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Parent–Adolescent Communication About Sex in Rural India: U.S.–India Collaboration to Prevent Adolescent HIV

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Abstract

In this article, we examine parent–adolescent communication about sex among rural Indian youth and their parents. We conducted in-depth interviews ($N = 40$) with mothers, fathers, and adolescent boys and girls aged 14 to 18 years in a rural community in Maharashtra, India. In the context of key cultural factors, including gender-related norms, we explore issues of sexual health and critically assess widely held beliefs that Indian parents are unwilling or unable to discuss sex-related topics with their children. Our findings suggest that despite communication barriers, e.g., lack of knowledge and cultural proscriptions, Indian families are interested in and willing to communicate about sex-related topics. Future research should seek to determine the viability of family-based HIV prevention interventions for Indian adolescents.

Keywords

adolescents/youth; Asia; South/Southeast; communication; HIV/AIDS prevention; parenting; sexuality/sexual health

HIV/AIDS is a significant and growing public health concern in India, with an estimated 2.4 million people currently living with HIV and overall prevalence of 0.36% (Joint United Nations Programme on HIV/ AIDS [UNAIDS], 2008). Youth aged 15 to 24 years comprise nearly a quarter of the country's population, yet they account for 31% of the AIDS burden (National AIDS Control Organization [NACO], 2006, 2008), and nearly two fifths of new HIV infections are among persons under age 25, suggesting an urgent need to address HIV prevention among Indian youth (NACO, 2004). This need is most dire in high HIV prevalence states such as Maharashtra, where at least 20% of India's HIV cases are located, but only one third to one half of youth report comprehensive knowledge of HIV and its transmission routes (International Institute for Population Sciences [IIPS], 2008). Furthermore, high-risk sexual behaviors, low knowledge about HIV/AIDS, and low condom usage are known to augment the risk for HIV and sexually transmitted diseases (STDs) in rural areas (Parasuraman, Kishor, Singh, & Vaidehi, 2009).

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Recognizing that successful prevention and treatment of HIV/AIDS requires international cooperation across multiple disciplines, the Indian Minister of Health and Family Welfare and the U.S. Secretary of Health and Human Services signed a bilateral agreement in 2006 to collaborate on the prevention of STDs and HIV/AIDS in India (Kronstadt, 2005; U.S. Department of Health & Human Services, & Republic of India Ministry of Family Welfare [DHHS], 2006). The overall goal of this agreement is to “promote and develop cooperation in the fields of HIV/AIDS and STD prevention, research, treatment and care, infrastructure development, training, and capacity-building on the basis of reciprocity and mutual benefit” (DHHS, p.1). More specific key areas for cooperation include “developing innovative intervention strategies for the prevention and treatment of HIV/AIDS” (DHHS, p.2).

The present study was a collaborative project by social scientists in India and the United States conducted under the aegis of this bilateral agreement. The overall goal of the project was to conduct formative research that informed the development of a family-based intervention to prevent HIV infection among Indian youth in a rural community in Maharashtra. The planned intervention integrated the principles of “highly-active HIV prevention” by incorporating contextual (e.g., family processes), biomedical (e.g., condoms), and behavioral (e.g., condom usage) prevention strategies deemed efficacious for preventing HIV transmission (Merson et al., 2008, p.1805; Rotheram-Brous, Swendeman, & Chovnick, 2009). A second goal was to scale up the knowledge base and research capacities of Indian and American social scientists to develop and implement innovative, culturally appropriate, effective, and sustainable HIV/AIDS prevention and treatment programs. The purpose of the present formative research was to address these two goals (Soletti, Guilamo-Ramos, Burnette, Sharma, & Bouris, 2009).

For several reasons, in this article we focus on boys and girls aged 14 to 18 and their parents who lived in a rural village in Maharashtra. First, Maharashtra has a disproportionately high incidence of HIV cases relative to other states in India, as shown in Figure 1 (NACO, 2008). Second, research suggests that HIV awareness and knowledge are particularly low among youth in rural Maharashtra. For example, in a study with rural Maharashtran girls and women aged 15 to 24 years, only 49% of participants were aware of AIDS and only 60% of those who knew of AIDS reported that it could be avoided (Pallikadavath, Sanneh, McWhirter, & Stones, 2005).

Additional risks stem from rural-to-urban migration by young men, particularly from Maharashtra to Mumbai, in search of economic opportunities. Sexual relationships with women, including sex workers, while in urban areas can create a bridge for HIV infection when these men return home to marry and start families (Venkataramana & Sarada, 2001). A recent study conducted in Mumbai revealed that most wives were unaware of their husband’s extramarital sexual behavior. Almost all women surveyed, however, did not consider themselves at any risk for HIV/STIs (Bojko et al., 2010). Additionally, research related to young women in Maharashtra has demonstrated early entry into marriage, involvement in commercial sex work, and rates of school dropout (Chattopadhyay & Durdhawale, 2009; Mohanty & Ram, 2011; Venkataramana & Sarada).

Taken together, increased HIV prevalence, the propensity to engage in high-risk sexual behaviors, and low comprehensive knowledge and persistent misconceptions about HIV/AIDS among rural Indian youth underscore the importance of comprehensive education about safe sex practices and modes of HIV transmission. Furthermore, a reluctance to talk openly about sex and sexual behavior poses a significant obstacle to the control of HIV transmission and the promotion of sexual health in India (Lambert & Wood, 2005).

Traditional cultural norms, most particularly those which relate to the family as the primary unit of social organization and those that treat gender as a core dimension of behavioral standards and practices in India, are pivotal to understanding intergenerational patterns of communication about sexuality. As in other Asian societies, traditional, individual, and community life in India are regulated by collectivist norms, which emphasize family integrity, family loyalty, and family unity. As such, individual decisions on key aspects of life—i.e., career choice, mate selection, and marriage—depend on cooperation among kin (Mullaatti, 1992; Shangle, 1995).

Structurally, these norms are promulgated through the joint family, which comprises a number of family units, often three to four generations, who reside in separate areas of the same house. Family members share resources, including income and property, and provide one another with a sense of support, security, and belonging (Desai, 2005). Joint families adhere to the culture's dominant patriarchal ideology, follow a patrilineal rule of descent, are patrilocal in residence, and endorse traditional gender role preferences. In a study of domestic violence and HIV prevention in Chennai by Go and colleagues (2003), study participants' descriptions of the "ideal man" and "ideal woman" succinctly captured traditional gender norms in India. They described the ideal man as foremost a provider who is responsible for maintaining the family's reputation in the community. Men emphasized an obligation to "improve society," whereas women highlighted the importance of men resisting "vices" such as excessive drinking and sexual relationships with other women. Three behavioral characteristics typified the ideal woman: disciplined, submissive, and respectful, particularly to their husbands. Men added that a woman should accept her husband's imperfections and put his needs before her own, listen to what her husband is saying, be chaste, and care for the home and family.

Traditional gender norms remain dominant in rural India, and the segregated worlds of men, women, and related power differentials influence communication about sex. Parent-child communication about sex is culturally proscribed (Selvan, Ross, & Parker, 2005), and when communication does occur, it is typically indirect (Lambert & Wood, 2005), and almost exclusively confined to mother-daughter and father-son relationships. Therefore, although there is no question that parental communication and general family dynamics influence adolescent sexuality, we restricted our examination to same-sex parent-adolescent dyads. There is evidence that Indian parents are increasingly concerned about their children acquiring HIV and experiencing other negative health outcomes (Khan, Mishra, & Morankar, 2007–2008; Mehra, Savithri, & Coutinho, 2002), in addition to wanting to help their children make appropriate decisions about marriage (Alexander, Garda, Kanade, Jejeebhoy & Ganatra, 2007; Mehra et al.).

Macro forces of globalization, westernization, and industrialization are changing social norms about families and gender roles, and are contributing to a dramatic rise in rural-to-urban migration in developing countries, including India. These changes come first to urban areas, however, and reliable sources of information about sexual matters, including contraception, are scarce for Indian youth (Nath, 2009). Studies highlight their reliance on peer groups, teachers, and the media rather than parents or other family members for information about sex (Banerjee & Mattle, 2005; IIPS, 2008; Khan et al., 2007–2008). For example, participants in a large survey of Maharashtra youth cited family members as infrequent and inconsistent sources of information on sex-related matters, and reported that they rarely discussed "sensitive topics" such as romantic relationships, sexual reproduction, and contraception with either parent (IIPS, 2008, p.103).

A growing body of research with young people in developing countries indicates, however, that parents can influence sexual decision making of their adolescent children (Blum &

Mmari, 2005; Phetla et al., 2008; Zhang, Li, Shah, Baldwin, & Stanton, 2007). These findings are consistent with the large body of literature from the United States that shows parents can influence factors including adolescent sexual debut (Moore et al., 2004), condom use (Miller, Kotchick, Dorsey, Forehand, & Ham, 1998), and acquisition of STIs (DiClemente et al., 2001). Evaluations of parent-based interventions in the United States also show that parents can reduce adolescent sexual risk behavior when given appropriate information and parenting strategies (Forehand et al., 2007; Guilamo-Ramos et al., 2011; Stanton et al., 2004; Villarruel, Cherry, Cabriaes, Ronis, & Zhou, 2008). An article recently published in *Qualitative Health Research* reported that once Mexican parents were sensitized to the risks that their ill-informed adolescent children faced regarding sexual and reproductive health, conversations directly related to these topics became easier to initiate (Campero, Walker, Rouvier, & Atienzo, 2010).

The purpose of this article is to explore parent–adolescent communication about sex among rural Indian youth and their parents. The study advances previous research in a number of ways. First, we use narrative data from mothers, fathers, and adolescent boys and girls to better understand rural Indian parent–adolescent communication. Second, we critically examine the widely held supposition that Indian families are unwilling or unable to discuss sex-related topics with their children. Finally, we explore issues of sexual health with rural Indian families in the context of cultural factors. We ultimately aim to inform and advance the development of family-based HIV prevention interventions for Indian rural youth.

Methods

Design

Given the exploratory aims of the project and the sensitive nature of the study topic, we employed an in-depth interviewing methodology to gather narrative accounts from adolescents and their parents on parent–adolescent communication about sex-related topics. Personal interviewing is a primary means of data collection across multiple qualitative methodologies, singularly or in tandem with, for example, observational and archival strategies. The principles and practices of in-depth interviewing also represent a unique approach to qualitative research. Drawing largely on Rubin and Rubin (2005) and Seidman (2006), we used this method to elicit individual narratives from adolescents and their parents in response to a semistructured series of questions about culturally normative and actual interpersonal communication on sex-related topics.

Rubin and Rubin (2005) suggested that qualitative interview projects build on a naturalistic, interpretive philosophy, be extensions of ordinary conversations, and involve interviewers and interviewees as partners in the process. They furthermore distinguished two broad categories of in-depth interviews: cultural and topical. More loosely structured and narrator-oriented cultural interviews explore “the ordinary, the routine, the shared history, the taken-for-granted norms and values, the rituals, and the expected behaviors of given group of people,” whereas more structured, researcher-oriented topical interviews examine “what happens in specific circumstances” (2005, p. 9). In practice, cultural and topical features usually coexist, with one predominating. We plan to use findings from these in-depth interviews to inform the development of a culturally appropriate, large-scale survey, making our approach more topically focused but necessarily imbued with cultural content.

In-depth interviews are more appropriate for investigating individual perspectives than group norms. They are an effective means to encourage people to talk about personal feelings, opinions, and experiences, and offer insights into how people interpret and organize their worlds. As Mack, Woodsong, MacQueen, Guest, and Namey (2005) pointed out in their field guide on qualitative data collection, in-depth interviews are especially

appropriate for sensitive topics, and have been used productively to study HIV-related matters with youth, families, service providers, and communities in other developing countries (Horizons Program, Kenya Project Partners, and Uganda Project Partners, 2001). The in-depth interviewing approach permitted us to elicit reports and develop insights about how individual experiences, family and peer influences, and cultural norms interact to guide perspectives and behaviors (see Rich & Ginsburg, 1999).

Community Context

Research was conducted in Aghai, a small village in the Thane district of Maharashtra. The district, which is northeast of Mumbai and adjacent to Pune, has a population of 8.1 million, of which 30% is rural. In 1986, the School of Social Work at Tata Institute of Social Sciences established an Integrated Rural Health and Development Project (IRHDP) in the village and its 20 surrounding *padas* (small settlements, typically smaller than a village). The IRHDP aims to promote health and education and to use and generate local resources for villagers in collaboration with the local primary health center.

The IRHDP has developed strong relationships with residents of the local *padas*. As part of their work, the IRHDP maps villages and monitors and records health work that occurs in each village. Using the IRHDP village map and the most recent community census, we selected a *pada* with which local health workers had a strong existing relationship but no special history of HIV/ AIDS-related work. Because of considerable distances between the 20 *padas* and difficulties of transportation, particularly during the monsoon season, we aimed to select a single *pada*. Judging from the community census, we determined that the selected *pada* had enough age-eligible boys and girls for the study. Of the 41 households in the selected *pada*, 25 had at least one unmarried adolescent between the ages of 14 and 18 years.

Recruitment and Consent

The 20 households that participated in the research were selected through area sampling. Using a randomly generated list of eligible households, a quota-type grid was developed with the number and gender of all eligible adolescents in the *pada*. Indigenous recruiters visited eligible households and invited an adolescent and his or her same-sex parent (in accord with cultural norms about sex-related communication) to participate in an individual interview on parent-adolescent communication about sex-related issues. In instances in which participating families reported more than one adolescent in the home, the investigative team adopted a systematic sampling method intended to reduce parental respondent bias by clearly delineating the referent child for the in-depth interviews. This procedure ensured that when a given parent responded to interview questions, the responses were consistently associated with a referent child. This was achieved by inviting the youngest eligible adolescent in all instances in which families had more than one adolescent in the targeted age group. Recruiters explained the purpose of the research, the nature of the interview process, and the right to refuse questions or participation without penalty. Families were also provided basic information about HIV as part of the consenting process. Recruiters were thoroughly trained on interview protocol, and paid careful attention to obtaining consent from parents and adolescents.

Recruitment proceeded until the targeted total of 40 individuals (10 mothers, 10 fathers, 10 boys, and 10 girls) were invited. All 40 of the invited individuals agreed, consented, and completed the interviews. The remaining five households were not approached for participation, but were held in reserve if needed. The research team opted to not pursue these additional five households given the saturation of themes emerging from the 40 individuals that did participate in the study. Adolescents were compensated 100 Indian rupees and

parents received 250 Indian rupees (about \$2 USD and \$5 USD, respectively). Institutional review board approval was obtained from both Indian and U.S. universities.

Data Collection

Individual in-depth interviews were conducted with mothers, fathers, adolescent boys, and adolescent girls. Interviews lasted between 1 and 2 hours, and took place in venues deemed private and convenient by the participant. Padas are small communities with limited common space; therefore, these venues included participants' homes, the local health clinic, and outdoor spaces. Only the trained interviewer and participant were present at each interview, and the utmost care was exercised to ensure privacy and confidentiality (Mack et al., 2005).

The success of in-depth interviews on sensitive topics depends largely on the quality of interviewer training. All interviewers for the present research were carefully selected locals who were fluent in the local language and had extensive experience with the cultural and demographic profile of the target population, but did not live in the community. Indian investigators provided rigorous training sessions for interviewers on the research purpose, protocols, skills, and techniques for in-depth interviewing and facilitating discussion on sensitive topics such as sexual behavior and HIV/AIDS. They also monitored the quality of incoming data through periodic auditing and feedback on completed interviews and transcripts, e.g., member checking, which provided external validity checks throughout the research process. Interviewers were guided by a protocol that was developed by the first three authors and refined with substantial, iterative input from indigenous project staff and community members. The questions in each interview focused on a broad range of topics, including family communication about HIV; gender; familial, social, and cultural norms surrounding parent-adolescent communication about HIV; and various aspects of sexual behavior. Similar types of questions were asked of the parents and of adolescents; however, interviewers were sensitive to the comprehension levels of participants, particularly adolescents, and framed questions in developmentally appropriate ways.

Although cultural factors (such as taboos against open discussions of sex, HIV/AIDS-related stigma, and gender norms for women) can influence participant responses, we sought to address these potential biases by matching interviewers and research participants on gender to minimize social desirability bias (McCombie & Anarfi, 2002). Furthermore, peer debriefing was carried out between the United States- and India-based researchers, which provided invaluable feedback during data collection and analysis. Researchers in the field were asked to keep field notes and memos, which were discussed in the debriefings as a way to foster awareness and address potential bias issues. These initial memos were followed by a second set of analytic memos used by researchers to additionally refine the themes that emerged from the data.

All interviews were audio recorded and a written verbatim transcript was produced in Marathi, the native language of respondents and official language of Maharashtra. Marathi transcripts were then translated into English and checked for accuracy using a forward-backward translation method (World Health Organization, 2009). In this procedure, a forward translation is made from the source language, Marathi, to the target new language, English. The target-language version is then translated back into the source language and compared to the original version. Errors in the target-language version are identified through changes in meaning that arise in the back translation. In addition, the translators reviewed transcripts carefully to ensure conceptual and linguistic equivalence in the translation process (Robine & Jagger, 2003). Nevertheless, despite our careful adherence to standard translation protocols, translations of qualitative text give rise to other issues that include, as Temple and Young (2004) pointed out, hierarchies of language power, situated language

epistemologies of researchers, and ethical and methodological issues of speaking for those viewed as “other.”

Data Analysis

We analyzed the data using thematic analysis. Braun and Clarke (2006) noted that a theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (p. 40). The themes that emerge from pattern recognition in the data become the categories for analysis. Following Fereday and Muir-Cochrane (2006), we used both a data-driven inductive approach described by Boyatzis (1998) and a deductive approach outlined by Crabtree and Miller (1999). In the latter instance, codes are derived from theoretical and analytic questions designed to elicit a detailed, nuanced account of a phenomenon. This tandem use of inductive coding and deductive thematic analysis allowed for discovery and description of novel themes in the transcribed interviews and proceeded to the point of saturation, when no new information or new themes were emerging from the data. Saturation was identified when the number of interviews provided a reliable sense of variability and thematic exhaustion within our data sample (Guest, Bunce, & Johnson, 2006).

Specifically, we followed the steps outlined by Braun and Clarke (2006). After becoming familiar with the overall data, we generated initial codes, which we then collated and refined to arrive at a limited number of key themes that mapped onto our theoretical approach. We then moved recursively between the full data set, coded excerpts, and our emergent analysis to thematically map the research question concerning parent–adolescent communication about HIV prevention. This process allowed us to refine the themes in the data and the overall accounts respondents had related in the interviews. In the final stage of analysis, we drafted the report once we had achieved a satisfactory thematic map of our data.

Given the cross-cultural nature of the research, we attended closely to reflexivity, or the ways in which we might have affected the research at each stage of the process. The use of multiple investigators from the United States and India was particularly helpful in fostering complementary and divergent dialogue about the research questions and context, and the processes of data collection and data analysis (Barry, Britten, Barbar, Bradley, & Stevenson, 1999; Malterud, 2001). For example, Indian researchers were initially challenged by the level and detail of questioning about sex that was proposed by U.S. researchers, stating that such questions would be too sensitive to ask. After lengthy discussion, however, both teams were able to reach an agreement about the importance of asking such questions and develop nuanced ways to do so.

Results

Prior research has generally portrayed Indian parents as unwilling or unable to talk about sex-related topics with their children, yet our findings suggest that communication barriers notwithstanding, both parties might in fact be open to such discussions. We identified five main themes related to facilitating such communication: (a) knowledge and awareness of HIV/AIDS, (b) barriers to communication, (c) perceptions about the consequences of sexual behavior, (d) style and content of communication, and (e) opportunities for communication.

Knowledge and Awareness of HIV/AIDS

The levels of awareness and knowledge of HIV/AIDS varied among adolescents and parents. Adolescent boys appeared to have higher awareness and more detailed knowledge of HIV/AIDS compared with adolescent girls, although the majority of both genders said that their parents had not discussed sexual topics or HIV/AIDS with them. Some boys were

aware of HIV transmission routes through sexual intercourse, sex with multiple partners, and needle sharing. One boy stated, "If a woman has sex with many men, then AIDS can happen," whereas another noted, "If one syringe used on one person is given to another person, then he can get AIDS." Some boys conveyed more detailed knowledge about HIV symptoms. As one boy explained, "In this disease, a person becomes completely weak; he finds difficulty passing stools, and after getting HIV he also coughs a lot because he gets TB [tuberculosis] and becomes very weak." A few boys also knew that using condoms was a preventive measure against contracting HIV/AIDS.

The level of awareness of HIV/AIDS was lower among adolescent girls. Those who knew that AIDS was a disease were able to identify the possibility of transmission through physical means. One girl noted, "The information I have got is that HIV persons should not have physical relationships and that the disease is transmitted through the blood." Another girl stated, "[HIV can spread] through injection needle which is infected by a wound on the HIV positive person and injected in the HIV negative person. The disease can spread in this manner." As with boys, the most frequently cited information sources about HIV/AIDS for girls were television campaigns promoting AIDS awareness, health workers, school teachers, and science textbooks. One girl explained, "It can spread from one person to another through syringe. I know because they show it on the TV [television] that disposable syringes should be used." One girl mentioned that she learned about HIV "from books, sometimes through TV programs," and another stated, "From the school. People like you come to the school and give information."

Fathers and mothers varied comparably in their level of awareness and knowledge about HIV/AIDS. Whereas some parents reported very detailed information about symptoms and modes of transmission, others had very limited knowledge. One father explained,

Now this AIDS disease has come up, and it can happen by sexual intercourse, also by doctor's needle. If while giving an injection, if the same needle is given to another, then this person can get AIDS if the previous person was an AIDS patient.

Another father, however, expressed limited knowledge: "As such, I don't know about AIDS. I don't know the symptoms of AIDS, how it happens, how it spreads."

Among those mothers who had some knowledge of HIV/AIDS, some knew mostly about how the disease is transmitted. For example, one mother stated, "If a man or a boy visits more than one prostitute, then he can be infected, and because of the man, it can also spread to a woman." Another mother stated that HIV/AIDS happens "due to injections. Then if they give us that dose, then from them we too can contract." A number of fathers and mothers reported very limited or inaccurate knowledge and information about HIV/AIDS. As one father indicated, "If a mosquito bites a person with AIDS and bites another person, then AIDS can spread from one to another." Similarly, a mother stated that "we have only heard about it, but don't know about it." Parents reported that their most common sources of information about HIV/AIDS were radio and television campaigns, newspaper articles, and information provided by local health clinics.

Barriers to Communication

Parents and adolescents identified a number of barriers to communication about sexual topics. The main obstacles they mentioned were (a) embarrassment in discussing sexual topics, (b) concerns that discussions about sex were not age appropriate, and (c) lack of information.

Parents and adolescents alike cited embarrassment as a major barrier to initiating or engaging in discussions about sexual topics. Adolescent boys often said it would feel

awkward to have such conversations with their fathers. One boy explained, “I will feel bad, meaning when he says a weird word.” Another noted, “Now, between parents and boys, sometimes asking certain words is awkward. If I ask, then what will Dad say? Will Dad beat me? I feel this.” Girls echoed this sentiment about conversations on sexual topics, particularly with their fathers. As one girl put it, “I would feel shy in the company of Father to speak.” Both boys and girls also feared that merely asking their parents about sex would arouse unwanted suspicion that they were sexually active. Parents also conveyed embarrassment about such discussions with their adolescent children. One mother stated, “I feel awkward. [I] haven’t spoken to her ever, so [I] feel scared.” Another feared that “she might say what dirty thing I am discussing with her!”

A second barrier to parent–adolescent communication was the belief that discussing sexual topics was inappropriate before marriage. Most boys and girls felt it was appropriate to discuss sexual matters with their parents between ages 18 and 21, or after marriage. One girl indicated, “I feel that older people will not agree to speak on this topic at such young age.” Another stated, “In our place, in a young age, parents don’t talk to you. Only after marriage they talk.” Indeed, few adolescents thought sex was an appropriate topic for young adolescents, who lacked the maturity to process such information. One boy said, “Younger boys sometimes make fun of such things.”

Parents also tended to believe that discussing sexual topics with their adolescents was not appropriate before marriage, and that even having such discussions could negatively affect the child’s sexual behavior and how the family would be seen in the wider community. Mothers, in particular, conveyed that they would feel more comfortable discussing sexual topics with their daughters only after marriage. One mother noted, “Once a girl gets married, then we can tell her how to behave with the husband.” Some mothers and fathers felt that talking openly with their children might lead them to sexual activity. As one father explained, “If we try to discuss too much in detail, it is likely that they might become curious and want to explore physical relations.” Another stated,

Among us, we don’t speak on [the] sexual relationship. If we speak among children, then it can be misused. It has effects on the children. It can lead to something grave. This is what we think. That’s why we don’t talk to our children directly.

Similarly, a mother noted, “I have never spoken on this topic. If I share with her these things, it might affect her thoughts.” Some parents, notably mothers, expressed concern that discussing sexual topics with their children would result in negative social consequences in the community. As one noted, “People will comment on you. They would say that the mother herself is a bad woman.” Another mother explained, “People will laugh at us, say it’s not right.”

Parents generally felt that they lacked adequate information to share with their children, particularly about HIV/AIDS. One father related, “I don’t know about AIDS—only whatever I read in the paper, newspaper and television. I don’t know the symptoms of AIDS; however, how it happens, how it spreads.” Some parents were thus more comfortable deferring information on sexual matters to others, such as doctors and health workers. “Doctors come and tell this. They encourage people; they tell that there is no harm in using condom. If this is told to children then they will not do [have sexual relations],” said a father. A mother echoed this sentiment in noting, “If others like health workers give the information, then I can make my daughter aware about it.”

Parent and Adolescent Perceptions About the Consequences of Sexual Behavior

Adolescents discussed social and health consequences of being sexually active. Girls talked about how having sex before marriage would damage their reputation in the community and bring shame on their family. As one girl noted, “The parents’ name will get spoiled.” Others framed the consequences of being sexually active in terms of health outcomes. A girl explained, “We might get infected with bad diseases or become pregnant.” Similarly, a boy noted, “It will decrease our body strength, and we will lose our potential and not be able to do any hard work.” Other adolescents feared parental punishment, which one boy explained as, “If parents come to know about it, they just beat up the child.”

Parents also framed the consequences of their adolescent being sexually active in terms of social and health outcomes. According to a mother, “If my daughter gets involved in such a thing and has physical relations, then she would lose her honor. Even the family would lose all its respect.” Some parents framed this message in terms of the risk of contracting a disease and the impact that would have on the child. As one father stated, “If he [son] has illegitimate relationship with that girl, and if she has some disease and if he contracts it, then his whole future will get devastated.”

Content and Style of Communication

Overall, communication about sex within these rural Indian families appeared limited. Few adolescents reported having direct or detailed conversations about sexual topics with their parents, including sexually transmitted diseases, HIV/AIDS, safe sex practices such as condom use, or reproductive health. Many adolescent boys and girls related that the main message they received from their parents, albeit indirectly, was that they should not engage in sex prior to marriage. Two adolescent girls summed up this sentiment, stating, “If my mother hears about some girl being pregnant, she says we should not be like her,” and, “My mother told me don’t talk to boys too much. Don’t keep any relations with boys, don’t go close to boys.”

Parents corroborated this message, noting that they conveyed to their adolescent children that they should not engage in sexual behavior prior to marriage. Such messages were typically framed as a dictum not to “roam around” or spend time with members of the opposite sex. As one mother stated, “We told [her] that she should always behave in a good manner; otherwise boys can take advantage.” Similarly, a father noted, “I just say never do anything wrong like this, don’t have friendships like this, and behave properly.” Parents were especially concerned about their daughters in this regard, as seen in one father’s message: “Little I have spoken: Don’t have sex at such an age. Meaning unless you are married, don’t do this.”

Not surprisingly, the geographic context of the community in which the research was conducted helped shape social and behavioral norms about and barriers to parent–adolescent communication about sex, including the style, frequency, and location of such communication. Adolescents felt that parents should speak with them in a sensitive manner that recognizes the potentially embarrassing nature of the conversation. As one boy put the point, “If Dad says good things, then I will listen to it nicely.” Another indicated that fathers should “not give information like fathers, but like friends,” and many expressed a preference for an open dialogue with parents, rather than a one-way conversation. “It should be a good conversation,” said one girl. “We must also ask them questions.” Some adolescents suggested that such dialogue was not always possible because, as one girl explained, “We don’t say anything to them or ask any questions. What Father says, we should listen to it.”

Adolescents also felt that parents should be consistent and direct in communicating about sexual topics, and should reiterate important points. Fathers should continue to speak on the

topic “till the time we understand,” said one boy. “He must make us understand.” Another indicated that fathers “must not have any hesitation, and whatever is discussed, it should be face to face, and the other person should understand it.” Boys and girls alike expressed the need for such talk to occur in private locations such as the home when other family members are not around, or in suitable places outside of the home. Some parents also thought that being open and candid would be an effective way to communicate about sexual topics with their adolescent children. “[We] should treat them [children] like friends, openly like friends they should speak,” said one father. Parents also stressed the need for repetition when conveying information about sex to their children. A father noted,

Now see, they are young children, so only when you keep repeating will they keep it in their mind. It’s like math: One has to repeat it once if [one] doesn’t understand, then twice, then thrice, then one has to show examples. Only then he gets it.

Another father agreed, but for a different reason: “When they don’t listen, then we have to tell again and again, to keep them in control.”

Opportunities for Communication

Despite apparent barriers to communication about HIV prevention within these rural Indian families, interviews with parents and adolescents conveyed a strong desire for more open discussions and more information about sexual topics and HIV/AIDS. Adolescent boys and girls expressed a decided interest in broaching sexual topics with their parents, and in receiving information from them. “We should get some information from our parents. If my parents give information, then I will take it,” said one boy. Another framed the benefit of talking with his father as a preventive measure against HIV/AIDS, noting, “I feel that whatever Father tells it is good, and I will get more and more information, which will help me stay safe from AIDS.”

Adolescents valued parental advice, and conveyed that getting accurate information from their parents would allow them to make informed choices about their sexual behavior. A girl explained, “If I come to know, from what they say, that it is bad to have sex, then I will not have sex.” A boy suggested that “parents should give good information, should tell that if you do this then this can happen, then AIDS can happen.” Another explained, “If we have information about it [HIV/AIDS], then we will not do it, and we will also understand what it is.”

Even though most parents had not initiated discussions about sex with their children, they did recognize the importance of talking with their children, particularly as a preventive measure against unwanted pregnancy or contracting a sexually transmitted disease. As one mother explained, “There is a need to talk about it, but like, we have never spoken about it directly.” Another mother stated, “If parents give this information, then that girl will behave in the proper manner. She will be under parent’s control.” A parent noted that if her daughters were given the proper information, “It will be likely they won’t get pregnant. Things like this can be avoided.” Moreover, parents expressed a keen interest in being better informed about topics such as HIV/AIDS from experts such as doctors and health care workers, so they could share such information with their children. They also identified possible strategies that they felt would help them initiate discussions with their children. One father identified an opportunity for discussing HIV/AIDS with his son by viewing televised AIDS-awareness campaigns with him. “When we sit to watch television and advertisement on AIDS comes, so he watches the advertisement, then he tells me that this—this happens and I clearly tell him not to do this [have sex].” A mother also noted that she had used such ads to stimulate discussion with her daughter.

Discussion

Among rural Indian adolescents and their parents, open communication about sexual topics and HIV/AIDS appears to be low, a finding consistent with previous research that has characterized India as having strong cultural barriers against such communication (Lambert & Wood, 2005; Nag, 1995). Despite existing cultural barriers, parents are concerned about the health and well-being of their children. Findings from this research suggest that rural adolescents and their parents are interested in talking about sexual topics with one another and do so, albeit in a nuanced way. Even though adolescent boys and girls consistently identified sources other than their parents for information about sex and HIV/AIDS (e.g., television, textbooks, teachers, and peers), they nonetheless conveyed a strong desire to receive such information from and have conversations with their parents. Although few parents had initiated discussions about sex with their adolescents because of factors such as lack of information and embarrassment, most expressed a desire and openness to having such discussions with their children, particularly in light of the health consequences of unwanted pregnancies, STIs, and HIV/AIDS. These findings are encouraging, and suggest that intervention strategies that help to mitigate cultural communication barriers can facilitate parent–adolescent discussions about sexual behavior and HIV/AIDS.

Interviews also demonstrated numerous barriers to communication for these rural Indian families. Lack of knowledge or limited knowledge about sexual topics and HIV/AIDS among parents and adolescents was a significant barrier to communication, a finding consistent with previous research (Guilamo-Ramos, Jaccard, Dittus, & Collins, 2008). Low levels of HIV knowledge were particularly evident among adolescent girls, owing in part to gender inequalities and gender norms within Indian families, and lower levels of education for girls. Such low levels of knowledge are significant given the fact that HIV/ AIDS is a growing public health concern in India. In the context of Maharashtra, a state identified as having high HIV prevalence rates (NACO, 2008), these findings are particularly troublesome. Furthermore, although we explored a broad range of sexual topics with families, including issues of same-sex behaviors, there were no reports of such behaviors from participants. Given the gendered and cultural norms in India surrounding same-sex behaviors, this finding is not surprising.

In the absence of information from their parents, rural adolescents reported that they relied primarily on peer groups, teachers, and the media for information related to sex and HIV/ AIDS, a finding that has been observed in previous research (Lambert & Wood, 2005; Nag, 1995; Nath, 2009). For their part, many parents felt that they lacked accurate information to share, which, in conjunction with existing cultural mores against open discussion about sex, contributed to a general lack of engagement with their adolescent children about sexual topics. Some parents were able to identify strategies that could potentially help them address gaps in knowledge and broach the discussion of sexual topics, such as using AIDS public awareness campaigns as a conversation entry point.

Our findings also suggest several promising areas for generating and examining theory. Perhaps most obvious is the gendered and generational nature of social norms that govern patterns of family communication about sexual health. Although not peculiar to rural India, the unilateral pattern of mother–daughter and father–son sex talk appears to be notably strong. Study participants also described numerous attitudinal and behavioral norms that support and ensure adherence to these established communication patterns. Many spoke, for example, of the expectation of deference to parental guidance and judgment, especially with respect to the same-sex parent in matters of sexuality, and the need to eschew people, thoughts, and situations that might taint or corrupt valued personal and social identities. More thorough, systematic inquiry is needed into how such parent–adolescent

communication about sexual health develops in a particular sociocultural and temporal context, and what elements and processes help to sustain it over time. This line of inquiry could help to build new indigenous models for facilitating effective communication on sexual health. Theory-based research is necessary to identify the determinants of such communication, which can be targeted in the context of a family-based intervention in the Indian context. Such information is necessary if we are to support the motivation of parents to effectively communicate with their adolescent children about how to reduce their risk of HIV infection.

Similarly, our findings suggest a need for a stronger theoretical grasp of how individual, familial, and community discourses shift in the face of new health and social circumstances—including those that reshape ideas and identities to accommodate, for example, personal vulnerability to a new, potentially life-threatening disease. Both parents and their adolescents expressed openness to discussing this topic with each other, yet few had done so or described immediate plans for doing so. Likewise, there seemed to be more variability in areas such as knowledge of HIV infection than might be expected given the small, intimate, and interdependent nature of the pada. These seeming contradictions might reflect a lack of knowledge, but they also suggest a degree of ambivalence or uncertainty as to how best to proceed after the revelation of a “public secret,” i.e., those secrets which the public chooses to keep safe from itself. In short, these interviews leave no doubt that more richly conceptualized and culturally contextualized theories of the social and behavioral elements of HIV prevention and intervention are key to controlling the incidence and personal, familial, and societal effects of this disease.

Conclusions

Qualitative research distinguishes itself from quantitative approaches in that the reliance on small, selective samples to gather in-depth information is a significant strength of the methodology. Hence, the findings of the research should be interpreted within the context of the intended purpose and methods. First, we focused on Indian adolescents and their families living in a rural setting. We did not conduct interviews with urban families, and the community from which we sampled families was relatively poor. The sample was selected from a small number of padas and divided by generation and gender. India is a diverse country, so our homogeneous sample might not be representative of other communities. We also recognize that the lack of reporting of same-sex behaviors can be seen as a limitation of the research, particularly given the relationship between same-sex experimentation and HIV risk, and the high rates of HIV among men who have sex with men in India (NACO, 2008). Future research should focus on the possibility of same-sex behaviors in HIV prevention interventions.

A particular strength of the research was the integration of perspectives from Indian adolescent girls, adolescent boys, and their mothers and fathers. Considering that the family is the primary unit for child and adolescent education and socialization, research focused on helping Indian adolescents avoid HIV needs to reflect the perspectives of all members of the family system. Furthermore, the scope and impact of HIV/AIDS in India necessitates international collaborations that can address the diversity of the epidemic. This research, a collaborative effort between United States and Indian social scientists, is one of several formative studies focused on developing an empirical body of literature on how to develop efficacious family-based HIV-prevention programs for rural Indian youth. The findings have important implications for researchers interested in developing family-based HIV prevention interventions for Indian adolescents. This is one of a range of preventive interventions expected to be effective in India and worthy of consideration given the cultural centrality of

family, rising rates of HIV infection in Maharashtra, and the clear message from both parents and adolescents that information on safe sex is needed and wanted.

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Figure 1.

HIV prevalence in India in 2005

From "HIV in India—A Complex Epidemic," by R. Steinbrook (2007). *New England Journal of Medicine*, 356(11), p.1090. Copyright 2007 by the Massachusetts Medical Society. Reprinted with permission.