials were too long and many times too small. A suggestion was made to make the slogans and words small, short and clear and written beneath a picture.

4.1.6. Negative rebound on the theme How HIV/AIDS do not Spread

Regarding the materials, it was noted that HOW HIV do not spread is creating problems. This participant poses a question, “do we have to mention how HIV/AIDS do not spread”. He explained that mentioning these confuses the people and put a question in their mind on other various accidents that could happen.

4.1.7 Gender Bias

Members of the group discussion also shared that the IEC written materials were not gender sensitive. It was shared that many times women’s vulnerability to the disease is misconceived and this misconception often lead women to a more depressing situation. One of the members shared the misconception that men had with regard to HIV/AIDS.

He said that, ‘men are saying that they had a lesser chance of infected and there is no need for protection as women does’. This statement was probed and other group members also shared that such kind of attitude does exist and they have experience it in their awareness campaigns, etc. This is an example, which could show the increasing feminisation of HIV/AIDS, which is making women more vulnerable and also put men at greater risks.

4.1.8 Validation

In case of translation, the issue of validation was also raised. There were participants who shared that translations were sometimes wrongly translated or sometimes does not uncover the meaning and thus loss its essence. Validation as such was kept in an important place when IEC materials are developed.

4.1.9 Outdated Information

No updating Some participants also suggest that updating the IEC materials is needed, a close study of IEC materials shows that many have not been updated. It was shared that the materials of the IEC is a recurring theme with less quality.

4.1.10. Inadequate Quantity

In district far from Aizawl, problem with regard to the quantity of IEC were raised. It was expressed that, ‘the material provided by MSAC is too less and could be distributed only to the target group’. The materials could not reach the villages where needed is high.

4.1.11 Insensitive towards PLWHA

Regarding the content of IEC, there were members expressing that the dangers of HIV has been highlighted too much, which brought stigma to those people already infected by the disease.

4.1.12 Linguistic Minorities Ignored

IEC that are written in Mizo language are not understood by majority of the population is speaking other languages in Mizoram. Although there are sanctions for such groups it was highlighted that the material is limited as the sanction is not enough to meet the needs.

4.1.13 Hoardings are Good IEC

Of all the IEC materials, the hoardings are the best as they can be imprinted in the minds has been reflected by the group discussion.

4.2 Awareness Programs

Regarding Awareness Programmes the view of the group is that it is more effective and fruitful when the people of a particular area invite them rather than when they organized it themselves. In this regard, the main drawback is that the general masses hold a wrong notion that if the programme is MSACS sponsored Programme they thought that they have to receive money benefit like TA/DA etc. They usually invite or approach NGOs to organize awareness programme with the objective of receiving money benefit for them.

Awareness campaigns according to the group do not reach the people who needed it most. Most of the group also pointed out the gap saying that although there is an

awareness campaigns, we only know the names and some little thing about the disease, there is a bored attitude on the part of many especially the youth.

The discussions also mentioned that the awareness level is very low especially in the villages, here it was also noted that awareness in the remote village is impossible due to financial constraints.

4.3 Television Programmes

Television was also considered to be effective tool for communicating the needs of the masses. In this respect, some of the critical assessment was given as –

The timings of the awareness program given should be in tune with the needs of the hearers. It was suggested that the best time should be given for the program so that it will reach the masses.

Regarding media presentation and advertisement, some districts expressed that the message of the advertisement is not in line with the particular society they live in. One negative result is that health centre and workers in prevention of HIV and their place of work are often being branded which result in people hesitating to approach the centres.

Television was considered an important tool and the NGO have had discussion organized and felt that the impacts have been better than expectations. The group felt that more awareness in this level is needed. It was also shared that people who talk of HIV in televisions are usually not trained people. It was felt that this has provided a chance for misconception to creep in.

4. 4. Radio Programmes

Radio was also considered to be a good way to spread awareness on the issue. The participants highlighted some of their experiences regarding radio talks and dramas, etc. Participants also feel that most of the listeners to radio are the people in the rural areas. Regarding timings and access to radios, the participants said that they have always been welcomed when such programmes had been sought for. However, the timings as expressed by them were most of the time limited and were set in times where there is not much listeners like two O'clock in the afternoon.

The members could not analyze the impact of radio, it was mentioned that people in the district capital have outgrown radio however they felt that the importance is still for those in the rural areas. One member shared that the literary style of the words were not good enough and this could lead to a communication barrier.

4.5. Behaviour Change Communication

As has been evidenced from the latest statistics on mode of transmission, the focus was on the excessive pre and extra marital sex. The group discussion on this issue shows two distinct ideas – one consisting of those who support for more rigorous intervention in the field of safe sex through awareness and condom promotion as sex was free and has become liberal to all people. Another was a group which feels that we should be culturally sensitive and approach the problem with culture in mind. The later group also argued that without proper research to back up the statement of the other group, it will not be right in considering that most people are practicing sex.

4.5.1. Sex both pre marital and extra marital is considered culturally wrong

It is was shared that difficult to go for condom to the hospital or health centres, as there is fierce stigma among the Mizos on sex outside wedlock or pre marital sex. This stigma is more severe as people in our society are close and it is a place where everyone can recognize any other person. Due to fear of being stigmatized, it is as such difficult for a person to go out and buy or take condoms.

4.5.2. Teaching of the Church Opposed to Immoral Behaviour

The Church considers sex outside any wedlock immoral. The church cannot as does not promote condom but stigmatizes those who need it. The Church according to many of the discussants was not taking part in providing sex education, prevention and care of HIV/AIDS too. The influence of the Church is still heavy and reaches every nook and corner of Mizoram; this has been seen as a reason for people not having access to condom.

4.5.3 Company of Condom Matters

For those who are having access to condom, it was also shared in the group that people who uses it feels that NERODH which is the brand given out by the Government is not good and thus many refuse to use it.

4.5.4 IEC Material not Attractive Enough

They said that the materials that distributed by the MSACS is not look attractive enough to impress the people

4.5.5. Lack of Confidentiality a barrier

Regarding the cases of HIV/AIDS, it was shared that the medical workers and those who are working in the hospitals do not maintain confidentiality. This has led to a

problem in client and worker relationship and of the general people as a whole. This has been seen as an obstacle of behaviour change in many districts.

4.5.6. Unavailability of condom in every place

Issues of certain category of people who were landlocked and are living in a separate community that does not have time to mingle with the general people were raised in some districts. These include people who are working in fields consisting of both Mizos and migrant workers. Another category was people in the force who are also not in the general community. It was shared that these people do not have access to condom nor do they have adequate training on prevention of HIV/AIDS. The very nature of their work and their work environment has proved to be an obstacle for BCC in terms of condom usage.

4.6 Suggestions

The following strategies for intervention were suggested:

4.6.1 House-to-House Awareness Campaigns

A new strategy that involves one to one advocacy and group discussion through peer educators was suggested. Although this was probed, there was no specific choice for peer educators or where the peer educators were to be attached.

4.6.2 Contents and strategy of Awareness Campaigns be Modified

For the prevention of HIV/AIDS, the group discussions shared that only HIV/AIDS have become boring to the masses and that the contents of awareness campaigns be modified so that it focus on strengthening value system, parenting skills and lifestyle education rather than the fully focus on HIV/AIDS

Most of the group discussion also focuses on awareness through capacity building like conducting the Drama competition or quiz or any kind of competition will be very effective.

4.6.3. Youth Red-Ribbon Club

The establishment of a youth red ribbon club attached to various NGO and will have a separate financial back up when needed.

4.6.4.Time Frame

Time Frame for the kind of information that MSACS wanted to give should be made. For all MSACS project, there would be a theme for a period of one month or so – in all offices, awareness programme (electronic or print).

4.6.5. More focus on Rural Areas

Concerns were raised on the limited sanction for the rural areas and there was a strong felt need for more education and awareness on HIV/AIDS. Suggestion was as such made so that the rural areas needs be met**.**

4.6.6. Focus on Migrant Population:

Awareness given to specific group like the migrant people who use to come in certain working season and those who are also coming to live for a certain period of time such as the Bru, the Burmese, etc.

4.6.7. Condom Promotion

Availability of condom was kept at an important place**.** A condom vending machine that will be available at all important transit place. Apart from this, the felt need of some of the members was on teaching all people the proper use of condom.

4.6.8. VCTC made more people Friendly

It was experienced that many clients and people are hesitant to approach the ICTC centre. For this, some suggested that NGO have their own testing centre at their own specific NGO.

4.6.9. Mobile Testing Centre

Blood test drive at the village is a much-felt need by many members of the discussion; it was shared that the awareness campaigns in villages has called for this need when they had feedback. It was shared that many people could not avail for test to be done in district capitals due to financial constraints.

4.6.10. Sensitizing Church Elders and Leaders

More intervention and awareness at the Church level was suggested as the platform of the church was seen as an important place for education and awareness building. If the Church was sensitized, it was perceived that the church could play important role in awareness and care of HIV/AIDS and PLWHA. It was further suggested that if the church incorporate HIV/AIDS education as a syllabus in the church Sunday school lessons and Wednesday night lessons, the result would be effective and beneficial for the masses.

4.6.11. Awareness campaigns made through CBOs such as YMA

Practical problem with regard to organizing awareness campaigns has been discussed and as a result of this, it was suggested that community organizations like YMA could take the role of organizing the meeting. When this was probed, representative from YMA said that there need not be any profit as such but materials such as LCD projectors, etc., have to be available in order to make it fully successful.

CHAPTER V

PUBLIC AWARENESS ON HIV/AIDS, SOCIAL DISTANCE WITH PLHA AND COMMUNICATION

The present study tries to assess the needs of community for information on HIV/AIDS. It also tries to assess the level of awareness of the people and their exposure to various channels of communication and their interrelationship. Further the social distance between the infected and non-infected has been assessed. In this chapter attempt has been made to discuss the primary data collected through field survey. The discussion has been presented on six sections. The first section presents the demographic and socio-economic profile of the respondents. The second section discusses the awareness of the respondent on HIV/AIDS. The third section deals with popular myths and misconceptions about HIV/AIDS. The fourth section discusses social distance with People Living with HIV/AIDS and the last section is devoted to mass media exposure.

5.1. Profile of Respondents

The profile of respondents described the structural bases of knowledge and perception on the problem of HIV/AIDS. It includes demographic, social and economic characteristics of the respondents.

5.1.1 Demographic Characteristics

The demographic characteristics of the respondents like gender, age group, and educational status of the respondents are discussed.

As regards gender there was an equal representation to both the genders. On the whole male constitutes 50 percent while female constitute nearly 50 percent of the sample. This over all patterns was invariably observed in most of the districts. Of course there were a few exceptions. In the districts of Serchhip, Champhai, Kolasib and Lunglei 51 percent of the sample was male while in the districts of Saiha, Lawngtlai and Mamit districts 50 percent of respondents were female (see Table 5.1).

Age of the respondents has been classified into four groups viz. Adolescent (13-18), Youth (18-35), Middle (35-60) and aged (60 and above). Youth group constitutes highest number (41%) followed by Middle age (39%), adolescent (12%) and the aged (6%). Similar age structure was observed in most of the districts. The only exception was that of Aizawl district where the middle age group has highest proportion in the sample (53%) followed by the youth (27%), adolescent (9%) and aged (12%)(see Table 5.1).

The mean years of age also indicates the predominance of youth in the sample. The mean years of age was worked out to be 36 years for the whole sample. The mean age of the sub samples of Aizawl (40 years), Serchhip (37 years), Kolasib (36 years), were greater than the over all mean age of the sample while the mean years of age while the mean years of age worked out for the districts of Champhai (33 years), Saiha (31 years), and Mamit (30 years) are less than 35 years.

As regards marital status, majority of the respondents was married while a significant portion of the sample was unmarried. More than half of the respondents (62%) were married on the whole while nearly one third of the respondents were unmarried (32%). A few widowed (3 %), divorced (2%) and remarried. A similar pattern of marital status was observed in all the district sub samples. Majority of the respondents were married in Kolasib (66%), Saiha (64%), Lunglei (63%), Mamit (62%), Aizawl (62%), Champhai (61%), Serchhip (60%), and Lawngtlai (59%) districts (see Table 5.1).

As regards the educational status of the respondents were classified into six levels viz. Illiterate, Primary (1-4), Middle (5-7), High School (8-10), HSSLC (11-12) and College and above. It was observed that almost all the respondents are literates. The literacy of the sample as a whole was worked out to be 98 percent. But most of the respondents had education up to high school level. Highest proportion of respondents had high school education (42%) followed by those with middle school education (18%), primary education (17%), higher secondary education (11%), college education (9%) and illiterate (2 %) (See Table 5.1). Though, this overall pattern of literacy was observed in case of Kolasib, Saiha, Aizawl, and Mamit districts in all the districts highest proportion of the respondents had high school education. The mean years of education too revealed the predominance of high school level of education. It was worked out to be 8.23 years for the entire sample. Though the districts of Lunglei (9.45 years), Lawngtlai (9.43 years), and Aizawl (8.78 years), have greater mean years of education majority of the respondents could not go beyond the high school level of education. On the whole nearly nine percent of the respondents had college education. The greater proportion of respondents as compared to the overall proportion of college education was observed in Aizawl (13%), Lunglei (12%), and Lawnglai (10%) districts. Interestingly there was no illiterate in the sub samples of Serchhip, Saiha, Lunglei, and Lawngtlai districts.

Locality of the respondents is classified into rural and urban sectors. On the whole majority of the respondents were urban. On the whole more than one half (51%) of the respondents rural respondents constitute live in urban settlement while 49% of the sample. This pattern of locality could be observed in case of all the districts except Aizawl and Lawngtlai. In Aizawl a predominant majority of the respondents were urban (76%) while in Lawngtlai all were rural (see Table 5.1).

5.1.2 Social Characteristics

Mizo social structure was reported to be based on Family-clan-sub-tribe pattern (Vidyarthi and Rai, 1976:153). To understand of social structural bases of respondents, analysis of social structural characteristics of sub tribe, type of clan and denomination has been attempted.

The respondents belong to different sub- tribes viz, Lusei, Lai, Hmar, Ralte, Paihte, Mara, Pang, Gangte, Kuki, and Bru. Majority of the respondents belong to Lusei sub-tribe (39%), which is followed by Lai (21%) and Hmar (20%), Ralte (14%), Paite (3%), and Mara (2%). Very few among the respondents are Bru (0.05%), Non-Mizo (0.15%), Gangte (0.29%) and Pang (0.64%). The predominance of members of Lusei sub tribe could be observed in the districts of Mamit (58%), Champhai (48%), Aizawl (44%), Serchhip (48%), and Lunglei (47%) while a significant proportion of them were in Lawngtlai (29%) and Kolasib (21%) districts. Respondents belonging to Lai sub tribe were prominent in the districts of Saiha (79%), and Lawngtlai (49%) while in significant proportion in Champhai (29%) and Lunglei (17%). As regards Hmar sub tribe, majority of the respondents of belonged to it in Kolasib (51%) while Hmar respondents constituted significant proportion in Mamit (23%), Aizawl (23%), Serchhip (19%), Champhai (11%), and Lunglei (11%) districts. Though respondents of Ralte sub tribe were present in all the districts, a significant of them could be observed only in the districts of Lunglei (20%), Aizawl (20%), Serchhip (14%), Kolasib (14%), and Mamit (11%). The respondents of Paite are present in Aizawl (5%), Serchhip (4%), Lunglei (3%), Champhai (3%), Kolasib (3%) and Mamit (2%) districts. Respondents of Mara sub tribe could be observed in case of Saiha (11%) district.

There are twelve religious denominations reportedly professed in Mizoram. They are Presbyterian, Baptist, United Pentecostal Church (UPC), The Salvation Army (SA), ~~IKK, LIKBK, ECM, EFCI~~, Seventh Day Adventist (SDA), (~~BBEC~~), Roman Catholic (RC) and others. Presbyterian Church is the largest denomination in

Mizoram while Baptist is the second largest denomination. The members of Presbyterian Church had formed the highest proportion of the respondents. Almost half of the respondent (49%) belongs to Presbyterian Church, followed by Baptist Church of Mizoram, (17%), United Pentecostal Church (13.32%), and the Salvation Army (6%). Predominant majority of the respondents of Aizawl (78%), Serchhip (74%) and majority of them in Champhai (62%) and Mamit (50%) districts reportedly were Presbyterians. A majority of the respondents of Lunglei (72%) and a significant proportion of them in Lawngtlai belonged to Baptist church. The members of United Pentecostal Church (UPC) were present among the respondents all over the districts of Mizoram but their presence was significant only in the districts of Saiha (34%), Champhai (22%), Lunglei (16%), and Kolasib (13%). The members of the Salvation Army were present among the respondents in all the districts except in Lunglei. But they were of significant proportion only in the districts of Mamit (18%) and Kolasib (15%).

5.1.3 Economic Characteristics

Economic characteristics of the respondents have been discussed in terms of type of occupation and level of household income.

The occupation of the respondents is classified into nine categories viz. Cultivator, Government service, Business, Labourer, professional, Artisan, Petty Trade None and Homemakers. There was a diversified occupational structured observed among the respondents as a whole. Most of the respondents are cultivators (38%), followed by those in Government service (28%), business (14%) labour (5%), professionals (4%), Artisans (3%), petty trade (3%) and homemakers (1%). Cultivation was occupation of a majority of the respondents the districts except Lunglei, Lawngtlai, Saiha and Aizawl. Majority of the respondents in Serchhip (71%), Mamit (62%), Kolasib (55%) and Champhai (52%) and a significant proportion of them in the Lunglei (32%), Lawngtlai (23%), Saiha (47%) and Aizawl (15%) districts too were cultivators. Government service was the main source of livelihood to a greater proportion of the respondents in Aizawl (42%) and Lunglei (44%) as well as a significant proportion of them in Lawngtlai (21%), Champhai (19%), Mamit (17%), and Kolasib (12%) districts. Business was occupation to a significant proportion of respondents in Aizawl (26%), Lunglei (15%), Champhai (13%), and Lawngtlai (13%) districts.

The annual income of the respondent has been classified into four categories viz. Less than 24000, Rs 24000-48000, Rs 48000-100000 and Above 100000. On the whole greatest proportion of respondents had annual household income between Rs 48, 000 and 100,000(37%) followed by those in the class of less than Rs 24000(22%) and above Rs100, 000(21%). There is noticeable inter district variation in annual household income across was found. Majority of the respondents in the districts of Mamit(76%), Kolasib(51%) and highest proportion of them in Saiha(46%), Serchhip(39%) had annual household income less than Rs 24000 while the highest proportion of the respondents of Lunglei(59%), Aizawl(46%), and Lawngtlai(42%) had annual household income between Rs 48000 and 100000. A notable proportion of the respondents' annual household income above Rs 100000 only in the districts of Lawngtlai (37%), Aizawl (35%) and Lunglei (25%). Mean annual household income also reveals a similar picture. The respondents in the districts of Lawngtlai (Rs140068), Aizawl (Rs 109729) and Lunglei (Rs 88693) had mean annual household income greater than that of the overall mean of the respondents annual household income which was worked out to Rs 79464.

5.2. Public Awareness on HIV/AIDS

The awareness of the respondents on HIV/AIDS was measured in terms of four dimensions viz., Problem, Symptoms, Mode of Transmission and prevention each with a few items.

5.2.1 The Problem of HIV/AIDS

The problem dimension of awareness had four items viz. concept of *AIDS, HIV*, *Difference* and no *Cure* and the awareness of the respondents is measured in terms of binary (yes or no) variable. The average of the three indicators was considered as ~~Problem Index.~~

The result indicates that the most of the respondents has knowledge on the problem of AIDS and *HIV*. The mean problem index on the whole was worked out to be 0.52, which means that majority of the respondents are aware of the problem of AIDS/HIV. But the awareness has not been even across the districts and indicators. Unfortunately a majority of the respondent does not know the difference between HIV and AIDS and a predominant majority did not know that the problem has no cure. Majority of the respondents only in the districts of Aizawl (0.64), Lawngtlai (0.60), Lunglei (0.63) were aware of the problem of AIDS/HIV while most of those of

Champhai (0.2), Saiha (0.38), Serchhip (0.42), and Mamit (0.47) were not aware of the problem.

Generally the majority of the respondents were aware of the acronyms AIDS and HIV but they could not know the difference as well the problem of no cure. More than two thirds of the respondents on the whole were aware of AIDS (78%) and HIV (66%) but only one third of them were aware of the difference (44%) and less than one fifth of them know the problem has no cure (19%). This overall pattern of public awareness on the problem of AIDS /HIV could not be seen all over the districts. Though most of the respondents on the whole aware of the acronyms of AIDS in the district of Champhai (21%) a minority of respondents could know it. Similarly, a minority of respondents in Serchhip (29%), Champhai (23%) and Mamit (46%) districts know HIV. On the contrary, though majority of the respondents were not aware of the difference on the whole, a majority of the respondents in Lunglei (64%), Lawngtlai (51%), and Aizawl were aware of it interestingly. But invariably in all the districts the majority of the respondents were not aware of the problem of no cure to AIDS/HIV.

5.2.2 The Symptoms of HIV/AIDS

Regarding the Symptoms of HIV/AIDS again the knowledge of the respondent was assessed in terms of two symptoms- excessive weight loss and Continuous Dysentery by binary measurement. A simple average of the proportions of excessive weight loss and continuous dysentery was considered as symptom index.

On the whole a majority of the respondents have aware of the symptoms of HIV/AIDS. The mean symptom index worked out to be 0.58. Unfortunately, in the districts of Serchip (0.22), Saiha (0.37) and Kolasib (0.43) a minority of respondents are aware of the symptoms.

On the whole a majority of the respondents have aware of excessive weight loss and continuous dysentery as the symptoms of HIV/AIDS. By and large most of the respondents do aware of both the symptoms excess. More than one half (56%) of the respondents know that excessive weight loss as the symptom of HIV/AIDS while more than one half (60%) knows that continuous dysentery as the symptom of HIV/AIDS. But a minority of the respondents were aware of excessive weight loss as a symptom in the districts of Serchip (23%), Saih (43%), and Kolasib (42%). Likewise, a minority of respondents in Serchip (20%), Saiha (13%) and Kolasib (43%) were aware of continuous dysentery as a symptom.

5.2.3 The Mode of Transmission of HIV/AIDS

Mode of transmission has been measured in terms of three binary indicators. They are sharing of syringe, unprotected sex and mother to child. As the earlier two dimensions of awareness on aids, this dimension to was measured as aggregate of simple average of the two proportions.

The result of analysis of aggregate index indicates that the most of respondents have knowledge on all the modes of transmission. The mean mode of transmission index was worked out to be 0.87. Except in the Serchip (0.22) district majority of the respondents were aware of the modes of transmission in all the districts.

On the whole more than two third (89 %) of the respondents know that HIV/AIDS is spread by sharing of Syringe, and again 89 percent of the respondents shared the notion that it is spread by unprotected sex, and 82 percent know that it can be spread from mother to her baby. Majority of the respondents were aware of the sharing syringes and unprotected as modes of transmission in all the districts. But a minority of the respondents of Serchip (13%) district was aware of the mother to child mode though majority of the members of other districts were aware of it.

5.2.4 The Prevention of HIV/AIDS

Regarding the prevention of HIV/AIDS three items are selected on the basis of which the knowledge/awareness of the respondents is assessed. The result reveals that most respondents are aware of the ways of preventing *AIDS/HIV*. More than two third (79%) of the respondents shared that HIV/AIDS can be prevented by having one faithful sex partner and 76% of the respondents shared that it can be prevented by using condom during sex. And again more than two third (85%) of the respondents know that it can be prevented by using sterilized needles (See Table 2).

For comparison the awareness of the respondents in each of the dimension was measured in terms of simple average of their items. Table 3 presents a comparative picture of the four dimensions of awareness across the districts. It is observed that it seems that awareness on the mode of transmission and prevention are relatively greater as compared to that on the problem and symptoms. The mean awareness scores on mode of transmission and prevention were worked out to 0.87 and 0.83 while the mean scores of problem and symptom were respectively 0.52 and 0.58.

Besides, the Mean indices by Gender and Age have been worked out in order to make a comparison between the awareness levels of male and female on the basis

of their age group. The result indicates that the awareness level of male people is better than female. The total mean score of female is 0.67 while the total mean score of male is 0.72. Again it was revealed that the younger the age the lower the awareness on HIV/AIDS both between male and female. But the result indicates that the awareness level of the aged is lower compare to the younger ones. The total mean score is 0.70.

The result also highlights that the level of awareness of the respondent is good enough as per the mean index. It was revealed that the mean index of low awareness (0-0.33) is 9.53 while the mean index of both Medium (0.33-0.66) and High (0.66-1) is 21.92 and 68.55 respectively. (See Table 7)

5.3.. Myths and Misconceptions

The popularity of myths and misconception among the respondents are assessed in terms of six yes or no questions. The result indicates that the popular myths and misconception among the majority of the respondents were a healthy looking person cannot be a PLWHA, PLWHA Children should not be admitted to regular schools and PLWHA should be kept separately. More than two thirds (83%) of the respondents shared hold that a healthy looking person cannot be positive. More than one half (63%) of the respondents shared that PLWHA should be kept separately.

Amazingly the myths and misconception less popular among the respondents were PLWHA are of loose bad character, PLWHA should not have a baby, and PLWHA should not get married. Less than one half (32%) of the respondents shared that PLWHAs are of loose character while 33% of the respondents shared that PLWHA should not have a baby. Again less than one half (41%) of the respondents shared that PLWHA should not get married. More than two third (71%) of the respondents shared that PLWHA children should not be admitted to regular school. (See Table 10)

5.4. Social Distance with People Living With HIV/AIDS (SDPLWHA)

The people living with HIV/AIDS are generally isolated. Hence, in this study an attempt has been made to assess the level of people's social distance with People Living With HIV/AIDS. In the present context social distance best captures the prejudice against the PLWHA. It is measured in terms of 11 items. The items are seeing People Living with HIV, Meeting People Living with HIV, Talking to People Living with HIV Hand Shake with People Living with HIV, Share Food with People

Living with HIV, Friendship with People Living with HIV, Share Toilet, Drink water in Same Cup, Invite for Dinner at Home, and Share the Same House. Theoretically, sharing the same house indicates no distance and non-concurrence to even the first item would indicate long social distance.

The result indicates that there is substantial social distance between the infected and non-infected people and the respondents are anxious that they would get infected from PLWHA. Most of the respondents were willing to have see, meet, talk, handshake, share food and have friendship with the PLWHA. But they did not like to share toilet, drink water in same cup, invite for dinner at home and share the same house. As the social distance is higher the proportion of the people subscribing to that declines. More than two third (87%) of the respondents shared that they have no problem in seeing those infected persons. More than one third of the respondents have no problem to meet (83%), talk (81%) and shake hands (75%) with the People Living With HIV/AIDS. Again more than one half of the respondents share that they have no problem to share food and have friendship relation with those infected persons. Less than one half (48%) of the respondents share that they want to share toilet with PLWHA and 42% share that they want to drink water in the same cup with PLWHA and 41% share that they may want to invite those PLWHA for dinner at home. Only 19% of the respondents shared that they want to share the same roof with PLWHA and only 1.67% share that they may want to marry those PLWHA. (See Table. 5).

The mean Score of Social Distance is worked out and it was highlighted that the mean score of low (1-4) is 47.57, Medium (4-8) is 32.29, High (8-11) and the mean score of None is 0.84. (See Table 11)

5.5 Mass Media Exposure

The purpose of the study is to identify the channels of communication to generate awareness on AIDS and changes in attitude and behaviour of the general public. Hence, the level of exposure of the respondents was measured in terms of Door Darshan, Local Television channels, Radio, and Print each with a different types of programmes. The results on the mass media exposure show that all these modern mass media channels of communication are very popular among the masses.

Doordarshan programmes were quite popular among the respondents. Songs, News, Drama, Talk show, and even documentary films were watched by majority of the respondents reportedly. More than one third (78%) of the respondents watch DD Songs, and DD News. More than one half (77%) watch DD Drama and again more than one half (67%) watch DD Talk Show and 68% watch DD Documentary (see table 6).

As regards the local TV channels most of the types of programmes are popular. Songs, news, drama, talk show, Mizo films and Hindi serials in Mizo were watched by majority of the respondents. More than two third of the respondents watch Local TV Songs, News Programme and Drama. More than one half of the respondents watch Talk Show/Discussion and Mizo Films. Almost one half of the respondents (48%) of the respondents watch local TV Hindi Films and more than one half of the respondents (56%) watch local TV Hindi Serials in Mizo. In this regard a discrepancy is found in different districts (see table 6).

Radio was also very popular among the respondents. But only songs and news are the popular types of radio programmes. More than one half of the respondents of the respondents listen Radio Songs and Radio News. Less than one half of the respondents listen Radio Drama, Radio Talk Show/ Discussion and Radio Live Phone in. Again in this regard Serchhip District very seldom listen any radio programme.

Print media was also popular among the respondents But people usually read the Mizo news papers, mizo local news papers and Mizo magazines and don't prefer the English news papers or English magazines. More than two third (70%) of the respondents read Mizo Newspaper. More than one half of the respondents read Mizo Magazine and Mizo Local Newspaper. Only 5% of the respondents read English Newspaper and 9% of the respondents read English Magazine while (See Table 7).

To know the relative popularity of the various channels of modern mass media the simple average scores of the items of each channel are worked out (see Table 8). Of the four channels Doordarshan is most popular and print is least popular. The local television channel and radio occupy the intermediate position in popularity. The mean

scores of Doordarshan have been worked out 0.75, that of local TV Channel is 0.64 while the mean score of radio is lowest (0.53).

5.6. **Relationship Between Awareness, Social Distance and Mass Media Exposure**

The basic question is that which channel of communication effectively works in generating awareness on AIDS and promoting positive attitude and reducing social distance. To answer this question the variables on communication channels, HIV/AIDS Awareness and Social distance were correlated. As always awareness and attitude are significantly correlated with age, gender, education, and locality to control the effects of these partial correlation coefficients were worked out (see table 9). The partial correlation coefficients indicate the nature and significance of relationship between controlling for a set of the intervening variables.

The dimensions of AIDS/HIV awareness are found interrelated positively while even controlling for the effects of age, gender, education and locality. The partial correlation coefficients of the dimension of problem with symptom (0.18) and mode of transmission (0.21) and prevention (0.21) are all positive and significant at 1 per cent level. Similarly the partial correlation coefficients of symptom with Mode (0.42), and prevention (0.38) are positive and significant at 1 percent level. Likewise, the partial correlation coefficient of Mode with prevention (0.70) is positive and significant at 1 percent level.

The next question is on the effect of mass media on awareness and social distance. All the four channels of mass media communication viz., Doordarshan, local television, radio and print are substantially contributing to awareness on AIDS/HIV and reducing social distance with PLWHA even if the effects of gender, age, education and locality are controlled for. The partial correlation coefficients of Problem dimension of awareness on AIDS/HIV with all the four channels of mass media viz., DD (0.13), Local TV (0.08), Radio (0.17) and Print (0.18) were positive and significant at 1 per cent level. Likewise, the partial correlation coefficients of awareness on symptom with DD (0.22), LTV (0.24), Radio (0.15), and Print (0.20) were all positive and significant at 1 per cent level. Similarly positive and significant partial coefficients were shown between awareness on mode of transmission and DD

(0.39), LTV (0.40), Radio (0.14), and Print (0.27). Also the partial correlation coefficients of prevention with DD (0.35), LTV (0.38), Radio (0.14), and Print (0.28) were positive and significant.

As regards social distance awareness on all the four dimensions significantly contributes to its reduction. In other words greater the awareness on AIDS /HIV less social distance has been observed. The partial correlation coefficients of social distance and problem (-0.8), symptom (-0.14), mode of transmission (-0.17) and prevention (-0.16) were negative and significant at 1 per cent level.

5.7. Perception on Condom Use

The respondents' perception on condom use is measured in terms of seven items viz, Method of Family Planning, Contrary to religious belief, Protection against HIV, Hundred percent safe, Spoils sexual pleasure, Unnecessary with Boy/Girl friends and Quality differs with company.

More than two third of the respondent shared that using condom during sex is one method of family planning (73%). More than one half (40%) shared that it is against their religious belief. More than two third (87%) shared that it is useful for preventing the spread of HIV/AIDS. 28% of the respondents shared that condom is hundred percent safe against contamination of sexually transmitted disease while 35% of the respondents shared that condom spoils sexual pleasure. Again 31% shared that it is not necessary to use with boy/girl friend and 43% of the respondents shared that quality of condom differs with company (See Table 12).

5.8. Preference of Interpersonal Communication Channel for Awareness Generation

The present study attempts to find out the respondents preference of Communication Channels for knowing about the HIV/AIDS. To accomplish this the respondents were asked to rank the channels of information on the basis of their preference. To obtain overall ranks of these channels the ranks were transmuted into

scores as per the procedure suggested by Garret (1966) and again the mean scores were ranked (see table 10).

Interestingly of the 17 channels ranked interpersonal channels like peer or project worker, health center worker, were most preferred and secured the top two positions while group channels- church meetings and YMA meetings obtained the third and fourth positions respectively. The mass media communication channels like Mizo newspapers and Doordarshan secured fifth and sixth positions in the order of preference.

Table 1 Demographic Profile

Sl.No	Characteristic	District								Total N=2035
		Serchhip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
I	**Gender**									
	Female	82 (49.40)	107 (49.08)	91 (49.73)	107 (48.64)	127 (49.03)	80 (50.00)	90 (50.00)	324 (49.92)	1008 (49.53)
	Male	84 (50.60)	111 (50.92)	92 (50.27)	113 (51.36)	132 (50.97)	80 (50.00)	90 (50.00)	325 (50.08)	1027 (50.47)
II	**Age Group**									
	Adolescent (13 -18)	15 (9.04)	32 (14.68)	48 (26.23)	16 (7.27)	26 (10.04)	32 (20.00)	32 (17.78)	51 (7.86)	252 (12.38)
	Youth(18-35)	73 (43.98)	107 (49.08)	78 (42.62)	105 (47.73)	132 (50.97)	70 (43.75)	97 (53.89)	175 (26.96)	837 (41.13)
	Middle Aged(35-60)	64 (38.55)	69 (31.65)	49 (26.78)	85 (38.64)	92 (35.52)	56 (35.00)	49 (27.22)	344 (53.00)	808 (39.71)
	Aged(60 and above)	14 (8.43)	10 (4.59)	8 (4.37)	14 (6.36)	9 (3.47)	2 (1.25)	2 (1.11)	79 (12.17)	138 (6.78)
	Mean Age	36.85	33.19	31.17	36.25	34.51	31.84	30.311	40.36	35.73
III	**Marital Status**									
	Unmarried	59 (35.54)	72 (33.03)	62 (33.88)	64 (29.09)	90 (34.75)	57 (35.63)	64 (35.56)	188 (28.97)	656 (32.24)
	Married	99 (59.64)	133 (61.01)	117 (63.93)	146 (66.36)	164 (63.32)	95 (59.38)	112 (62.22)	404 (62.25)	1270 (62.41)
	Divorced	4 (2.41)	2 (0.92)	4 (2.19)	4 (1.82)	4 (1.54)	7 (4.38)	2 (1.11)	19 (2.93)	46 (2.26)
	Remarried	1 (0.60)	5 (2.29)	0 (0.00)	2 (0.91)	0 (0.00)	0 (0.00)	1 (0.56)	1 (0.15)	10 (0.49)
	Widowed	3 (1.81)	6 (2.75)	0 (0.00	4 (1.82)	1 (0.39)	1 (0.63)	1 (0.56)	37 (5.70)	53 (2.60)

Source: Computed

Table 2 Education Status

Sl.No.	Education Status	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
1	Illiterate	0 (0.00)	10 (4.59)	0 (0.00)	15 (6.82)	0 (0.00)	0 (0.00)	1 (0.56)	16 (2.47)	42 (2.06)
2	Primary(1-4)	36 (21.69)	39 (17.89)	61 (33.33)	41 (18.64)	22 (8.49)	16 (10.00)	33 (18.33)	93 (14.33)	341 (16.76)
3	Middle(5-7)	30 (18.07)	49 (22.48)	38 (20.77)	46 (20.91)	37 (14.29)	25 (15.63)	57 (31.67)	94 (14.48)	376 (18.48)
4	High School(8-10)	71 (42.77)	96 (44.04)	63 (34.43)	92 (41.82)	126 (48.65)	67 (41.88)	73 (40.56)	274 (42.22)	862 (42.36)
5	HSC(11-12)	16 (9.64)	21 (9.63)	13 (7.10)	10 (4.55)	42 (16.22)	36 (22.50)	8 (4.44)	86 (13.25)	232 (11.40)
6	College (13 and Above)	13 (7.83)	3 (1.38)	8 (4.37)	16 (7.27)	32 (12.36)	16 (10.00)	8 (4.44)	86 (13.25)	182 (8.94)
	Mean Years of Education	8.01	7.22	6.79	7.28	9.45	9.43	7.43	8.78	8.23

Source: Computed

Table 3 Locality and Sub-tribe

Sl.No	Sub-tribe	District								Total N = 2035
		Serchip N =166	Champhai N =218	Saiha N = 183	Kolasib N = 220	Lunglei N = 259	Lawngtlai N =160	Mamit N =180	Aizawl N = 649	
I	**Locality**									
	Rural	103 (62.05)	126 (57.80)	121 (66.12)	119 (54.09)	135 (52.12)	160 (100)	120 (66.67)	156 (24.04)	1040 (51.11)
	Urban	63 (37.95)	92 (42.20)	62 (33.88)	101 (45.91)	124 (47.88)	0 (0.00)	60 (33.33)	493 (75.96)	995 (48.89)
II	**Sub-tribe**									
	Lusei	80 (48.19)	105 (48.17)	11 (6.01)	47 (21.36)	122 (47.10)	46 (28.75)	104 (57.78)	286 (44.07)	801 (39.36)
	Lai	23 (13.86)	61 (27.98)	145 (79.23)	16 (7.27)	45 (17.37)	78 (48.75)	12 (6.67)	48 (7.40)	428 (21.03)
	Hmar	32 (19.28)	25 (11.47)	4 (2.19)	112 (50.91)	29 (11.20)	11 (6.88)	42 (23.33)	148 (22.80)	403 (19.80)
	Ralte	24 (14.46)	20 (9.17)	2 (1.09)	30 (13.64)	53 (20.46)	9 (5.63)	19 (10.56)	132 (20.34)	289 (14.20)
	Paihte	7 (4.22)	7 (3.21)	1 (0.55)	6 (2.73)	9 (3.47)	0 (0.00)	3 (1.67)	32 (4.93)	65 (3.19)
	Mara	0 (0.00)	0 (0.00)	20 (10.93)	0 (0.00)	1 (0.39)	1 (0.63)	0 (0.00)	0 (0.00)	22 (1.08)
	Pang	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	13 (8.13)	0 (0.00)	0 (0.00)	13 (0.64)
	Gangte	0 (0.00)	0 (0.00)	0 (0.00)	6 (2.73)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	6 (0.29)
	Kuki	0 (0.00)	0 (0.00)	0 (0.00)	3 (1.36)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.15)	4 (0.20)
	Non-Mizo	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.63)	0 (0.00)	2 (0.31)	3 (0.15)
	Bru	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.63)	0 (0.00)	0 (0.00)	1 (0.05)

Source: Computed

Table 4 Religious Denomination

Sl.No	Denomination	District								Total N=2035
		Serchip N =166	Champhai N =218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N = 160	Mamit N =180	Aizawl N = 649	
1	Presbyterian	123 (74.10)	136 (62.39)	6 (3.28)	111 (50.45)	23 (8.88)	22 (13.75)	69 (38.33)	507 (78.12)	997 (48.99)
2	Baptist	2 (1.20)	0 (0.00)	24 (13.11)	0 (0.00)	187 (72.20)	74 (46.25)	25 (13.89)	27 (4.16)	339 (16.66)
3	United Pentecostal	23 (13.86)	48 (22.02)	63 (34.43)	29 (13.18)	41 (15.83)	13 (8.13)	11 (6.11)	43 (6.63)	271 (13.32)
4	The Salvation Army	2 (1.20)	2 (0.92)	3 (1.64)	33 (15.00)	0 (0.00)	3 (1.88)	33 (18.33)	38 (5.86)	114 (5.60)
5	IKK	4 (2.41)	18 (8.26)	24 (13.11)	0 (0.00)	1 (0.39)	5 (3.13)	17 (9.44)	9 (1.39)	78 (3.83)
6	LIKBK	0 (0.00)	0 (0.00)	9 (4.92)	0 (0.00)	0 (0.00)	41 (25.63)	0 (0.00)	0 (0.00)	50 (2.46)
7	ECM	0 (0.00)	0 (0.00)	42 (22.95)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	42 (2.06)
8	EFCI	0 (0.00)	0 (0.00)	0 (0.00)	35 (15.91)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	35 (1.72)
9	Seventh Day Adventist	4 (2.41)	5 (2.29)	5 (2.73)	2 (0.91)	4 (1.54)	0 (0.00)	0 (0.00)	4 (0.62)	24 (1.18)
10	BBEC	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	14 (7.78)	0 (0.00)	14 (0.69)
11	Roman Catholic	5 (3.01)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.63)	3 (1.67)	5 (0.77)	14 (0.69)
12	Others	3 (1.81)	9 (4.13)	7 (3.83)	10 (4.55)	3 (1.16)	1 (0.63)	8 (4.44)	16 (2.47)	57 (2.80)

Source: Computed

Table 5 Economic Characteristics: Occupation and Household Income

Sl.No	Particulars	District								Total N=2035
		Serchip N =166	Champhai N =218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N = 160	Mamit N =180	Aizawl N = 649	
I	**Occupation**									
	Cultivators	118 (71.08)	114 (52.29)	86 (46.99)	121 (55.00)	84 (32.43)	35 (21.88)	112 (62.22)	98 (15.10)	768 (37.74)
	Government Service	14 (8.43)	41 (18.81)	43 (23.50)	26 (11.82)	114 (44.02)	33 (20.63)	31 (17.22)	272 (41.91)	574 (28.21)
	Business	11 (6.63)	29 (13.30)	7 (3.83)	11 (5.00)	38 (14.67)	21 (13.13)	4 (2.22)	167 (25.73)	288 (14.15)
	Labourers	5 (3.01)	10 (4.59)	18 (9.84)	13 (5.91)	12 (4.63)	2 (1.25)	16 (8.89)	44 (6.78)	120 (5.90)
	Professionals	11 (6.63)	0 (0.00)	15 (8.20)	22 (10.00)	4 (1.54)	7 (4.38)	3 (1.67)	23 (3.54)	85 (4.18)
	Artisans	7 (4.22)	5 (2.29)	4 (2.19)	3 (1.36)	5 (1.93)	5 (3.13)	4 (2.22)	31 (4.78)	64 (3.14)
	Petty Trade	0 (0.00)	19 (8.72)	9 (4.92)	9 (4.09)	2 (0.77)	0 (0.00)	10 (5.56)	12 (1.85)	61 (3.00)
	None	0 (0.00)	0 (0.00)	1 (0.55)	0 (0.00)	0 (0.00)	52 (32.50)	0 (0.00)	2 (0.31)	55 (2.70)
	Home Makers	0 (0.00)	0 (0.00)	0 (0.00)	15 (6.82)	0 (0.00)	5 (3.13)	0 (0.00)	0 (0.00)	20 (0.98)
II	**Level of Household Income**									
	Less than Rs 24000	64 (38.55)	17 (7.80)	84 (45.90)	113 (51.36)	0 (0.00	7 (4.38)	137 (76.11)	23 (3.54)	445 (21.87)
	Rs 24000 - 48000	25 (15.06)	119 (54.59)	49 (26.78)	38 (17.27)	40 (15.44)	27 (16.88)	16 (8.89)	101 (15.56)	415 (20.39)
	Rs 48000 - 100000	61 (36.75)	63 (28.90)	31 (16.94)	49 (22.27)	154 (59.46)	67 (41.88)	23 (12.78)	297 (45.76)	745 (36.61)
	Above Rs 100000	16 (9.64)	19 (8.72)	19 (10.38)	20 (9.09)	65 (25.10)	59 (36.88)	4 (2.22)	228 (35.13)	430 (21.13)
	Mean Annual Household Income	58030.12	54884.40	47950.27	48129.09	88693.05	140067.50	23067.78	109729.28	79464.33

Source: Computed

Table 6 Awareness on AIDS/HIV

Sl.No.	Dimension/Item	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
I	**Problem**									
	AIDS	111 (66.87)	46 (21.10)	98 (53.55)	191 (86.82)	227 (87.64)	138 (86.25)	160 (88.89)	626 (96.46)	1597 (78.48)
	HIV	48 (28.92)	50 (22.94)	91 (49.73)	166 (75.45)	198 (76.45)	126 (78.75)	83 (46.11)	573 (88.29)	1335 (65.60)
	Difference	41 (24.70)	41 (18.81)	51 (27.87)	70 (31.82)	167 (64.48)	82 (51.25)	81 (45.00)	365 (56.24)	898 (44.13)
	No Cure	80 (48.19)	34 (15.60)	38 (20.77)	34 (15.45)	57 (22.01)	40 (25.00)	14 (7.78)	88 (13.56)	385 (18.92)
II	**Symptoms**									
	Excessive Weight Loss	39 (23.49)	118 (54.13)	79 (43.17)	92 (41.82)	185 (71.43)	126 (78.75)	125 (69.44)	367 (56.55)	1131 (55.58)
	Continuous Dysentery	33 (19.88)	147 (67.43)	57 (31.15)	95 (43.18)	213 (82.24)	106 (66.25)	136 (75.56)	424 (65.33)	1211 (59.51)
III	**Mode of Transmission**									
	Sharing of Syringes	88 (53.01)	211 (96.79)	111 (60.66)	190 (86.36)	244 (94.21)	152 (95.00)	179 (99.44)	637 (98.15)	1812 (89.04)
	Unprotected Sex	131 (78.92)	204 (93.58)	105 (57.38)	189 (85.91)	232 (89.58)	154 (96.25)	174 (96.67)	623 (95.99)	1812 (89.04)
	Mother to Child	21 (12.65)	196 (89.91)	110 (60.11)	170 (77.27)	238 (91.89)	143 (89.38)	175 (97.22)	614 (94.61)	1667 (81.92)
IV	**Prevention**									
	Having one Faithful Sex Partner	22 (13.25)	187 (85.78)	94 (51.37)	176 (80.00)	219 (84.56)	141 (88.13)	157 (87.22)	611 (94.14)	1607 (78.97)
	Condom Use	58 (34.94)	180 (82.57)	93 (50.82)	159 (72.27)	213 (82.24)	135 (84.38)	153 (85.00)	562 (86.59)	1553 (76.31)
	Using Sterilized Needles	108 (65.06)	189 (86.70)	99 (54.10)	177 (80.45)	223 (86.10)	146 (91.25)	176 (97.78)	607 (93.53)	1725 (84.77)

Source: Computed

Table 7 Pattern of Awareness on AIDS/HIV: Mean Indices

Sl.No	Dimension	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
I	**Awareness on AIDS/HIV**									
	Problem	0.42	0.20	0.38	0.52	0.63	0.60	0.47	0.64	0.52
	Symptoms	0.22	0.61	0.37	0.43	0.77	0.73	0.73	0.61	0.58
	Mode of Transmission	0.48	0.93	0.59	0.83	0.92	0.94	0.98	0.96	0.87
	Prevention	0.40	0.89	0.53	0.81	0.88	0.90	0.94	0.94	0.83
	Mean Awareness Index	0.38	0.66	0.47	0.65	0.80	0.79	0.78	0.79	0.70
II	**Level of Awareness**									
	Low (0 - 0.33)	80 (48.19)	5 (2.29)	71 (38.80)	26 (11.82)	2 (0.77)	4 (2.50)	0 0.00	6 (0.92)	194 (9.53)
	Medium (0.33 - 0.66)	69 (41.57)	93 (42.66)	33 (18.03)	69 (31.36)	45 (17.37)	25 (15.63)	25 (13.89)	87 (13.41)	446 (21.92)
	High (0.66 -1)	17 (10.24)	120 (55.05)	79 (43.17)	125 (56.82)	212 (81.85)	131 (81.88)	155 (86.11)	556 (85.67)	1395 (68.55)

Source: Computed

Table 8 Awareness on AIDS/HIV: Mean Indices by Gender and Age

Sl.No	Gender	Age Group	Problem	Symptoms	Mode of Transmission	Prevention	Awareness on AIDS/HIV
I	**Female**	Adolescent (13 -18)	0.48	0.52	0.85	0.75	0.65
		Youth(18-35)	0.48	0.57	0.86	0.81	0.68
		Middle Aged(35-60)	0.47	0.56	0.88	0.82	0.68
		Aged(60 and above)	0.46	0.34	0.86	0.84	0.63
		Total	0.47	0.55	0.86	0.81	0.67
II	**Male**	Adolescent (13 -18)	0.56	0.62	0.86	0.82	0.71
		Youth(18-35)	0.59	0.61	0.87	0.86	0.73
		Middle Aged(35-60)	0.55	0.63	0.88	0.86	0.73
		Aged(60 and above)	0.48	0.42	0.85	0.82	0.64
		Total	0.56	0.60	0.87	0.85	0.72
III	**Total**	Adolescent (13 -18)	0.51	0.56	0.86	0.78	0.68
		Youth(18-35)	0.53	0.59	0.86	0.83	0.70
		Middle Aged(35-60)	0.51	0.59	0.88	0.84	0.71
		Aged(60 and above)	0.47	0.40	0.86	0.83	0.64
		Total	0.52	0.58	0.87	0.83	0.70

Source: Computed

Table 9 Correlates of Awareness on AIDS/HIV: Karl Pearson's Correlation Coefficients

Sl.No.	Independent Variable	Problem	Mode of Transmission	Symptoms	Prevention	Awareness on AIDS/HIV
1	Locality	0.23**	0.16**	0.06**	0.14**	0.19**
2	Age Group	-0.03	0.01	-0.05	0.04	-0.01
3	Gender	0.14**	0.01	0.06**	0.08**	0.10**
4	Education Status	0.36**	0.18**	0.23**	0.20**	0.32**
5	Annual Household Income	0.17**	0.12**	0.09**	0.12**	0.16**

Source: Computed

**Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table 10 Popular Myths and Misconceptions about AIDS/HIV

Belief	District								Total N=2035
	Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
A healthy looking person cannot be PLWHA	149 (89.76)	167 (76.61)	152 (83.06)	184 (83.64)	199 (76.83)	124 (77.50)	163 (90.56)	544 (83.82)	1682 (82.65)
PLWHA should be kept separately	116 (69.88)	132 (60.55)	119 (65.03)	115 (52.27)	170 (65.64)	97 (60.63)	104 (57.78)	442 (68.10)	1295 (63.64)
PLWHA are of loose bad character	57 (34.34)	60 (27.52)	91 (49.73)	55 (25.00)	91 (35.14)	43 (26.88)	45 (25.00)	222 (34.21)	664 (32.63)
PLWHA should not have a baby	47 (28.31)	45 (20.64)	106 (57.92)	82 (37.27)	92 (35.52)	61 (38.13)	54 (30.00)	193 (29.74)	680 (33.42)
PLWHA should not get married	58 (34.94)	69 (31.65)	104 (56.83)	85 (38.64)	127 (49.03)	59 (36.88)	71 (39.44)	270 (41.60)	843 (41.43)
PLWHA Children should not be admitted to regular schools	131 (78.92)	158 (72.48)	131 (71.58)	129 (58.64)	186 (71.81)	110 (68.75)	133 (73.89)	468 (72.11)	1446 (71.06)

Source: Computed

Table 11 Patterns of Social Distance with People Living with HIV

Sl.No.	Social Distance	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
I	**Social Distance**									
1	Seeing People Living with HIV	161 (96.99)	212 (97.25)	135 (73.77)	145 (65.91)	225 (86.87)	130 (81.25)	169 (93.89)	599 (92.30)	1776 (87.27)
2	Meeting People Living with HIV	155 (93.37)	205 (94.04)	123 (67.21)	121 (55.00)	213 (82.24)	113 (70.63)	150 (83.33)	593 (91.37)	1673 (82.21)
3	Talking to People Living with HIV	152 (91.57)	204 (93.58)	118 (64.48)	116 **(52.73)**	211 (81.47)	104 (65.00)	148 (82.22)	587 (90.45)	1640 (80.59)
4	Hand Shake with People Living with HIV	142 (85.54)	186 (85.32)	97 **(53.01)**	108 (49.09)	207 (79.92)	92 **(57.50)**	130 (72.22)	553 (85.21)	1515 (74.45)
5	Share Food with People Living with HIV	117 (70.48)	163 (74.77)	80 (43.72)	89 (40.45)	169 (65.25)	77 (48.13)	103 (57.22)	506 (77.97)	1304 (64.08)
6	Friendship with People Living with HIV	103 (62.05)	148 (67.89)	69 (37.70)	84 (38.18)	153 (59.07)	71 (44.38)	92 **(51.11)**	474 (73.04)	1194 **(58.67)**
7	Share Toilet	87 **(52.41)**	126 **(57.80)**	61 (33.33)	61 (27.73)	134 **(51.74)**	60 (37.50)	75 (41.67)	381 (58.71)	985 (48.40)
8	Drink water in Same Cup	73 (43.98)	99 (45.41)	54 (29.51)	55 (25.00)	109 (42.08)	53 (33.13)	61 (33.89)	353 (54.39)	857 (42.11)
9	Invite for Dinner at Home	68 (40.96)	97 (44.50)	54 (29.51)	54 (24.55)	102 (39.38)	53 (33.13)	61 (33.89)	341 **(52.54)**	830 (40.79)
10	Share the Same House	29 (17.47)	36 (16.51)	34 (18.58)	39 (17.73)	14 (5.41)	18 (11.25)	46 (25.56)	190 (29.28)	406 (19.95)
11	Be Married	3 (1.81)	4 (1.83)	4 (2.19)	5 (2.27)	11 (4.25)	2 (1.25)	0 (0.00)	5 (0.77)	34 (1.67)
	Mean Social Distance Score	4.70	4.91	3.19	2.89	4.33	3.42	4.08	5.23	4.36
II	**Level of Social Distance**									
	None	2 (1.20)	3 (1.38)	3 (1.64)	2 (0.91)	4 (1.54)	2 (1.25)	0 0.00	1 (0.15)	17 (0.84)
	Low(1- 4)	86 (51.81)	123 (56.42)	58 (31.69)	59 (26.82)	131 (50.58)	58 (36.25)	75 (41.67)	378 (58.24)	968 (47.57)
	Medium(4-8)	64 (38.55)	78 (35.78)	57 (31.15)	55 (25.00)	77 (29.73)	44 (27.50)	73 (40.56)	209 (32.20)	657 (32.29)
	High(8-11)	14 (8.43)	14 (6.42)	65 (35.52)	104 (47.27)	47 (18.15)	56 (35.00)	32 (17.78)	61 (9.40)	393 (19.31)

Source: Computed

Table 12 Perceptions on Condom Use

Sl.No		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	Total N=2035
1	Method of Family Planning	114 (68.67)	163 (74.77)	106 (57.92)	149 (67.73)	198 (76.45)	124 (77.50)	161 (89.44)	474 (73.04)	1489 (73.17)
2	Contrary to religious belief	79 (47.59)	80 (36.70)	46 (25.14)	78 (35.45)	121 (46.72)	82 (51.25)	51 (28.33)	285 (43.91)	822 (40.39)
3	Protection Against HIV	148 (89.16)	200 (91.74)	118 (64.48)	182 (82.73)	230 (88.80)	148 (92.50)	172 (95.56)	589 (90.76)	1787 (87.81)
4	Hundred Percent Safe	34 (20.48)	70 (32.11)	53 (28.96)	71 (32.27)	65 (25.10)	58 (36.25)	74 (41.11)	150 (23.11)	575 (28.26)
5	Spoils Sexual Pleasure	32 (19.28)	90 (41.28)	34 (18.58)	73 (33.18)	123 (47.49)	69 (43.13)	112 (62.22)	195 (30.05)	728 (35.77)
6	Unnecessary with Boy/Girl Friends	15 (9.04)	147 (67.43)	51 (27.87)	61 (27.73)	88 (33.98)	61 (38.13)	72 (40.00)	137 (21.11)	632 (31.06)
7	Quality Differs with Company	25 (15.06)	98 (44.95)	54 (29.51)	72 (32.73)	143 (55.21)	92 (57.50)	152 (84.44)	259 (39.91)	895 (43.98)

Source: Computed

Table 13 Mass Media Exposure: Television

Sl.No.	Media / Programme	District								Total N=2035
		Serchip N =166	Champhai N =218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
I	**Door Darshan**									
	DD Songs	18 (10.84)	190 (87.16)	130 (71.04)	192 (87.27)	222 (85.71)	135 (84.38)	168 (93.33)	524 (80.74)	1579 (77.59)
	DD News	31 (18.67)	201 (92.20)	135 (73.77)	195 (88.64)	230 (88.80)	145 (90.63)	174 (96.67)	561 (86.44)	1672 (82.16)
	DD Drama	66 (39.76)	186 (85.32)	122 (66.67)	179 (81.36)	207 (79.92)	132 (82.50)	157 (87.22)	523 (80.59)	1572 (77.25)
	DD Talk Show / Discussion	65 (39.16)	154 (70.64)	112 (61.20)	163 (74.09)	187 (72.20)	112 (70.00)	144 (80.00)	441 (67.95)	1378 (67.71)
	DD Documentary	44 (26.51)	160 (73.39)	110 (60.11)	163 (74.09)	198 (76.45)	111 (69.38)	153 (85.00)	447 (68.88)	1386 (68.11)
II	**Local Television Channels**									
	LTV Songs	19 (11.45)	186 (85.32)	81 (44.26)	92 (41.82)	237 (91.51)	100 (62.50)	117 (65.00)	612 (94.30)	1444 (70.96)
	LTV News	29 (17.47)	196 (89.91)	79 (43.17)	91 (41.36)	234 (90.35)	99 (61.88)	118 (65.56)	631 (97.23)	1477 (72.58)
	LTV Drama	40 (24.10)	171 (78.44)	69 (37.70)	87 (39.55)	221 (85.33)	88 (55.00)	117 (65.00)	559 (86.13)	1352 (66.44)
	LTV Talk Show / Discussion	56 (33.73)	154 (70.64)	65 (35.52)	72 (32.73)	203 (78.38)	77 (48.13)	110 (61.11)	525 (80.89)	1262 (62.01)
	LTV Mizo Films	25 (15.06)	188 (86.24)	75 (40.98)	163 (74.09)	210 (81.08)	83 (51.88)	115 (63.89)	538 (82.90)	1397 (68.65)
	LTV Hindi Films	5 (3.01)	134 (61.47)	62 (33.88)	148 (67.27)	142 (54.83)	55 (34.38)	90 (50.00)	358 (55.16)	994 (48.85)
	LTV Hindi Serials in Mizo	4 (2.41)	150 (68.81)	64 (34.97)	142 (64.55)	164 (63.32)	61 (38.13)	98 (54.44)	448 (69.03)	1131 (55.58)

Source: Computed

Table 14 Mass Media Exposure: Radio

Sl.No.	Media/Programme	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
I	**Radio(AIR)**									
	Radio Songs	15 (9.04)	84 (38.53)	149 (81.42)	141 (64.09)	217 (83.78)	150 (93.75)	128 (71.11)	311 (47.92)	1195 (58.72)
	Radio News	20 (12.05)	91 (41.74)	155 (84.70)	147 (66.82)	232 (89.58)	152 (95.00)	138 (76.67)	377 (58.09)	1312 (64.47)
	Radio Drama	18 (10.84)	63 (28.90)	124 (67.76)	110 (50.00)	180 (69.50)	119 (74.38)	115 (63.89)	250 (38.52)	979 (48.11)
	Radio Talk Show / Discussion	36 (21.69)	65 (29.82)	121 (66.12)	118 (53.64)	171 (66.02)	113 (70.63)	113 (62.78)	224 (34.51)	961 (47.22)
	Radio Live Phone in	19 (11.45)	63 (28.90)	118 (64.48)	116 (52.73)	175 (67.57)	118 (73.75)	112 (62.22)	242 (37.29)	963 (47.32)
II	**Print**									
	English News Paper	0 0.00	5 (2.29)	14 (7.65)	27 (12.27)	14 (5.41)	8 (5.00)	3 (1.67)	48 (7.40)	119 (5.85)
	English Magazine	3 (1.81)	16 (7.34)	15 (8.20)	31 (14.09)	32 (12.36)	29 (18.13)	6 (3.33)	70 (10.79)	202 (9.93)
	Mizo News Paper	96 (57.83)	154 (70.64)	105 (57.38)	156 (70.91)	163 (62.93)	97 (60.63)	108 (60.00)	555 (85.52)	1434 (70.47)
	Mizo Magazine	66 (39.76)	130 (59.63)	110 (60.11)	139 (63.18)	211 (81.47)	130 (81.25)	94 (52.22)	483 (74.42)	1363 (66.98)
	Mizo Local News Paper	75 (45.18)	186 (85.32)	78 (42.62)	191 (86.82)	246 (94.98)	98 (61.25)	124 (68.89)	610 (93.99)	1608 (79.02)

Source: Computed

Table 15 Age Group Gender and Mass Media Exposure: Doordarshan Programmes

Sl.No	Age Group	Gender	Songs	News	Drama	Talk Show/ Discussion	Documentary
I	**Adolescent (13 -18)**	Female	120 (83.33)	122 (84.72)	123 (85.42)	95 (65.97)	100 (69.44)
		Male	89 (82.41)	94 (87.04)	92 (85.19)	71 (65.74)	79 (73.15)
		Total	209 (82.94)	216 (85.71)	215 (85.32)	166 (65.87)	179 (71.03)
II	**Youth(18-35)**	Female	341 (77.15)	361 (81.67)	349 (78.96)	286 (64.71)	300 (67.87)
		Male	311 (78.73)	328 (83.04)	307 (77.72)	258 (65.32)	281 (71.14)
		Total	652 (77.90)	689 (82.32)	656 (78.38)	544 (64.99)	581 (69.41)
III	**Middle Aged(35-60)**	Female	267 (70.08)	291 (76.38)	274 (71.92)	240 (62.99)	232 (60.89)
		Male	348 (81.50)	371 (86.89)	333 (77.99)	325 (76.11)	306 (71.66)
		Total	615 (76.11)	662 (81.93)	607 (75.12)	565 (69.93)	538 (66.58)
IV	**Aged(60 and above)**	Female	30 (73.17)	31 (75.61)	30 (73.17)	30 (73.17)	25 (60.98)
		Male	73 (75.26)	74 (76.29)	64 (65.98)	73 (75.26)	63 (64.95)
		Total	103 (74.64)	105 (76.09)	94 (68.12)	103 (74.64)	88 (63.77)
	Total	Female	758 (75.20)	805 (79.86)	776 (76.98)	651 (64.58)	657 (65.18)
		Male	821 (79.94)	867 (84.42)	796 (77.51)	727 (70.79)	729 (70.98)
		Total	1579 (77.59)	1672 (82.16)	1572 (77.25)	1378 (67.71)	1386 (68.11)

Source: Computed

Table 16 Age Group Gender and Mass Media Exposure: Local Television Programmes

Sl.No	Age Group	Gender	Songs	News	Drama	Talk Show / Discussion	Mizo Films	Hindi Films	Hindi Serials in Mizo
I	Adolescent (13 -18)	Female	104 (72.22)	101 (70.14)	99 (68.75)	75 (52.08)	105 (72.92)	93 (64.58)	88 (61.11)
		Male	76 (70.37)	74 (68.52)	67 (62.04)	53 (49.07)	74 (68.52)	48 (44.44)	52 (48.15)
		Total	180 (71.43)	175 (69.44)	166 (65.87)	128 (50.79)	179 (71.03)	141 (55.95)	140 (55.56)
II	Youth(18-35)	Female	301 (68.10)	301 (68.10)	285 (64.48)	247 (55.88)	316 (71.49)	260 (58.82)	292 (66.06)
		Male	279 (70.63)	290 (73.42)	265 (67.09)	254 (64.30)	263 (66.58)	173 (43.80)	186 (47.09)
		Total	580 (69.30)	591 (70.61)	550 (65.71)	501 (59.86)	579 (69.18)	433 (51.73)	478 (57.11)
III	Middle Aged(35-60)	Female	275 (72.18)	288 (75.59)	259 (67.98)	252 (66.14)	264 (69.29)	184 (48.29)	239 (62.73)
		Male	309 (72.37)	319 (74.71)	281 (65.81)	282 (66.04)	285 (66.74)	174 (40.75)	198 (46.37)
		Total	584 (72.28)	607 (75.12)	540 (66.83)	534 (66.09)	549 (67.95)	358 (44.31)	437 (54.08)
IV	Aged(60 and above)	Female	29 (70.73)	31 (75.61)	28 (68.29)	29 (70.73)	26 (63.41)	20 (48.78)	27 (65.85)
		Male	71 (73.20)	73 (75.26)	68 (70.10)	70 (72.16)	64 (65.98)	42 (43.30)	49 (50.52)
		Total	100 (72.46)	104 (75.36)	96 (69.57)	99 (71.74)	90 (65.22)	62 (44.93)	76 (55.07)
	Total	Female	709 (70.34)	721 (71.53)	671 (66.57)	603 (59.82)	711 (70.54)	557 (55.26)	646 (64.09)
		Male	735 (71.57)	756 (73.61)	681 (66.31)	659 (64.17)	686 (66.80)	437 (42.55)	485 (47.22)
		Total	1444 (70.96)	1477 (72.58)	1352 (66.44)	1262 (62.01)	1397 (68.65)	994 (48.85)	1131 (55.58)

Source: Computed

Table 17 Age Group Gender and Mass Media Exposure: Radio Programmes

Sl.No	Age Group	Gender	Songs	News	Drama	Talk Show / Discussion	Live Phone in
I	Adolescent (13 -18)	Female	100 (69.44)	99 (68.75)	78 (54.17)	65 (45.14)	83 (57.64)
		Male	80 (74.07)	80 (74.07)	60 (55.56)	49 (45.37)	60 (55.56)
		Total	180 (71.43)	179 (71.03)	138 (54.76)	114 (45.24)	143 (56.75)
II	Youth (18-35)	Female	257 (58.14)	270 (61.09)	205 (46.38)	193 (43.67)	202 (45.70)
		Male	264 (66.84)	286 (72.41)	213 (53.92)	211 (53.42)	202 (51.14)
		Total	521 (62.25)	556 (66.43)	418 (49.94)	404 (48.27)	404 (48.27)
III	Middle Aged (35-60)	Female	163 (42.78)	190 (49.87)	145 (38.06)	138 (36.22)	131 (34.38)
		Male	261 (61.12)	299 (70.02)	216 (50.59)	236 (55.27)	224 (52.46)
		Total	424 (52.48)	489 (60.52)	361 (44.68)	374 (46.29)	355 (43.94)
IV	Aged (60 and above)	Female	18 (43.90)	22 (53.66)	14 (34.15)	16 (39.02)	13 (31.71)
		Male	52 (53.61)	66 (68.04)	48 (49.48)	53 (54.64)	48 (49.48)
		Total	70 (50.72)	88 (63.77)	62 (44.93)	69 (50.00)	61 (44.20)
V	Total	Female	538 (53.37)	581 (57.64)	442 (43.85)	412 (40.87)	429 (42.56)
		Male	657 (63.97)	731 (71.18)	537 (52.29)	549 (53.46)	534 (52.00)
		Total	1195 (58.72)	1312 (64.47)	979 (48.11)	961 (47.22)	963 (47.32)

Source: Computed

Table 18 Age Group Gender and Mass Media Exposure: Print Media

Sl.No	Age Group	English News Paper	English Magazine	Mizo News Paper	Mizo Magazine	Mizo Local News Paper
I	Adolescent (13 -18)	10 (6.94)	16 (11.11)	101 (70.14)	100 (69.44)	106 (73.61)
		9 (8.33)	13 (12.04)	79 (73.15)	82 (75.93)	82 (75.93)
		19 (7.54)	29 (11.51)	180 (71.43)	182 (72.22)	188 (74.60)
II	Youth(18-35)	24 (5.43)	33 (7.47)	292 (66.06)	279 (63.12)	334 (75.57)
		37 (9.37)	75 (18.99)	305 (77.22)	301 (76.20)	333 (84.30)
		61 (7.29)	108 (12.90)	597 (71.33)	580 (69.30)	667 (79.69)
III	Middle Aged(35-60)	10 (2.62)	15 (3.94)	228 (59.84)	202 (53.02)	287 (75.33)
		27 (6.32)	47 (11.01)	332 (77.75)	320 (74.94)	358 (83.84)
		37 (4.58)	62 (7.67)	560 (69.31)	522 (64.60)	645 (79.83)
IV	Aged(60 and above)	0 (0.00)	0 (0.00	23 (56.10)	16 (39.02)	30 (73.17)
		2 (2.06)	3 (3.09)	74 (76.29)	63 (64.95)	78 (80.41)
		2 (1.45)	3 (2.17)	97 (70.29)	79 (57.25)	108 (78.26)
V	Total	44 (4.37)	64 (6.35)	644 (63.89)	597 (59.23)	757 (75.10)
		75 (7.30)	138 (13.44)	790 (76.92)	766 (74.59)	851 (82.86)
		119 (5.85)	202 (9.93)	1434 (70.47)	1363 (66.98)	1608 (79.02)

Source: Computed

Table 19 Pattern of Mass Media Exposure

Sl.No	Media	District								Total
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	N=2035
I	**Television**	0.21	0.80	0.53	0.66	0.79	0.65	0.75	0.79	0.69
	Doordarshan	0.27	0.82	0.67	0.81	0.81	0.79	0.88	0.77	0.75
	Local TV Channels	0.15	0.77	0.39	0.52	0.78	0.50	0.61	0.81	0.64
II	Radio	0.13	0.34	0.73	0.57	0.75	0.82	0.67	0.43	0.53
III	Print	0.29	0.45	0.35	0.49	0.51	0.45	0.37	0.54	0.46
	Mean Index Mass Media Exposure	0.21	0.53	0.54	0.58	0.69	0.64	0.60	0.59	0.56
IV	**Level of Mass Media Exposure**									
	Low(0.33-0.66)	138 (83.13)	35 (16.06)	27 (14.75)	33 (15.00)	14 (5.41)	7 (4.38)	22 (12.22)	57 (8.78)	333 (16.36)
	Medium (0.33 - 0.66).	22 (13.25)	120 (55.05)	97 (53.01)	103 (46.82)	78 (30.12)	86 (53.75)	80 (44.44)	342 (52.70)	928 (45.60)
	High(0.66-1)	6 (3.61)	63 (28.90)	59 (32.24)	84 (38.18)	167 (64.48)	67 (41.88)	78 (43.33)	250 (38.52)	774 (38.03)

Source: Computed

Table 20 Level of Mass Media Exposure by Age Group and Gender

Sl.No.	Gender/ Level	Age Group				Total
		Adolescent (13 -18)	Youth (18-35)	Middle Aged (35-60)	Aged (60 and above)	
I	**Female**					
	Low(0.33-0.66)	19 (13.19)	84 (19.00)	91 (23.88)	9 (21.95)	203 (20.14)
	Medium (0.33 - 0.66).	61 (42.36)	202 (45.70)	187 (49.08)	21 (51.22)	471 (46.73)
	High(0.66-1)	64 (44.44)	156 (35.29)	103 (27.03)	11 (26.83)	334 (33.13)
	Total	144 (100)	442 (100)	381 (100)	41 (100)	1008 (100)
II	**Male**					
	Low(0.33-0.66)	8 (7.41)	52 (13.16)	48 (11.24)	22 (22.68)	130 (12.66)
	Medium (0.33 - 0.66).	55 (50.93)	161 (40.76)	208 (48.71)	33 (34.02)	457 (44.50)
	High(0.66-1)	45 (41.67)	182 (46.08)	171 (40.05)	42 (43.30)	440 (42.84)
	Total	108 (100)	395 (100)	427 (100)	97 (100)	1027 (100)

Source: Computed

Table 21 Patterns of Relationship Between AIDS/ HIV Awareness, Social Distance and Mass Media Exposure: Partial Correlation Coefficients Controlling for Age Group, Gender, Locality and Education

S.No.	Variable	PROBLEM	SYMPTOM	MODE	Prevention	DISTANCE
1	**PROBLEM**	1	0.18	0.21	0.21	0.08
2	**SYMPTOM**	0.18	1	0.42	0.38	0.14
3	**MODE**	0.21	0.42	1	0.70	0.17
4	**Prevention**	0.21	0.38	0.70	1	0.16
5	**DISTANCE**	0.08	0.14	0.17	0.16	1
6	**DD**	0.13	0.22	0.39	0.35	0.06
7	**LTV**	0.08	0.24	0.40	0.38	0.16
8	**RADIO**	0.17	0.15	0.14	0.14	-0.05
9	**PRINT**	0.18	0.20	0.27	0.28	0.12

Source: Computed

Table 22 Respondents Ranking of Preference of Communication Channels: Mean Transmuted Scores by District

Sl.No	Communication Channel	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
1	Peer or Project Worker	30.18	52.15	68.00	46.27	63.20	69.92	64.72	56.00	56.29
2	Health Centre Worker	42.33	45.62	70.85	47.32	59.31	63.94	53.87	48.62	52.67
3	Church Meetings	46.87	47.47	46.60	46.19	54.68	60.15	55.78	49.76	50.58
4	YMA Meetings	44.63	39.65	47.09	46.72	55.36	56.48	62.07	50.24	50.17
5	Mizo New Papers	18.92	37.08	55.11	43.40	54.48	55.65	55.96	48.18	46.79
6	TV DD	26.26	41.91	44.98	39.45	51.91	46.28	54.86	46.47	44.86
7	Student Meetings	12.80	35.23	37.23	38.55	51.74	54.89	54.67	50.30	44.11
8	Radio	10.34	28.07	50.73	35.87	53.28	52.75	56.49	47.07	43.23
9	Local TV Network	24.63	38.73	29.99	33.98	48.88	47.36	50.78	50.11	42.95
10	Local News Papers	12.20	38.13	50.73	40.27	51.25	50.33	51.85	38.93	41.48
11	Mizo Magazine	17.34	30.52	54.22	37.64	50.97	53.93	50.40	39.02	41.26
12	Hoardings / Wall Papers	12.08	29.17	52.98	25.94	42.91	41.94	39.58	27.94	32.85
13	MHIP Meetings	15.89	26.06	38.75	33.15	44.36	43.86	47.53	26.12	32.79
14	Pamphlets / Booklets	9.07	27.69	50.55	25.31	40.23	41.24	40.43	26.62	31.42
15	Stickers with Slogans	5.24	18.80	42.74	18.03	33.19	35.91	31.02	19.07	24.11
16	MUP Meetings	9.41	13.56	32.63	21.87	31.42	37.24	28.45	18.16	22.76
17	Polythene Bags with Slogans	8.30	18.42	38.90	17.03	29.42	36.38	27.83	17.50	22.64

Source: Computed

Table 23 Respondents Ranking of Preference of Communication Channels: Mean Transmuted Scores by Age Group and Gender

Age Group / Gender	Adolescent (13 -18)			Youth (18-35)			Middle Aged (35-60)			Aged (60 and above)			Total		
	Female n=144	Male n=108	Total n=252	Female n=442	Male n=395	Total n=837	Female n=381	Male n=427	Total n=808	Female n=41	Male n=97	Total n=138	Female n =1008	Male n = 1027	Total N = 2035
Peer or Project Worker	59	51	56	58	58	58	55	56	56	50	48	49	57	56	56 (1)
Health Centre Worker	57	54	55	56	52	54	51	51	51	45	48	47	54	52	53 (2)
Church Meetings	52	51	51	50	49	49	53	51	52	51	48	49	51	50	51 (3)
YMA Meetings	52	54	53	50	51	50	50	51	50	34	46	42	50	51	50 (4)
Mizo New Papers	51	48	49	49	49	49	43	47	45	36	41	39	46	47	47 (5)
TV DD	47	47	47	46	45	45	44	45	44	43	41	42	45	45	45 (6)
Student Meetings	52	50	51	43	46	44	44	42	43	41	39	40	44	44	44 (7)
Radio	45	45	45	43	45	44	41	44	42	40	36	38	43	44	43 (8)
Local TV Network	44	47	45	45	42	44	43	41	42	40	38	38	44	42	43 (9)
Mizo Magazine1	45	44	45	46	44	45	37	38	38	31	33	32	42	41	41 (10)
Local News Papers	46	44	45	44	44	44	37	42	40	27	32	31	41	42	41 (11)
Hoardings / Wall Papers	38	40	39	38	35	36	28	30	29	12	24	20	33	33	33 (12)
MHIP Meetings	39	35	37	36	32	34	33	30	31	22	28	26	34	31	33 (13)
Pamphlets / Booklets	39	37	38	37	33	35	25	30	27	13	23	20	32	31	31 (14)
Stickers with Slogans	30	30	30	29	26	28	20	21	20	9	17	15	25	24	24 (15)
Polythen Bags with Slogans	29	27	28	27	25	26	18	20	19	12	16	15	23	22	23 (16)
MUP Meetings	26	27	26	23	24	24	21	21	21	12	24	21	22	23	23 (17)

CHAPTER VI

PERSPECTIVES OF COMMUNITY LEADERS, YOUTH, WOMEN: RESULTS OF FOCUS GROUP DISCUSSIONS

6.1. COMMUNITY LEADERS

Focus group discussions were conducted among community leaders, women and youth in the sample villages and localities in all the districts of Mizoram with the exception of Farm Veng, in Lunglei district. As such a total of 15 FGDs were held in different districts of Mizoram. The community leaders consist of Village council members, MHIP committee members, members from YMA, KTP/TKP, Women's fellowships and Elders from the Churches. The total number of persons partaking in the FGD was 171 in numbers with 31 women members.

6.1.1 Awareness on HIV/AIDS

The awareness level of community leaders on HIV/AIDS is at a reasonable extent. All the modes of transmission such as sexual contact, sharing of needle and syringes, mother to child, blood transfusion were well recognised invariably in all FGDS when the problem of HIV/AIDS was discussed.

6.1.2. Myth and Misconceptions:

Living and sharing can spread the virus

It was shared in some district that sharing and living together or even getting close with the PLWHA is one way of infection.

Fewer white blood cells more vulnerable to HIV/AIDS

Besides the above, another point shared was that a person with fewer white blood cells can get HIV/AIDS easily. Although this was probed, the participants were not able to explain how or where they know it, they just expressed that they know it.

6.1.3 Perceived Reasons for Spread of HIV/AIDS

Three interrelated processes of liberalisation and secularisation of Mizo social structure, weakening family ties, and increased mobility of women were perceived by the leaders as responsible for spread of HIV/AIDS in Mizoram.

Liberalisation and Secularalisation of Social Structure

In more than one third of the FGDs, it was described that spread of HIV in associated with the changing social system, which is more and more liberal and secular in nature. This has paved a way for a free lifestyle, the sense of wanting to be 'in the group', loose character with no values and ethics.

Weakening of Family Ties

It was also perceived that the leaders perceived the weakening of family structure especially marital breakdown, broken family and discord within the family as the major cause of the spread of the disease. Family system was seen to be closely linked with the spread of the disease directly and indirectly in most of the FGDs.

Increased Mobility of Women

The leaders perceived women as transmitters of the disease. The argument was that there is increasing mobility of women for earning livelihood, which led them to be free and pick up loose character.

6.1.3 Policy and Communication

6.1.3.1 Policy Suggestions

Isolation of PLHA

More than one third of the discussion highlighted that a separate home for PLHA should be made available for all. Both negative and positive reasons were pointed out. For the positive aspects, it was shared that a medical treatment including support will be made available for the PLWHA. Negatively, the central idea for the system is to prevent the spread of the disease.

Publishing the Names of the PLHA

Almost twenty percent of the FGD reflected that as community leaders, it is their responsibility to know the HIV status of the people within their own community. It will also be the responsibility of the community leaders to announce the names of the persons if it is necessary. The reason given for this is prevention and protection of the uninfected.

Promoting Enabling Environment

In less than a third of the groups, positive attitude towards PLHA pointed out in the discussions. For those who argue on humanitarian perspective, focus was on promoting enabling environment so that discrimination will decrease and a society where PLWHA are treated equally was envisaged. It was argued that if equality is present, the PLWHA will also have a feeling of worth and shall live a positive life. Key words used when this was discussed were love and care, support, and providing employment to those infected with HIV/AIDS.

Employment Opportunities for Youth Emphasised

In the group discussions, the discussant has mainstreamed the excessive multiplication of victims to other factors such as unemployment. It was perceived that leisure hours and time are the factors that contribute to the laxity of youth, which need to be addressed to when HIV/AIDS is discussed about.

Isolation and Restriction of Mobility

HIV/AIDS and the spread of the disease is closely linked with certain category of people such as Sex Workers, HIV Positives themselves, mobile workers like drivers, businessmen, tourists, etc. There were many leaders who felt that harsher punishment for offenders of such character as important means for preventing HIV/AIDS at community level. The problems related with commercial sex workers were discussed elaborately. It was suggested in almost half of the FGDs that a separate red light area be created so that the spread of the virus by CSW could be controlled.

Setting up of Drop-in Centres and AIDS Cells

In rural areas, there was a suggestion to open up NGOs, which will work in these issues. The reasons given are that these places are remote and there are no organizations to generate the awareness of the people regarding HIV/AIDS the result being low awareness level.

Compulsory Blood Test

It was shared in less than a third of the discussion that a compulsory blood test is needed for all. This was discussed in line with compulsory blood test before marriage. It was shared that HIV/AIDS test may be conducted in every village by pretending that it is a government scheme for Malaria or TB Control Programme like that etc.

Condom Distribution

Almost half of the discussion also focuses on the need for promotion and distribution of Condom. In other FGD also, it was suggested that for the easy access of condom a vending machine should be introduced in places like public toilet etc. In rural places, it was shared that community leaders can be entrusted to promote condoms. In this, it was clearly highlighted that distribution of condom should be done in a careful manner as some people may think that they are free to have sex without fear of getting infected or pregnant.

Syringe Needle Exchange

The discussion also highlighted the importance of prevention and control of drug and alcohol. For this purpose, attempt for stronger control was suggested; it was also shared in one fourth of the discussion that Syringe Exchange Programme should be encouraged especially among the Injecting Drug Users so as to reduce infection to a great extent.

Distribution of Gloves for the Community Leaders

Distribution of gloves for the Community Leaders for preparing and touching the dead body was suggested by community leaders. The present system of managing corpse was also discussed. In the rural places, it was shared that managing corpses was a problem. In the light of this, distribution of glove was emphasized for the community leaders.

Role of the Church

The role of the Church was discussed in great detail. In one third of the discussion, the importance of the Church was highlighted. It was suggested that if the church elders and even the pastors take keen interest and preach about HIV/AIDS in

the pulpit it will be very effective for the prevention of this disease as they are usually respectable and influential. Besides, awareness campaign and education to the church members can also be carried out in different activities of the church like youth fellowship etc in which awareness can be done as one part of the activity.

Networking

It was shared that the cooperation of various Government and Non – Government Organization is the cornerstone for combating HIV/AIDS effectively. In this concern the roles and responsibilities of the community leaders are to support and work hand in hands with those who work in this field. This is a recurring suggestion in almost half of the focus group discussion.

The focus group discussion cantering on perceptions revealed that there is awareness on the general masses however; there are still myths and misconceptions regarding the infection. The discussion on mode of transmission and its channels reveals that HIV/AIDS is still associated with certain category of people.

6.1.3.2 Information, Education and Communication (IEC) Strategies

In the discussions the main focus of the leaders was around the use of group and interpersonal communication methods rather than mass media channels.

Promoting Cultural Ethos and Values

It was shared that one reason why many people especially the youngsters indulge in loose behaviour is because of the decay and fade of cultural ethos and value system of the society. Social and cultural ethos, which bound the lives of the people in the past, are no longer existed and decayed. So it was suggested that promotion of cultural ethos and value system would be emphasized so that the rate of HIV/AIDS infection will be decreased to a great extent.

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Channels of Communication

Although it was shared that seminars and workshop or awareness campaigns were considered an important means of education, the FGD highlighted that the present system of awareness campaign is not effective. The reason for this given in all the group discussion was that awareness campaign has not reached the general masses, the grass root level. They said that there are many cultivators, daily labourers,

dairy farmer, etc., who do not have time for attending awareness campaigns. Besides, in places like Serchhip, it was shared that attendants of the awareness have always been the same persons over and over again. They shared that as community leaders, they have been recipient of the awareness level. However, these have not reached the community level and most people do not know what exactly HIV/AIDS is. It was also suggested that more visual aid be used, as these tools are attractive to the general masses.

We can recall that community leaders has shared that they have been recipient of many trainings, the result of such training as such is reflected on the this discussion. More than half of the FGD highlighted that for the prevention of HIV/AIDS in the community, the community leaders has the most important role and first of all should be thoroughly aware of what HIV/AIDS is. It seems that even though community leaders have training in this regard, the training has not led them to become trainers or have sensitised them enough to carry the message on their own. It was shared that even the community can generate awareness to the grass root level if they are fully aware of it. So it was suggested that more and deeper awareness for the community leaders should be emphasized in order to give awareness to the general masses.

It was shared and discussed in the FGDs that displaying words about HIV/AIDS in placard, board, hoarding etc should be emphasized and carried in an interesting way.

Education in School on HIV/AIDS

One third of the discussants also shared the importance of education on HIV/AIDS, STD and Sex education at school. By education, the discussion highlights the importance of formalizing and systematizing the system. It was suggested that curriculum should include all these topics. What the participant meant by sex education was probed however there was no clear-cut definition or answer; one aspect that comes out when sex education was discussed in places like Niawhtlang was that ‘the value of virginity should be emphasized’. This has shown that value system has been addressed to and is kept at an important place when sex education is being imparted.

6.2 WOMEN

Focus Group discussion with women was conducted in all the districts. The participants were 185 in numbers. The first concern of the focus group discussion was the perception of participating members regarding HIV/AIDS. Here the perceptions of the participants regarding the modes of transmission of this disease are summarized as under:

6.2.1 Awareness on HIV/AIDS

Although there are several myths and misconceptions with regard to the mode of transmission, the brain storming on the group discussions reveals that all the routes of transmission of HIV/AIDS have been well recognized.

6.2.2 Myths and Misconceptions

Mosquito and Leeches Bite

One misconception and belief that was reflected in two group discussions describe HIV/AIDS as transmitted through mosquito and leeches bite.

Sharing Toilet, Smoking Cigarette

Another rural village group also feels that sharing toilet, smoking the same cigarette can also cause HIV to spread from one person to another.

As easy to Infect as Common Cold

In another village, it was also reflected that HIV/AIDS is as easy to infect as common cold.

Kissing and Oral Sex

Kissing and Oral sex was also seen as a way that can spread HIV/AIDS. When probed, they were not able to explain it but said that they have heard people say it.

Women have High Blood Pressure

An interesting but serious misconception shared in one FGD is that there is a higher chance for women to get HIV/AIDS as they have high blood pressure, so risk is high in women

Indirect Infection During Menstruation

Women have It was further shared that if a woman goes to attend funeral function of a dead infected person during her menstrual period it is a high chance of getting infection for her.

6.2.3 Perceived Reasons for Spread of HIV/AIDS

The perceptions on HIV/AIDS among mothers in the focus group discussion show that the problem of HIV/AIDS has been discussed in relation to the vulnerability of women in the present patriarchal society.

Women's Vulnerability to HIV/AIDS

Women perceive that contracting HIV/AIDS from their spouse is the easiest way of getting infected. One woman said 'it is through husbands that many mothers are getting infected'. The women have seen mobility of husbands for work coupled with insincerity as a major problem. Besides this, a recurring expression of the women 'it is difficult for a wife to convince her husband to use condom' is of major concern. Although it was probed, not much explanation came out except in one discussion where it was shared that women are submissive and it is our role to be submissive. Other discussions shared that as women "we are inferior, physically and biologically".

Mobility and Freedom of Men in the Society

The description of the character of male was 'loose' which signify that men have more freedom to move around or have pre marital or extra marital sex. Freedom to have sex according to the women for men has been socially sanctioned. For this reason, it was felt that they it has becoming increasingly difficult for a girl to choose a husband for the present generation too. This freedom of men coupled with insincerity was feared, and antagonized by the women.

HIV/AIDS Associated with Moral Character

Women also increasingly see HIV/AIDS as akin to a character. It was shared that a person with loose character, who is not guided by any principle, who indulge in alcohol, drugs and sex transmits it to others.

Mobile Workers-truckers, Contractors etc

Almost twenty percent of the FGD reflected that mobile workers-contractors, officers, and truckers etc who usually indulge in unprotected sex spread HIV/AIDS in the society.

Accident or Carelessness

What constitute accidents or carelessness was not discussed upon. However, this aspect was pointed out in the group discussion where it was seen that a person could easily be infected through such means.

Persons who Reaped what they Sowed

HIV+ are mostly seen to be drug and alcohol abusers, sex workers, persons of loose character etc and are seen to reap what they sowed. It was further reflected that there is no need for humanitarian treatment, love and support, as they deserve what they got.

6.2.4 Suggestions

Publication of Names of PLHA

It was shared in the FGD that the names of PLWHA should be publicized and made known to the general public so that the people will keep themselves away from getting infection.

Isolation of PLHA

In one fourth of the FGD it was shared that PLWHA should be kept in separate place and should not interact with the general masses. This they believe will further prevent the spread of HIV/AIDS among the general masses. It was shared in some of the group discussion that they do not want to see or hear of HIV+.

Again here the social distance between the infected and non-infected is highlighted. It was shared in some of the FGD that they do not want to stay together with the PLWHA under the same roof share food, toilet etc.

Positive and Humanitarian Attitudes

Again almost in twenty percent of the FGD it was shared that those PLWHA are human being and should be treated on humanitarian basis and their problems and needs should be taken into consideration by showing love, care and affection.

It was reflected in more than one third of the FGD that acceptance of a PLWHA depends upon the person him/herself. They further expressed that if the person is their relative they can easily accept and treat him/her. But on the other hand

if the person is an unknown stranger it will be difficult to accept and treat him on humanitarian basis.

6.2.5 Information Education and Communication Strategies

Regarding the awareness to be generated, women feel that they have high responsibility to their family and for their own. Suggestions put forth are summarized as follow:

Family Education

Women felt that educating their children about HIV/AIDS, STDs and even sex education in the family is important. This importance has been shared in almost all the group discussions.

Promoting Condom

It was also shared that promoting condom use is important not only for extra marital or pre marital sex but also in wedlock. Convincing their husband to use condom during sex if they are suspicious of having extra marital sex

Family Counselling

It has also been suggested that family counselling is needed so that the gaps within the family be challenged. As this was probed, it was shared in some FGD that it is impossible and difficult for a mother to teach her children about sex and its related issues and counsellors could easily do that which would benefit the child. This suggestion calls for an outside intervention on the family level through inter personal relation.

Awareness for women

It was also suggested that there be a separate awareness program for women so that mothers and women will have better knowledge towards HIV/AIDS and will in turn educate their family members.

6.3 YOUTH

Approach on the method of FGD differs in all the districts. In some districts, the group discussion was held separately for male and female while in some FGDs, the group mixes up**.** A total of 251 youth participated in the discussion. Out of this, 99 were young girls. The age group of the participants range from 14 – 35 years.

6.3.1 Awareness

The youth are also able to clearly share the various modes of communication of HIV/AIDS in the group discussions. The youth are different in the sense that when they talk about blood transfusion as a means of communication, they have included 'unscreened blood transfusion' and when they talk about sex as the method of transmission, the first choice of word being 'unprotected sex'**.**

6.3.2 Myths and Misconceptions

Mosquito Bite

A misconception reflected in the FGDs was that HIV/AIDS is spread through mosquito bites just like malaria.

Sweat and Perspiration

Another misconception was again highlighted in two FGDs where it was shared that there is a chance of getting infection with HIV/AIDS through sweat and perspiration.

Deep Kissing

It was highlighted and shared in one FGD that there is a chance of getting infection through deep kissing. It was further highlighted that if the chance of getting infection is high if there is bleed or injure in the mouth.

6.3.3 Perceived Reasons for Spread of HIV/AIDS

Lack of Sex Education

It was reflected in one FGD that the spread of HIV/AIDS is because of lack of Sex Education in the family. It was further shared that the youth who do not receive sex education in the family usually indulge in loose behaviour and pre and extra

marital affairs. It was reflected in some of the FGD that sex education is never imparted to them in their own family and parents do not give importance to this.

Transmission Related with Behaviour

It was shared the FGD that there is a high chance of getting infection among those who are loose character or immoral behaviour. This is cause by free lifestyle, low level of education, excessive exposure to pornographic movies and the increasing liberal minded attitude towards pre-marital sex.

Excessive Indulgence of Youth in Pre-marital Sex

It is interesting to note that most of the youth discussion on sex as a cause of HIV infection has reflected that pre-marital sex among the youth is a common occurrence. It was shared that youth are usually sexually active and curious about sex. It was also shared even the girls are more and more liberal regarding pre-marital sex in their behaviour It was also repeatedly highlighted that those who practice pre-marital sex do not practice safe sex at all as they usually have sex without using condom.

When the reason for excessive pre marital sex was probed, it was reflected that the old tradition, which was held in the past among the male youth, is still prevalent among the youth in the present context; which is - a male youth still hold that if they have more sex with girl they will be respectable and would brag about it.

Another reason why the youth indulge in pre-marital sex as highlighted the group discussion is that the youth are having much leisure time and excessive freedom outside the home. It was further shared that there are many social gatherings and activities in the community so this somehow leads the youth to use pre-marital sex. It was shared in one FGD that the dresses and fashion of girls are sexually attractive and further believed that this leads male youth sexually active.

Mass and Electronic Media Impact

One of the main challenge and obstacles for behaviour change is electronic and mass media, which was reflected in almost fifty percent of the FGD. It was shared that there are so many pornographic movies and pictures, which are of easy access. Sexy movies and pictures arouse the sexual desires of the youth and leads to indulgence in pre-marital sex. This is reflected in both rural and urban areas.

Generation Gap direct impact on family

It was shared in one fourth of the FGD that modernization, westernisation and technological like computer and Internet advancement have a negative impact on the minds of the youth.

When this issue was probed, it was shared that the parents find it difficult to comply with modernized lifestyles and cannot understand material culture of their children, as they are conservative and narrow-minded in their outlook; which has in turn problematic effect on family. It was discussed that parents exert excessive control their children this in turn leads to misuse of freedom when and where they feel free. It was also shared that youth does not talk to parents even when they need them to make decisions about sex or girlfriends/boyfriends. Gap as such according to the youth is present in the family, which makes it impossible for youth to change their behaviour.

Influence of Electronic Media and Pornography

It was shared in one fourth of the FGD that the attitudes of youth on sex undergo tremendous change, which they shared, is a result of mass and electronic media like pornographic movies and pictures. In some of the FGDs, it was shared that Direct-To- Home movie channel stands in the way of behavioural change as pornographic movies are broadcast every time. This according to them has paved the way for indulgence in sex.

Excessive Freedom and Lack of Recreation Facilities

It was highlighted in the FGD that most of the youth who have excessive freedom usually misuse their freedom and or over enjoy life by indulging in loose behaviour. When this was probed, the problem highlighted by the youth shows that there are lack recreational facilities. It was shared that the youth have no good place for recreational and leisure time activities as a result they seek something to enjoy life. Sex and other kinds of loose related activities such as taking drugs became the most enjoyable leisure moments.

Lack of Employment

One interesting point highlighted in one FGD as the obstacle for behaviour change is unemployment among the youth. It was shared that lack of employment among the youth stands in the way of behavioural change.

Prevalence of Traditional Values on Sex among Male Youth

It was reflected in many of the FGD that the value systems, which dominate the life of the male youth in the past regarding sex, are still held by many male youth. It was said that those who have sexual contact with many girls were respected and placed in a high position in the past and this value system is still prevalent among the male youth.

Negligence and Ignorance of Parents

Another important point highlighted and shared in FGDs is negligence and ignorance of parents. It was shared that most of the parents do not give proper attention to their children.

6.3.4 Information Educations and Communication

Education to Parents on Parenting Skills

It was shared in almost twenty percent of the FGD that parents do not give prior importance to their children. The relationship ties between parents and children is not desirable as friendly and cordial relationship are rarely found in the Mizo family. Suggestion was put so as parents will get education on parenting and this will accord the group discussions will help in the fight against the spread of HIV/AIDS.

Sex Education

In almost one half of the FGD it was suggested that sex education should be introduced from the grass root level, church, social gathering and even it should be included in the school curriculum. It was further suggested sex education should be imparted in a careful manner and the recipient should be selected carefully on the basis of their age level.

It was shared in most of the discussion that youth are really in need of sex education in order not only to avoid infection with STD but also sexual abuse. It is a must to start sex education for the youth so as HIV/AIDS can be prevented to a great extent.

Condom Promotion

Although a larger percentage of the group discussion highlighted that condom promotion will lead to bad effect like indulging in more sexual activities with no fear of STD or pregnancy, significant contribution of the youth was that they feel shy of buying condom even if they want to have sex. This has according to many lead to unsafe sex.

CHAPTE VII

CONCLUSION AND SUGGESTION

The last chapter presented the results and discussion of the information collected through field survey using structured interview and focus group discussion. Here attempt is made to draw conclusions and major recommendations and suggestions for effective measures in combating HIV/AIDS in Mizoram.

7.1 Profile of Respondents

The profile of respondents has been discussed with a view to find out structural bases of knowledge and perception on the problem of HIV/AIDS. The demographic characteristics of the respondents like gender, age group, locality and educational status of the respondents are discussed.

7.1.1 Demographic Characteristics

As regard gender male population constitutes higher number as a whole and female constitutes fewer in number. This over all patterns was invariably observed in the cases of all the districts.

Age of the respondents has been classified into four age groups viz. Adolescent (13-18), Youth (18-35), Middle (35-60) and aged (60 and above). Youth group constitutes highest number followed by Middle age. Similar age structure was observed in most of the districts.

Regarding locality of the respondents it is classified into rural and urban locality. On the whole more than one half of the respondents live in urban settlement. There were variations in the distribution of respondents across locality. In the districts of Serchhip, Saiha, Lawngtlai, Mamit and Aizawl the disparity between rural and urban is so high. In Lawngtlai District alone all the respondents settle in rural setting whereas in Aizawl District more than two third are urban dwellers.

As regard the educational status of the respondents again it was classified into six levels viz. Illiterate, Primary (1-4), Middle (5-7), High School (8-10), HSSLC (11-12) and College and above. It was observed that almost all the respondents are literates. But most of the respondents had not gone beyond high school. Illiterate constitutes very less proportion while the respondents who pursue higher education (college and above) constitutes less than ten percent. Almost half of the respondent attended High School standard, which is highest in number, and 18% attended Middle School and 17% of the respondents attended Primary School.

7.1.2 Social Characteristics.

To understand the social structural bases is one of the objectives of the present study. Mizo social structure was reported to be based on Family-clan-sub-tribe pattern (Vidyarthi and Rai, 1976:153). To accomplish the understanding of social structural basis of respondents, analysis of social structural characteristics of respondent's viz., sub tribe, type of clan and denomination has been attempted.

Religious Denomination professed by the respondent has been classified into twelve categories viz, Presbyterian, Baptist, United Pentecostal Church. The Salvation Army, IKK, LIKBK, ECM, EFCI, Seventh Day Adventist, BBEC, Roman Catholic and Others. Presbyterian Church is the largest denomination in Mizoram and Baptist is the second largest denomination. The result also highlights that Presbyterian Church had formed the highest proportion. Almost half of the respondent belongs to Presbyterian Church, followed by Baptist Church of Mizoram, and United Pentecostal Church.

The respondents belong to different Sub- tribe viz, Lusei, Lai, Hmar, Ralte, Paihte, Mara, Pang, Gangte, Kuki, Non-Mizo and Bru. Majority of the respondents belong to Lusei sub-tribe, which is followed by Lai and Hmar. Among the respondents 0.05% are Bru, Non-Mizo 0.15%, Gangte 0.29% and Pang 0.64%.

7.1.3. Economic characteristics

Economic characteristics of the respondents have been discussed and measured in terms of type of occupation and level of household income. The occupation of the respondents is classified into nine items viz. Cultivator, Government service, Business, Labourer, professional, Artisan, Petty Trade None and Homemakers. It was found that most of the respondents are cultivators, which is followed by Government service and Businessperson. Homemakers consist of only 0.98% and those who have no particular occupation consists of 2%.

The annual income of the respondent has been classified into four categories viz. Less than 24000, Rs 24000-48000, Rs 48000-100000 and Above 100000. The respondent with the income of less than Rs 24000 were 21.87% and 20.39% of the respondents fall in the income of between Rs 24000-48000. Most of the respondents are with income of Rs 48000-10000 and 21.13% of the respondents are in the income of Above Rs 100000. On the whole the mean annual income of the respondent is 79464.33.

7.2. Awareness on HIV/AIDS

The awareness of the respondents on HIV/AIDS was measured in terms of four dimensions viz., Problem, Symptoms, Mode of Transmission and prevention each with a few items.

The problem dimension of awareness had four items viz. concept of *AIDS, HIV*, *Difference* and no *Cure* are selected and the awareness of the respondents is measured. The result indicates that the most of the respondents have knowledge on *AIDS* and *HIV* but majority of the respondent does not know the difference between HIV and AIDS and the problematic of no cure. More than two third know what AIDS is and more than one half know HIV as well. Almost one half knows the difference between HIV and AIDS. On the whole the knowledge of Champhai District on AIDS and HIV is lowest where as the knowledge of Aizawl District is highest. But amazingly only 18% of the respondents know that there is no cure for HIV/AIDS.

Regarding the Symptoms of HIV/AIDS again the knowledge of the respondent was assessed in terms of two symptoms- Excessive weight loss and Continuous Dysentery. The result indicates that the knowledge of the most of the respondents do aware of both the symptoms. More than one half of the respondents know that excessive weight loss and continuous dysentery as the symptoms of HIV/AIDS.

Regarding the mode of transmission three dimensions are selected viz. Sharing of Syringe, Unprotected Sex and Mother to Child. The result indicates that the most of respondents have knowledge on all the modes of transmission. On the whole more than two third of the respondents know that HIV/AIDS is spread by sharing of Syringe, and unprotected sex, and from mother to her baby. Regarding the prevention of HIV/AIDS three items are selected on the basis of which the knowledge/awareness of the respondents is assessed. The result reveals that most respondents are aware of the ways of preventing *AIDS/HIV*. More than two third of the respondents shared that HIV/AIDS can be prevented by having one faithful sex partner and again more than two third of the respondents shared that it can be prevented by using condom during sex and by using sterilized needles.

For comparison the awareness of the respondents in each of the dimension was measured in terms of simple average of their items. It is observed that it seems that awareness on the mode of transmission and prevention are relatively greater as compared to that on the problem and symptoms. The mean awareness scores on mode of transmission and prevention were worked out to 0.87 and 0.83 while the mean scores of problem and symptom were respectively 0.52 and 0.58.

Besides, the Mean indices by Gender and Age have been worked out in order to make a comparison between the awareness levels of male and female on the basis of their age group. The result indicates that the awareness level of male people is better than female. The total mean score of female is 0.67 while the total mean score of male is 0.72. Again it was revealed that the younger the age the lower the awareness on HIV/AIDS

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Table 1 Demographic Profile

Sl.No	Characteristic	District								
I	**Gender**	**Mamit N=180**	**Kolasib N =220**	**Aizawl N=649**	**Champhai N=218**	**Serchhip N=166**	**Lunglei N =259**	**Lawngtlai N=160**	**Saiha N = 183**	**Total N=2035**
	Female	90 (50.00)	107 (48.64)	324 (49.92)	107 (49.08)	82 (49.40)	127 (49.03)	80 (50.00)	91 (49.73)	1008 (49.53)
	Male	90 (50.00)	113 (51.36)	325 (50.08)	111 (50.92)	84 (50.60)	132 (50.97)	80 (50.00)	92 (50.27)	1027 (50.47)
II	**Age Group**									
	Adolescent (13 -18)	32 (17.78)	16 (7.27)	51 (7.86)	32 (14.68)	15 (9.04)	26 (10.04)	32 (20.00)	48 (26.23)	252 (12.38)
	Youth(18-35)	97 (53.89)	105 (47.73)	175 (26.96)	107 (49.08)	73 (43.98)	132 (50.97)	70 (43.75)	78 (42.62)	837 (41.13)
	Middle Aged(35-60)	49 (27.22)	85 (38.64)	344 (53.00)	69 (31.65)	64 (38.55)	92 (35.52)	56 (35.00)	49 (26.78)	808 (39.71)
	Aged(60 and above)	2 (1.11)	14 (6.36)	79 (12.17)	10 (4.59)	14 (8.43)	9 (3.47)	2 (1.25)	8 (4.37)	138 (6.78)
	Mean Age	30.311	36.25	40.36	33.19	36.85	34.51	31.84	31.17	35.73
III	**Marital Status**									
	Unmarried	64 (35.56)	64 (29.09)	188 (28.97)	72 (33.03)	59 (35.54)	90 (34.75)	57 (35.63)	62 (33.88)	656 (32.24)
	Married	112 (62.22)	146 (66.36)	404 (62.25)	133 (61.01)	99 (59.64)	164 (63.32)	95 (59.38)	117 (63.93)	1270 (62.41)
	Divorced	2 (1.11)	4 (1.82)	19 (2.93)	2 (0.92)	4 (2.41)	4 (1.54)	7 (4.38)	4 (2.19)	46 (2.26)
	Remarried	1 (0.56)	2 (0.91)	1 (0.15)	5 (2.29)	1 (0.60)	0 (0.00)	0 (0.00)	0 (0.00)	10 (0.49)
	Widowed	1 (0.56)	4 (1.82)	37 (5.70)	6 (2.75)	3 (1.81)	1 (0.39)	1 (0.63)	0 (0.00	53 (2.60)

Source: Computed

Table 2 Education Status

		District								
Sl.No.	**Education Status**	**Mamit N=180**	**Kolasib N =220**	**Aizawl N=649**	**Champhai N=218**	**Serchip N=166**	**Lunglei N =259**	**Lawngtlai N=160**	**Saiha N = 183**	**Total N=2035**
1	Illiterate	1 (0.56)	15 (6.82)	16 (2.47)	10 (4.59)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	42 (2.06)
2	Primary(1-4)	33 (18.33)	41 (18.64)	93 (14.33)	39 (17.89)	36 (21.69)	22 (8.49)	16 (10.00)	61 (33.33)	341 (16.76)
3	Middle(5-7)	57 (31.67)	46 (20.91)	94 (14.48)	49 (22.48)	30 (18.07)	37 (14.29)	25 (15.63)	38 (20.77)	376 (18.48)
4	High School(8-10)	73 (40.56)	92 (41.82)	274 (42.22)	96 (44.04)	71 (42.77)	126 (48.65)	67 (41.88)	63 (34.43)	862 (42.36)
5	HSC(11-12)	8 (4.44)	10 (4.55)	86 (13.25)	21 (9.63)	16 (9.64)	42 (16.22)	36 (22.50)	13 (7.10)	232 (11.40)
6	College (13 and Above)	8 (4.44)	16 (7.27)	86 (13.25)	3 (1.38)	13 (7.83)	32 (12.36)	16 (10.00)	8 (4.37)	182 (8.94)
	Mean Years of Education	7.43	7.28	8.78	7.22	8.01	9.45	9.43	6.79	8.23

Source: Computed

Source: Computed

Table 3 Locality and Sub-tribe

		District								
Sl.No.	**Sub-tribe**									
I	**Locality**	**Mamit N =180**	**Kolasib N = 220**	**Aizawl N = 649**	**Champhai N =218**	**Serchip N =166**	**Lunglei N = 259**	**Lawngtlai N =160**	**Saiha N = 183**	**Total N = 2035**
	Rural	120 (66.67)	119 (54.09)	156 (24.04)	126 (57.80)	103 (62.05)	135 (52.12)	160 (100)	121 (66.12)	1040 (51.11)
	Urban	60 (33.33)	101 (45.91)	493 (75.96)	92 (42.20)	63 (37.95)	124 (47.88)	0 (0.00)	62 (33.88)	995 (48.89)
II	**Sub-tribe**									
	Lusei	104 (57.78)	47 (21.36)	286 (44.07)	105 (48.17)	80 (48.19)	122 (47.10)	46 (28.75)	11 (6.01)	801 (39.36)
	Lai	12 (6.67)	16 (7.27)	48 (7.40)	61 (27.98)	23 (13.86)	45 (17.37)	78 (48.75)	145 (79.23)	428 (21.03)
	Hmar	42 (23.33)	112 (50.91)	148 (22.80)	25 (11.47)	32 (19.28)	29 (11.20)	11 (6.88)	4 (2.19)	403 (19.80)
	Ralte	19 (10.56)	30 (13.64)	132 (20.34)	20 (9.17)	24 (14.46)	53 (20.46)	9 (5.63)	2 (1.09)	289 (14.20)
	Paihte	3 (1.67)	6 (2.73)	32 (4.93)	7 (3.21)	7 (4.22)	9 (3.47)	0 (0.00)	1 (0.55)	65 (3.19)
	Mara	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.39)	1 (0.63)	20 (10.93)	22 (1.08)
	Pang	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	13 (8.13)	0 (0.00)	13 (0.64)
	Gangte	0 (0.00)	6 (2.73)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	6 (0.29)
	Kuki	0 (0.00)	3 (1.36)	1 (0.15)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	4 (0.20)
	Non-Mizo	0 (0.00)	0 (0.00)	2 (0.31)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.63)	0 (0.00)	3 (0.15)
	Bru	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.63)	0 (0.00)	1 (0.05)

Source: Computed

Table 4 Religious Denomination

		District								
Sl.No	**Denomination**	**Mamit N=180**	**Kolasib N =220**	**Aizawl N=649**	**Champhai N =218**	**Serchip N =166**	**Lunglei N =259**	**Lawngtlai N = 160**	**Saiha N = 183**	**Total N=2035**
1	Presbyterian	69 (38.33)	111 (50.45)	507 (78.12)	136 (62.39)	123 (74.10)	23 (8.88)	22 (13.75)	6 (3.28)	997 (48.99)
2	Baptist	25 (13.89)	0 (0.00)	27 (4.16)	0 (0.00)	2 (1.20)	187 (72.20)	74 (46.25)	24 (13.11)	339 (16.66)
3	United Pentecostal	11 (6.11)	29 (13.18)	43 (6.63)	48 (22.02)	23 (13.86)	41 (15.83)	13 (8.13)	63 (34.43)	271 (13.32)
4	The Salvation Army	33 (18.33)	33 (15.00)	38 (5.86)	2 (0.92)	2 (1.20)	0 (0.00)	3 (1.88)	3 (1.64)	114 (5.60)
5	IKK	17 (9.44)	0 (0.00)	9 (1.39)	18 (8.26)	4 (2.41)	1 (0.39)	5 (3.13)	24 (13.11)	78 (3.83)
6	LIKBK	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	41 (25.63)	9 (4.92)	50 (2.46)
7	ECM	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	42 (22.95)	42 (2.06)
8	EFCI	0 (0.00)	35 (15.91)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	35 (1.72)
9	Seventh Day Adventist	0 (0.00)	2 (0.91)	4 (0.62)	5 (2.29)	4 (2.41)	4 (1.54)	0 (0.00)	5 (2.73)	24 (1.18)
10	BBEC	14 (7.78)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	14 (0.69)
11	Roman Catholic	3 (1.67)	0 (0.00)	5 (0.77)	0 (0.00)	5 (3.01)	0 (0.00)	1 (0.63)	0 (0.00)	14 (0.69)
12	Others	8 (4.44)	10 (4.55)	16 (2.47)	9 (4.13)	3 (1.81)	3 (1.16)	1 (0.63)	7 (3.83)	57 (2.80)

Source: Computed

Table 5 Economic Characteristics: Occupation and Household Income

Sl.No	Particulars	District								
I	Occupation	Mamit N =180	Kolasib N =220	Aizawl N = 649	Champhai N =218	Serchip N =166	Lunglei N =259	Lawngtlai N = 160	Saiha N = 183	Total N=2035
	Cultivators	112 (62.22)	121 (55.00)	98 (15.10)	114 (52.29)	118 (71.08)	84 (32.43)	35 (21.88)	86 (46.99)	768 (37.74)
	Government Service	31 (17.22)	26 (11.82)	272 (41.91)	41 (18.81)	14 (8.43)	114 (44.02)	33 (20.63)	43 (23.50)	574 (28.21)
	Business	4 (2.22)	11 (5.00)	167 (25.73)	29 (13.30)	11 (6.63)	38 (14.67)	21 (13.13)	7 (3.83)	288 (14.15)
	Labourers	16 (8.89)	13 (5.91)	44 (6.78)	10 (4.59)	5 (3.01)	12 (4.63)	2 (1.25)	18 (9.84)	120 (5.90)
	Professionals	3 (1.67)	22 (10.00)	23 (3.54)	0 (0.00)	11 (6.63)	4 (1.54)	7 (4.38)	15 (8.20)	85 (4.18)
	Artisans	4 (2.22)	3 (1.36)	31 (4.78)	5 (2.29)	7 (4.22)	5 (1.93)	5 (3.13)	4 (2.19)	64 (3.14)
	Petty Trade	10 (5.56)	9 (4.09)	12 (1.85)	19 (8.72)	0 (0.00)	2 (0.77)	0 (0.00)	9 (4.92)	61 (3.00)
	None	0 (0.00)	0 (0.00)	2 (0.31)	0 (0.00)	0 (0.00)	0 (0.00)	52 (32.50)	1 (0.55)	55 (2.70)
	Home Makers	0 (0.00)	15 (6.82)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	5 (3.13)	0 (0.00)	20 (0.98)
II	**Level of Household Income**									
	Less than Rs 24000	137 (76.11)	113 (51.36)	23 (3.54)	17 (7.80)	64 (38.55)	0 (0.00	7 (4.38)	84 (45.90)	445 (21.87)
	Rs 24000 - 48000	16 (8.89)	38 (17.27)	101 (15.56)	119 (54.59)	25 (15.06)	40 (15.44)	27 (16.88)	49 (26.78)	415 (20.39)
	Rs 48000 - 100000	23 (12.78)	49 (22.27)	297 (45.76)	63 (28.90)	61 (36.75)	154 (59.46)	67 (41.88)	31 (16.94)	745 (36.61)
	Above Rs 100000	4 (2.22)	20 (9.09)	228 (35.13)	19 (8.72)	16 (9.64)	65 (25.10)	59 (36.88)	19 (10.38)	430 (21.13)
	Mean Annual Household Income	23067.78	48129.09	109729.28	54884.40	58030.12	88693.05	140067.50	47950.27	79464.33

Source: Computed

Table 6 Awareness on AIDS/HIV

Sl.No.	Dimension/Item		District							
I	**Problem**	**Mamit N=180**	**Kolasib N =220**	**Aizawl N=649**	**Champhai N=218**	**Serchip N=166**	**Lunglei N =259**	**Lawngtlai N=160**	**Saiha N = 183**	**Total** N=2035
	AIDS	160 (88.89)	191 (86.82)	626 (96.46)	46 (21.10)	111 (66.87)	227 (87.64)	138 (86.25)	98 (53.55)	1597 (78.48)
	HIV	83 (46.11)	166 (75.45)	573 (88.29)	50 (22.94)	48 (28.92)	198 (76.45)	126 (78.75)	91 (49.73)	1335 (65.60)
	Difference	81 (45.00)	70 (31.82)	365 (56.24)	41 (18.81)	41 (24.70)	167 (64.48)	82 (51.25)	51 (27.87)	898 (44.13)
	No Cure	14 (7.78)	34 (15.45)	88 (13.56)	34 (15.60)	80 (48.19)	57 (22.01)	40 (25.00)	38 (20.77)	385 (18.92)
II	**Symptoms**									
	Excessive Weight Loss	125 (69.44)	92 (41.82)	367 (56.55)	118 (54.13)	39 (23.49)	185 (71.43)	126 (78.75)	79 (43.17)	1131 (55.58)
	Continuous Dysentery	136 (75.56)	95 (43.18)	424 (65.33)	147 (67.43)	33 (19.88)	213 (82.24)	106 (66.25)	57 (31.15)	1211 (59.51)
III	**Mode of Transmission**									
	Sharing of Syringes	179 (99.44)	190 (86.36)	637 (98.15)	211 (96.79)	88 (53.01)	244 (94.21)	152 (95.00)	111 (60.66)	1812 (89.04)
	Unprotected Sex	174 (96.67)	189 (85.91)	623 (95.99)	204 (93.58)	131 (78.92)	232 (89.58)	154 (96.25)	105 (57.38)	1812 (89.04)
	Mother to Child	175 (97.22)	170 (77.27)	614 (94.61)	196 (89.91)	21 (12.65)	238 (91.89)	143 (89.38)	110 (60.11)	1667 (81.92)
IV	**Prevention**									
	Having one Faithful Sex Partner	157 (87.22)	176 (80.00)	611 (94.14)	187 (85.78)	22 (13.25)	219 (84.56)	141 (88.13)	94 (51.37)	1607 (78.97)
	Condom Use	153 (85.00)	159 (72.27)	562 (86.59)	180 (82.57)	58 (34.94)	213 (82.24)	135 (84.38)	93 (50.82)	1553 (76.31)
	Using Sterilized Needles	176 (97.78)	177 (80.45)	607 (93.53)	189 (86.70)	108 (65.06)	223 (86.10)	146 (91.25)	99 (54.10)	1725 (84.77)

Source: Computed

Table 7 Pattern of Awareness on AIDS/HIV: Mean Indices

Sl.No	Dimension		District							
I	**Awareness on AIDS/HIV**	**Mamit N=180**	**Kolasib N =220**	**Aizawl N=649**	**Champhai N=218**	**Serchip N=166**	**Lunglei N =259**	**Lawngtlai N=160**	**Saiha N = 183**	**Total** N=2035
	Problem	0.47	0.52	0.64	0.20	0.42	0.63	0.60	0.38	0.52
	Symptoms	0.73	0.43	0.61	0.61	0.22	0.77	0.73	0.37	0.58
	Mode of Transmission	0.98	0.83	0.96	0.93	0.48	0.92	0.94	0.59	0.87
	Prevention	0.94	0.81	0.94	0.89	0.40	0.88	0.90	0.53	0.83
	Mean Awareness Index	0.78	0.65	0.79	0.66	0.38	0.80	0.79	0.47	0.70
II	**Level of Awareness**									
	Low (0 - 0.33)	0 0.00	26 (11.82)	6 (0.92)	5 (2.29)	80 (48.19)	2 (0.77)	4 (2.50)	71 (38.80)	194 (9.53)
	Medium (0.33 - 0.66)	25 (13.89)	69 (31.36)	87 (13.41)	93 (42.66)	69 (41.57)	45 (17.37)	25 (15.63)	33 (18.03)	446 (21.92)
	High (0.66 -1)	155 (86.11)	125 (56.82)	556 (85.67)	120 (55.05)	17 (10.24)	212 (81.85)	131 (81.88)	79 (43.17)	1395 (68.55)

Source: Computed

Table 8 Awareness on AIDS/HIV: Mean Indices by Gender and Age

Sl.No	Gender	Age Group	Problem	Symptoms	Mode of Transmission	Prevention	Awareness on AIDS/HIV
I	**Female**	Adolescent (13 -18)	0.48	0.52	0.85	0.75	0.65
		Youth(18-35)	0.48	0.57	0.86	0.81	0.68
		Middle Aged(35-60)	0.47	0.56	0.88	0.82	0.68
		Aged(60 and above)	0.46	0.34	0.86	0.84	0.63
		Total	0.47	0.55	0.86	0.81	0.67
II	**Male**	Adolescent (13 -18)	0.56	0.62	0.86	0.82	0.71
		Youth(18-35)	0.59	0.61	0.87	0.86	0.73
		Middle Aged(35-60)	0.55	0.63	0.88	0.86	0.73
		Aged(60 and above)	0.48	0.42	0.85	0.82	0.64
		Total	0.56	0.60	0.87	0.85	0.72
III	**Total**	Adolescent (13 -18)	0.51	0.56	0.86	0.78	0.68
		Youth(18-35)	0.53	0.59	0.86	0.83	0.70
		Middle Aged(35-60)	0.51	0.59	0.88	0.84	0.71
		Aged(60 and above)	0.47	0.40	0.86	0.83	0.64
		Total	0.52	0.58	0.87	0.83	0.70

Source: Computed

Table 9 Correlates of Awareness on AIDS/HIV: Karl Pearson's Correlation Coefficients

Sl.No.	Independent Variable	Problem	Mode of Transmission	Symptoms	Prevention	Awareness on AIDS/HIV
1	Locality	0.23**	0.16**	0.06**	0.14**	0.19**
2	Age Group	-0.03	0.01	-0.05	0.04	-0.01
3	Gender	0.14**	0.01	0.06**	0.08**	0.10**
4	Education Status	0.36**	0.18**	0.23**	0.20**	0.32**
5	Annual Household Income	0.17**	0.12**	0.09**	0.12**	0.16**

Source: Computed

**Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Table 10 Popular Myths and Misconceptions about AIDS/HIV

Belief	District								Total N=2035
	Mamit N=180	Kolasib N =220	Aizawl N=649	Champhai N=218	Serchip N=166	Lunglei N =259	Lawngtlai N=160	Saiha N = 183	
HIV can spread by sharing seat	161 (89.44)	176 (80.00)	577 (88.91)	196 (89.91)	151 (90.96)	226 (87.26)	134 (83.75)	165 (90.16)	1786 (87.76)
A healthy looking person cannot be PLWHA	163 (90.56)	184 (83.64)	544 (83.82)	167 (76.61)	149 (89.76)	199 (76.83)	124 (77.50)	152 (83.06)	1682 (82.65)
PLWHA should be kept separately	104 (57.78)	115 (52.27)	442 (68.10)	132 (60.55)	116 (69.88)	170 (65.64)	97 (60.63)	119 (65.03)	1295 (63.64)
PLWHA are of loose bad character	45 (25.00)	55 (25.00)	222 (34.21)	60 (27.52)	57 (34.34)	91 (35.14)	43 (26.88)	91 (49.73)	664 (32.63)
PLWHA should not have a baby	54 (30.00)	82 (37.27)	193 (29.74)	45 (20.64)	47 (28.31)	92 (35.52)	61 (38.13)	106 (57.92)	680 (33.42)
PLWHA should not get married	71 (39.44)	85 (38.64)	270 (41.60)	69 (31.65)	58 (34.94)	127 (49.03)	59 (36.88)	104 (56.83)	843 (41.43)
PLWHA Children should not be admitted to regular schools	133 (73.89)	129 (58.64)	468 (72.11)	158 (72.48)	131 (78.92)	186 (71.81)	110 (68.75)	131 (71.58)	1446 (71.06)

Source: Computed

Table 11 Patterns of Social Distance with People Living with HIV

Sl.No.	Social Distance	District								
			Mamit N=180	**Kolasib N =220**	**Aizawl N=649**	**Champhai N=218**	**Serchip N=166**	**Lunglei N =259**	**Lawngtlai N=160**	**Saiha N = 183**	**Total N=2035**
1		Seeing People Living with HIV	169 (93.89)	145 (65.91)	599 (92.30)	212 (97.25)	161 (96.99)	225 (86.87)	130 (81.25)	135 (73.77)	1776 (87.27)
2		Meeting People Living with HIV	150 (83.33)	121 (55.00)	593 (91.37)	205 (94.04)	155 (93.37)	213 (82.24)	113 (70.63)	123 (67.21)	1673 (82.21)
3		Talking to People Living with HIV	148 (82.22)	116 **(52.73)**	587 (90.45)	204 (93.58)	152 (91.57)	211 (81.47)	104 (65.00)	118 (64.48)	1640 (80.59)
4		Hand Shake with People Living with HIV	130 (72.22)	108 (49.09)	553 (85.21)	186 (85.32)	142 (85.54)	207 (79.92)	92 **(57.50)**	97 **(53.01)**	1515 (74.45)
5		Share Food with People Living with HIV	103 (57.22)	89 (40.45)	506 (77.97)	163 (74.77)	117 (70.48)	169 (65.25)	77 (48.13)	80 (43.72)	1304 (64.08)
6		Friendship with People Living with HIV	92 **(51.11)**	84 (38.18)	474 (73.04)	148 (67.89)	103 (62.05)	153 (59.07)	71 (44.38)	69 (37.70)	1194 **(58.67)**
7		Share Toilet	75 (41.67)	61 (27.73)	381 (58.71)	126 **(57.80)**	87 **(52.41)**	134 **(51.74)**	60 (37.50)	61 (33.33)	985 (48.40)
8		Drink water in Same Cup	61 (33.89)	55 (25.00)	353 (54.39)	99 (45.41)	73 (43.98)	109 (42.08)	53 (33.13)	54 (29.51)	857 (42.11)
9		Invite for Dinner at Home	61 (33.89)	54 (24.55)	341 **(52.54)**	97 (44.50)	68 (40.96)	102 (39.38)	53 (33.13)	54 (29.51)	830 (40.79)
10		Share the Same House	46 (25.56)	39 (17.73)	190 (29.28)	36 (16.51)	29 (17.47)	14 (5.41)	18 (11.25)	34 (18.58)	406 (19.95)
11		Be Married	0 (0.00)	5 (2.27)	5 (0.77)	4 (1.83)	3 (1.81)	11 (4.25)	2 (1.25)	4 (2.19)	34 (1.67)
		Mean Social Distance Score	4.08	2.89	5.23	4.91	4.70	4.33	3.42	3.19	4.36
II		**Level of Social Distance**									
		None	0 0.00	2 (0.91)	1 (0.15)	3 (1.38)	2 (1.20)	4 (1.54)	2 (1.25)	3 (1.64)	17 (0.84)
		Low(1- 4)	75 (41.67)	59 (26.82)	378 (58.24)	123 (56.42)	86 (51.81)	131 (50.58)	58 (36.25)	58 (31.69)	968 (47.57)
		Medium(4-8)	73 (40.56)	55 (25.00)	209 (32.20)	78 (35.78)	64 (38.55)	77 (29.73)	44 (27.50)	57 (31.15)	657 (32.29)
		High(8-11)	32 (17.78)	104 (47.27)	61 (9.40)	14 (6.42)	14 (8.43)	47 (18.15)	56 (35.00)	65 (35.52)	393 (19.31)

Source: Computed

Table 12 Perceptions on Condom Use

Sl.No	Perception	District								
		Mamit N=180	Kolasib N =220	Aizawl N=649	Champhai N=218	Serchip N=166	Lunglei N =259	Lawngtlai N=160	Saiha N = 183	Total N=2035
1	Method of Family Planning	161 (89.44)	149 (67.73)	474 (73.04)	163 (74.77)	114 (68.67)	198 (76.45)	124 (77.50)	106 (57.92)	1489 (73.17)
2	Contrary to religious belief	51 (28.33)	78 (35.45)	285 (43.91)	80 (36.70)	79 (47.59)	121 (46.72)	82 (51.25)	46 (25.14)	822 (40.39)
3	Protection Against HIV	172 (95.56)	182 (82.73)	589 (90.76)	200 (91.74)	148 (89.16)	230 (88.80)	148 (92.50)	118 (64.48)	1787 (87.81)
4	Hundred Percent Safe	74 (41.11)	71 (32.27)	150 (23.11)	70 (32.11)	34 (20.48)	65 (25.10)	58 (36.25)	53 (28.96)	575 (28.26)
5	Spoils Sexual Pleasure	112 (62.22)	73 (33.18)	195 (30.05)	90 (41.28)	32 (19.28)	123 (47.49)	69 (43.13)	34 (18.58)	728 (35.77)
6	Unnecessary with Boy/Girl Friends	72 (40.00)	61 (27.73)	137 (21.11)	147 (67.43)	15 (9.04)	88 (33.98)	61 (38.13)	51 (27.87)	632 (31.06)
7	Quality Differs with Company	152 (84.44)	72 (32.73)	259 (39.91)	98 (44.95)	25 (15.06)	143 (55.21)	92 (57.50)	54 (29.51)	895 (43.98)

Source: Computed

Table 13 Mass Media Exposure: Television

Sl.No.	Media / Programme	District	Total N=2035

		Mamit N=180	Kolasib N =220	Aizawl N=649	Champhai N =218	Serchip N =166	Saiha N = 183	Lunglei N =259	Lawngtlai N=160	
I	**Door Darshan**									
	DD Songs	168 (93.33)	192 (87.27)	524 (80.74)	190 (87.16)	18 (10.84)	130 (71.04)	222 (85.71)	135 (84.38)	1579 (77.59)
	DD News	174 (96.67)	195 (88.64)	561 (86.44)	201 (92.20)	31 (18.67)	135 (73.77)	230 (88.80)	145 (90.63)	1672 (82.16)
	DD Drama	157 (87.22)	179 (81.36)	523 (80.59)	186 (85.32)	66 (39.76)	122 (66.67)	207 (79.92)	132 (82.50)	1572 (77.25)
	DD Talk Show / Discussion	144 (80.00)	163 (74.09)	441 (67.95)	154 (70.64)	65 (39.16)	112 (61.20)	187 (72.20)	112 (70.00)	1378 (67.71)
	DD Documentary	153 (85.00)	163 (74.09)	447 (68.88)	160 (73.39)	44 (26.51)	110 (60.11)	198 (76.45)	111 (69.38)	1386 (68.11)
II	**Local Television Channels**									
	LTV Songs	117 (65.00)	92 (41.82)	612 (94.30)	186 (85.32)	19 (11.45)	81 (44.26)	237 (91.51)	100 (62.50)	1444 (70.96)
	LTV News	118 (65.56)	91 (41.36)	631 (97.23)	196 (89.91)	29 (17.47)	79 (43.17)	234 (90.35)	99 (61.88)	1477 (72.58)
	LTV Drama	117 (65.00)	87 (39.55)	559 (86.13)	171 (78.44)	40 (24.10)	69 (37.70)	221 (85.33)	88 (55.00)	1352 (66.44)
	LTV Talk Show / Discussion	110 (61.11)	72 (32.73)	525 (80.89)	154 (70.64)	56 (33.73)	65 (35.52)	203 (78.38)	77 (48.13)	1262 (62.01)
	LTV Mizo Films	115 (63.89)	163 (74.09)	538 (82.90)	188 (86.24)	25 (15.06)	75 (40.98)	210 (81.08)	83 (51.88)	1397 (68.65)
	LTV Hindi Films	90 (50.00)	148 (67.27)	358 (55.16)	134 (61.47)	5 (3.01)	62 (33.88)	142 (54.83)	55 (34.38)	994 (48.85)
	LTV Hindi Serials in Mizo	98 (54.44)	142 (64.55)	448 (69.03)	150 (68.81)	4 (2.41)	64 (34.97)	164 (63.32)	61 (38.13)	1131 (55.58)

Source: Computed

Table 14 Mass Media Exposure: Radio

Sl.No.	Media/Programme	District							
	Radio(AIR)	Mamit N=180	Kolasib N =220	Aizawl N=649	Serchip N=166	Lunglei N =259	Lawngtlai N=160	Saiha N = 183	Total N=2035
	Radio Songs	128 (71.11)	141 (64.09)	311 (47.92)	15 (9.04)	217 (83.78)	150 (93.75)	149 (81.42)	1195 (58.72)
	Radio News	138 (76.67)	147 (66.82)	377 (58.09)	20 (12.05)	232 (89.58)	152 (95.00)	155 (84.70)	1312 (64.47)
	Radio Drama	115 (63.89)	110 (50.00)	250 (38.52)	18 (10.84)	180 (69.50)	119 (74.38)	124 (67.76)	979 (48.11)
	Radio Talk Show / Discussion	113 (62.78)	118 (53.64)	224 (34.51)	36 (21.69)	171 (66.02)	113 (70.63)	121 (66.12)	961 (47.22)
	Radio Live Phone in	112 (62.22)	116 (52.73)	242 (37.29)	19 (11.45)	175 (67.57)	118 (73.75)	118 (64.48)	963 (47.32)
II	**Print**								
	English News Paper	3 (1.67)	27 (12.27)	48 (7.40)	0 0.00	14 (5.41)	8 (5.00)	14 (7.65)	119 (5.85)
	English Magazine	6 (3.33)	31 (14.09)	70 (10.79)	3 (1.81)	32 (12.36)	29 (18.13)	15 (8.20)	202 (9.93)
	Mizo News Paper	108 (60.00)	156 (70.91)	555 (85.52)	96 (57.83)	163 (62.93)	97 (60.63)	105 (57.38)	1434 (70.47)
	Mizo Magazine	94 (52.22)	139 (63.18)	483 (74.42)	66 (39.76)	211 (81.47)	130 (81.25)	110 (60.11)	1363 (66.98)
	Mizo Local News Paper	124 (68.89)	191 (86.82)	610 (93.99)	75 (45.18)	246 (94.98)	98 (61.25)	78 (42.62)	1608 (79.02)

Source: Computed

Table 15 Age Group Gender and Mass Media Exposure: Doordarshan Programmes

Sl.No	Age Group	Gender	Songs	News	Drama	Talk Show/ Discussion	Documentary
I	**Adolescent (13 -18)**	Female	120 (83.33)	122 (84.72)	123 (85.42)	95 (65.97)	100 (69.44)
		Male	89 (82.41)	94 (87.04)	92 (85.19)	71 (65.74)	79 (73.15)
		Total	209 (82.94)	216 (85.71)	215 (85.32)	166 (65.87)	179 (71.03)
II	**Youth(18-35)**	Female	341 (77.15)	361 (81.67)	349 (78.96)	286 (64.71)	300 (67.87)
		Male	311 (78.73)	328 (83.04)	307 (77.72)	258 (65.32)	281 (71.14)
		Total	652 (77.90)	689 (82.32)	656 (78.38)	544 (64.99)	581 (69.41)
III	**Middle Aged(35-60)**	Female	267 (70.08)	291 (76.38)	274 (71.92)	240 (62.99)	232 (60.89)
		Male	348 (81.50)	371 (86.89)	333 (77.99)	325 (76.11)	306 (71.66)
		Total	615 (76.11)	662 (81.93)	607 (75.12)	565 (69.93)	538 (66.58)
IV	**Aged(60 and above)**	Female	30 (73.17)	31 (75.61)	30 (73.17)	30 (73.17)	25 (60.98)
		Male	73 (75.26)	74 (76.29)	64 (65.98)	73 (75.26)	63 (64.95)
		Total	103 (74.64)	105 (76.09)	94 (68.12)	103 (74.64)	88 (63.77)
	Total	Female	758 (75.20)	805 (79.86)	776 (76.98)	651 (64.58)	657 (65.18)
		Male	821 (79.94)	867 (84.42)	796 (77.51)	727 (70.79)	729 (70.98)
		Total	1579 (77.59)	1672 (82.16)	1572 (77.25)	1378 (67.71)	1386 (68.11)

Source: Computed

Table 16 Age Group Gender and Mass Media Exposure: Local Television Programmes

Sl.No	Age Group	Gender	Songs	News	Drama	Talk Show / Discussion	Mizo Films	Hindi Films	Hindi Serials in Mizo
I	Adolescent (13 -18)	Female	104 (72.22)	101 (70.14)	99 (68.75)	75 (52.08)	105 (72.92)	93 (64.58)	88 (61.11)
		Male	76 (70.37)	74 (68.52)	67 (62.04)	53 (49.07)	74 (68.52)	48 (44.44)	52 (48.15)
		Total	180 (71.43)	175 (69.44)	166 (65.87)	128 (50.79)	179 (71.03)	141 (55.95)	140 (55.56)
II	Youth(18-35)	Female	301 (68.10)	301 (68.10)	285 (64.48)	247 (55.88)	316 (71.49)	260 (58.82)	292 (66.06)
		Male	279 (70.63)	290 (73.42)	265 (67.09)	254 (64.30)	263 (66.58)	173 (43.80)	186 (47.09)
		Total	580 (69.30)	591 (70.61)	550 (65.71)	501 (59.86)	579 (69.18)	433 (51.73)	478 (57.11)
III	Middle Aged(35-60)	Female	275 (72.18)	288 (75.59)	259 (67.98)	252 (66.14)	264 (69.29)	184 (48.29)	239 (62.73)
		Male	309 (72.37)	319 (74.71)	281 (65.81)	282 (66.04)	285 (66.74)	174 (40.75)	198 (46.37)
		Total	584 (72.28)	607 (75.12)	540 (66.83)	534 (66.09)	549 (67.95)	358 (44.31)	437 (54.08)
IV	Aged(60 and above)	Female	29 (70.73)	31 (75.61)	28 (68.29)	29 (70.73)	26 (63.41)	20 (48.78)	27 (65.85)
		Male	71 (73.20)	73 (75.26)	68 (70.10)	70 (72.16)	64 (65.98)	42 (43.30)	49 (50.52)
		Total	100 (72.46)	104 (75.36)	96 (69.57)	99 (71.74)	90 (65.22)	62 (44.93)	76 (55.07)
	Total	Female	709 (70.34)	721 (71.53)	671 (66.57)	603 (59.82)	711 (70.54)	557 (55.26)	646 (64.09)
		Male	735 (71.57)	756 (73.61)	681 (66.31)	659 (64.17)	686 (66.80)	437 (42.55)	485 (47.22)
		Total	1444 (70.96)	1477 (72.58)	1352 (66.44)	1262 (62.01)	1397 (68.65)	994 (48.85)	1131 (55.58)

Source: Computed

Table 17 Age Group Gender and Mass Media Exposure: Radio Programmes

Sl.No	Age Group	Gender	Songs	News	Drama	Talk Show / Discussion	Live Phone in
I	Adolescent (13 -18)	Female	100 (69.44)	99 (68.75)	78 (54.17)	65 (45.14)	83 (57.64)
		Male	80 (74.07)	80 (74.07)	60 (55.56)	49 (45.37)	60 (55.56)
		Total	180 (71.43)	179 (71.03)	138 (54.76)	114 (45.24)	143 (56.75)
II	Youth (18-35)	Female	257 (58.14)	270 (61.09)	205 (46.38)	193 (43.67)	202 (45.70)
		Male	264 (66.84)	286 (72.41)	213 (53.92)	211 (53.42)	202 (51.14)
		Total	521 (62.25)	556 (66.43)	418 (49.94)	404 (48.27)	404 (48.27)
III	Middle Aged (35-60)	Female	163 (42.78)	190 (49.87)	145 (38.06)	138 (36.22)	131 (34.38)
		Male	261 (61.12)	299 (70.02)	216 (50.59)	236 (55.27)	224 (52.46)
		Total	424 (52.48)	489 (60.52)	361 (44.68)	374 (46.29)	355 (43.94)
IV	Aged (60 and above)	Female	18 (43.90)	22 (53.66)	14 (34.15)	16 (39.02)	13 (31.71)
		Male	52 (53.61)	66 (68.04)	48 (49.48)	53 (54.64)	48 (49.48)
		Total	70 (50.72)	88 (63.77)	62 (44.93)	69 (50.00)	61 (44.20)
V	Total	Female	538 (53.37)	581 (57.64)	442 (43.85)	412 (40.87)	429 (42.56)
		Male	657 (63.97)	731 (71.18)	537 (52.29)	549 (53.46)	534 (52.00)
		Total	1195 (58.72)	1312 (64.47)	979 (48.11)	961 (47.22)	963 (47.32)

Source: Computed

Table 18 Age Group Gender and Mass Media Exposure: Print Media

Sl.No	Age Group	English News Paper	English Magazine	Mizo News Paper	Mizo Magazine	Mizo Local News Paper
I	Adolescent (13 -18)	10 (6.94)	16 (11.11)	101 (70.14)	100 (69.44)	106 (73.61)
		9 (8.33)	13 (12.04)	79 (73.15)	82 (75.93)	82 (75.93)
		19 (7.54)	29 (11.51)	180 (71.43)	182 (72.22)	188 (74.60)
II	Youth(18-35)	24 (5.43)	33 (7.47)	292 (66.06)	279 (63.12)	334 (75.57)
		37 (9.37)	75 (18.99)	305 (77.22)	301 (76.20)	333 (84.30)
		61 (7.29)	108 (12.90)	597 (71.33)	580 (69.30)	667 (79.69)
III	Middle Aged(35-60)	10 (2.62)	15 (3.94)	228 (59.84)	202 (53.02)	287 (75.33)
		27 (6.32)	47 (11.01)	332 (77.75)	320 (74.94)	358 (83.84)
		37 (4.58)	62 (7.67)	560 (69.31)	522 (64.60)	645 (79.83)
IV	Aged(60 and above)	0 (0.00)	0 (0.00	23 (56.10)	16 (39.02)	30 (73.17)
		2 (2.06)	3 (3.09)	74 (76.29)	63 (64.95)	78 (80.41)
		2 (1.45)	3 (2.17)	97 (70.29)	79 (57.25)	108 (78.26)
V	Total	44 (4.37)	64 (6.35)	644 (63.89)	597 (59.23)	757 (75.10)
		75 (7.30)	138 (13.44)	790 (76.92)	766 (74.59)	851 (82.86)
		119 (5.85)	202 (9.93)	1434 (70.47)	1363 (66.98)	1608 (79.02)

Source: Computed

Table 19 Pattern of Mass Media Exposure

		District								
Sl.No.	Mass Media	Mamit N=180	Kolasib N =220	Aizawl N=649	Champhai N=218	Serchip N=166	Lunglei N =259	Lawngtlai N=160	Saiha N = 183	Total N=2035
I	**Television**	0.75	0.66	0.79	0.80	0.21	0.79	0.65	0.53	0.69
	Doordarshan	0.88	0.81	0.77	0.82	0.27	0.81	0.79	0.67	0.75
	Local TV Channels	0.61	0.52	0.81	0.77	0.15	0.78	0.50	0.39	0.64
II	Radio	0.67	0.57	0.43	0.34	0.13	0.75	0.82	0.73	0.53
III	Print	0.37	0.49	0.54	0.45	0.29	0.51	0.45	0.35	0.46
	Mean Index Mass Media Exposure	0.60	0.58	0.59	0.53	0.21	0.69	0.64	0.54	0.56
IV	**Level of Mass Media Exposure**									
	Low(0.33-0.66)	22 (12.22)	33 (15.00)	57 (8.78)	35 (16.06)	138 (83.13)	14 (5.41)	7 (4.38)	27 (14.75)	333 (16.36)
	Medium (0.33 - 0.66).	80 (44.44)	103 (46.82)	342 (52.70)	120 (55.05)	22 (13.25)	78 (30.12)	86 (53.75)	97 (53.01)	928 (45.60)
	High(0.66-1)	78 (43.33)	84 (38.18)	250 (38.52)	63 (28.90)	6 (3.61)	167 (64.48)	67 (41.88)	59 (32.24)	774 (38.03)

Source: Computed

Table 20 Level of Mass Media Exposure by Age Group and Gender

Sl.No.	Gender/ Level	Age Group				Total
		Adolescent (13 -18)	Youth (18-35)	Middle Aged (35-60)	Aged (60 and above)	
I	**Female**					
	Low (0.33-0.66)	19 (13.19)	84 (19.00)	91 (23.88)	9 (21.95)	203 (20.14)
	Medium (0.33 - 0.66).	61 (42.36)	202 (45.70)	187 (49.08)	21 (51.22)	471 (46.73)
	High (0.66-1)	64 (44.44)	156 (35.29)	103 (27.03)	11 (26.83)	334 (33.13)
	Total	144 (100)	442 (100)	381 (100)	41 (100)	1008 (100)
II	**Male**					
	Low (0.33-0.66)	8 (7.41)	52 (13.16)	48 (11.24)	22 (22.68)	130 (12.66)
	Medium (0.33 - 0.66).	55 (50.93)	161 (40.76)	208 (48.71)	33 (34.02)	457 (44.50)
	High (0.66-1)	45 (41.67)	182 (46.08)	171 (40.05)	42 (43.30)	440 (42.84)
	Total	108 (100)	395 (100)	427 (100)	97 (100)	1027 (100)

Source: Computed

Table 21 Patterns of Relationship Between AIDS/ HIV Awareness, Social Distance and Mass Media Exposure: Partial Correlation Coefficients Controlling for Age Group, Gender, Locality and Education

S.No.	Variable	PROBLEM	SYMPTOM	MODE	Prevention	DISTANCE
1	**PROBLEM**	1	0.18	0.21	0.21	0.08
2	**SYMPTOM**	0.18	1	0.42	0.38	0.14
3	**MODE**	0.21	0.42	1	0.70	0.17
4	**Prevention**	0.21	0.38	0.70	1	0.16
5	**DISTANCE**	0.08	0.14	0.17	0.16	1
6	**DD**	0.13	0.22	0.39	0.35	0.06
7	**LTV**	0.08	0.24	0.40	0.38	0.16
8	**RADIO**	0.17	0.15	0.14	0.14	-0.05
9	**PRINT**	0.18	0.20	0.27	0.28	0.12

Source: Computed

Table 22 Respondents Ranking of Preference of Communication Channels: Mean Transmuted Scores by District

Sl.No	Communication Channel	District								Total N=2035
		Serchip N=166	Champhai N=218	Saiha N = 183	Kolasib N =220	Lunglei N =259	Lawngtlai N=160	Mamit N=180	Aizawl N=649	
1	Peer or Project Worker	30.18	52.15	68.00	46.27	63.20	69.92	64.72	56.00	56.29
2	Health Centre Worker	42.33	45.62	70.85	47.32	59.31	63.94	53.87	48.62	52.67
3	Church Meetings	46.87	47.47	46.60	46.19	54.68	60.15	55.78	49.76	50.58
4	YMA Meetings	44.63	39.65	47.09	46.72	55.36	56.48	62.07	50.24	50.17
5	Mizo New Papers	18.92	37.08	55.11	43.40	54.48	55.65	55.96	48.18	46.79
6	TV DD	26.26	41.91	44.98	39.45	51.91	46.28	54.86	46.47	44.86
7	Student Meetings	12.80	35.23	37.23	38.55	51.74	54.89	54.67	50.30	44.11
8	Radio	10.34	28.07	50.73	35.87	53.28	52.75	56.49	47.07	43.23
9	Local TV Network	24.63	38.73	29.99	33.98	48.88	47.36	50.78	50.11	42.95
10	Local News Papers	12.20	38.13	50.73	40.27	51.25	50.33	51.85	38.93	41.48
11	Mizo Magazine	17.34	30.52	54.22	37.64	50.97	53.93	50.40	39.02	41.26
12	Hoardings / Wall Papers	12.08	29.17	52.98	25.94	42.91	41.94	39.58	27.94	32.85
13	MHIP Meetings	15.89	26.06	38.75	33.15	44.36	43.86	47.53	26.12	32.79
14	Pamphlets / Booklets	9.07	27.69	50.55	25.31	40.23	41.24	40.43	26.62	31.42
15	Stickers with Slogans	5.24	18.80	42.74	18.03	33.19	35.91	31.02	19.07	24.11
16	MUP Meetings	9.41	13.56	32.63	21.87	31.42	37.24	28.45	18.16	22.76
17	Polythene Bags with Slogans	8.30	18.42	38.90	17.03	29.42	36.38	27.83	17.50	22.64

Source: Computed

Table 23 Respondents Ranking of Preference of Communication Channels: Mean Transmuted Scores by Age Group and Gender

Age Group Gender	Adolescent (13 -18)			Youth (18-35)			Middle Aged (35-60)			Aged (60 and above)			Total		
	Female n=144	Male n=108	Total n=252	Female n=442	Male n=395	Total n=837	Female n=381	Male n=427	Total n=808	Female n=41	Male n=97	Total n=138	Female n =1008	Male n = 1027	Total N = 2035
Peer or Project Worker	59	51	56	58	58	58	55	56	56	50	48	49	57	56	56 (1)
Health Centre Worker	57	54	55	56	52	54	51	51	51	45	48	47	54	52	53 (2)
Church Meetings	52	51	51	50	49	49	53	51	52	51	48	49	51	50	51 (3)
YMA Meetings	52	54	53	50	51	50	50	51	50	34	46	42	50	51	50 (4)
Mizo New Papers	51	48	49	49	49	49	43	47	45	36	41	39	46	47	47 (5)
TV DD	47	47	47	46	45	45	44	45	44	43	41	42	45	45	45 (6)
Student Meetings	52	50	51	43	46	44	44	42	43	41	39	40	44	44	44 (7)
Radio	45	45	45	43	45	44	41	44	42	40	36	38	43	44	43 (8)
Local TV Network	44	47	45	45	42	44	43	41	42	40	38	38	44	42	43 (9)
Mizo Magazine1	45	44	45	46	44	45	37	38	38	31	33	32	42	41	41 (10)
Local News Papers	46	44	45	44	44	44	37	42	40	27	32	31	41	42	41 (11)
Hoardings / Wall Papers	38	40	39	38	35	36	28	30	29	12	24	20	33	33	33 (12)
MHIP Meetings	39	35	37	36	32	34	33	30	31	22	28	26	34	31	33 (13)
Pamphlets / Booklets	39	37	38	37	33	35	25	30	27	13	23	20	32	31	31 (14)
Stickers with Slogans	30	30	30	29	26	28	20	21	20	9	17	15	25	24	24 (15)
Polythen Bags with Slogans	29	27	28	27	25	26	18	20	19	12	16	15	23	22	23 (16)
MUP Meetings	26	27	26	23	24	24	21	21	21	12	24	21	22	23	23 (17)

Interview Schedule
COMMUNICATION NEEDS ASSESSMENT

Schedule No. **Village/Town/Ward :**
District : **R.D. Block :**
Field Investigator: **Locality: Rural /Urban**
Date: **Time:**

I. Profile of Respondents

1. Name: 2. Age: Years 3. Sex: 1.Male / 2.Female
4. Marital Status: 1. Unmarried / 2. Married / 3. Divorced/4.Remarried/5. Widowed
5. Education Qualification: 6. Religion/Denomination:
7. Tribe/Sub tribe 8. Earner/Dependent:
9. Primary Occupation: 10. Secondary Occupation (If any):
11. Annual Personal Income: Rs 12. Annual Household Income: Rs

13.

	Do you know	**No**	**Yes**
1.	There are diseases transmitted through sexual intercourse	0	1
2.	Tell me some such disease	0	1

II. HIV/AIDS

14. Knowledge of HIV/AIDS – HIV/AIDS: What is HIV/AIDS?

	No	**Yes**		**No**	**Yes**
i) What is AIDS	0	1	iii)What is the difference between HIV and AIDS	0	1
ii)What is HIV	0	1	iv)AIDS has no cure	0	1

15. What are the symptoms of HIV/AIDS?

Symptoms	**No**	**Yes**	**Symptom**	**No**	**Yes**
i) Excessive weight loss	0	1	iv) TB	0	1
ii) Eye problem	0	1	v) Prolonged fever over a month Swelling of glands	0	1
iii) Continuous dysentery over a month	0	1	vi) Skin Rashes	0	1

16. How HIV/AIDS spread?

Source/Cause	**No**	**Yes**	**Source/Cause**	**No**	**Yes**
i) Mosquito bite	0	1	iv)Kissing	0	1
ii)Sharing of syringe/needles	0	1	v)Mother to child	0	1
iii)Unprotected sex	0	1	vi)Shaking hands	0	1

17. How can we prevent the spread of HIV?

By	No	Yes
Using mosquito nets	0	1
Having only one faithful sexual partner	0	1
Immunization	0	1
Using condoms	0	1
Using sterilized needles	0	1

18. Beliefs/misconceptions

Do you believe that	No	Yes
i)A healthy looking person cannot be PLWHA	0	1
ii)PLWHA should be made to live away from others	0	1
iii)PLWHA are of loose bad character	0	1
iv)A PLWHA woman should not have a baby	0	1
v)PLWHA should not get married	0	1
vi)PLWHA Children should not be admitted to regular schools.	0	1

19. Social Distance with PLWHA

Sl.No	Would you	No	Yes
a)	Like to see an HIV+	0	1
b)	Like to meet with PLWHA	0	2
c)	Like to talk to an HIV+	0	3
d)	Like to shake hand with HIV+	0	4
e)	Share food with HIV+ in a community feast	0	5
f)	Have friendship with PLWHA	0	6
g)	Share toilet with HIV +	0	7
h)	Drink water from the same cup	0	8
i)	Invite a HIV + for a dinner in your house	0	9
j)	Share the same house with HIV+	0	10
k)	Be married to HIV+	0	11

IV. CONDOM

20. Attitudes and Beliefs about Condom

Do you believe using condom …	No	Yes
Is for Family planning	0	1
It is against my religious conviction	0	1
Is for protection against HIV/AIDS is good	0	1
Is 100% safe for protection and prevention against STDs	0	1
Spoils sexual pleasure	0	1
Is unnecessary with boyfriends	0	1
The quality of condom is determined by the manufacturing company	0	1

V. Communication

21. Mass media exposure: Television

Media	Are you watching	No	Yes
Doordarshan	Songs	0	1
	News	0	1
	Drama	0	1
	Talk Show/Discussion	0	1
	Documentary	0	1
Local TV	Songs	0	1
	News	0	1
	Drama	0	1
	Talk Show/Discussion	0	1
	Mizo Films	0	1
	Hindi Films	0	1
	Hindi Serials	0	1

22. Are you listening following types of radio programmes?

Radio	Songs	0	1
	News	0	1
	Drama	0	1
	Talk Show/Discussion	0	1
	Live Phone in	0	1

23. Are you reading?

Print	English News Paper	0	1
	English: Magazines	0	1
	Mizo: News Papers	0	1
	Mizo: Mizo Magazines	0	1
	Mizo: Local news paper	0	1

24. Kindly order channels of Information on HIV/AIDS/STD on the basis of preference.

Sl. No	Channel	Rank
1	MHIP meeting	
2	Peer/project worker	
3	Mizo News Papers	
4	Mizo Magazine	
5	Local news papers	
6	Hoardings/ Wall Papers	
7	Pamphlets / Booklets	
8	Stickers with Slogans	
9	Polythene bags with slogans	
10	Church meeting	
11	YMA meeting	
12	Health centre/worker	
13	MUP meeting	
14	Student meeting	
15	Radio	
16	TV-Doordarshan	
17	TV-Local Networks	