



A study on open discussion of HIV/ AIDS among secondary school students with their parents in national capital region (NCR) of India

Binkey Srivastava¹ and Ashish Srivastava²

¹Department of Management Studies, Krishna Institute of Engineering & Technology, Ghaziabad.

²Paharpur Cooling Towers Ltd. New Delhi, India.

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ABSTRACT

Teenagers in India, like many others on the globe, are likely to be at risk for contracting HIV through unprotected sexual intercourse. Yet the issue of how to help youth avoid risky sexual behavior through family communication / education on HIV/AIDS is still of serious arguments within the society. This paper studies the practice of open family discussion on HIV/AIDS among secondary school students. The research is descriptive using 480 secondary school students selected by multi-stage random sampling. The semi-structured questionnaire is used to collect relevant data. Only 50 (11%) reported family as the first source of information. However, most of the students 360 (79.7%) had open family discussion on HIV/AIDS with their family members. The study reveals there is a gender difference in practice of family discussion. Significantly higher proportion of the female students had family discussion as compare to their male counterparts. The educational status of the parents determines whether a student had family interaction on HIV/AIDS. As in the studied population it is observed that there is considerable level of family discussion this could be considered to encourage further family members.

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Introduction

According to recent data AIDS epidemic update, new HIV infections have been reduced by 17% over the past eight years. Since 2001, when the United Nations Declaration of Commitment on HIV/AIDS was signed, the number of new infections in sub-Saharan Africa is approximately 15% lower, in East Asia new HIV infections declined by nearly 25% and in South and South East Asia by 10% in the same time period. But still, in some countries there are signs that new HIV infections are rising again. (Source: UNAIDS, 2009)

The report, by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), highlights that about 33.4 million people are living with HIV worldwide, 2.7 million were newly infected and 2 million people died of AIDS related illness. As far as Asia is concern in 2008, 4.7 million [3.8 million–5.5 million] people were living with HIV, including 350 000 [270 000–410 000] who became newly infected last year and an estimated 330 000 [260 000–400 000] AIDS-related deaths occurred in Asia. So though the annual number of AIDS-related deaths in South and South-East Asia in 2008 was approximately 12% lower than the mortality peak in 2004, the rate of HIV-related mortality in East Asia keeps on increasing, with the number of deaths in 2008 more than three times higher than in 2000. This states that India accounts for roughly half of Asia's HIV prevalence where Asia, carries to 60% of the world's population in terms of the number of people living with HIV.

The above facts indicates that the economic consequences of AIDS will force an additional 6 million households in Asia into poverty by 2015 until and unless national responses are significantly strengthened (Commission on AIDS in Asia, 2008).

Therefore the significant improvements in HIV surveillance systems are evident in various countries. But the issue of how to help school going teenagers to avoid risky sexual behaviour through family interaction/education on HIV/AIDS is still of serious arguments within the society. According to the latest survey most in India become sexually active before marriage, many while still in their teens. Studies (*dnaindia report, 2009*) have shown that up to 26% of unmarried young male aged 15 – 19years had been indulge in sexual activity. The mean age found for sexual initiation was 14.8 years. Most teenagers engaged in sex without proper protection and awareness about sexually transmitted infections. Family interaction between teenagers and their parent about sexuality and HIV/AIDS can control this high risk behaviour and practices. This study is conducted to find the practice of family interaction on HIV/AIDS among high school students with a view to identifying important factors that determine the practice of family discussion on HIV/AIDS between parents and their children or wards.

Research Methodology

The descriptive research was carried out among high school pupils in the major cities of National Capital Region (NCR), India involving 18 administrative wards with 48 high schools (secondary schools). Thirty-three of the schools were public schools and 15 were private. Out of the 48 schools, 13 were “uni-sex” (all students are of the same sex) while 35 had both sexes as students.

The study uses the Fisher's formula to calculate the sample size and a minimum sample size of 420 was arrived at. However, 480 students were approached and involved in the study. Multi-stage sampling technique was used to randomly select wards and schools within NCR Cities that were used for

the study. The number of students sampled from each school was proportionately determined based on the student population. Final selection of the students interviewed was done through systematic random sampling technique using the students' register as the sampling frame. Students in the eleventh standard of the senior secondary schools were used because of their relatively matured age; and also for the fact that students in twelfth standard of the senior secondary schools were taking their board examination, hence were not readily available.

The formal informative consent was obtained from each student before being issued a questionnaire. The semi-structured questionnaire was distributed to the respondents. Information on the bio-data of the respondents and questions relating to family members open discussion on HIV/AIDS were major issues captured in the questionnaire. All completed questionnaires were returned on the same day. Manual checking of the returned questionnaires was done and 452 were found to be properly completed and suitable for analysis. This gave a response rate of 94%. Data entry and analysis was done using online statistical analysis software. The statistical difference in cross tabulated variables with level of significant set at P value <0.05 is determined using Chi-square test.

Research Findings

As per the analysis majority of the respondents were male 261 (57.79%); and about three-quarters of the students were within the age group 16-20 years, with a mean age of 16.7 ± 2.2 years. About two-thirds 286 (63.3%) of the students were from monogamous family; while the rest belongs from polygamous homes. Respondents with family size of 6 or more persons 371(82.1%) were more than those with family size of less than six 81(17.9%).

Almost majority of the students had some information about HIV/AIDS, and the most common source of first information on HIV/AIDS was the electronic media 95(21%). Just 50(11%) reported family as the first source of information (Refer Table 1).

Still, most of the students stated to have family discussion on HIV/AIDS with their family members 360 (79.65%). The certain major issues discussed on HIV/AIDS by the family includes: HIV transmission mode 360(100%), use of condom 353(98%) and pre-marital sex 121(33.6%) (Refer Table 2). The highly involved family member in family open discussion was the mother 157 (43.6%), followed by the father 104 (28.9%). The research shows that there is a gender difference in practice of family discussion. Higher proportion of the female students had family discussion more as compare to male counterparts. This is statistically significant as P- value equals to 0.0248.

The analysis also focuses that students with family size of 5 or less tends to have more family discussion than those with larger family size. This is also statistically significant $P=0.0224$ (Refer Table 3).

Similarly, the educational status of the parents significantly determined whether or not a student had family discussion on HIV/AIDS (P - value = 0.00001).

However, there was just an insignificant proportion of students with family discussion among polygamous and monogamous family (P-value= 0.9241).

Conclusion

The virulent disease as HIV/AIDS is a major health problem for developing countries specifically India. The highly affected age-group are youngsters aged 15- 24. The respondents of this research are students' population aged between 16 – 20

years and are within the sexually active population that is at risk of HIV/AIDS. The major source of information on mode of HIV/AIDS transmission among these students is electronic media. In India the electronic media is among the leading source of health information among educated people. But unfortunately this source of information is also the common source of information that promotes sexual activity among these young school goers. This study reflects, the family is not the major source of information and has significantly the low level of open discussion between parents and children on issues related to sex. Various research studies showed that discussions about HIV/AIDS with parents tend to decrease the likelihood of teenagers will engage in risky behavior, on contrary interaction with peers tends to increase that likelihood.

The family being a primary school of socialization can easily employ a strong influence on adolescent teen's sexual behaviour. But as the study reveals that most secondary school students get more information from the electronic media, the family hence may have little or no influence on their sexual behaviour. Further the Indian culture does not really promote open discussion on sex between parents and their offspring. Thus culture seems to play a significant role in determining the health of the individual and the family. Positive open discussion between parents and their adolescents helps young adult to found individual values and capable to take sexually healthy decisions. Although most parents want their children to know about abstinence, contraception, and how to prevent HIV and other sexually transmitted infections (STIs), as they often have difficulty in open interaction about sex.

But the educated parents are likely to have smaller family size and are less bound to cultural beliefs and practices that limits discussion between parents and their children.. This improvement in discussion between parents and their adolescents on issues specifically sexuality in developing countries as India is encouraging.

The real concern of parents for their offspring not been infected with this horrifying disease probably influenced this. But this needs to be rife to include every family and family member irrespective of social status and culture to help twig the increasing awareness of HIV/AIDS particularly among young adult.

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Table 1: Age - Sex Distribution of the respondents and First source of information on HIV/AIDS

Age group (years)	Male	Female	Total
15 yrs	35 (7.7%)	25(5.5%)	60 (13.2%)
16 – 20 yrs	191(42.3%)	157(34.7%)	348(77%)
Total	261(57.7%)	191(42.3%)	452(100%)
First Information source	Frequency	Percentage	
Print media	90	20	
Electronic Media	95	21	
Peers / friends	140	31	
Health workers	54	12	
Teachers	23	5	
Family member	50	11	
Total	452	100	

Table 2: Family Discussion on HIV/AIDS

a. Aspects of HIV/AIDS discussed (N = 360 Multiple Responses) Issues on HIV/AIDS discussed	
	Frequency (%)
Transmission mode of HIV	360(100%)
Use of Condom	353(98%)
Multiple sexual partner	64(17.8%)
Sexual behavior/practices	57(15.8%)
Premarital sex	121(33.6%)

b. Family members most involved in discussion on HIV/AIDS	
Family Member	Frequency (%)
Mother	157(43.6%)
Father	104(28.9%)
Sister	39(10.8%)
Brother	60(16.7%)
Total	360(100%)

Table 3: Factors influencing the practice of family discussion

Practice of Family Discussion				
Factors	Yes	No	Total	P-value
Sex				
Male	198(76%)	63(24%)	261	0.0248
Female	164(86%)	27(14%)	191	
Family Size				
5	29(100%)	0(0%)	29	0.0224
6	323(76.4%)	100(23.6%)	423	
Family Type				
Polygamous	133(80.1%)	33(19.9%)	166	0.9241
Monogamous	228(79.7%)	58(20.3%)	286	
Father's Educational status				
Formal Education	338(85.6%)	57(14.4%)	395	0.00001
No formal Education	23(40.3%)	34(59.7%)	57	
Mother's Educational status				
Formal Education	295(86%)	48(14%)	343	0.00001
No formal Education	65(60%)	44(40%)	109	