Socialisation and AIDS Awareness among Students in Manipur

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Abstract

Every society's beliefs and practices concerning health and disease are transmitted from one generation to another through socialisation process. The references and definitions of what is good health and what are sound health practices are learnt through the socialisation process. There are dos and don'ts a child learns within the family, peer groups, community and school/college. While the family, peer groups, community and mass media engage in informal socialisation of the child, the school/college socialises formally or officially aspects of health and disease.

The study aimed to understand how the family, peer groups and the educational institutions shape the students' perception towards health/disease in general and HIV/AIDS in particular within the socio-cultural context of Manipur. A semi-structured interview schedule is used to collect data from the students. The total sample size consists of 310 student respondents.

The result reveals that there are certain variations in the way the family transacts knowledge about health and disease to their children. Even the schools and teachers are found to be not transacting any issues relating to HIV/AIDS in the way they should have been in a state like Manipur where HIV/AIDS is in alarming proportions. Nothing is done to inform the students about health and disease, particularly about the risks of HIV/AIDS. Due to shyness and lack of knowledge about HIV/AIDS on the part of the parents, the students could not discuss HIV/AIDS with their parents. However, the most important reason for not discussing with teachers was the lack of time on the part of the teachers. However, the informal peer groupings within the formal school/college are also very important ways of raising real or false awareness of HIV/AIDS among students.

KEYWORDS: HIV/AIDS, Education, Socialisation, Students

Introduction

Education, both formal and informal, performs the crucial role of transmitter of the process of socialisation of the child or adolescent or adult. The informal socialisation that takes place at home, in the peer groups and in the community, transmit both facts and myths about sound health practices that may shape the health behaviour and beliefs of an individual. While the facts have positive effects on the individual and group behaviour, myths tend to perpetuate ignorance, fear, taboos, etc. On the other hand, the formal socialisation in the school or in the college may further accentuate or reinforce both the facts and myths in the minds of an individual. Schools/colleges transmit values of health through curriculum, through the teacher, through specific campaigns of 'good' health, etc.

A child's socialisation in informal settings such as family, community, peer groups and formal settings such as schools/colleges are crucial to the learning of and about the disease and health practices in a society. Therefore, the study aimed to understand how the family, peer groups and the educational institutions shape the students' perception towards health/disease in general and HIV/AIDS in particular. The study chose HIV/AIDS as a case because, it is still not explored in so far as research studies in social sciences are concerned and not many studies have focussed on the socio-cultural context of HIV/AIDS awareness among the undergraduate youth in the country.

In recent times, rates of HIV infection continue to rise among the young people. More than half of all new HIV infections occur among young people (aged 15- 24 years) and almost 11.8 million youth are living with HIV/AIDS in the world. The growing menace of the HIV infection and AIDS among the young people is seen as a threat to the progress and development of a society. Since vaccine and cure for AIDS remain elusive, the steep increase in the number of young people living with AIDS is an issue of universal concern and a great challenge. Thus, awareness continues to be one of the most important strategies in the fight against AIDS. That is why, the present study explores the linkages between socialisation, culture and awareness about AIDS. Manipur is selected as it is one of the high HIV/AIDS prevalence states in India and it has been an interesting case on the HIV/AIDS map of the country. Primarily, HIV/AIDS in Manipur is spread mainly through Intravenous Drug Users (IDUs), but now spreading rapidly through sexual transmission even among the general population.

The Family and Socialisation in terms of Health Practices

The family is by far the most important primary group in any society. The primary socialisation of the new generation through the family is probably the most important aspect of the socialisation process. By responding to the approval and disapproval of parents, the child learns the basic behaviour patterns, required norms, beliefs, values, etc. of the society. The family represents the primary setting within which individuals acquire information concerning health, learn specific health-related behaviours, and function as caregivers to others (UNAIDS, not dated). It has a significant influence on the variety of health related behaviours. From their family, most children learn basic health and hygiene, eating habits, beliefs and a prescribed set of values.

Further, norms at home, encouragement from family members, emotional support and positive or negative reinforcements are extremely strong influences on a child's health-related behaviour (Potvin, 1995). For example, how food is viewed and used in a family has a powerful influence on a child's eating behaviour and his or her future dietary choices. Parents' attitudes make a difference as to whether or not children will adopt certain desirable or undesirable behaviours. Their health related behaviour also strongly influences whether a child or adolescent will adopt a healthy behaviour and family support is an important determinant of an individual's ability to change an unhealthy life style (Campbell and Larivara, 2004). American researchers, Nolte *et al.*, (1983) found that a child whose parents disapprove of smoking is five times less likely to start smoking than one whose parents show no objection.

A family environment that enables children to develop autonomy and a sense of responsibility generally leads to their adoption of healthier lifestyles. According to Potvin

(1995), children from families offering a lot of verbal exchange and emotional support have been found to have healthier diets. On the other hand, low family cohesion, high family conflict, too rigid or too permeable family boundaries, lack of clear communication and poor spousal support have all been consistently linked with poor health. Traditionally, elders of the family guide and regulate the individual choices of lifestyle and behaviour. As individuals experience greater freedom, they are exposed to new situations, opportunities and problems having to take decisions on their own (Hans, 1994: 26).

Secondary Informal Socialisation and Health Practices

Firstly, community plays an important role in the socialisation of an individual. It plays an important role in health and disease by adopting practices designed to prevent illness and promote health. Public health measures such as sanitation, safe drinking water supply, immunization of children against diseases, maternal and child health care, nutritious food, health education of community members, etc. help in the socialisation of the child (Mehta, 1992: 26).

Secondly, a child's peer group allows them to escape the direct supervision of adults. Children are free to act like children rather than like adults. Children talk more freely about topics that they may not feel comfortable discussing with adults (sex, drugs, girls/boys) (Rogers, 1999). Peer groups become more prominent during adolescence. As adolescents begin spending more time with their friends and less time under their parents' supervision, their greatest source of influence may change from that of family to that of their peer group (Selvan and Kurpad, 2004). Peer groups aid in the socialisation process because children in certain groups conform to the ideals/accepted ways of that group while disliking other groups. Joint activities, sharing, trust, and mutual understanding become key concerns while interacting with peers (Tiwari and Kumar, 2002). Sometimes children learn the norms and behaviour patterns of members of their groups and these may be in contradiction to those of their family. An adolescent's health behaviours or practices are also largely influenced by his peer groups.

Further, education in schools is aimed at preparing students for adult roles and responsibilities through socialisation and transmission of knowledge and skills. The "School" here, is used to refer to a whole range of formal educational institutions. It is an example of formally organised agency for the purpose of inducing the child into his/her society. Schools enlarge children's social world to include people of more diverse socio-cultural backgrounds. In other words, the school is the official agency where a society transmits its accumulated knowledge and skills from one generation to the other.

Schools provide two contexts for students. The first is the formal context of the classroom wherein the content of socialisation is determined by the curriculum, text books and the cognitive aims of the process of teaching. Whatever the students learn through curricula and co-curricular activities of the school is a part of the cultural heritage of the society (Shah and Shah, 1998). The second context is informal and can be perceived in the interpersonal relations of students with teachers and also among students (peer group). Regardless of the relative strength of these influences, schools are designed to promote learning in this moral, social sense as well as in academic work (Shipman,

1976: 173). Sometimes, schools may formalise the information about health and disease by including it as a part of the curriculum or sometimes they may simply launch informal educational camps/campaigns to make students aware of the problems of health and disease.

Thus, in the process of socialisation, health and health related behaviours are transmitted from one generation to another through informal and formal socialisation of a student. It is in this context that the present study aims to understand the linkages between cultures, socialisation and health practices with reference to HIV/AIDS. The study aimed to understand how cultural elements are incorporated into the education of the students in terms of health practices, mainly in terms of the educational elements that are taken into account at the level of the family, peer groups and the formal structures like schools and colleges. The focus here is on how informal and formal education influences a student understands and awareness of health and disease.

Methodology

Data Collection

With a view to provide an objective empirical support to the present study, both primary and secondary sources are used. The primary data is collected from the under-graduate college students of Manipur, one of the HIV/AIDS high prevalence states in India, using a pre-tested, semi-structured interview schedule. The interview schedule included questions for assessing the type of information the students got from their parents and school/college, the role of the parents and school/college in HIV/AIDS awareness and the barriers in discussing HIV/AIDS with parents and teachers, and their interaction with peer groups about HIV/AIDS.

Sample Selection

The study is conducted among the under-graduate students in Manipur. In the present study, multi-stage quota sampling is used to suit the purpose of the study. In the first instance, the colleges are selected based on their location in high, medium and low HIV prevalence districts of Manipur. Though all the nine districts in Manipur are affected by HIV, they vary in their degree of prevalence. For the present study, three colleges are selected from the three districts based on highly, medium and less affected districts by the epidemic in the state.

In all, 310 students, 162 men and 148 women students are interviewed. Of which, 54.2 percent are from the rural and 45.8 percent are from the urban areas of residence. The sampling procedure adopted at this stage of selecting respondents is purposive sampling keeping in view the intention of taking both men and women, and rural and urban students in nearly equal proportions. The data analysis, however, presents an additional variable of ethnic category (tribal or Meitei) in order to enhance the understanding varying cultural contexts. However, it may be pointed out that the tribal and Meitei students are not equally distributed and sample has higher number of Meitei students compared to the tribal students.

Results and Discussion

Part I: Culture, Family Socialisation and HIV/AIDS

This part provides a description of students' perception of the role of the parents, family and the peers on various aspects of health, disease and AIDS awareness. Firstly, *students are asked whether they received any awareness about health and disease from their parents and if so, what type of information did they receive*. Table 1 shows the distribution of perceptions of men and women students in this regard.

It is clear from the table that a majority (90.3 percent) of the students received some kind of awareness about health and disease from their parents. The type of information they received ranges from basic health and hygiene to information about the dreaded disease like HIV/AIDS. However, the proportion of the students who reported that they received information about HIV/AIDS from their parents is very few (20.0 percent). Thus, most of the students did receive some awareness at home about diseases and health practices.

While the role of the family is found to be crucial in making a student aware of general approaches to health and disease, it is important to note certain variations in the way the family transacted knowledge about health and disease to certain categories of students. For instance, among those students who stated that their parents did not transact any information about health and disease, the proportion of women is slightly more than the men students. In terms of place of residence, the data shows that a majority of both the rural and urban students did receive some form of awareness about health and disease from their parents. However, what is interesting here is that all those who have stated that they did not receive any kind of awareness from their parents are from the rural areas. There was none from the urban areas. This may be because of the lack of parental education at home for students from rural habitations. Many of the parents of the rural students themselves are disadvantaged in terms of accessing information about health and disease as they are non-literates.

Table 1: Did you receive any awareness about health and disease from your parents?

Variables	Did you receive any awareness about health and disease from your parents?		Total
	Yes	No	
Gender			
Men	148(92.5)	12(7.5)	160(100.0)
Women	132(88.0)	18(12.0)	150(100.0)
Total	280(90.3)	30(9.7)	310(100.0)
Place of residence			
Rural	138(49.3)	30(100.0)	168(54.2)

Urban	142(50.7)	0(0.0)	142(45.8)
Total	280(100.0)	30(100.0)	310(100.0)
Category of students			
Tribal	78(27.9)	24(80.0)	102(32.9)
Meitei	202(72.1)	6(20.0)	208(67.1)
Total	280(100.0)	30(100.0)	310(100.0)

Similarly, a majority of tribal as well as Meitei students has mentioned that their parents do pass on some kind of information about health and disease to their children even today. However, among those who mentioned that they did not receive any kind of awareness from their parents are mostly tribals. It may be pointed out here that most of these tribals are also rural dwellers, which corroborates the finding that most rural students are less informed about health and disease than that of urban and non-tribal students. Thus, it may be noted that the access to information and awareness restricts with the intersections of more than one disadvantage, in this case, both caste/tribe as well as place of residence.

Role of Parents in AIDS Awareness

In many ways, children today are growing up faster than ever. They learn about violence and sex through the media and their peers, but they rarely have all the facts before them. Thus, there are alternative ways of receiving information if the parents do not talk to their children about sex, sexually transmitted diseases (STDs), and HIV/AIDS. In India, discussing HIV/AIDS with their adolescent children is far from the expectation of the parents. Because of the association of the AIDS virus with sex and drugs, there is a taboo with the word HIV/AIDS. It is not talked about openly in the society, more so, it is difficult to talk to children in the family about these aspects.

In order to understand the role played by parents in bringing about awareness of HIV/AIDS to their children, *students are asked whether they discussed or talked about HIV/AIDS with their parents. If they discussed, in what context and, if not, what are the barriers in doing so*? It is observed from table 2 that a majority (80 percent) of the students did not discuss aspects of HIV/AIDS with their parents. Many men students regarded communication with parents about HIV/AIDS and sex as a taboo and said that it is not easy to talk with either parent (father or mother) on this topic. Both mothers and fathers never discussed HIV/AIDS with them and they knew about HIV/AIDS through the media, particularly radio. Only 20 percent of the total students reported that they did discuss how HIV is transmitted and how they can protect themselves from the virus with their parents. A few revealed that they discussed HIV/AIDS only when there is news of death from AIDS in their locality or among their relatives.

A majority of both men and women students reported that communication with parents about HIV/AIDS is not easy, as parents are not open with them on such subjects,

and they could not imagine themselves discussing with their mothers and fathers. However, interestingly, the number of women who discussed HIV/AIDS with their parents is slightly higher than their men counterparts. At the same time, the number of men who didn't discuss with their parents is slightly higher than their women counterparts.

Table 2: Do you discuss with parents about HIV/AIDS?

Variables	Do you discuss with parents about HIV/AIDS?		Total
	Yes	No	
Gender			
Men	26(16.3)	134(83.8)	160(100.0)
Women	36(24.0)	114(76.0)	150(100.0)
Total	62(20.0)	248(80.0)	310(100.0)
Place of residence			
Rural	30(48.4)	138(55.6)	168(54.2)
Urban	32(51.6)	110(44.4)	142 (45.8)
Total	62(100.0)	248(100.0)	310(100.0)
Category of students			
Tribal	18(29.0)	84(33.9)	102(32.9)
Meitei	44(71.0)	164(66.1)	208(67.1)
Total	62(100.0)	248(100.0)	310(100.0)

In terms of place of residence, it is revealed that out of the total students who discussed HIV/AIDS with their parents, about 51.6 percent are from the urban areas. However, within rural and urban students, the number of students who didn't discuss far exceeds those who discussed in both rural and urban areas. Further, it is observed that out of the total number of students who didn't discuss HIV/AIDS with their parents, a majority (66.1 percent) belonged to Meitei community.

Barriers in Discussing HIV/AIDS with Parents

In all cultural traditions, the role of the family has been essential in the health education of children. Family socialisation exerts an indispensable influence on youth health behaviour. However, as mentioned earlier, HIV/AIDS is rarely discussed among parents and children, issues pertaining to sex are considered 'taboo'. UNESCO (2001) also suggests that most of the adolescent children do not talk about sex and HIV/AIDS with their parents. Many parents still hesitate to talk to their children about the topic and related matters. Evidence also suggests that parents themselves often do not feel comfortable discussing sex issues with their children for a variety of reasons ranging from cultural or social shame associated with discussion of sex and sexual practices, to

fear and lack of their own knowledge about HIV/AIDS (Hilber & Colombini, 2002).

Students are asked if they do not discuss HIV/AIDS with their parents, what could be the possible reason or barrier for it. All students, irrespective of gender, place of residence and community, the reasons/barriers for not discussing with parents about HIV/AIDS centred around three factors. They are: (i) Shyness, (ii) Parents don't have adequate knowledge about HIV/AIDS and (iii) No need for discussion as both parents and children have enough knowledge (Table 3).

The data shows that lack of adequate knowledge about HIV/AIDS among parents was the most important factor for not discussing with parents (47.1 percent). About 27.7 percent of students have stated that due to shyness, they could not discuss HIV/AIDS issues with their parents. There are a few students who thought that parents as well as they themselves have enough knowledge about HIV/AIDS (5.2 percent). So, they expressed that there was no need to discuss with each other.

Gender wise distribution of the students shows that out of those who reported "shyness" as the factor for not discussing, a majority are men. At the same time, more women than men students reported, "parents don't have adequate knowledge about HIV/AIDS". It is also observed that among those who discussed with their parents, 51.6 percent are from the urban areas. Again, among the students who cited "shyness" as the reason for not discussing with their parents, a majority are from the urban areas. However, those who expressed "parents do not have enough knowledge about HIV/AIDS, a majority (76.7 percent) are from the rural areas. Among those who thought that there was no need for discussion between parents and themselves, a majority (62.5 percent) are from the urban areas.

Table 3: Factors/Barriers for not discussing with parents about HIV/AIDS

Variables	**Factors/Barriers for not discussing with parents about HIV/AIDS**				Total
	Discuss with parents	**Shyness**	**Parents don't have enough knowledge about HIV/AIDS**	**No need for discussion, both parents and children have enough knowledge**	
Gender					
Men	26(16.3)	60(37.5)	68(42.5)	6(3.8)	160(100.0)
Women	36(24.0)	26(17.3)	78(52.0)	10(6.7)	150(100.0)
Total	62(20.0)	86(27.7)	146(47.1)	16(5.2)	310(100.0)
Place of residence					
Rural	30(48.4)	20(23.3)	112(76.7)	6(37.5)	168(54.2)

Urban	32(51.6)	66(76.7)	34(23.3)	10(62.5)	142(45.8)
Total	62(100.0)	86(100.0)	146(100.0)	16(100.0)	310(100.0)
Category of students					
Tribal	18(29.0)	14(16.3)	64(43.8)	6(37.5)	102(32.9)
Meitei	44(71.0)	72(83.7)	82(56.2)	10(62.5)	208(67.1)
Total	62(100.0)	86(100.0)	146(100.0)	16(100.0)	310(100.0)

Further, it is also clear that those who discussed HIV/AIDS with their parents, a majority (71.0 percent) belong to the Meitei community. Out of those who cited "shyness" as the reason for not discussing HIV/AIDS with their parents, a majority (83.7 percent) are Meiteis. Those who stated that parents do not have adequate knowledge about HIV/AIDS, about 56.2 percent are Meiteis. At the same time, those who expressed that there was no need for discussion as both parents and children have enough knowledge about HIV/AIDS, a majority (62.5 percent) belong to Meitei. For all the factors discussed above, Meiteis are in higher proportion than the tribals. As stated earlier, this may be due the higher proportion of the Meitei students than the Tribal students in the total sample.

Thus, the family particularly, the parents provide information about basic health and hygiene to their children. In rural areas where modern medical facilities are inadequate or inaccessible, traditional healers are consulted for different kinds of illnesses by a few parents and students. There are certain variations in the way the family transacted knowledge about health and disease to their children who are coming from different places of residence and belonging to different communities.

Part II: Role of School/ College in HIV/AIDS awareness

The circle of influence on healthy behaviour of adolescents extends beyond the individual and family systems. The formal educational institutions like schools and colleges give students the knowledge and skills to thrive physically, mentally, emotionally and socially. This knowledge helps students to meet the challenges of growing up. School health campaigns help students to recognise the causes of ill health and to understand the benefits of good hygiene and appropriate medical care. Students also become aware of the dimensions of good health: physical soundness, ability to concentrate, expression of emotions in a healthy way and positive relations with family and peers.

Many adolescents adopt high risk behaviour due to numerous myths and lack of skills to deal with peer pressure. They also have a poor access to health and disease information and services and mainly rely on peers – who themselves may be poorly

informed – and the media to gain health related information. Adolescents have to cross many "gatekeepers" before they can even express their needs – especially which are related to sexual health and HIV/AIDS. Furthermore, the reluctance on the part of parents and teachers to address the adolescent sexual health issues and their own ignorance regarding various myths, and misconceptions about HIV/AIDS leave only the medical practitioners and some voluntary agencies to fill in the gap (Nayar, 2006). A UNAIDS (1997) position paper on HIV/AIDS prevention in the school setting suggests that education to prevent HIV/AIDS should be integrated into education about reproductive health, life skills, alcohol/substance use, and other important health issues.

Thus, the study aimed to understand the strategies adopted by the formal educational institutions like schools/colleges in addressing the issues of health and disease in general, and HIV/AIDS, in particular, and how do they propagate the information among the students. The study focused mainly on the responses of the students to these strategies adopted by the schools and colleges they attended.

Firstly, *students are asked whether they received any information about health and disease when they were at the school and, if so what type of information did they receive.* All the students, irrespective of the gender, place of residence and ethnicity reported that they received some information about health and disease while they were at school. Information received in school ranges from basic health and hygiene, balanced diet, importance of regular exercise, early sleep and early rising habits, etc. to communicable diseases and disease like HIV/AIDS and how to protect themselves from them.

However, at the college level, students irrespective of their background stated that they hardly received information about health and disease. In their college, there is no particular course/ programme about health and disease for all students. Information is not provided to all the students but only to certain students in the class if it is relevant to their course/syllabus. For instance, there is an optional subject at the first year of their graduation which has chapters on health and disease. The students who opted for the subject, thus, have received information about health and disease and those who didn't opt, didn't receive information.

A negligible percentage (2.6 percent) of the students expressed that they couldn't get any information about HIV/AIDS (Table 4). It is revealed that those who didn't receive any information about HIV/AIDS attended their high and senior secondary school education from the Boards, such as, Central Board of Secondary Education (CBSE). For those who studied under the Manipur Board (Council of Higher Secondary Education and Board of Secondary Education Manipur), it could be related to the fact that top priority was accorded to the IEC (Information, Education and Communication) campaigns by the state government for effective and efficient implementation of the AIDS Control Programme in the state. Gender-wise, there is no significant difference. Similarly, there is no significant difference between rural and urban students and Meitei and tribal students who received information about HIV/AIDS while they were at the school.

Table 4: Did you receive any information about HIV/AIDS at the school?

Variables	Did you receive information about HIV/AIDS at the school?		Total
	Yes	No	
Gender			
Men	154(96.3)	6(3.8)	160(100.0)
Women	148(98.7)	2(1.3)	150(100.0)
Total	302(97.4)	8(2.6)	310(100.0)
Place of residence			
Rural	164(54.3)	4(50.0)	168(54.2)
Urban	138(45.7)	4(50.0)	142(45.8)
Total	302(100.0)	8(100.0)	310(100.0)
Category of students			
Tribal	100(33.1)	2(25.0)	102(32.9)
Meitei	202(66.9)	6(75.0)	208(67.1)
Total	302(100.0)	8(100.0)	310(100.0)

Table 5: HIV/AIDS awareness programmes in the college

Gender	*Are there any AIDS awareness programmes in your college?*			Total
	Yes	No	Don't know	
Men	8(5.0)	146(91.3)	6(3.8)	160(100.0)
Women	10(6.7)	138(92.0)	2(1.3)	150(100.0)
Total	18(5.8)	284(91.6)	8(2.6)	310(100.0)

Students are asked about the awareness programmes in their colleges (Table 5). It is found that an overwhelming proportion (91.6 percent) of the students reported that

there is no HIV/AIDS awareness programmes in their colleges. Only about 5.8 percent of the students expressed that there are HIV/AIDS awareness programmes in their college. Teachers and doctors deliver talks on health and HIV/AIDS during National Service Schemes (NSS) Camps. However, these NSS camps in the college, through which HIV/AIDS awareness programmes are conducted under UTA Project, are organized for a group of students only and that too are not organised very often. A few students (2.6 percent) reported that they didn't know whether there are any awareness programmes in their colleges.

Role of the Teachers in HIV/AIDS Awareness

For children, a teacher becomes a model with authority and knowledge. In schools and colleges, teachers may provide students information and experiences about the change in the modes of living, in the fields of health and health practices, leisure, vocation, etc. Sometimes, schools may formalise information about health and disease in their syllabus. In this regard, the teachers have a great role to play in imparting knowledge of HIV/AIDS to the students. Teachers can pass the information to their students. Similarly, the students once informed about HIV/AIDS, may go back home and tell their parents and friends what they have learnt (Pembrey, 2007). It must be kept in mind, however, that the teachers themselves may require information and skills to socialise students about the disease and health practices.

Table 6: Do you discuss about HIV/AIDS at the college with teachers?

Variables	*Do you discuss about HIV/AIDS at the college with teachers?*		Total
	Yes	No	
Gender			
Men	20(12.5)	140(87.5)	160(100.0)
Women	16(10.7)	134(89.3)	150(100.0)
Total	36(11.6)	274(88.4)	310(100.0)
Place of residence			
Rural	16(44.4)	152(55.5)	168(54.2)
Urban	20(55.6)	122(44.5)	142(45.8)
Total	36(100.0)	274(100.0)	310(100.0)
Category of students			
Tribal	12(33.3)	90(32.8)	102(32.9)

Meitei	24(66.7)	184(67.2)	208(67.1)
Total	36(100.0)	274(100.0)	310(100.0)

In the study, *students are asked whether they discuss or talk about HIV/AIDS with their teachers*. From table 6, it is found that an overwhelming proportion (88.4 percent) of the students reported that they didn't discuss HIV/AIDS issues with their teachers at the college. Only 11.6 percent of students stated that they discussed HIV/AIDS issues with their teachers. They discussed mainly issues such as the transmission of the virus, how it is transmitted through sharing of syringe or needle among the intravenous drug users, why there has been large scale drug users among the Manipuri youth, about the risks of infecting the virus when a person donates his/her blood, etc. There are no significant differences between the students with respect to their gender, place of residence and ethnicity (tribal and Meitei) in this regard.

Barriers in Discussing HIV/AIDS with Teachers

Moreover, teachers have the potential to be important leaders in HIV prevention in schools and in their community. They are very aware of the negative impact of AIDS. However, there may be barriers in fulfillment of their role. Barriers may include internal factors, especially discomfort discussing sex with young people and stigma associated with HIV and AIDS, and external barriers including lack of training and knowledge, and lack of emphasis on HIV/AIDS in the curriculum.

It is found that a majority of the students in the present study didn't discuss HIV/AIDS at the college with their teachers. There could be certain factors or barriers for not discussing HIV/AIDS with their teachers. It was found that there were certain factors or barriers that inhibit students in discussing issues relating to HIV/AIDS with their parents. For example, shyness, lack of knowledge about HIV/AIDS on the part of the parents, etc., were some of the important factors for not discussing. Similarly, students are asked the possible reason for not discussing with their teachers regarding matters relating to HIV/AIDS. The responses are varied. The reasons/barriers for not discussing with teachers about HIV/AIDS mainly centred around three factors (Table 7). These are: (i) teachers don't have time to discuss HIV/AIDS, (ii) non-inclusion of HIV/AIDS in the syllabus and (iii) shyness.

Table 7: Factors/Barriers for not discussing with teachers about HIV/AIDS

Variables	**Factors/Barriers for not discussing with teachers about HIV/AIDS**				**Total**
	Discuss with teachers	**Teachers don't have time to discuss**	**Non-inclusion in the syllabus**	**Shyness**	
Gender					
Men	20(12.5)	118(73.8)	22(13.8)	0(0.0)	160(100.0)

Women	16(10.7)	94(62.7)	34(22.7)	6(4.0)	150(100.0)
Total	36(11.6)	212(68.4)	56(18.1)	6(1.9)	310(100.0)
Place of residence					
Rural	16(44.4)	112(52.8)	38(67.9)	2(33.3)	168(54.2)
Urban	20(55.6)	100(47.2)	18(32.1)	4(66.7)	142(45.8)
Total	36(100.0)	212(100.0)	56(100.0)	6(100.0)	310(100.0)
Category of students					
Tribal	12(33.3)	66(31.1)	20(35.7)	4(66.7)	102(32.9)
Meitei	24(66.7)	146(68.9)	36(64.3)	2(33.3)	208(67.1)
Total	36(100.0)	212(100.0)	56(100.0)	6(100.0)	310(100.0)

It is found that the teachers at the college do not have time to discuss HIV/AIDS in the classroom as well as outside of it. About 68.4 percent of the total students stated this as a reason/factor for not discussing. They observed that the teachers take their classes and go. The topic of HIV/AIDS never came up in the class. A few students (18.1 percent) reported that since it is not part of their syllabus, they couldn't discuss. If the topic of HIV/AIDS was included in their syllabus, they mentioned that they would surely have discussed with their teachers about HIV/AIDS. Another factor/reason for not discussing with teachers was "shyness".

There is no significant difference in the perception of men and women students in this regard except that the "teachers don't have time to discuss" was stated by larger proportion of men than women students while "non-inclusion of the HIV/AIDS in the syllabus" was stated by more women than men students. Interestingly, though small in proportion, only women students mentioned that they feel shy to talk about HIV/AIDS issues with their teachers. This could be related to the differences in gender socialisation. In Indian society, girls are culturally prohibited from discussing issues of sex, sexuality, etc. with non-spousal men or in front of men or even with women. Thus, it is not

uncommon a girl not to discuss the matters of sex with teachers, even if the teacher is a woman. Thus, it is in this cultural context, the awareness of HIV/AIDS may be understood in Indian as well as Manipur context.

In terms of place of residence, though there are no significant differences, those who discussed HIV/AIDS with their teachers, about 55.6 percent are from the urban areas whereas those who cited that non-inclusion of HIV/ AIDS in the syllabus as the reason for not discussing, about 67.9 percent are from the rural areas. Further, it is also clear that those discussed HIV/AIDS with their teachers, a majority (66.7 percent) belong to the Meitei community. Again, for all the factors discussed above, for not discussing with their teachers, Meiteis are in higher proportion than the tribals.

Discussion about HIV/AIDS with Friends

Besides teachers, the students rely heavily on their peers in the school/college for information on various aspects. It is this informal grouping within the formal school/college that is crucial for information and awareness about a disease like HIV/AIDS. However, ill-informed a peer group may be, it socialises and wields a great amount of influence over its members. The school/college break times, the leisure time within the formal classroom engagement, during the play time in the ground, the students discuss matters of every kind. Particularly, it is in these informal settings within the schools and colleges that issues relating to perceived 'taboos' of the society such as sex, drugs, HIV/AIDS are discussed.

Thus, the *students are also asked whether they discussed HIV/AIDS issues with their friends and if they discussed, in what context did they discuss* (Table 8). A majority (60.0 percent) of the students reported that they didn't discuss issues pertaining to HIV/AIDS with their friends. They stated that the topic never came up when they talked with their friends. However, the remaining 40 percent of the students informed that they discussed with their friends about HIV/AIDS. They talked about HIV testing of their partner before marriage, about the modes of transmission of the virus through commercial sex workers, homosexuals, etc. However, they observed that they never talked/discussed HIV/AIDS with the friends of opposite sex. The most important reason for this was shyness. Because of the association of HIV transmission with unprotected sex and drugs, no student was willing to talk/discuss with their friends of opposite sex.

Table 8: Did you ever discuss about AIDS among your friends?

Variables	***Did you ever discuss about HIV/AIDS among your friends?***		**Total**
	Yes	**No**	
Gender			
Men	74(46.3)	86(53.8)	160(100.0)
Women	50(33.3)	100(66.7)	150(100.0)
Total	124(40.0)	186(60.0)	310(100.0)
Place of residence			

Rural	58(46.8)	110(59.1)	168(54.2)
Urban	66(53.2)	76(40.9)	142(45.8)
Total	124(100.0)	186(100.0)	310(100.0)
Category of students			
Tribal	36(29.0)	66(35.5)	102(32.9)
Meitei	88(71.0)	120(64.5)	208(67.1)
Total	124(100.0)	186(100.0)	310(100.0)

Gender-wise, the proportion of men students who discussed HIV /AIDS with their friends is more than the proportion of women students. For example, about 46.3 percent of the men students reported that they discussed HIV/AIDS with their friends whereas only 33.3 percent of women students discussed with their friends. In terms of the place of residence, it is observed that out of the total students who discussed HIV/AIDS with their friends, about 53.2 percent are from the urban areas. However, within rural and urban students itself, the proportion of students who didn't discuss with their friends is higher than those who discussed HIV/AIDS in both rural and urban areas. Further, it is observed that out of the total students who did not discuss HIV/AIDS with their friends, a majority (64.5 percent) are Meiteis. At the same time, when we study the proportion of students who discussed HIV/AIDS, the proportion of Meitei students is higher than that of the tribal students. However, when we see within the tribal category itself, it is found that the proportion of students who didn't discuss HIV/AIDS with their friends are much more than those who discussed.

Thus, formal educational settings like schools/colleges provide opportunities to enhance awareness about HIV/AIDS. It is also found that at the college, almost all the students reported that they hardly got information about HIV/AIDS and that there are no proper and well organised HIV/AIDS awareness programmes to inform the students. Nothing is done to inform the students about the risk of HIV/AIDS (except one/two lectures in a year that also as part of NSS programe). Besides, due to lack of time on the part of the teachers, the students could not discuss issues of HIV/AIDS with their teachers.

Conclusion

It is in the family that the process of socialisation begins. It is from the family and schools/colleges, a child/student receive information about health, hygiene and disease. But there are certain variations in the way the family transacts knowledge about health and disease to their children in terms of those who are coming from different places of residence and belonging to different ethnic communities. However, there are no proper and well organised HIV/AIDS awareness programmes to inform the students. Nothing is done to inform the students about the risks of HIV/AIDS. It is also found that as far as HIV/AIDS is concerned, only a few students discussed with their parents and teachers. Due to shyness and lack of knowledge about HIV/AIDS on the part of the parents, the students could not discuss HIV/AIDS with their parents. However, the most important

reason for not discussing with teachers was the lack of time on the part of the teachers. Other factors like shyness and non-inclusion of the HIV/AIDS in the syllabus are also the reasons for lack of any interaction between the students and teachers in terms of awareness towards HIV/AIDS. However, the informal peer groupings within the formal school/college are also very important ways of raising real or false awareness of HIV/AIDS among students.

Thus, the manner in which the young people are socialised depends upon the characteristics of the society. Exposure of the young people to the modern values has been contributing to the cultural gap between the parents and the young people. In the present study, despite the seriousness of HIV/AIDS situation and many awareness campaigns, most parents feel uncomfortable talking with their children about HIV/AIDS and other sex related issues. Besides, the lack of sustained campaign for healthy habits and awareness at the college may relapse an adolescent/youth into a sort of taken-for-granted behaviour. The college going student may assume that all is well with his/her behaviour and habits pertaining to health, hygiene and nutrition. As mentioned earlier, this combines with the very nature of adolescence and youth which leads the young students to experiment and taste the 'new' ways of life and living, declaring the symbolic 'arrival' of the adulthood. A young college going student confronts the dilemmas of family based restrictions regarding various social, cultural and health behaviours and also at the same time, may take pride of the fact that he/she is 'growing up' and that it is the time to exercise freedom, 'to be one's own' and to 'break away' from the shackles of the home and parents. Thus, if colleges do not sustain the socialisation of a child/student in terms of health beliefs and disease and infection awareness, the child/student may tend to reinforce ignorance and myths of the society at large; rather than dealing with them as an informed individual or adolescent.

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