

**ALCOHOL RELATED PROBLEMS, FAMILY TYPE AND  
YOUTH HIV/AIDS RISK BEHAVIOUR**

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**ABSTRACT**

This paper examined the extent to which youth involvement in HIV/AIDS risk behaviours is related to their patterns of alcohol consumption and differences in family structure. Random surveys were conducted and data collected from pre-degree male and female students at two institutions of higher learning in Akwa Ibom State, Nigeria. Two scales were used for data collection: Alcohol Use Disorder Identification Test (AUDIT) and HIV/AIDS Risk Behaviour Questionnaire (HRBQ) and the collected data were subjected to Chi-square goodness of fit test. Two hypotheses were tested in this study. The first hypothesis predicted a significant association between alcohol-related problems and youth HIV/AIDS risk behavior was confirmed  $\{X^2(4) = 39.91, p < 0.05\}$ . Results also confirmed the second hypothesis which predicted that family type would be significantly related to youth HIV/AIDS risk behaviour  $\{X^2(1) = 4.48, p < 0.05\}$ . The results were discussed in line with existing relevant literature. Practical implications of results and recommendations were also highlighted.

**KEY WORDS:** Alcohol dependence, alcohol abuse, family type, hazardous drinking, responsible drinking

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**INTRODUCTION**

Across the world, between 35-45 million people are living with HIV and AIDS (United Nations Agency for International Development, UNAID, 2005). Of this number, about 25.5 million live in the African continent. So far, more than 13 million of them have died of this disease. South Africa is the region with highest (67%) HIV infection (Parry, 2010). Nigeria has the third largest population of people living with HIV/AIDS in the world after India and South Africa. The prevalence

rate in Nigeria has been on the increase from 1.8% in 1991, through 5.4% in 1999, to 4.4% in 2005 (Federal Ministry of Health Sentinel Survey, 1999; 2005). Youth make up the largest segment of the population that is particularly vulnerable to HIV/AIDS (World Health Organization, 2006). Altogether, 50% of HIV transmission takes place among those aged 15-24, accounting for 5,000-6,000 youth becoming infected daily (WHO, 2006).

The preceding evidence, associating a large number of youth with HIV/AIDS transmission could be explained by the higher tendency

and frequency with which they get involved in HIV/AIDS risk behaviour. Youth risk behavior are those responses, actions and/or activities that increase the actor(s) probability of contracting or transmitting HIV/AIDS (Umoh, 2003). Such behaviours include having unprotected sexual intercourse, having multiple sex partners, sharing injection needles and other body piercing devices. The periods of adolescence and early adulthood are often associated with increased tendency for experimentation, and greater risk taking, thus increasing their vulnerability to HIV/AIDS. Several other factors associated with increased vulnerability include, but not limited to: lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, sexual coercion and violence, distorted family background, trafficking and growing up without parental guidance, or lack of other forms of positive role models and protection from exploitation and abuse, peer influence, frequent and unrestricted exposure to and availability of psychotropic substances (WHO, 2006).

The world drug report of the United Nations Office on Drugs and Crime (UNODC, 2009) estimated the total number of people using illicit drugs at upwards of 250 million people – equivalent to about 4% of the global population. Of this number, as many as 38 million people are drug dependent, but only about 4.9 million of them receive evidence – based drug dependence treatment and care. Harmful alcohol use seems to present fundamental health issues which affect physical, social and psychological well-being and thus forms a major health dimension in the determination of behaviour, HIV/AIDS risk behaviour inclusive (Adelekan & Adeniran, 1991; Ikuesan, 1994; USAID report, 2005). There is emerging evidence (Alwan, 2010) that harmful use of alcohol contributes to the health burden caused by communicable diseases such as tuberculosis and HIV/AIDS, although it is one of the four most common modifiable and preventable risk factors for major infections. A growing body of epidemiological and social science research, much of it conducted in developing countries

experiencing severe HIV epidemics, suggests that alcohol use is associated with the sexual behaviours that put people at risk for HIV and other sexually transmitted infections (Cook & Clark, 2005; Kalichman, Leickness, Michelle, Demetria & Sean, 2007).

In India, sex under the influence of alcohol was independently associated with having an STI or HIV among men who patronize female sex workers (Madhivanan, Harnandez, Gogate et al., 2005). Use of alcohol before sex increased HIV acquisition by 50 percent in a study of over 14000 women and men in Uganda ( Zablotska, Ronald, Davidet al., 2006). Having sex while intoxicated was strongly associated with having recently acquired HIV infection in Zimbabwe (Fritz, Woelk, Bassett et al., 2002). A review of studies on the use of alcohol in Nigeria shows that there has been a rapid increase in alcohol availability, consumption, and abuse with young adults in universities and colleges being primary victims (Abiodun, 1991; International Narcotic Control Board report, 1996; Ijeomah, 1997). Olisah, Adekeye, Sheikh and Yusuf (2009) also found a significant association between alcohol related problems and risky sexual behavior among HIV patients. In simple terms, Olisah et al. (2009), observed that a history of heavy alcohol use has been correlated with a life time tendency towards high risk sexual behavior. In this research however, alcohol-related problems have been categorized into three - alcohol abuse, hazardous use and alcohol dependence; dimensions which will make for comparison with the “no alcohol-related problem group”. We have also dichotomized family type into intact and separated family.

Alcohol abuse is said to occur when it is occasionally or continuously used: when not medically necessary, maladaptive or contrary to socially sanctioned ways or levels, against legal prohibitions (Eze & Omeje, 1999). On the other hand, alcohol dependence is developed if an individual is unable to do without the particular alcohol because he/she suffers psychological, physiological or physical distress when he stops taking it. The DSM-IV (APA, 1994) sees dependence as a cluster of

three or more of the symptoms listed below occurring at any time in the same twelve months period: tolerance, withdrawal syndrome, taking the substance in large amounts or over a longer period than was originally intended by the individual, persistent but unsuccessful desire to cut down, regulate or discontinue use of the substance, spending a greater deal of time obtaining the substance, using the substance or recovering from its effects, associating with substance using friends valued over family activities and hobbies and taking extra care to use the substance in privacy. In other words, alcohol dependence is associated with continuous drinking in spite of negative consequences.

Families are assumed to be the frontline agents of socialization. Its type, structure and dynamics could therefore be implicated in the formation of adaptive or antisocial behaviour, HIV/AIDS risk behavior inclusive (National Drug Law Enforcement Agency, 1997). According to Donenberg and Pao (2005), families influence youth sexual behaviour in four different perspectives; the dimensions often targeted in focused HIV/AIDS programmes-Instrumental characteristics, effective parent behavior, parental attitude about sex and parent-teen communication.

At this juncture, it is important to acknowledge that youth involvement in HIV/AIDS risk behavior, like other maladaptive behaviours, seems to constitute a major channel through which HIV/AIDS is contracted and transmitted (Olisah et al., 2009; Cook & Clark, 2005; Kalichman et al., 2007b, Zablotska, 2006; Fritz et al., 2002; Madhivanan et al., 2005; Bisika et al., 2008). This behaviour seems to be facilitated when youth are exposed to variables like alcohol availability, intake and unhealthy family background. This study is imperative for HIV/AIDS intervention planning as it aids the identification of alcohol related problems population among the Nigerian University/college students.

While research interests and efforts in Nigeria have hitherto concentrated on the causes, prevalence, consequences, prevention, and other alcohol-related epidemiological issues,

attempts however appear inadequate in addressing the problems of the already existing population of abusers, hazardous users before they manifest dependence symptoms and the involvement of this at-risk group in HIV/AIDS risk behavior; a situation that has impeded effective HIV/AIDS intervention strategies in the last decades. An understanding of these would not only sensitize stakeholders on the existence of this at risk group, but would also be useful in designing alcohol treatment/intervention strategies in Nigerian Universities as an integral part of HIV/AIDS reduction campaign efforts. It is also hoped that this work will contribute to the scanty literature in this area of study. This study investigates the association between alcohol related problem, family type and youth HIV/AIDS risk behavior. Specifically, it is tailored to determine the extent to which alcohol related problems are associated with youth HIV/AIDS risk behavior. The study will also find out whether family type (intact or separated family) relates to youth HIV/AIDS risk behaviour.

Scholars have used a couple of theoretical and empirical evidence to explain the distinct concepts of alcoholism, family dynamics and sexually transmitted infections. A theoretical explanation that lends credence to these concepts could be gleaned from Bandura's social learning model (Ghodse & Maxwell, 1990). According to this theory, alcohol is taken by both social drinkers and problem drinkers as well, due to the expectation that pleasant consequences will follow. Most of these behaviours are learned from parents or significant others at the family background, while others are learned through direct experience. After this initial learning and experimentation, a sort of selective attention leads to drinkers anticipating pleasurable effect while trying to ignore punishing consequences such as, risk of contracting STIs or HIV/AIDS, threatened loss of job, etc. As a heavy drinker begins to experience problems, Ghodse and Maxwell submitted that a set of negative expectations develop so that there are strong reasons to want to do alcohol and strong reasons to avoid it. This ambivalence reflects an approach-avoidance

conflict which is experienced as a compulsion to drink (Ghodse & Maxwell, 1990).

Empirical literature linking alcohol misuse with STIs and HIV/AIDS risk behaviours seems to be consensual. Olisah, Adekeye, Sheikh and Yusuf (2009) investigated the rate of alcohol related problems and high risk sexual behavior in patients with HIV/AIDS attending medical clinic in a Nigerian University Teaching Hospital. A consecutive sample of 120 patients with HIV/AIDS attending the medical out-patient Department in Ahmadu Bello University Teaching Hospital, Zaria-Nigeria was assessed. All participants were screened for alcohol-related problems using the Alcohol Use Disorder Test (AUDIT). High Risk Sexual Behaviour Questionnaire (HRBQ) was also used to generate data for High risk Sexual behavior. Alcohol-related problems were found in 28.3% of participants (10% had hazardous use, 3.3% had harmful use and 15% were alcohol dependent). Chi-square analysis of data collected revealed a significant association between alcohol-related problems and risky sexual behavior  $\{X^2(1) = 42.449, P < .05\}$ .

In the same vein, Bisika, Konyani, Chamangwana and Khanyizira (2008), in an epidemiologic study of the prevalence of HIV among drug abusers in Malawi, collected a purposive sample of 200 drug abusers. They were invited to provide urine and blood samples. The blood samples were tested for HIV. The study found a high prevalence of HIV among non-injection drug abusers, with those who abused alcohol being more likely to be HIV positive compared to cannabis abusers.

In a review of the pattern, contexts and impacts of alcohol use associated with commercial sex reported in global literature, Qing, Xiaoming, and Bonita (2010), identified peer-reviewed articles from 1980 to 2008 reporting alcohol consumption among Female Sex Workers (FSWs) and male clients. The use of alcohol to facilitate the transition into the practice of commercial sex among both FSWs and male clients was observed. Also significant was the association between harmful use of alcohol, HIV/ sexually transmitted infections and unprotected sex.

Interest in the psychosocial context of sexual behavior and risk taking has been renewed in the wake of concerns about HIV infections, STDs and unintentional pregnancy in youth. While studying youth sexual risk-taking behavior in single parent ethnic minority families, Forehand, Rex, Kotchick, Beth, Dorsey, Shannon, Miller and Kimis (2004), asserted that parents have a potential role as models for their youth with regard to sexual behavior. The study supports the assertion that family structure has an important influence on adolescents' sexual socialization.

Similarly, Santelli, Brener and Robin (2010) assessed the relation of socioeconomic status, family structure and race/ethnicity to adolescent sexual behaviour that are key determinants of pregnancy and sexually transmitted diseases. The 1992 Youth Risk Behaviour Survey/ Supplement to the National Health Interview survey provided family data from Household adults and behavioural data from adolescents. among male and female adolescents, greater parental education, living in a 2-parent family and white race were independently associated with never having had sexual intercourse. Parental education did not show any linearly association with other behaviors. Adjustment for socioeconomic status and family structure had some effects on the association between race/ethnicity and sexual behaviour.

Prior to this study however, Yoisin and Dexter (2002) examined the relationship between family ecology and HIV sexual risk behavior. Family psychosocial and HIV risk factors were assessed in 171 African American and 187 Puerto Rican adolescent males (aged, 14-19 years). Demographic information including age, race, grade level, family composition, household membership, family income and parents' educational level were obtained. Other measures used included the Social Support Survey, the Male Sexual Behavior Questionnaire, the Exposure to Violence Probe and the Self-Efficacy Scale. Findings suggest that family ecology, culture and gender role variables differentially affected HIV/AIDS sexual risk behavior within these groups.

The reviewed literature led us to hypothesize that a significant association would exist between alcohol-related problems and youth HIV/AIDS risk behavior. It was further hypothesized that family type would be significantly related to youth HIV/AIDS risk behavior.

## METHOD

### Participants

One hundred and eighty two (182) respondents comprising 79 males and 101 females were randomly selected from the population of pre-degree students of two higher institutions of learning in Akwa Ibom State, Nigeria; namely: University of Uyo (64 students) and State Polytechnic, Ikot Ekpene (118 students). Their age ranged from 15 to 25 years of age, with a mean of 22.48.

### Instruments/materials

Alcohol use Disorder Identification Test (AUDIT) and the HIV Risk taking Behaviour Questionnaire (HRBQ) were used to collect data for this study. These instruments were administered in conjunction with questions to probe into the socio-demographic status of the respondents. AUDIT identifies people who abuse alcohol, those who are dependent on alcohol and those whose alcohol consumption has become hazardous or harmful to their health. Participants Scores in AUDIT Scale correlated with the clinical diagnosis of alcohol related problems using the Composite International Diagnostic Interview (CIDI) with a correlation coefficient of 0.780 ( $P < 0.001$ ) (Adewuya, 2005), cited in Olisah et al. (2009).

The HRBQ was used in assessing respondents' HIV/AIDS risk taking behaviour which was dichotomized into 'high risk behaviour' and 'low risk behaviour'. The instrument is structured to be sensitive to both Injection Drug Use (IDU) and sexual behaviours. Ward, Darke and Hall (1990) posited however that the scale is free from culture and gender bias. Item 3 in section A of the questionnaire probed into the family background

of the respondents. Options of the family setting ranged from intact family (where the respondents grew up with both parents and the sibling), to separated family structure (where the respondents lived with either of the parents or the uncles, aunties, grandparents or significant others).

### Scoring

AUDIT is a 10 item instrument incorporating questions about the quantity and frequency of alcohol use. It is structured in a five-option format ranging from 'never', through 'less than monthly' to 'daily or almost daily use of alcohol' with 'never' attracting a score of 0, while 'daily or almost daily' attracts a score of 4. However, items 9 and 10 on the scale are structured to have three options of: (a) – never, (b) – yes, but not last year and (c) – yes during the last year. 0, 2 and 4 are attached to options a, b and c respectively. AUDIT therefore has a maximum score of 40 and a minimum of 0. Adewuya (2005) however stipulates a cut-off of 5 and above for hazardous alcohol use with sensitivity of 0.935 and specificity of 0.915 in Nigerian sample. Cut-offs of 7 and 9 respectively were also recommended for diagnosis of harmful use and alcohol dependence respectively. Thus scores between 0 (total abstinence) and 4 were taken to represent "no alcohol-related problem group".

The HIV risk-taking Behaviour scale (HRBS) is a brief 11-item Questionnaire developed to measure the Injection Drug use and Sexual behaviours of respondents. This scale provides three scores: a drug use sub-total indicating level of HIV risk-taking behaviour due to drug taking practices, a sexual behaviour sub-total indicating level of risk associated with unsafe sex and a gross total score indicating level of HIV risk the respondent has of contracting or transmitting HIV occasioned by one's involvement in either one or both dimensions of HIV/AIDS risk behavior (Ward et al., 1990). The scale is structured in a six option format. Therefore, in this study, respondents that reported two or less risk factors were categorized as having low HIV risk behavior, while those that

reported more were defined as having high risk behaviour.

**Procedure**

Approval to conduct this study in the institutions was obtained from the Heads of Departments, who assigned lecturers to assist the researchers in conducting the survey. Informed consent was obtained from participants who were randomly selected to participate in the research. Respondents were briefed of the aim of the research, and questionnaires administered. Information was gathered anonymously and responses could not be traced back to any particular respondent. The respondents were encouraged to work independently to avoid undue influences from friends and/or colleagues during decision making. Two hundred (200) questionnaires were administered. Eighteen (18) of these were discarded on grounds of either not being properly filled or respondents being above the age range of interest (15-25 years) or both; the researchers were left with a total of 182 questionnaires to use in data analysis.

**RESULTS**

Result of the chi square ( $X^2$ ) analysis of data shows a significant association between alcohol related problems and youth HIV/AIDS risk behavior {  $X^2 (3) = 24.15, p < .05$  }. A significant relationship between family type and HIV/AIDS risk behavior was also found {  $X^2 (1) = 4.48, p < .05$  }. These results are presented in tables 1 and 2 below.

From Table 1, about 41 (22.5%) respondents were alcohol dependent, 26 (14.3%) of these were involved in high HIV/AIDS risk behavior, while 15(8.2%) indicated low risk behavior. Similarly, harmful users and hazardous users of alcohol recorded high HIV/AIDS risk behaviours. Of the 13(7.1%) respondents that reported harmful use of alcohol, 11(6.0) indicated high HIV/AIDS risk behavior, while 2(1.1%) indicated low risk behavior. In the same vein, among respondents who were hazardous users of alcohol, high risk behavior was observed in about 10 (5.5%), while 8 (4.4%) were low in HIV/AIDS risk behavior. When the alcohol-related problem group was compared

**Table1:** Chi-square table showing the association between alcohol related problems and youth involvement in HIV/AIDS risk behavior (n, %)

HIV/AIDS risk behaviour	No problem	Hazardous use	Harmful use	Dependence	SumF
High	38 (20.9)	10 (5.5)	11 (6.1)	26 (14.3)	85 (46.7)
Low	72 (39.6)	8 (4.4)	2 (1.1)	15 (8.2)	97 (53.3)
Sum	110 (60.4)	18 (9.9)	13 (7.1)	41 (22.5)	182 (100)

$X^2 (3) = 24.15, p < 0.05$

**Table2:** Table of Chi-square analyses showing family settings and youth involvement in HIV/AIDS risk behaviour

HIV/AIDS Risk Behaviour	Intact Family	Separated family	SumF
High	42 (23.1)	43 (23.6)	85 (46.7)
Low	63 (34.6)	34 (18.7)	97 (53.3)
Sum	105 (57.7)	77 (42.3)	182 (100)

$X^2 (1) = 4.48, p < .05$

to the no alcohol problem group (72: 39.6%) vs (110: 60.4%), it was obvious that only 38 (20.9%) of the respondents with no alcohol problem were involved in high HIV/AIDS risk behavior against 72 (39.6%) respondents with low HIV/AIDS risk behavior. Of participants in high HIV risk behavior, 10 (20.9%) respondents in the alcohol-related problem group reported hazardous drinking behavior, 11 (6.0%) reported harmful use, and 26(14.3%) were dependent on alcohol against low HIV risk self report of 8 (4.4%), 2 (1.1%) and 15 (8.2%) for hazardous users, harmful users and dependents respectively. Consequently, result of the chi-square ( $X^2$ ) analysis of data shows a significant association between alcohol-related problems and youth involvement in HIV/AIDS risk behaviour  $\{X^2(3) = 24.15, p < .05\}$ .

From table 2, it could be seen that a little over half of the respondents 105 (57.7%) were from the intact family setting. Of this proportion, 63 (34.6%) reported low involvement in HIV/AIDS related risk behavior, while 42 (23.1%) were observed to have high risk of contracting HIV/AIDS. Conversely, 77 (42.3%) respondents came from the separated family background. About 43(23.6%) of these respondents reported high involvement in HIV/AIDS risk behavior; a sharp contrast with 34 (18.7%) which indicated low risk behaviour.

This result, no doubt, implicates the family setting in youth HIV/AIDS risk behaviour as a chi-square ( $X^2$ ) analysis of data reveals a significant relationship between family type and HIV/AIDS risk behavior  $\{X^2(1) = 4.48, p < .05\}$

## DISCUSSION

This work set to examine the association between alcohol related problems, family type and HIV/AIDS risk behaviour among youth in Nigerian higher institutions of learning. It was hypothesized that a significant association would exist between alcohol related problems and HIV/AIDS risk behavior. Analyses of the data supported this hypoth-

esis. This finding is consistent with many other global empirical positions presenting a positive association between harmful drinking and HIV/AIDS risk behaviour (Amoteng et al., 2007; Bisika et al., 2008; Cook & Clark, 2005; kalichman et al., 2007; Fritz et al., 2002; Zablotska et al., 2006, Olisah et al., 2009). As an explanation to this observed association, much of the risk behaviour typically associated with drinking is attributable to the pharmacological properties of alcohol, which decreases cognitive capacity to accurately judge risk inherent in unprotected sex and sharing of needles while it increases attention to sexual arousal (George and Stone, 2000; Davis, Hendershot, George, and Heiman, 2007). Put differently, alcohol, a depressant - known to act directly on the brain - slows down neural activities by enhancing the activities of GABA, thus reducing inhibitions, cognition, sense of judgment, reaction time just as it impairs risk perception (Eze and Omeje, 1999). Additionally, research has also shown that alcohol use before sex (among the youth) may be motivated by the expectation that alcohol will improve enjoyment of sex or sexual performance (kalichman et al, 2007).

Furthermore, hypothesis II, which predicted a significant relationship between family type and youth involvements in HIV risk behaviour was also confirmed. This finding corroborates the results of Forehand et al. (2004) and Yoisin & Dexter (2002), who posited that family structure has an important influence on youths' sexual socialization; family ecology, culture, and gender role variables differentially affect HIV/AIDS sexual risk behaviour within the youth group. Thus youth without positive parental influence tend to be socialized by peers into maladaptive behaviours while in school, HIV/AIDS risk behavior inclusive.

### Practical implications of results

A wide variety of alcohol-related problems can have devastating impacts on individuals and their families and can seriously affect community life (Alwan, 2010). Apart from the devastating effects of alcohol on the health sector, other sectors - the economic,

education, law enforcement and justice - do report similar increasing burdens in terms of treatment (Kasirye, 2010). Associated violence and injuries, increasing poverty level, decrease in academic performance among students, increase in law enforcement costs and shortages in food security are all closely related with alcohol trends. This paper does not only contribute to the volume of literature on alcohol related problems and its implication on youth HIV/AIDS risk behavior in Nigeria, but also reaffirms that alcohol trends in the African society, coexist with the HIV/AIDS pandemic. It is expected that findings of this study would draw stakeholders' attention to the hitherto neglected at-risk population (abusers and hazardous users) on our campuses before they graduate into alcohol dependents. These findings have also brought to the fore the urgent need for intervention/treatment for harmful users of alcohol as an integral part of HIV/AIDS reduction plan in Nigeria. The role of the household in reducing the spread of HIV/AIDS through wise and proper parental management is also evident.

### **Recommendation and Conclusion**

As HIV/AIDS is spreading fast among Nigerian youth, it is imperative to turn research interest to variables that do not only increase the risk of infection but those that also impede the progress of HIV/AIDS intervention programmes in the country. Reducing the harmful use of alcohol by effective policy measures and by providing relevant infrastructure to successfully implement those measures is much more than a public health issue. Indeed, it should be seen as a development issue, since the level of risk associated with the harmful use of alcohol in developing countries is much higher than that in high income countries where people are increasingly protected by comprehensive laws and interventions. Efforts aimed at combating HIV/AIDS in Nigeria cannot be isolated from alcohol related problem intervention initiatives and strategies. Findings of this study suggests that alcohol -related problems (harmful use, alcohol abuse and al-

cohol dependence) are associated with high risk sexual behaviours and intravenous drug use which are two major modes of HIV transmission among Nigerian youth in institutions of higher learning. This at-risk population do abuse alcohol, contributing to the difficulties in preventing the spread of the infection and treatment of infected persons. Alcohol-related problem population often delay testing for HIV, accessing appropriate medical care and initiating antiretroviral therapy (ART) which may hasten disease progression to full-blown AIDS (Kendall, Bryant, Steve, Scot and Deira, 2010). It therefore follows that decreasing alcohol use in people who are at risk for becoming infected reduces the spread of HIV and the diseases associated with it. This scientific evidence provides a compelling call to action. As Nigeria is battling with severe HIV/AIDS epidemic, addressing harmful drinking in conjunction with interventions to reduce sexual risk behavior may have the potential to reduce HIV/AIDS transmission much more than conventional HIV/AIDS prevention intervention alone. This paper therefore advances curriculum – based alcohol and HIV interventions for Nigerian students in the universities and colleges as a measure of improving on the current campaign against HIV/AIDS.

It is also evident from our findings that the more stable the family is, the less the involvement of youth from such family in HIV/AIDS risk behaviours. Thus, ways of strengthening the stability of the family, through discouraging separation in marriages and increased parent-ward communication/ attention must be worked out. Programmes aimed at protecting children in single parent homes from indulging in maladaptive behaviours should also be initiated.

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