

## Cultural Beliefs and Practices towards HIV/AIDS amongst High School Learners in Swaziland

K. N. Nxumalo<sup>a</sup>, C. I. O. Okeke<sup>b</sup> and K. J. Mammen<sup>b</sup>

<sup>a</sup>*University of Swaziland*

<sup>b</sup>*University of Fort Hare, East London Campus, South Africa*

**KEYWORDS** Swaziland. HIV/AIDS. Beliefs. Learners. Curriculum. Implementation

**ABSTRACT** A quantitative descriptive research design was applied to establish the cultural beliefs and practices of high school learners in the Lubombo region in Swaziland, which impact upon the spread of HIV/AIDS. Respondents comprised 351 (169 males and 182 females) Form IV learners in 12 high schools spread across the Lubombo region of Swaziland. A five-point Likert scale questionnaire instrument was developed and used by the researchers in obtaining data for the study. The questionnaire was translated to both siSwati and English. Once ethical requirements were met by the researchers, the questionnaire was administered. Data were analysed using descriptive statistics. The results of the study showed that cultural beliefs and practices had a role in transmitting HIV/AIDS in Swaziland. There was also no statistical significant difference between boys and girls regarding cultural perceptions on HIV/AIDS. The results also showed that high school learners appeared to have adequate knowledge and information on HIV/AIDS. It is suggested that school curriculum policy formulation and programme implementation should target culture-specific practices.

### INTRODUCTION

The role of socio-cultural factors and myths in sexual aspects and the spread, control and prevention of HIV/AIDS have been of interest to several researchers, and this interest continues in the African continent. Several recent research outputs, for example, from Nigeria (Maliki et al. 2006; Modo and Enang 2011); South Africa (John and Rule 2006), Zambia (Mukuka and Sloni-Nevo 2006), Kenya (Mugambi 2006; Kemboi et al. 2011), and Botswana (Lopang et al. 2013) are evidence for this trend. Maluwa-Banda (2004) conducted a study among 1400 high school students drawn from ten mainstream secondary schools in southern Malawi. The results of the study showed that for many girls the most common place where sexual coercion and harassment were experienced was the school. The current paper reports on a study which sought the cultural beliefs and practices of high school learners which impact on HIV/AIDS in the Lubombo region in Swaziland.

### HIV/AIDS as a Health Pandemic and Social Issue

The researchers have been warning the world about the pandemic and attempting to expose

---

*Address for correspondence:*  
Dr. C. I. O. Okeke,  
University of Fort Hare,  
East London Campus, South Africa  
*E-mail:* cokeke@ufh.ac.za

misconceptions about the disease. For example, Voisin et al. (2000) observed that HIV and AIDS have become major public health concerns of the highest priority and the situation continued unabated. de Lange et al. (2006) emphasized the reality that AIDS was a disease for the poor and rich, the educated and uneducated. This disease has claimed the lives of children, adolescents and the old. It affects sex workers and homosexuals just as it affects those in legitimate marriages. Togarasei (2002) reported that HIV/AIDS pandemic was no longer a medical but a social problem and Pattman (2006) viewed it as a development crisis. The pandemic has wrecked havoc in the world and graveyards in general have become heaps of freshly turned graves. It has wiped out decades of national development, widened the gap between the rich and poor nations, and pushed already stigmatised groups closer to the margins of society (Muthukrishna and Mitchell 2006).

### HIV/AIDS and the Economy

Poverty, the strongest force that motivates people to behave in ways that put them at risk of HIV, such as the exchange of sex for money, rural to urban migration and the low status of women are some factors, amongst others, that create an environment that facilitates HIV (Nzyuko et al. 1997; Sunmola et al. 2003). The former study in Kenya and the latter in Nigeria highlighted girls falling prey to 'sugar daddies', and boys to

'sugar mummies', older men and women respectively who give favours and financial assistance with school fees, clothing, foods, and offer expensive gifts. By infecting young people of between 20 and 49 years, HIV/AIDS is robbing the nations of their most productive, professional and skilled citizens. Togarasei (2002) observed that the old who have reached the end of their lives are left to fend for the children left by those killed by the disease. As a result, the disease has enormous pressure on personal budgets too besides the national ones. This seems to suggest that the economy of countries that are greatly affected by the HIV/AIDS pandemic would have to suffer as a result of reduced productivity.

#### **HIV/AIDS, Culture and Traditional Healers**

Some researchers (Tobias 2001; Saller 2009) have argued that the impact of cultural beliefs towards HIV/AIDS is fundamental because culture not only provides a specific set of conceptions but also constructs particular pathways for its prevalence. However, a major challenge facing the researchers examining cultural beliefs towards HIV/AIDS concerns the definition of culture itself. Studies on culture have shown that culture exists at multiple levels. Put differently, on any given attribute, the within-culture variance may be as large as or even larger than the between-culture variance. Matsumoto (2000: 24) defines culture as "a dynamic system of rules, explicit and implicit, established by groups in order to ensure their survival ... but harboured differently by each specific unit within the group, communicated across generations, relatively stable but with the potential to change across time". Therefore, cultural beliefs at the different societal levels involve mainstream average tendencies but cannot involve all behaviours of all people in any culture. For Pattman (2006) culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems and traditions and beliefs. Culture is to ensure that it keeps its distinct characteristics but continues to serve the interests of its practitioners. Nevertheless, in a changing world, culture must also change if it is to remain useful.

Price (2009) argues that safer sexual practice can conserve culture, although it may not preserve it. Several studies in different countries, for example, Malawi (Maluwa-Banda 2004), Zimbabwe (Chireshe and Chireshe 2003), Zambia (Mukuka and Sloni-Nevo 2006), South Africa (John and Rule 2006) and Kenya (Kemboi et al. 2011) indicate that in prevention strategies where cultural beliefs and norms have not been taken into account, prevalence rates of HIV/AIDS continue to rise. Other studies on cultural beliefs and HIV prevalence appear to concur that cultural beliefs are factors in the social trends that contribute to HIV/AIDS infection (Chenge 2006; Rule and John 2008; Price 2009).

The cultural factor is not an isolated one for Africa. de Lange et al. (2006) reported that advances in implementing empirically validated prevention programmes have been challenged by differing ideologies of prevention strategies and inadequate or poorly co-ordinated research efforts. The study noted that although several major campaigns have been mounted to address alarming rise of HIV/AIDS among the youth in Trinidad and Tobago, the interplay of cultural beliefs and socio-economic factors have severely challenged the success of these initiatives. For example, embedding sex education in the school curricula was difficult because sex and sexuality was traditionally proscribed in a vast majority of the islands' schools. Many young people also indicated having some difficulty talking about sex and reproduction with parents or adult caregivers. Accordingly, many youth had incorrect information on how HIV/AIDS transmitted and were uneducated about what safe sex entailed. As such, they continued in unprotected sexual intercourse (Petzer et al. 2007). Saller's (2009) study of 483 adolescents (262 males and 221 females) aged 10-19 in the Ashanti region of Ghana made up of 181 rural and 302 urban respondents revealed that multiple sexual partners, gender inequality, refusing to use a condom during sexual intercourse, infidelity to partner, alcohol and drug abuse were some cultural practices implicated in the ever growing HIV/AIDS infection among adolescents. Misconceptions in cultural beliefs and myths about HIV/AIDS emerged noting that most myths and misconceptions are rooted in the cultural context of societies. These results suggest that mechanisms should be developed to reach young people to reduce misperceptions in cultural be-

liefs and practices which may not only fuel HIV/AIDS infection but also cause stigma and discrimination. Saller (2009) argued for a strong need to provide and disseminate information and hence this study was designed in Swaziland to help fill that gap.

Many aspects of health-seeking behaviour cannot be readily put into effective use because of cultural beliefs that are a barrier to HIV/AIDS prevention (Muthukrishna and Mitchel 2006). Another study by Price (2009) suggested similar findings that cultural beliefs are a key driver of the HIV pandemic in Southern Africa. The study assumed that women's lack of empowerment, which is largely culturally defined, is linked to women's inability to negotiate safer sex. A paradigm shift in cultural beliefs towards sexuality and HIV/AIDS infection is necessary to all stakeholders if we are to fight a successful war against the pandemic. Another key aspect of cultural approaches to HIV education involves advocacy against people having multiple partners. It is assumed that the traditional culture of much of Southern Africa sanctions multiple partnerships and that this is linked to increased vulnerability to HIV infection. The study by Price (2009) also revealed that some people suggest that abstinence is not part of their culture.

Slonim-Nevo and Mukuka (2002) collected data by means of interviews from 126 traditional healers in the village of Kitwe outside Lusaka in Zambia. The major findings of the study was that HIV/AIDS was considered as an old disease caused by having sex with a woman who had a miscarriage and that only the divine intervention of ancestral spirits could heal the disease. Some believed it was a curse from ancestors and some saw it as the result of witchcraft. Other beliefs on contracting HIV/AIDS held by the African indigenous people and traditional doctors are, among others, through sexual relationship with a woman who had an abortion or miscarriage, as the effect of witchcraft, through mosquito bites, by shaking hands with those who are infected, teenagers are HIV-free and sex with them kills the virus, sexual intercourse with a virgin cures the disease, only faith-healing or traditional-doctor healing can cure the disease (Jack 2001; Slonim-Nevo and Mukuka 2002; Pratt 2005; Chege 2006; John and Rule 2006; Bhana et al. 2006; Petzer et al. 2007; Saller 2009).

In a descriptive study, Tobias (2001) sampled 137 Swazi nursing students aged between

20 and 29 enrolled in two nursing programmes, located in different parts of Swaziland. Out of these, 84% and 16% were female and male respectively and 80% had never been married, 10% were married and 1% was divorced or separated. Amongst those who were married, 23 percent were in polygamous relationships while 17 percent were in monogamous marriages. Data from Tobias' study revealed that culture influences sexual behaviour, culturally sanctioned gender-based power differentials exist, religious and cultural taboos influence HIV/AIDS beliefs and behaviours, myths exist concerning condoms; intrapersonal/religious conflicts influence condom use and limited support systems were available for women.

### **Culture, Women and HIV**

The studies conducted by USAID (2009) focussed on interrogating culture, women's rights and HIV/AIDS in Namibia and Mozambique. Specifically, the studies examined the inter-linkages between cultural practices and beliefs, customary and general statutory laws, vulnerability to HIV and the impact on women and girls. The study population in Namibia included traditional leaders (community elders, headmen, tribal council members, midwives and government officials), groups of women and men, groups of HIV activists, a group of HIV positive women working in a community project, and other persons living with HIV/AIDS. The findings indicated four overarching central themes: male dominance, importance of marriage, value of children and the separation of men's and women's rights.

The Mozambican study took the form of a case study, which allowed the researchers to undertake in-depth exploration at a small sample. The study found that the achievement of universal practice of safer sexual behaviour is problematic because of the power dynamics which means that often, men alone control the use of condoms in a relationship. Interestingly, the study identified some of the harmful traditional and cultural practices that were perceived as increasing the vulnerability of women to both gender violence and HIV and other sexually transmitted infections (STI's). These include: men's abuse of power; the accepted male dominance and women's subordinate positions; polygamy; the acceptance of male promiscuity;

multiple concurrent partnerships; widow inheritance and widow cleansing; the desire for children at all costs, which leads to women and men to engage in unprotected sex even when the partner is known to be HIV positive; culture of silence which makes it a taboo for men and women, parents and children and husbands and wives to speak about sex; and lastly, the reluctance by men to use condoms and women's failure to control condom use and other birth controls especially in marriage. From both the Namibia and Mozambique studies, there is clear empirical evidence that women are more vulnerable to HIV infection. Some of the reasons for this conclusion appear to include the inability to refuse sex, the risk of being forced to engage in transactional sex to alleviate the challenge of poverty and unemployment. This, therefore, calls for opportunities to be created to take into account the present contexts of modern life and technologies, and a serious introspection of cultural beliefs and norms in the general society and specifically those affected by such cultural issues. It was also found that options about frequency of sexual contact and condoms can only be made available by the males (Tobias 2001).

### **The Context of the Present Study**

The Kingdom of Swaziland in Southern Africa is generally known to the international community as Swaziland. Except the eastern border with Mozambique, it is surrounded by South Africa. As such, it is a landlocked country in Southern Africa. The length and breadth are about 200 kilometres north to south and 130 kilometres east to west. The population is primarily ethnic Swazis whose language is siSwati. The main language is siSwati, which is a Bantu language of the Nguni group. siSwati is also spoken in South Africa. siSwati has 2.5 million speakers and is taught in schools. It is one of the official languages of Swaziland. Most Swazis also speak Zulu. About 83% of the total population adheres to Christianity, making it the most common religion in Swaziland. Swaziland is one of the sub-Saharan countries worst hit by HIV infection.

Swaziland's economic growth and societal integrity are highly endangered by the HIV/AIDS epidemic. The average life expectancy in Swaziland was estimated as only 40.2 years in 2008 and HIV/AIDS is the major contributory

factor for this (UNAIDS 2012). The last national survey that included HIV biological testing among the general population was conducted in 2007. The survey revealed that the country has generalized hyper-endemic HIV; the national prevalence among the population aged 2 and older was 19% (22% females and 15% male) and 26% (31% women and 20% men) for the reproductive population aged 15-49 years. Percentage of young people aged 15 – 24 who are HIV infected stood at 34.0%. HIV prevalence among the age group 15-24 is used to estimate the recent trends in HIV incidence and behaviour. The HIV Sentinel Surveillance Survey conducted in 2010 by the Ministry of Health show that prevalence within the age group 15-24 is at 34.0% overall and in age groups 15-19 and 20-24 the HIV prevalence is 20.4% and 40.8% respectively. HIV prevalence among the 15-24 age groups is on a downward trend compared to 38.9% in 2008 which shows that the current prevalence rate as comparable to prevalence rates in 2006. The most common modes of HIV transmission in Swaziland are primarily heterosexual, sharing infected syringes among injecting drug users, and mother-to-child transmission. Research reports have documented that Swaziland has the second highest prevalence rate for HIV infection in the world among adults between the ages of 15 and 49. These studies estimated that in Swaziland 25.5% of the population is infected with the AIDS virus. The rate of HIV/AIDS infection among the youth continues to escalate. Hence, the present study was designed to find out if cultural beliefs and practices among high school students contribute to the spread of HIV/AIDS infection (Swaziland Ministry of Health and Social Welfare 2006; UNAIDS 2012).

HIV/AIDS has become a devastating calamity affecting the lives of people, their families, communities, organisations and the country as a whole. It is estimated that more than 450 000 Swazis out of a population of slightly over 1 million are now living with HIV infection and many others still do not know their status. According to research conducted in 2009, HIV prevalence rate in Swaziland is higher among women than men. More than 300 000 Swazi women aged between 15 and 49 are HIV-positive compared to an estimated 150 000 of their male counterparts (USAID 2009).

This study was conducted in the Lubombo region, which is one of the four geographical



regions in Swaziland. The Lubombo region is also one of the driest regions in the country. The scarcity of rains in this region has led to severe drought, and food production has always remained a challenge. As a result, poverty levels are very high hence sex for food and sex for money transactions is a common feature. The only economic activity common in this region is sugar production, as all the three sugar mills in Swaziland are in this region. In addition to the sugar mills, there are several citrus plantations. Men and women leave their families to come and stay in the residential properties built by the companies so that they are close to work. This kind of set-up encourages multiple-sexual partners, extra-marital affairs, and prostitution which are vehicles for spreading HIV/AIDS. The sugar belt allocates residential properties owned by companies to all their employees, whether employed on permanent, seasonal, contractual and temporal bases; these encourage cheating and exchange of lovers amongst men and women who have their husbands/wives away from their areas of work. It would seem these cultural practices may be encouraging the transmission and spread of HIV/AIDS in this region.

The Lubombo region is mostly rural and therefore traditional. The following cultural practices are very common; Sitsemu (polygamy), Bunganwa (having multiple female partners), Kushenda (having extra-marital relationships), Kungena (wife inheritance), Kuhlanta (a younger sister having children with her infertile sister's husband), Kujuma (occasional short-term or overnight visits between unmarried lovers) and Kulamuta (having sexual relations with the younger sisters of one's wife). The region is also home to the head office of the Traditional Healers' Association of Swaziland. The region has only one hospital that houses the Voluntary Counselling and Testing (VCT) facility. VCT is provided for people who want to know their status. It is an entry point for counselling-based programmes to support people who test negative to maintain their status, and support those who test positive to live positively and access treatment and care when needed (UNAIDS 2012).

### Research Question

The main research question the study sought to address was: what were the cultural beliefs and practices towards HIV/AIDS amongst high

school students in Swaziland? The following research sub-questions were formulated and used during the study: i) what cultural beliefs and practices impact the perception on HIV/AIDS among high school students in Swaziland? ii) How do Swazi cultural beliefs and practices mediate high school students' perceptions of HIV/AIDS? iii) Do differences exist between the cultural beliefs and perceptions on HIV/AIDS among high school boys and girls? And iv) what educational programmes may be put in place to assist high school students' understanding of the HIV/AIDS pandemic?

### Theoretical Orientation

The Interactionist approach according to Rose (2006) is based on the concept of culture. Culture develops through shared sets of symbols that provide meaning to the inhabitants. Without such shared sets of meaning, it would be difficult and virtually impossible to interact with others. Interactionists want to understand each individual, and how they act within society (Coleman 2003). In the views of Haralambos and Holborn (2004) interactionism begins from the assumption that action is meaningful to those involved and people act within the context of their own culture and beliefs. Allen (2007) asserts that meanings are not fixed entities; they depend in part on the context of interaction. Meanings are also created, developed, modified and changed within the actual process of interaction (Haralambos and Holborn 2000).

HIV/AIDS is largely a sexually transmitted disease, and like many other diseases, involves interaction between an ill person, relatives and medical personnel. However, AIDS is different from other diseases as people regard the victim's behaviour as the cause for contracting the virus and interactions might reflect these. So, while people sympathise with an HIV/AIDS victim, they also blame him/her. Of particular interest are the Interactionists' concept of self labelling and its effects. This means when a person becomes ill the relationship with others is disturbed. When AIDS has developed, individuals worry about how people perceive their condition. HIV/AIDS has provoked reactions of fear, divisions, inequalities, discrimination and stigmatisation in societies. As a viral disease, its symptoms are distinct and identical and AIDS has become a disease of labels. For example,

AIDS sufferers are labelled as promiscuous, drug peddlers, prostitutes, homosexuals or gays (Paicheler 1992). This indicates that the condition of HIV and AIDS has negative labels based on how people behaved leading to HIV infection. The reason why the researchers employed the Interactionist approach for the present study was because the Interactionist perspective is anchored on culture but also allowed flexibility in that there was no hypotheses and the researchers were not rooted in attempting to prove dogma or theory. Instead the researchers reacted to what they discovered, not assuming about the variable(s) under the study.

### METHODOLOGY

The study was a descriptive survey research design. The target population of this study was all Form IV students in the Lubombo region of Swaziland as at the time of this study. The Form IV streams were selected to participate in this study because they were not taking external examinations, hence minimum disturbances in their academic endeavours. The region had a total of 45 high schools and all were mixed schools. Out of the 45 high schools in the Lubombo region, 23 were public schools, 9 were community schools, 6 were company-aided schools, 5 were mission schools and 2 were private schools. The Lubombo region had a total of 2988 Form IV students at the time of this study and of these, 1562 (52.28%) were females and 1426 (47.72%) were male.

According to Cohen et al. (2005), for a target population of between 2000 and 3000, at least 10% could be considered a representative sample of the population. The sample size of the study comprised 351 Form IV students taken from 12 high schools selected using the stratified cluster random sampling procedure (1 private, 2 mission, 2 company aided and 7 public/community schools). Out of the 351 students, 169 (48.1%) were males and 182 (51.9%) were females. Age-wise, the numbers were 15 years (20), 16-years (62), 17 years (103), 18 years (76), 19 years (44) and 20-24 years (46). The percentage distribution of respondents per type of school was 48% (public/community schools), 23% (company aided schools), 19% (mission schools) and 10% (private schools). The urban-rural distribution was 193 (55%) from rural schools and 158 (45%) from urban schools.

Data were collected through the use of a questionnaire. Questionnaire was preferred because it enabled the researchers to gather data from a wide geographical area, costs were relatively low, easier and quicker for respondents to answer, and respondents enjoyed a high degree of freedom in completing the questionnaire. The questionnaire was divided into five sections consisting of the respondents' demographic data; perceptions of cultural beliefs versus HIV/AIDS; level of knowledge on HIV/AIDS; attitudes towards HIV/AIDS; and educational programmes that might assist students to deal better with issues regarding HIV/AIDS. Validity of the questionnaire was obtained with the involvement of experts who were asked to review the instrument and to make recommendations thereof. A pilot study was then conducted with a smaller sample comprising 55 students at one school in another region of the country (Hhohho) to determine the viability of the instrument. Means and standard deviations were obtained to determine those cultural beliefs and practices which were perceived to be drivers for HIV. The mean for the different sections of the instrument reflected 3.9987 for cultural perception towards HIV and AIDS, which was positive while knowledge of HIV and AIDS had a mean of 2.4550 which was negative because it was below the threshold. Then to ensure instrument reliability, the researchers employed the Cronbach's alpha co-efficient. At pilot, the results were approximately 0.30 for most of the sections. To reach the 0.70 threshold, the instrument was revised and questions translated to siSwati. Both English and siSwati featured in the questionnaire to improve reliability.

### Ethical Considerations, Data Collection and Analysis

The sensitive nature of the study required that the researchers observed all ethical requirements. Official permissions from the principals of the twelve selected schools were sought and were obtained. All the 351 learners that took part in the study were fully informed of the objectives of the study. The researchers also explained to the participants, why they were selected for the study. Participants were given the choice to opt out of the study before or during the study. Assurance regarding the anonymity of participants was given. All participants were

asked to complete the consent forms. The researchers administered the questionnaires in each school and waited to collect the questionnaire from the respondents after completion.

**Data Analysis**

Descriptive and explanatory analyses and summated scales were used. Inferential statistics was used to test for differences between boys and girls and between the stratified schools. Summated scales (averages for each section) were calculated from the items of each section in the questionnaire. A summated scale was built from individual items that were supposed to describe the same phenomenon. An indicator was generated by first transforming the response items into codes/numbers. Then item codes were summed and averaged to generate a score/indicator for the level of perception for that section. Some items/questions in the questionnaire were reverse worded (positive statements), so the scale was reversed before the point values was compared or used in a summated scale.

**FINDINGS**

The purpose of research sub-question one, was to establish perception levels on culture, knowledge and attitudes amongst the sample. Table 1 shows the average HIV/AIDS perception levels on culture, knowledge, attitudes and campaigns. The table shows that the perception level on attitudes towards HIV/AIDS was high among respondents having a mean of 3.92. This mean score indicates that respondents have positive attitudes towards HIV/AIDS because it is more than 3 which is half of the 5 Likert scale questions. This was followed by a mean score of 3.65 on cultural perception on HIV/AIDS revealing that most respondents are aware of the cultural practices that help to spread the HIV/AIDS virus. On HIV/AIDS knowledge, it showed

**Table 1: Average HIV/AIDS perception levels on culture, knowledge, attitudes and campaigns (N=351)**

<i>Factor</i>	<i>Mean</i>
Attitudes towards HIV/AIDS	3.92
Cultural perception on HIV/AIDS	3.65
HIV/AIDS knowledge	2.34
Perceptions about HIV/AIDS campaign programmes	1.80

a mean score of 2.34 indicating the sample do not have adequate knowledge regarding HIV/AIDS. The last mean score of 1.80 on perceptions about HIV/AIDS campaigns indicates that a majority of the respondents were unaware of campaigns or programmes that help to combat HIV/AIDS.

Research sub-question 2 attempted to examine how Swazi cultural beliefs and practices mediated high school student’s perceptions of HIV/AIDS in Swaziland. Table 2 shows mean scores that are greater than 3 (3.6421 and 3.6496) for both urban and rural schools on cultural perceptions on HIV/AIDS. These mean scores fell on the disagree scale implying that most respondents did not agree that culture had an influence on HIV/AIDS. Research sub-question three explored whether differences existed between the cultural beliefs and perceptions on HIV/AIDS among high school boys and girls.

**Table 2: Mean scores by location**

	<i>Location</i>	<i>N</i>	<i>Mean</i>
<i>Cultural Perception on HIV/AIDS</i>	Urban	158	3.6421
	Rural	193	3.6496

Table 3 shows a mean of 3.6202 with a standard deviation of 0.36103 for females. This indicated that there was no significance difference between boys and girls regarding cultural perceptions on HIV/AIDS. On HIV/AIDS knowledge, males had a mean score of 2.3677 and a standard deviation of 0.41756 while females had a mean score of 2.3210 and a standard deviation of 0.43702. This also indicated that there was no statistical significance difference between boys and girls. On attitudes towards HIV/AIDS males had a mean score of 3.8580 and a standard deviation of 0.46448. Females on the other hand, had a mean score of 3.9736 and a standard deviation of 0.38561. This again showed that there was no statistical difference between boys and girls. Regarding perceptions about HIV/AIDS males showed a mean score of 1.8056 and a standard deviation of 0.57766 and females showed a mean score 1.7857 and a standard deviation of 0.51666. This did not only show that there was no statistical significance between boys and girls but also that it was a weak significant difference.

The purpose of research sub-question four was to identify educational programmes which

**Table 3: t- test to compare average perceptions between respondents by urban sexgroup statistics**

	<i>Sex</i>	<i>N</i>	<i>Mean</i>	<i>Std. deviation</i>	<i>Std. error mean</i>
<i>Cultural Perception on HIV/AIDS</i>	Male	169	3.6202	0.35878	0.02760
	Female	182	3.6703	0.36103	0.02676
<i>HIV/AIDS Knowledge</i>	Male	169	2.3677	0.41756	0.03212
	Female	182	2.3210	0.43702	0.03239
<i>Attitudes towards HIV/AIDS</i>	Male	169	3.8580	0.46448	0.03573
	Female	182	3.9736	0.38561	0.02858
<i>Perceptions about HIV/AIDS Campaigns/Programmes</i>	Male	169	1.8056	0.57766	0.04444
	Female	182	1.7857	0.51666	0.03830

could assist high school students' understanding of the HIV/AIDS pandemic and its prevention thereof. Table 4 shows the correlation coefficients that are negative and p-value that is close to zero. The negative correlation coefficient implies an inverse relationship, for example, when correlation value is -0.17, it means increasing programmes and campaigns do not add to increasing knowledge on HIV/AIDS, and also the p-value close to zero such as 0.001 which are insignificant implies a nil relationship. This could suggest that respondents were probably not exposed to campaigns and programmes addressing issues on HIV/AIDS.

### DISCUSSION

By now, it ought to be common knowledge that Human Immune Deficiency Virus (HIV) causes Acquired Immune Deficiency Syndrome (AIDS) and that the virus severely depletes the human immune system, making the body unable to defend itself against infections. HIV virus was first discovered in 1983 at the Pasteur Institute in France (Jackson 1992). Although AIDS is a sexually transmitted disease (STD), it can also

be transmitted through blood or from mother to child and through using the same needles, injections and razor blades (Chireshe and Chireshe 2003). The current study revealed that there are many cultural factors that put girls and women at risk of HIV infection. In terms of the first research question bordering on cultural beliefs and practices that impact the perception of HIV/AIDS among Swazi high school students, participants noted that quite a number of practices appeared to be widespread in the kingdom. It was found that various forms of incisions including female genital mutilation, traditional male circumcision, body-piercing and indiscriminate sharing of sharp objects had an impact on the spread of HIV/AIDS among Swazis. Such revelations appeared to be consistent with those of Chireshe and Chireshe (2003) who earlier noted that HIV virus can be transmitted through the use of same needles, injections and razor blades. Equally consistent with the above findings, are the Mozambican and Namibian studies (USAID 2009), which identified some of the harmful traditional and cultural practices that were perceived as increasing the vulnerability of women to both gender violence and HIV and other sexually transmitted infections (STI's).

**Table 4: Spearman's rho correlation coefficients of perception factors**

		<i>Correlation coefficient</i>	<i>p-value</i>	<i>Sample size</i>
<i>Cultural Perception on HIV/AIDS</i>	HIV/AIDS Knowledge	-0.17	0.001	351
	Attitudes towards HIV/AIDS	0.096	0.071	351
	Perceptions about HIV/AIDS campaigns/programmes	-0.138	0.010	351
<i>HIV/AIDS Knowledge</i>	Attitudes towards HIV/AIDS	-0.166	0.002	351
	Perceptions about HIV/AIDS campaigns/programmes	-0.001	0.981	351
	Perceptions about HIV/AIDS campaigns/programmes	-0.139	0.009	351
<i>Attitudes towards HIV/AIDS</i>	Perceptions about HIV/AIDS campaigns/programmes	-0.139	0.009	351



Participants were also unanimous on the consequences of sexual coercion and harassment, polygamous marital relationships as well as the keeping of multiple partners because such habit can only exacerbate the chances of HIV transmission. The above findings appear to be in congruence with the findings of earlier studies on the impact of culture on the spread of HIV virus (see for instance, Jack 2001; Maluwa-Banda 2004; Chege 2006; Rule and John 2006; Mweru 2008; Price 2009; Saller 2009; Kemboi et al. 2011). These studies had earlier noted that cultural beliefs are factors in the social trends that contribute to HIV/AIDS infection in most societies. It was also found that Swazis were engaged in occasional short-term visits between unmarried lovers, which increased the infection rate of HIV/AIDS among such persons. Extramarital affairs as well as blood transfusion were thought to be among the practices that exposed those involved to HIV/AIDS. One finding of the study consistent with many previous findings on the spread of HIV/AIDS was the belief among Swazis that having sex with a virgin prevents HIV/AIDS. This was the belief students who took part in the study thought was rife in the Kingdom of Swaziland. Coincidentally, this very pathetic finding appeared to have been echoed in previous studies by Pratt (2005), Chege (2006), John and Rule (2006), Bhana et al (2006) and Petzer et al. (2007) who found sexual intercourse with a virgin cures the HIV/AIDS disease. As such, the inferences from this study reveal that Swaziland has not been an exception.

For research question two that sought to understand how such cultural beliefs and practices mediate high school students' perceptions of HIV/AIDS, participants thought that HIV/AIDS is a disease for prostitutes. The boys and girls who participated in the study also were of the opinion that people living with HIV and AIDS should be allowed to keep their status secret, although they equally acknowledged the fact that in Swaziland, such people are easily identified as a lot of stigma appears attached to the disease and to those infected by it. Notwithstanding, participants believed that those infected should be allowed to continue with their work or school lives in order to avoid them not being drawn more close to poverty. Their thinking was consistent with those of Nzyuko et al. (1997), Togarasei (2002) and Sunmola et al. (2003) who noted HIV could be a major driver of poverty. It

is implied from the result of the present study that in spite of widespread information on the aetiology and epidemiology of the disease, HIV/AIDS was still seen as a myth among Swazis. Interestingly, most participants in the study noted that it was a belief among some sections of Swazis that there is nothing like HIV/AIDS. Equally important revelation that appeared to be consistent with previous findings (see for instance, Jack 2001; Slonim-Nevo and Mukuka 2002; Pratt 2005; Chege 2006; John and Rule 2006; Bhana et al. 2006; Petzer et al. 2007; and Saller 2009), is the fact that some of the participants held the view that traditional medicine can easily cure AIDS as the disease appeared to be associated with witchcraft.

On whether differences existed between the cultural beliefs and perceptions on HIV/AIDS among high school boys and girls, our findings did not deviate from previous studies. There were no significant differences between the perception of high school boys and girls regarding their perceptions on cultural beliefs on HIV/AIDS. Earlier studies by Tobias (2001), Sathiparsad and Taylor (2006) and Strydom and Strydom (2006) noted that in terms of their cultural beliefs on HIV/AIDS, the gap in differences between boys and girls appeared to narrow down quite significantly. These studies found that the perception of boys and girls regarding cultural beliefs on HIV/AIDS did not show any significant disparities and in that sense, the findings of the present study are confirmatory.

Another finding revealed by the present study on educational programmes, which the researchers found quite disturbing was the indication that educational programmes such as outreach programmes, abstinence programmes, billboards, storytelling and pamphlets did not appear to help respondents add knowledge concerning HIV/AIDS. While studies conducted elsewhere by other the researchers (Strydom and Raath 2002; Strydom and Strydom 2006), found that, where more information was provided in a variety of forms, it assisted people to conceptualise and comprehend the concept of HIV/AIDS. These findings may also suggest that information on programmes and campaigns on HIV/AIDS should be provided in a variety of ways so that the different media can stimulate and motivate interest and enthusiasm, creating a lasting impression. As the study was limited only to how cultural beliefs and practices might influ-

ence the spread of HIV/AIDS among high school students in Swaziland, we did not collect data on the pedagogical effectiveness of various approaches adopted in the use of those programmes. Perhaps, more studies may be required that target the understanding of the strategies for effective educational programmes that enable the benefits inherent in such programmes to be manifested and therefore, thereby made beneficial to the target audiences.

### CONCLUSION

For students, parents and society at large, this study provides empirical data on the perception of cultural beliefs and practices amongst Swazi high school learners in relation to the continued spread of the AIDS virus. The study ought to have influenced positive behaviour changes among participants so that they might embrace only those cultural beliefs and practices that might not put them at risk of contracting HIV. The findings also might be helpful to empower parents to be proactive by revising belief systems and cultural practices in order to guide their children to avoid the risk of contracting the virus. The study will also benefit the society as it will provide evidence and information on those cultural beliefs, norms and practices that may be contributing to the persistent spread of the disease. Equipped with such information, the Swazi and other societies at large will be carefully selective when instilling lifestyles, value systems and beliefs to society, and to avoid or modify those that put society at risk of contracting or transmitting HIV/AIDS. Health care professionals, in particular in Swaziland, will also benefit from this study in that it will provide them with information that will enable them to deal better with clients with great amount of sensitivity about their cultural beliefs and practices. The counselling options need to be based on the patient's religion and cultural preferences.

Moreover, the study will be of great help to the general education system particularly curriculum developers, teachers and counsellors. The empirical data that emerged from this study will assist curriculum designers to develop programmes that will embrace all aspects of the HIV/AIDS epidemic including culture and HIV. If this component of the curriculum is examinable, teachers will teach it earnestly and students will pay close attention to it. Government will be as-

sisted with the findings of the study to formulate health policies and in particular HIV/AIDS policies that will discourage those lifestyles, traditions, norms and beliefs systems that put people at risk of getting the deadly virus.

### RECOMMENDATIONS

In view of the findings of this study that high school students do not view cultural beliefs and practices as having an impact on the perception of HIV/AIDS. The researchers suggest that high school students and young people in general should be taught about culture so that they develop a deep understanding of what it entails. Furthermore, such educational empowerment will also assist in defining the need for boys and girls to perceive themselves as equal partners. This will promote mutual respect for each other in all aspects of life to enable them avoid exposing each other to risks of contracting HIV/AIDS. Strategies and policies need to be put in place where adults, in particular teachers, are trained on culture in order for accurate information on HIV/AIDS to be disseminated. Findings regarding educational programmes and campaigns imply that when presenting information on HIV/AIDS to students and the youth, it must be presented in a variety of ways that is motivating and stimulating to them, otherwise if provided in the conventional way, it will fail to yield the desired results. It would also be helpful to strike a link between HIV/AIDS programmes to other developmental issues, such as poverty alleviation, so that the youth can see relevance in exposing themselves to knowledge on HIV/AIDS.

### LIMITATIONS OF THE STUDY

The researchers would like to emphasise on some limitations that could have impacted the generalisation of the findings of this study. While the researchers recognise that there were multifaceted causes that might contribute to the spread and high prevalence of HIV/AIDS among high school students, the study was limited only to how cultural beliefs and practices might influence the spread of HIV/AIDS among high school students in Swaziland. The first major challenge was the time constraint. The researchers would have preferred the use of both quantitative and qualitative approaches. The qualitative ap-

proach would have allowed the researchers to conduct some sort of semi-structured interviews and or focus group discussions to gain more insight into the complexity of cultural beliefs and practices and the impact thereof on HIV/AIDS. Further research that applies a mixed method approach may reveal more insights. Notwithstanding the limitations, the findings of this study have lessons to learn from.

### REFERENCES

- Allen H 2007. *Justice Unbalanced: Paradoxes and Paradigms*. Buckingham: Open University Press.
- Bhana D, Morrell R, Epstein D, Moletsane R 2006. The hidden work of caring: Teachers and the maturing AIDS epidemic in diverse Secondary Schools in Durban. *Journal of Education*, 38: 4-24.
- Chege F 2006. Teacher's gendered identities, pedagogy and HIV/AIDS education in African settings within the ESAR. *Journal of Education*, 38: 25-46.
- Chireshe E, Chireshe R 2003. Advanced level student's perceptions of the causes and effects of HIV/AIDS: A case study of Masvingo Urban High Schools. *Zimbabwe Journal of Educational Research*, 15: 11-27
- Cohen L, Manion L, Morrison K 2005. *Research Methods in Education*. New York: Routledge Falmer.
- Coleman O 2003. *Theories for Practice: Symbolic Interactionist*. London: Longman.
- De Lange N, Mitchell C, Molestane L, Stuart J, Buthelezi T 2006. Seeing with the body: Educators' representations of HIV and AIDS. *Journal of Education*, 38: 45-63.
- Haralambos M, Holborn M 2000. *Sociology: Themes and Perspectives*. London: Harper Collins.
- Haralambos M, Holborn M 2004. *Sociology: Themes and Perspectives*. London: Harper Collins.
- Jack N 2001. HIV/AIDS in Caribbean adolescents and children. *Journal of HIV/AIDS Prevention and Education in Adolescents*, 4(2): 23-40
- Jackson H 1992. *AIDS Action Now: Information, Prevention and Support*. Harare: AIDS Counselling Trust.
- John V, Rule P 2006. Shifting ground: Making sense of context in examining HIV/AIDS and schooling. *Journal of Education*, 38: 165-186.
- Kemboi GJ, Onkwere K, Ntobo OM 2011. Socio-cultural factors that perpetuate the spread of HIV among women and girls in Keiyo district, Kenya. *International Journal of Sociology and Anthropology*, 3(5): 147-152.
- Lopang AJ, Hoque ME, Heever H 2013. Factors of non-acceptance of the routine HIV test among patients attending a district hospital in Botswana. *Ethno-Med*, 7(1): 7-11.
- Maliki AE, Omohan ME, Uwe EA 2006. HIV/AIDS and use of condom: The role of counsellors. *Stud Tribes Tribals*, 4(2): 151-155.
- Maluwa-Banda D 2004. HIV/AIDS related knowledge and self-reported sexual behaviour of secondary school students in Southern Malawi: Implications for AIDS education and counselling. *Zimbabwe Journal of Educational Research*, 4: 85-101.
- Matsaamoto D 2000. *Culture and Psychology*. Brooks: Pacific Groove.
- Modo IVO, Enang PI 2011. Sociocultural factors responsible for increasing rate of HIV/AIDS in Akwa Ibom state of Nigeria. *Ethno Med*, 5(2): 141-147.
- Mugambi J 2006. The impact of HIV/AIDS on Kenyan rural women and the role of counselling. *International Social Work*, 49(1): 87-96.
- Mukuka L, Sloni-Nevo V 2006. The role of the Church in the fight against HIV/AIDS infection in Zambia. *International Social Work*, 49(5): 641-649.
- Muthukrishna N, Mitchell C 2006. Researching HIV/AIDS and education in sub-Saharan Africa: Examining situated spaces. *Journal of Education*, 38: 1-3.
- Mweru M 2008. Women, migration and HIV/AIDS in Kenya. *International Social Work*, 21 (3): 337-347.
- Nzyuko S, Lurie P, Mcfarlandi W, Leyadeni W, Nyamwaya D, Mandel JS 1997. Adolescent sexual behaviour along the Trans- African Highway in Kenya. *AIDS*, 10(1): 11-36.
- Paicheler M 1992. Society facing AIDS. *Current Sociology*, 40(3): 11-36.
- Pattman R 2006. Making pupils the resources and promoting gender equality in HIV/AIDS education. *Journal of Education*, 38: 89-115.
- Petzer K, Oladimeji Y, Morakinyo O 2007. Factors affecting condom use among Nigerian University students. *Zimbabwe Journal of Educational Research*, 10: 283-303.
- Pratt RJ 2005. *HIV and AIDS: A Strategy for Nursing Care*. London: Edward Arnold.
- Price L 2009. Conserving (not preserving) culture: Avoiding the damage to culture of veiled moralism in HIV education. *Southern African Journal of HIV Medicine*, 10(2): 12-15.
- Rose AM 2006. *Human Behaviour and Social Processes*. London: Routledge and Kegan Paul.
- Rule P, John V 2008. Unbinding the other in the context of HIV/AIDS and education. *Journal of Education*, 43: 79-95.
- Saller AN 2009. Correlates of misconceptions in HIV knowledge and attitudes towards people living with HIV/AIDS among in-school and out-of school adolescents in Ghana Africa. *Health Sciences*, 2: 82-91.
- Sathiparsad R, Taylor M 2006. "Diseases come from Girls": Perspectives of male learners in rural Kwa-Zulu – Natal of HIV infection and AIDS. *Journal of Education*, 38: 117-143.
- Slonim-Nevo V, Mukuka L 2002. Traditional and modern health practitioners together against AIDS. *International Social Work*, 14(17): 124-160.
- Strydom H, Raath H 2002. The psychological needs of adolescents affected by HIV/AIDS. *International Social Work*, 48(5): 569-580.
- Strydom H, Strydom C 2006. The level of knowledge of South African pupils regarding HIV/AIDS. *International Social Work*, 49(4): 495-505.
- Sunmola AM, Dipeolu M, Babalola S, Adebayo OD 2003. Reproductive knowledge, sexual behaviour and contraceptive use among adolescents in Niger State of Nigeria. *African Journal of Reproductive Health*, 7(1): 37-48.
- Swaziland Ministry of Health and Social Welfare 2006. *Prevention of HIV Infection in Young People (10 – 24) Years: A Strategic Approach to Accelerating*

- HIV Prevention Within the Health Sector Towards Universal Access*. Mbabane: Government Printer.
- Tobias BQ 2001. A descriptive study of the cultural mores and beliefs towards HIV/AIDS in Swaziland, Southern Africa. *International Journal for Advancement of Counseling*, 23: 99-113.
- Togarasei M 2002. Teaching Old Testament studies in Zimbabwe's theological institutions in the HIV/AIDS era. *Zimbabwe Journal of Educational Research*, 14(3): 254-269.
- UNAIDS 2012. Swaziland Country Report on Monitoring the Political Declaration on HIV and AIDS. From <[https://www.unaids.org/en/dataanalysis/know-yourresponse/countryprogressreports/2012countries/ce\\_SZ\\_Narrative\\_Report\[1\].pdf](https://www.unaids.org/en/dataanalysis/know-yourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report[1].pdf)> (Retrieved on 26 July 2013).
- USAID 2009. United States Agency for International Development. Interrogating Culture, Women's Rights and Culture in Namibia and Mozambique: A Report Synopsis. From <<http://www.genderlinks.org.za/article/interrogating-culture-womens-rights-and-hiv-aids-in-namibia-and-mozambique-a-report-synopsis-2010-03-08>> (Retrieved on 22 January 2011).
- Voisin DR, Baptiste DR, Da Costa D, Henderson M, Henderson G 2000. Exporting a US HIV/AIDS prevention program to a Caribbean island-nation. *International Social Work*, 49(1): 75-86.