UGANDAN STUDENTS’ PERSPECTIVES ON THE SPREAD AND PREVENTION OF
HIV/AIDS: CULTURAL PRACTICES AND EDUCATION

by

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Abstract

My study investigated perspectives that underlie Ugandan high school students’ understandings of the spread and prevention of HIV/AIDS and how they influenced by cultural practices. I adopted an interpretive case study approach that employed mixed methods, guided by the sociocultural and practice theoretical frameworks. Data were collected on students from seven select schools in central Uganda over 12 weeks. The students participated in the study by completing an adopted HIV/AIDS knowledge questionnaire with a transformed scale from True/Fase to Likert before and after experiencing HIV/AIDS lesson instructions. The questionnaire served as a stimulus to evocation of the students’ perspectives. These perspectives were extracted from the questionnaire data using Principal Component Analysis. Results revealed five key perspectives: Perceptual and behavioural risks associated with proximity to HIV/AIDS victims; Hygienic practices; Behavioural/practice causes and transmission of HIV/AIDS; Predictive, preventive and transmissive knowledge of HIV/AIDS; and Naïve notions of prevention and treatment of HIV/AIDS. These perspectives were further interrogated through qualitative methods including classroom observation and focus group interview/discussions. After HIV/AIDS-focused lessons, a similar analysis on the after lesson questionnaire data also revealed that underlay students’ understandings of the spread and prevention of HIV/AIDS. Three of the pre-lesson perspectives persisted while two (Hygienic practices and Behavioural/practice causes and transmission of HIV/AIDS) collapsed, with two new ones (Taboo-like prescriptions of knowledge of infection) emerging in the after lesson experience analysis. Also a realization emerged among the students of the greater risk of HIV/AIDS infection if they subverted the cultural norms. It became noteworthy that the students...
communicated their understandings metaphorically, which often conveyed unscientific understandings about the spread and prevention of HIV/AIDS.

The study’s findings have critical implications for policy and the way curricula and instruction are interpreted and enacted in the classroom.
Preface

This dissertation is original, unpublished and independent work by the author, E. Namazzi. This study obtained the approval of the UBC Research Ethics Board (Behavioural Research Ethics Board; UBC BREB Number: H12-01028), and that of Uganda National Council for Science and Technology, Reference Number: SS 2930.
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ABC</td>
<td>Abstain, Be faithful, Condomize</td>
</tr>
<tr>
<td>ARRM</td>
<td>Aids risk Reduction Model</td>
</tr>
<tr>
<td>EFP</td>
<td>Education For Peace</td>
</tr>
<tr>
<td>HBM</td>
<td>Health Belief Model</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
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<tr>
<td>NCDC</td>
<td>National Curriculum Development Council</td>
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<tr>
<td>PCA</td>
<td>Principal Component Analysis</td>
</tr>
<tr>
<td>RE</td>
<td>Religious Education</td>
</tr>
<tr>
<td>TRA</td>
<td>Theory of Reasoned Action</td>
</tr>
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<td>UNAIDS</td>
<td>United Nations on AIDS</td>
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<td>UNESCO</td>
<td>United Nations Education Social Cultural Organization</td>
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<td>UNICEF</td>
<td>United Nations Children’s Educational Fund</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>TFCD</td>
<td>Teacher Facilitated class discussion</td>
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Chapter One: Introduction

“Until the lion has his or her own storyteller, the hunter will always have the best part of the story.” (Proverb of the Ewe-mina of Benin, Ghana and Togo; Adagba, 2006)

Whose perspective?

The above proverb indicates that very often the one who does not have the voice is often the loser: the lion to the hunter, the servant to the master and the student to the teacher. Unless the lion voices its perspective of the story, the unknown part of the struggle between him and the hunter in the forest is considered incomplete. No matter where one stands, each perspective or point of view is very important.

Thus,

I believe in the complexity of the human story and that there’s no way you can tell that story in one way and say, This is it. Always there will be someone who can tell it differently depending on where they are standing; the same person telling the story will tell it differently. I think of that masquerade […] that dances in the public arena. If you want to see it well, you must not stand in one place. The masquerade is moving through this big arena. Dancing. If you’re rooted to a spot, you miss a lot of the grace. So you keep moving, and this is the way I think the world’s stories should be told—from many different perspectives. (Chinua Achebe in an interview with Jerome Brooks of The Paris Review, 2011)

This study reports the investigation of Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS, and how these are influenced by cultural practices. The aim is to obtain insights into high school students’ perspectives on the spread and prevention of HIV/AIDS while identifying cultural practices that influence these students’ perspectives. I view students’ perspectives as the lens through which they view their world and make meaning of it. In this way, I equate perspectives to people’s viewpoints on their world or to their worldviews (Figueroa & Harding, 2003; Harding, 1987). Griffin (2009) refers to perspectives as both mental and physical opinions from which people view their world.
Ordinarily, what people know about a phenomenon shapes their opinions in daily life (Figueroa & Harding, 2003; Harding, 1987; Hartsock, 1998). In this way, it is believed that an individual's own perspectives are shaped by his or her experiences in social locations and social groups (Harding, 1993; Hartsock, 1998). Thus perspectives are individual or group epistemologies that share morally and scientifically preferable explanations for social life (Harding, 1993). Harding further explains that such preferred explanations for social life are located in people’s experiences. These explanations are very important, as they enable existing scientific explanations to be called into question and different versions or explanations may be preferred to others (Smith, 1987).

As epistemologies, perspectives do not only seek reality through the intellect, but also guide individuals to know how they ought to live with that reality within the world (Harding 1993). Wood (2009) observes that since power relations generate unequal social locations and structure society, the way people understand and communicate with themselves and their world is shaped by their location within society. Consistent with this view is Harding’s (1998) assertion that,

In societies stratified by race, ethnicity, class, gender, sexuality, or some other politics shaping the very structure and meanings of social relations, the activities or lives […] of those at the top both organize and set limits on what persons who perform such activities can understand about themselves and the world around them (Harding, 1998, p.150).

For example, based on my knowledge about the social stratification of the African traditional society, children and youth are relegated to the lowest position. Youth are generally considered children until they are either initiated into adulthood through ritualistic rites, or are prepared for marriage. It is this position or location in society that forms their frames of reference and affects
how they view and experience their world. Thus, people’s perspectives are a product of social activity, as well as the cultural conditions that typically surround their lives (Wood, 2009). In this way, perspectives are grounded in context and circumstances.

While socio-cultural factors influence people’s perspectives, perspectives in turn influence how people see, respond, think and act on their world (Gyekye, 1995). In other words, the way they look at their world informs the way they understand it based on their socio-cultural background. This scenario portrays an intricate relationship between perspectives and perceptions, since it is from people’s perspectival stance that they derive perceptions or understandings. Parallel to this view, Piaget (2013) classifies both perspectives and perceptions under social cognition. Piaget further argues that students’ ability to view and see the world from a given point of view is fundamentally an aspect of human cognition. However, Harding (1987) notes that although perspectives may be based on collective experiences and viewpoints, it does not necessarily follow that members of the same group are always homogeneous, since experiences of members of the same group may vary greatly from one member to another.

Often, in the process of curriculum development and reform students’ perspectives and lived experiences are devalued and ignored as offering anything contributory. It is believed that education can enhance reduced risk of HIV/AIDS infection (Kelly, 2000). However, if conventional school curriculum does not address students’ perspectives on the spread and prevention of HIV/AIDS with a focus on how cultural practices influence these perspectives, school systems are bound to fail in their efforts to deliver transformative education. This necessitated understanding students’ salient perspectives that drive their understandings of the spread and prevention of HIV/AIDS. Moreover, it was also important to understand what and how African cultural practices influence these perspectives in order to understand what
implications they bear on HIV/AIDS curriculum. Thus, this study did not aim to critique cultural practices, but rather, it sought to understand students’ perspectives, and how they drive their understandings of the spread and prevention of HIV/AIDS. Further, it sought to understand the cultural practices that frame students’ understandings, with a view to making cultural practices safer in a way that is culturally acceptable.

1.1. Rationale for the Study

Given that the number of new HIV/AIDS infections were estimated at 120,000 in 2009, which exceeded the number of annual AIDS deaths, it was feared that HIV/AIDS prevalence in Uganda was on the rise again particularly in the age group of 13 to 19 (UNAIDS, 2010). Although the HIV/AIDS mortality rate dropped to an estimated 62,000 deaths in 2011, marking the lowest record since 2000, new annual infections rose to 150,000 since 2011 (UNAIDS, 2012). A US-financed survey carried out in 2012 indicates that in spite of Uganda’s success story in the fight against HIV/AIDS, infection rates had again risen from 6.4% in 2005 to 7.3% in 2012 (UNAIDS, 2013). Kron (2012) identifies the need to further address the socio-cultural dimensions of the problem. While the centrality of cultural practices is recognized as crucial to the spread and prevention of HIV/AIDS from a social perspective, young people’s perspectives on the spread and prevention of HIV/AIDS and how African cultural practices influence their understandings have not been adequately explored.

Chondoka (2004) observes that risky behaviours are enmeshed in complex webs of economic, legal, political, cultural and psychosocial determinants that must be analyzed and addressed. Diverse cultural practices of African societies have been credited with obscuring promiscuity among teenagers for fear of harsher societal repercussions. This has led to flawed perception of the African culture’s ability to contain the spread of HIV/AIDS pandemic by
emphasizing abstinence across the age span. Besides, there is a growing dilemma among high
school students that appears to originate from variance between cultural explanations and
practices and the science of HIV/AIDS (UNDP, 2002; Mutonyi, Nashon & Nielsen, 2009).

Also, a number of studies, for example, in Swaziland and Uganda, testify to this dilemma
(IRIN Swaziland, 2002; Jones & Norton, 2007; Kendrick & Kakuru, 2012; Mutonyi, Nashon, &
Nielsen, 2007; Norton & Mutonyi, 2007; 2010). Typically, sociocultural perceptions about the
disease are believed to be at variance with the spread and prevention of HIV/AIDS. Although
there has been an official policy in Uganda aimed at promoting HIV/AIDS knowledge in high
schools as well as major achievements in the area of prevention of the spread of HIV/AIDS in
Uganda, there is no clear understanding of high school students’ perspectives on the spread and
prevention of HIV/AIDS and how cultural practices influence these perspectives. As well, the
extent to which the policy can be interpreted and implemented in high school curriculum is
unclear.

Moreover, the widely known concept of attributing a human cause to occurrence in
society among many African societies can be a double-edged sword (Jegede, 1995; Nashon,
2004): positive in terms of controlling human behaviour such as sexual, but negative in terms of
perpetuating superstitious falsehoods such as a cure for HIV/AIDS (Mugenyi, 2008; Rodlach,
2005; Stwert & Strathern, 2004; Van Dyke, 2001). This belief coupled with other diverse
cultural practices and the way they are perceived by young people can profoundly influence the
way teenagers in many African societies view and respond to the spread and prevention of
HIV/AIDS, resulting in false perspectives of mitigation measures (Bruner, 1990; Joshephson,
2000). Cultural expectations and practices can profoundly affect young people’s perspectives on
the spread and prevention of HIV/AIDS and their ability to change their behaviour to alleviate the risk of infection (Hulton, Cullen, & Khalokho, 2000).

Hence, there is the need for a study to investigate Uganda’s high school students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives and consequent implications for high school curriculum and instruction.

1.1.1. Purpose of the Study

The purpose of this study was to investigate students’ perspectives on the spread and prevention of HIV/AIDS and how cultural practices influence these perspectives. Research indicates that there is a potential link between education and behaviour change in HIV/AIDS prevention efforts since schools are key settings for educating youth about HIV/AIDS and for halting its further spread (Basch, 1989). Generally in combating HIV/AIDS infection, the crucial responsibility of education is to teach young people how to avoid either contracting the disease or transmitting it to others. Kelly (2000) observes that provision of clear information about the modes of HIV/AIDS transmission plays a major role in awareness about HIV/AIDS infection risk and allows those at risk to understand and to make better judgment between options. Moreover, it is believed that the cognitive skills required for informed choices in respect to HIV/AIDS risk prevention and for behavioural change appear to be substantively dependent on the ability of teachers to effectively drive home the messages (Kelly, 2000). I contend that as the spread of the HIV/AIDS epidemic continues, the potential of education to mitigate the root causes and to facilitate its prevention depends on teachers’ awareness about what perspectives students hold about the spread and prevention of HIV/AIDS. This study therefore has implications for curriculum and instruction if students are to hold perspectives that facilitate the prevention of the spread of HIV/AIDS.
1.1.2. **Research Questions**

Teaching about HIV/AIDS in schools mainly focuses on the knowledge dimensions of HIV/AIDS related to modes of transmission and means of prevention (National Development Curriculum Center (NCDC), 2013). However, as Kelly (2000) suggests, teachers often lack the curriculum and time to adequately address the issue within schools. Evidence indicates that teachers rely on rote learning that promotes an academic and overly scientific interpretation of the subject (Kelly 2003). Moreover, this is without ensuring that students have a true understanding of the factors that affect transmission of the disease, leaving them relatively unequipped to prevent becoming infected. This situation is aggravated by the fact that it is not even clear if teachers are aware of what thoughts students hold about the spread and prevention of HIV/AIDS and how these thoughts are influenced by diverse cultural practices in Ugandan society. This thesis raises awareness about the students’ perspectives on the spread and prevention of HIV/AIDS and the ways in which cultural practices influence these perspectives. Based on this background, the research questions that guided this study are:

1. What are Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS?
2. What core cultural practices have the greatest influence on Ugandan high school/Form 5 students’ understanding of the spread and prevention of HIV/AIDS?
3. How might this study’s findings inform policy and practice, theory, and research and methodology?

1.1.3. **Significance of the Study**

This largely interpretive and descriptive study assumed that knowing what perspectives students hold about the spread and prevention of HIV/AIDS and what and how African cultural
practices influence these perspectives would not only provide teachers with insights into the best pedagogical approaches for delivering HIV/AIDS transmission and prevention related content, but would also help teachers to know which misconceptions and naïve understandings to challenge and if possible influence their replacement with correct knowledge (Lansdown, 2003). It was further assumed that identifying key perspectives that drive students’ understandings of the spread and prevention of HIV/AIDS would inform HIV/AIDS curricula and instruction to benefit Uganda’s students generally. It was also assumed that students who participated in the study would understand more clearly HIV/AIDS transmission and preventive routes and be able to apply the necessary knowledge in order to make informed decisions about what would be fair outcomes of their behaviour.

1.2. Researcher Positionality

Carrying out a research study on Ugandan high school students’ perspectives on the spread and prevention of HIV/AIDS posed a dilemma for me. What constitutes Ugandan high school students in Uganda is a problematic distinction for me, given that I am a Ugandan doctoral student at the University of British Columbia, Canada. On one hand, similar cultural backgrounds and nationality might have aligned me with my participants. However, on the other hand, my own personal cultural, educational and work background, which includes late introduction into my own culture, eventual diverse knowledge of Uganda’s multiethnic cultures, and interest in HIV/AIDS related issues gave me an altogether new experience and insights into the diverse cultural practices and how they influence people’s worldviews.

I was ten when I returned home from northeastern Uganda. Narozari was my village near the shores of Lake Victoria located in central Uganda. There was a lot of land. Much of it cultivated. Grandpa lived here surrounded by fields of bananas, maize and cotton, as well as
gardens of beans, cassava, sweet potatoes, peanuts and various fruit trees, including mangoes, pawpaws and jackfruit. Food, vegetables and fruits were picked from the farm, not bought from the market. In the morning I could see adults working in the gardens tilling the ground, while children cleaned the yard and carried water from the well. Chickens and goats ran around as we played in the yard. Occasionally we chased and caught them to form part of the day’s menu. It was here that I also met my cousins and other extended family members during cultural events such as the naming ceremony of a newly born baby. Unfortunately, I could not freely interact. Mother tongue was foreign to me. Wondering faces of my playmates told it all: never had they seen a kid that could not speak mother tongue. It was the most humiliating feeling of estrangement I had ever experienced. I stood on the outside looking in.

Father was a civil servant, and his job dictated where we moved as a family away from home. From Narozari to Kampala to Kabale to Mbale to Soroti, to Kapchorwa, I gained an understanding about places and people across Uganda. Having moved among half a dozen languages and as many local cultures as a child, I was being shaped by a wide range of experiences, languages and cultures. My worldview was being orientated but in a direction away from home and without any sense of belonging.

Father took me back to my home village at the age of ten because he wanted to stop me from losing my cultural roots. During the 1960s, the move involved packing up all household goods on a huge truck commonly known as “Tenda” provided by the government. Father carried with him his cultural beliefs and values. In a wooden suitcase, possibly made for him at the Mission carpentry workshop, he stacked old tattered books that contained traditional stories, riddles and proverbs.
After I learned mother tongue, I felt transformed. Father could now read to me stories from his tattered books. One most memorable book was ‘Tuula tuwaye” (translated as sit and we converse). Although still intact, the frayed edge of its pages could tell how much it had been turned. It was poetically written and particularly entertaining through its use of rhythmic words that resulted in tongue twisting such as: “Akawala akaawa Kaawa kaawa akaawakaawa kaawa? (Where does the little girl who gave Kaawa bitterish coffee live?). Through listening to stories from this book I learned the different types of termites/white ants (“ennaka, ensejjere, empawu, embaala, olubobya and obumpowooko”). I also learned that each type or species of termite/white ants is associated with a particular type of mushroom and that they all serve different purposes. I further learned that traditionally, termites/white ants (enswa) were used in payment of debts, compensation, payment of bride price and were also considered delicacies perhaps in much the same way that Western cultures revere shrimp, octopus or frog legs.

Father taught me the linguistic skills of my ethnic community. Learning mother tongue greatly transformed me and instilled in me a sense of belonging. Listening to the traditional stories and proverbs he read to me grounded me in both language and culture as each story and proverb had a moral teaching embedded in it. I understood that there is a fundamental relationship between our language and our culture since everything spoken is a manifestation of a social cultural norm of my community. I think in his wisdom, my father was aware that language is the vehicle of expression of culture, which is comprised of its people’s beliefs and practices (Lenzerini, 2011). I believe father acted on behalf of his loyalty and allegiance to his community and culture, and a conviction that language is an important source of continuity and identity in a culture (Lenzerini, 2011). As a young girl, language engaged me with my culture.
This cultural relationship was the basis of my inspiration and interest in the cultural issues of my world today.

Also, in 1997 after 14 years of teaching and school administration, I followed a basic palliative program on home-care for HIV/AIDS and cancer patients at Hospice Uganda. As a non-clinical person, I was primarily concerned with the social aspect of the phenomenon and the need to understand the challenges that faced young people who played caring roles towards adults who lived with HIV/AIDS in home contexts. My aim was to support young people, particularly high school students, to equip them with caring skills and encouragement. As I interacted with many young people while on home visits I noticed their struggle to understand and to accommodate the tensions that emanated from cultural practices in order to cope with lives devastated by HIV/AIDS. I became interested in understanding young people’s perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on their perspectives.

As an insider/outsider, I was constantly called upon to maintain both objectivity and subjectivity as I drew on the diverse perspectives that surrounded and framed this study (Lave & Wenger, 1991). As a Ugandan graduate student in Canada, my positionality offered me a unique perspective for understanding the dynamics of researching within participants of my nationality and culture (Merriam et al., 2001; Rose, 1997). In line with McDowell’s (1992) assertion that researchers must particularly take into account their own position in relation to the participants and research setting, throughout the research process, I critically considered what I did, how I did it and why, and as well thought about my participants. In this study, each ethnic community speaks a different language and therefore has a different culture or cultural practices although some cultural practices cut across several ethnic communities.
1.3. Thesis Overview

This thesis is divided into six chapters. Chapter One as the introductory chapter provides the rationale for the study, purpose, research questions, significance of the study and the researcher background. Chapter Two discusses the theoretical frameworks directing this study, namely, the sociocultural and practice theories. The theories conceptualized the belief that learning is social and that it comes largely from our experience of participating in daily life (Wenger, 1998). Learning involves a process of engagement in what Lave (1993) and Wenger (1998) refer to as a community of practice. Communities of practice are everywhere and we are generally involved in a number of them, whether at work, school or home (Lave & Wenger, 1991). In this chapter, the review of literature related to people’s perceptions of HIV/AIDS and its spread identified elements of interest. It also discusses health behaviour models that inform people’s perceptions of disease and health. I will show how a gap in the existing literature provides a rationale for this study. Chapter Three discusses the methodological perspectives and procedures employed in the research design and the context of the study. It also describes the research participants. It further outlines with justification data collection methods used in the study. The chapter goes on to discuss the trustworthiness and credibility of the data collected and concludes with ethical considerations. Chapter Four analyses the quantitative questionnaire and qualitative data sets in an integrated manner and presents the results. Chapter Five discusses the results. Chapter Six provides a summary of the study and outlines implications for policy, curriculum and instruction, theory, and research in response to research question three and offers recommendations.
Chapter Two: Theoretical Framework and Literature Review

Central to this thesis is the understanding of students’ perspectives on the spread and prevention of HIV/AIDS and how cultural practices influence these perspectives. The notion of perspectives is a broad construct that involves the mind and subconscious (Gibson, 2013). From common understanding, perspectives could be defined as a mental framework (Danesh & Clarke-Habibi, 2007) that constitutes the basis for one’s thoughts and actions. They involve a mental evaluation and analysis of something, and take into consideration belief systems, which comprise current situations, values, culture and past experiences. It is within this framework that individuals and groups interpret the nature of reality, the purpose of life and the norms that govern human relationships. In this way, perspectives are linked to cognition, understanding, awareness and comprehension, which connote knowledge and understanding. Seen as an approximate interpretation of reality by an individual, perspectives are closely related to knowledge. Based on Kolb’s (1984) experiential learning cycle in which experience is translated through reflection into concepts, the assumption is that as informed opinion, knowledge is transformed into concrete concepts in the mind. The conviction that accrues from this knowledge, understanding or perception then forms the basis of an individual’s actions.

Webster (1985) describes perspectives generally as relating to understanding one’s environment. Gibson (1979) refers to perspectives as a process by which individuals organize and interpret their sensory impressions in order to give meaning to their environment. This also conforms to the notion that perspectives involve awareness, understanding and interpretation of one’s environment. Drawing on Feuerstein (1990) and Lantolf (2000), just like perceptions, also perspectives are a culturally mediated phenomenon, shaped by learning, memory and expectations. While different people hold different perspectives, they allow them to understand
fellow human’s viewpoints about their world. UNAIDS (2000) contends that specific to culture, perspectives are intrinsically linked to actions and attitudes of communities and societies. Perspectives are believed to lead to decision and action taking. The meaning an individual gives to what he/she thinks or perceives shapes his/her choice of action in response. Gibson (1979) asserts that perspectives guide actions and cultural assumptions and expectations plague people’s interactions and influence the way they perceive their world as well as the way they behave. In this thesis, students’ perspectives on the spread and prevention of HIV/AIDS are examined within the context of learning HIV/AIDS-focused RE/Moral Education.

In this thesis, I refer to perspectives as the knowledge or cognition by which people determine attributes about events or situations in form of views, opinions and points of view drawing on their experiences. Learning makes specific epistemological claims about the nature of knowledge and learning. Locating perspectives within a broader social and cultural context proposes conceptual frameworks that define cultural practices as social processes that are used to create and maintain social control. Such frameworks imply an exploratory approach intended to identify and assess concepts that take into consideration the social and cultural determinants of students’ perspectives on the spread and prevention of HIV/AIDS. Mitchell and Cody (1993) suggests that theoretical frameworks help to guide the investigation in order to establish the association between possible relevant cause and effect, and to explain the “how” and “why” of the phenomenon.

In order to understand students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives, I employed Vygotsky’s (1978) sociocultural theory and Bourdieu’s (1977) Theory of Practice to constitute my interpretive frameworks. These approaches have strong links with classroom discussion and social
interactions. A common thread among them is a focus on learning as developing through social interactions. Methodologically, the sociocultural and practice theoretical frameworks facilitate cause and effect explanatory knowledge in favour of “a science that emphasizes the emergent nature of the mind in activity and acknowledges the central role for interpretation in its explanatory framework” (Cole, 1996, p. 104). The HIV/AIDS-focused moral education lesson provides the important context where knowledge is socially constructed and the students’ perspectives manifest.

Considering that schooling and cultural practices are all embedded in social relations, I viewed the two as social practices. In this way, it made sense to draw on a combination of the sociocultural and practice theories as frameworks or tools to understand students’ perspectives on the spread and prevention of HIV/AIDS and how cultural practices influence them. I also draw on these frameworks to assess and interpret the students’ perspectival persistence and changes after experiencing an instructional intervention. The literature review on the other hand, helped to understand the models used in previous studies to interpret people’s perspectives on the spread and prevention of HIV/AIDS in relation to cultural practices.

This chapter reviews the sociocultural and practice theoretical frameworks while demonstrating their assumptions to link them to students’ perspectives. In addition, it highlights the relationships involved with the purpose of clearly identifying what is being explored, examined, measured and described. It also reviews literature on theoretical models used in previous studies to identify the existing knowledge gap and to understand how these models are used to interpret people’s perspectives on HIV/AIDS transmission and prevention.
2.1. **Social Constructivism**

Learning has always taken place as an aspect of collective and interactional activity (Lave & Wenger, 1991). In this thesis, learning is viewed from a social constructivist perspective, which emphasizes the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding (Derry, 1999; McMahon, 1997). The units of analysis to understanding learning are: the social activity, the mutual environment that shapes thinking, the interactions between people, or a combination of all these units. While the interactional activities demonstrate how a socio-constructivist view of learning is enacted, the sociocultural lens offers a window on the social aspects of interaction that enable students to understand the knowledge they construct (John-Steiner & Mahn, 1996).

Social constructivists view learning as an active, constructive process in which learners construct new ideas or concepts based upon their current or past knowledge (Bruner, 1986). Social-constructivist epistemology contains a clear view of how learning proceeds in practice (Davidson, 1999). Thus, as a process, learning is understood to modify and strengthen people’s worldviews, beliefs, opinions, attitudes, behaviour, understandings, and knowledge.

2.2. **Sociocultural Framework**

Social cultural theories have always been used to demonstrate how students learn and form their opinions or perspectives, through participation in cultural, linguistic and historically formed settings such as family life, peer group interactions and institutional contexts like schooling (Lantolf & Thorne, 2007). Students’ perspectives on the spread and prevention of HIV/AIDS and the manner in which cultural practices influence them can best be understood drawing on the cultural settings of their school and home communities. Social constructivists highly consider that learning occurs within a social context (Wertsch, 1991) and that new
information is obtained by individuals constructing knowledge through interaction with and influence from their social environment.

The epistemological stance on the sociocultural theory is that knowledge of reality is obtained through social constructions (Walsham, 1993). In this thesis, sociocultural theory conveys knowledge as being enacted through physical interactions between students and students and their teachers drawing on their social and environmental experiences. Thus the students actively participate in construction of the world around them as they search for reality. This suggests that knowledge and reality are socially constructed as meaning and understanding derived from interaction with others. The emphasis is on the relationality between learning, development and the cultural context in which the individual is situated. Influence of the social environment on the individual’s learning activities is seen as essential because as Scribner (1985) puts it, what individuals learn is what they are bound to do. In this context culture is seen as learned rather than inherited. The focus is on the individual’s interaction. It emphasizes social participation, relationships and knowledge. It is on the basis of this background that nature and content of an individual’s mental life can hardly be understood independent of her environment or cultural context (Bakhurst, 1995). In this way, cultural and environmental factors or groups of people function together for the good of an individual (Duffy & Cunningham, 1996).

Given that interaction is the most fundamental concept in a sociocultural framework, within its broader context perspectives are seen as a product of social interactions and constructions while reality is believed to be negotiated depending on one’s context (Lantolf, 2000). Based on the intimate relationship between culture and the mind, Lantolf (2004) does not foresee an individual acting on the world without interaction with the cultural tools and others. Gitari (2006) asserts that a sociocultural framework helps educators think about learning in
cultural contexts. This is consistent with Vygotsky’s (1978) and Lave and Wenger’s (1991) assertion that the individual acquires knowledge through contacts and interactions with people as the first step, then later assimilates and internalizes this knowledge adding personal value to it. According to Vygotsky (1978) the mental transition from social to personal perception is a transformation of what one learns through a history of interactions. This then explains that the goal of a sociocultural theoretical framework is to understand the relationship between the individual and the social, cultural, historical and institutional contexts in which the individual lives (Wertsch, 2003). Kozulin (2003) argues that since sociocultural phenomena normally have links between socially organized modes of interaction and cognition, their interpretation can only be understood through a sociocultural theoretical framework.

Cole and Scribner (1974) view perspectives as linked to participation. They argue that interconnections between individuals and objects in their environment, which signifies culture as a complex whole that includes knowledge, beliefs, morals, customs and any other capabilities and habits acquired by humans as members of a society, can best be investigated through a sociocultural theoretical framework. The social constructivist perspective on the role of the individual, on the importance of meaning making and on the active role of the learner, are the elements that make the sociocultural theoretical framework most appropriate for guiding this study.

From a social learning perspective, Bandura (1986) suggests that students’ perspectives are guided by socially and culturally accepted norms. The classroom setting poses a field of communication and interaction between teachers and students, although students in the same class may perceive things differently (Goodlad, 1984). The culture of the school is viewed as the existence of an interplay between the students’ attitudes and beliefs both inside the school and in
the external environment, the cultural norms of the school and the relationships between persons in the school. The interrelatedness of these factors affect the way students perceive and behave. In addition, researchers contend that the culture of a school reflects the local culture in many ways (Rosman, Corbett & Firestone, 1988; Welch, 1989). Parker and Aggleton (2003) observe that social phenomena may not be fully examined outside the cultural contexts that give them meaning. Thus in considering the relevance of a sociocultural theoretical framework to investigating students’ perspectives on the spread and prevention of HIV/AIDS, one must also consider the role of sociocultural influences including the community and the social environment. A sociocultural theoretical framework provided a lens through which I was able to probe into perspectives and meanings as well to address the implications of the socially and culturally constructed meanings.

2.3. A Practice Framework

A practice theory, sometimes referred to as a theory of social practices (Reckwitz, 2002), explains action and social order about which individuals are often conscious in their reflections and thoughts. Practice theory as a theoretical approach to understanding social practices, attempts to explain social phenomenon in terms of individual action while taking into consideration the participants’ experiences (Postil, 2010; Rayan, 1970). A practice theoretical framework assumes that the mind is social and grows out of joint activity (Cole, 1996; Russell, 2002). Cole and Engersrtom (1993) view human activity as collective and human behaviour as originating from within the social realm. Social groups within societies are seen to manage a regulated inter-generational transmission of real and symbolic cultural reproduction (Nash, 1990). Therefore, practice-based approach focuses on real life investigations of actual practices and is concerned with people’s perspectives, perceptions and values (Bourdieu, 1977; Giddens,
Yildiz (2010) views culture and action as intertwined and influencing each other in the realm of practice, particularly in the context of performing certain acts to meet specific goals. Consistent with the practice theory, he contends that social practices are the most appropriate units of analysis to understand human perspectives and actions. This is because practices are conceived as places where agency and structure meet. Given that intelligibility of individual actions often depends on their sociocultural context, a practice framework that reconciles the social or cultural structure with the individual agency (Rouse, 2007). The framework takes into consideration the concept of human agency and social interactions. A Practice-based approach posits that perspectives and cultural practices can best be analyzed within their specific local context (Postill, 2010). Besides, knowledge gained through practice-based approaches provides a basis for reflection on the current state of affairs, trends and interventions that can bring about transformative change (Orthner, 2006).

This study assumes students’ perspectives and beliefs about cultural practices impact heavily on their attitudes and understandings about the spread and prevention of HIV/AIDS and their efforts to mitigate this spread. Orthner (2006) contends that in practice theory culture does not define people, but rather, people define culture by giving it meaning in their lives. It is for this reason that while carrying out this study, as the researcher, I was not only interested in participants’ perspectives on the spread and prevention of HIV/AIDS, but also their experiences, thus rendering the study partially phenomenological. A phenomenological approach claims that human behaviour has more meaning than is observable (Wilson, 1977). This corresponds to Bourdieu’s (1977) view that according to practice theory people are not only influenced by their social structures, but they too influence their social structures as well. Practice theory also assumes that the concept of experience is central to phenomenology, and that the social world is
natural and obvious (Nash, 1990). In this context, Bourdieu (1977) asserts that the intention of phenomenology is to make primary experiences explicit. This neatly weaves together the phenomenological and ethnographic approaches for this study given its circular relationship between people and their society, and appropriately blends the practice and socio-cultural frameworks.

While a practice framework seeks to explain the relationships that exist between human relationships and their world/environment (Reckwitz, 2002), a socio-cultural framework, focuses on the role participation plays in social interactions and culturally organized activities such as schooling and rituals, and how they influence individuals’ perspectives, explain how individual mental functioning is related to cultural, institutional and historical contexts (Chaiklin & Lave, 1993; Leontiev, 1981). A sociocultural framework does not only view learning as a cognitive process, but also examines how social, cultural, and community contexts impact people’s learning and understanding (Rogoff, 2003). This conforms to Vygotsky’s (1978) view that its social, cultural and historical environment influences the human mind. Parker’s (2000) observation that action has increasingly come to be understood as socially constructed, and Bourdieu’s (1990) assertion that practice theory views social life as a constant struggle to construct life out of the cultural resources one’s social experience offers, provides us with almost a seamless blending between practice theory and the sociocultural theory. Thus from a sociocultural perspective of learning as an interaction between individuals and their environmental contexts, Bourdieu’s (1977) practice theory and Vygotsky’s (1978) sociocultural theory neatly weave together to complementarily facilitate a comprehensive understanding of the phenomenon under study.
2.4. Appropriateness and Limitations of Sociocultural and Practice Theoretical Frameworks to Studying Social Constructs in a Ugandan Context

I consider the sociocultural and practice theoretical frameworks to be appropriate because of their inherent ability to enable one to directly address issues that surround family and society. Also, both frameworks have a mediative power between the researcher’s, the researched and the phenomenon’s cultural context. According to Vygotsky (1978) mediation refers to the part played by other significant people (such as teachers) to enhance students’ learning by selecting and shaping the learning experiences presented to them. This also involves helping students to move from one level of knowledge or understanding to another. Postill (2010) remarks that within the practice theoretical framework, social life is a constant struggle to construct a life out of the cultural resources one’s social experience offers, in the face of formidable social constraints. By living in a society structured by such constraints, and organized by the successful practices of [others], one develops predispositions to act in certain ways.

However, given that Vygotsky’s (1896-1934) sociocultural and Bourdieu’s (1977) practice theoretical frameworks were developed in early and late 20th century in Russian and French contexts respectively, studying a phenomenon such as students’ perspectives on the spread and prevention of HIV/AIDS within an African setting necessarily requires complementary framework developed by African scholars. As such, I have also drawn on perspectives from scholars such as Akwara et al. (2003), Gyekye (1987) and (Mbiti (1970). Gyekye (1987) observes that African ways of life, beliefs and values are rooted in ways of thinking relevant to their existential circumstances. Similarly, the aims, nature and characteristics of learning in the traditional context are all underpinned by this way of thinking. According to Mbiti (1970), for traditional communities such as those in Uganda, learning puts emphasis on
participation. This is what Gyekye (1987) refers to in his assertion that learning in the African context is based on communalism and involves sharing of knowledge.

2.5. **HIV/AIDS Literacy in RE/Moral Education**

Ugandan schools play a distinct role in providing HIV/AIDS information to young people. In the RE (Religious Education)/Moral Education curriculum, HIV/AIDS literacy is handled under Part 4 titled, “Approaches to Social Issues” (National Curriculum Development Center [NCDC], 2013). The term “RE/Moral Education” is used to include both the idea of moral valuing and non-moral choice making. This concept of RE/Moral Education refers to learning how to think critically in addressing evaluative, particularly moral issues, dilemmas or controversies such as those that relate to sex, marriage, family, as well as HIV/AIDS (NCDC, 2013). RE/Moral Education in Uganda’s school system has the explicit dual objective of providing formal knowledge of a religious tradition (e.g., its sources, rituals and history), and of engaging young people in a search for meaning, value and purpose in life with a focus on the religious and traditional/cultural perspectives (NCDC, 2013).

The first object aims to provide students with intellectual resources that enable them to make informed and responsible judgment about difficult matters of moral importance. The latter aims at providing students with moral socialization and moral training through nurturing in them those virtues and values that make them good people (Nord & Haynes, 1998). The subject is intended to teach students a rational approach to evaluative problems and to cultivate the ability to think logically and independently. This involves both the exploration of beliefs and values and how such beliefs and values are expressed. The subject also teaches students to learn how to question others’ and their own positions, views, attitudes, or beliefs that may be grounded in incorrect or logical reasoning. Within RE/Moral Education subject, HIV/AIDS literacy aims at
empowering students with information about HIV/AIDS transmission, how they can protect themselves from infection, and as well, skills and the means to foster and sustain behaviour that reduces HIV/AIDS risks (NCDC, 2013). Within this context of HIV/AIDS-focused RE/Moral Education learning, sociocultural and practice theoretical frameworks are used as lenses for understanding students’ perspectives on the spread and prevention of HIV/AIDS that manifested in the course of classroom conversations, which collectively enacted or initiated by the teachers.

2.6. Culture and Cultural Practices

Culture is a complex term, as it does not present a fixed meaning. Most social scientists today view culture as consisting primarily of the symbolic, ideational, and intangible aspects of human societies (Banks, Banks & McGee, 1989). Banks et al. (1989) assert that the essence of a culture is not its artifacts, tools, or other tangible cultural elements but how the members of the group interpret, use, and perceive them. It is the values, symbols, interpretations, and perspectives that distinguish one people from another (Banks, Banks & McGee, 1989). Besides, it is believed that culture organizes life and helps interpret existence (Linton, 1945).

Researchers have variously defined culture. Thus, Linton (1945) describes culture as "a configuration of learned behaviors and results of behavior whose component elements are shared and transmitted by the members of a particular society" (p. 32). Kluckhohn (1945) describes culture as:

… the total way of life of people, the social legacy the individual requires from his group, a way of thinking, feeling and believing, an abstraction from behaviour, a theory […] about the way in which a group of people […] behave, a store house of pooled learning, a set of standardized orientations to current problems, learned behaviour […] a sieve and a matrix (p. 5).
The UNESCO Mexico Declaration of 1982 describes culture as:

the whole complex of distinctive spiritual, material, intellectual and emotional features that characterize a society or social group. It includes not only the arts and letters, but also modes of life, the fundamental rights of the human being, value systems, traditions and beliefs; that it is culture that gives [a person] the ability to reflect upon him/herself. It is culture that makes us specifically human, rational beings, endowed with a critical judgment and a sense of moral commitment. It is through culture that we discern values and make choices. It is through culture that [a person] expresses him/herself, becomes aware of him/herself, recognizes his/her incompleteness, questions his/her own achievements, seeks untiringly for new meanings and creates works through which he/she transcends his/her limitations” (Rautenbach, 2011, p. 3).

This definition is broad and encompasses a wider spectrum of the multiple definitions and perspectives about culture. Kroeber and Kluckhohn (1952) describe culture as essentially consisting of traditional (i.e. historically derived and selected) ideas and their attached values. Mazrui (1986) refers to culture as “a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society” (p. 239). Yet, Bates and Plog (1990) describe culture as “a system of shared beliefs, values, customs, behaviours and artifacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning” (p. 7). Serrat (2008) views culture as a way of life through which a society manifests the totality of its beliefs, values and knowledge and tell how they interpret their environment. Spradley (1980) defines culture as the acquired knowledge people use to interpret experience and generate behaviour. Yet in broader terms Helman (1994) views culture as a set of guidelines which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or Gods, and to the natural environment. Nanda (1987) refers to culture as the patterned way of life shared by a group of people. Geertz (1973) situates culture within the framework of power and control
that allows for the exploration of inequality, particularly in relation to gender, and defines it as a set of control mechanisms for governing people’s behaviour (pp. 44-45).

From a cognitive perspective, Hofstede (1998) views culture as impacting individuals’ behaviour and therefore, mediating between societal culture and specific individual personality. Viewing culture from a cognitive perspective leads us into understanding it as shared representations that define groups, relationships and contexts, making it possible to process meanings and order information. It is on this premise that Hofstede (1994) describes culture as “the collective programing of the mind which distinguishes the members of one group from another” (p. 5). In a way, all the above descriptions denote the common elements of culture that include habits, customs, traditions, histories, and geographies; everything that connects the members of a culture together and defines them.

In this thesis I adopt Geertz’s (1966) description of culture, which denotes an “historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men [people] communicate, perpetuate, and develop their knowledge about and attitudes toward life” (p. 89). Geertz (1993) observes that humans make sense of their world based on the way they respond to the changing social and cultural influences, where culture refers to “that complex whole which includes knowledge, belief, art, morals, laws, customs and any other capabilities and habits acquired by [humans] as a member(s) of society” (Taylor, 1871, p. 1).

Cultural practices are nested within cultures, and thus people’s cultures manifest through their cultural practices. Weisinger and Salipante (2000) observe that culture is embedded in everyday and evolving practices, jointly negotiated by actors within specific contexts and constituting situated learning. They cover many aspects of daily life and influence behaviors of
individuals and entire societies. As social processes, cultural practices are used to create and maintain social control (Nanda & Warm, 2007). Broadly speaking, cultural practices are diverse and vary significantly around the world. They include a wide range of activities that encompass both religious and social practices (Nanda & Warm, 2007). They are generally norms in behaviors and standards specific to particular communities. They are important aspects of identity by which individuals describe their sense of belonging to a particular community.

Of all factors that influence human understanding of disease, perhaps none is more intoxicating than the way people think about and view cultural practices. Research reveals a dynamic relationship between perceptions and cultural practices. While specific to culture, perceptions are intrinsically linked to actions and attitudes of communities and societies (UNAIDS, 2000). Based on Gibson’s (1979) assertion that perceptions guide actions, cultural assumptions and expectations plague people’s interactions and influence the way they perceive their world as well as the way they behave. Cultural components that include symbols, rituals and values exert pressure on the worldviews or behaviour of communities, groups of people or individuals (Gyekye, 1987). Rituals for example, as collective activities anchored in culture play a pivotal role in influencing the mindset of people of a given culture (Gyekye, 1987). Geertz (1973) however explains that while culture is reflected in values, norms, and practices, it is contextual. In other words cultural practices have meaning in specific social contexts. Belief in the values embedded in them motivate members specific to that particular community to participate in them, while failure to do so, believed to breach the cultural taboos of the community, also affects those that specifically belong to a given community and culture. Thus, in relation to perspectives, culture is known to involve social beings and their distinctive ideas, beliefs, values and knowledge (UNAIDS, 2000). Characterization of culture more by
group relations than individualism, portrays perspectives as predominantly behavioural, (Weisinger & Salipante, 2000).

Williams, Parker and Turner (2007) suggest that within group contexts, people’s perspectives greatly depend on the degree to which they interact and identify with a given group. Particular cultural practices and environments that govern people’s day-to-day lives constantly frame culturally specific ways of looking at their world. Cultural practices therefore frame people’s perspectives characteristic of their given cultures. Similarly, Makgoba (1997) subscribes to this view in his assertion that people’s perspectival stances are guided by the shared values that are fundamental features of their identity and culture. Nyasani (1997) postulates that epistemological perspectives by which people know and view the world around them is a product of their unique cultural societies and cultural resources that arise from their environmental conditioning and long-lasting cultural traditions. The goal of this thesis is to enhance understanding of students’ perspectives on the spread and prevention of HIV/AIDS and the influence cultural practices exert on these perspectives.

2.7. Models/Frameworks Used in Previous Studies

Literature germane to this study reveals that a substantial amount of work has been done in relation to understanding people’s perceptions of HIV/AIDS and people’s basic HIV/AIDS transmission knowledge, accurate risk perceptions and understanding of effective precautions in relation to HIV/AIDS (Abraham et al., 1995; Aggleton, et al., 1994; Akwara et al., 2003; Heather, Antil, Kerr, & Thompson, 2007; Hurley & McGriff, 1996; Ijadunola et al., 2007; Polacek et al., 2006; Kamala & Aboud, 2006; Kolawole, 2010; Kowalewski et al., 1997; Nzioka, 2001; Omoteso, 2009; Prohaska et al., 1990; Ward et al., 2004). Theories mainly used are drawn from various disciplines such as psychology, sociology and anthropology. They include the
AIDS-risk reduction model [ARRM] (Cantania, Kengeles & Coates, 1990), the Health Belief Model [HBM] (Rosenstock et al., 1994), theory of reasoned action [TRA] (Fishbein & Ajzen, 1975) the stages of change model (Prochaska & DiClement, 1992) and the Social Cognitive Theory [SCT] (Bandura, 1977). Borrowed from the biomedical field, these are individual and behaviour change theoretical models that focus on individuals’ cognition, behaviour and interactions. UNAIDS (1999) however notes that some of these models tend to ignore the interactive relationships in the individuals’ social and cultural contexts. Kalichman (1999) observes that individual and behaviour change theories agree that the power to alter a risk-producing situation lies with the individual’s capability, social relationships, risk perceptions, attitudes, self-efficacy beliefs, intentions and outcome expectations.

Other theoretical models used in some studies relating to people’s perceptions of HIV/AIDS are social models. Social theories are deemed to offer insight into understanding issues related to cultural practices and HIV/AIDS; they include the social influence and social network models, the gender and power theory, the sociocultural and socio-ecological theories (UNAIDS, 2010). Unlike the individual behaviour change theories, the social theories aim at change at the community level. They take into consideration the social, cultural and economic dimensions of the phenomenon under study. Tavallaei and Abu-Talib, (2010) contend that social theories allow consideration of multiple perspectives where each perspective suggests a reasonable explanation about the phenomenon under study. A review of literature in this context helped me as the researcher to make an informed decision for appropriate frameworks, while identifying what theoretical models have been used in previous studies. For the bounds of this study I limit the review to only key theoretical models employed in the reviewed literature.
2.7.1. Socio-ecological Model

The socio-ecological theoretical model is premised on the assumption that the physical and social environments are integral to a socio-ecological analysis (Stokols, 1992). This is based on the belief that a phenomenon may not be fully understood independent of the individual’s personal, interpersonal, as well as the social, cultural and environmental contexts. Moore (2003) contends that individual behaviour is determined to a large extent by social environment that includes community norms, values and regulations. Kolawole (2010) successfully used the socio-ecological model of health to investigate students’ awareness and perceptions of HIV/AIDS preventive strategies. He draws on the socio-ecological model aware that culture and its structural factors play an important role in the participants’ understanding of HIV/AIDS preventive strategies. The socio-ecological model recognizes the interwoven relationship that exists between the individuals and their environment. It takes into consideration the participants’ individual attributes, which include behaviour, knowledge and skills, beliefs and values, self-efficacy and perceived norms, as well as their perceived risks.

In this context the socio-ecological model emphasizes the aspect of interdependence between the environmental conditions, the individual, community and culture, which together exert independent and joint influence on the individual (Bronfenbrenner, 1979). The socio-ecological model also takes into consideration the individual and collective roles of a group in their efforts to modify or change their behaviour. The model enables the researcher to interrogate the what, how and why of the participants’ actions (Miles & Huberman, 1994). It also calls for diverse methodologies such as questionnaire, behaviour observation and interviews, in order to effectively assess those factors that put individuals at risk of contracting HIV/AIDS. In this case, the socio-ecological model can provide a comprehensive framework for understanding the range
of social and environmental factors that have an effect on peoples’ perceptions of HIV/AIDS preventive strategies (Bronfenbrenner, 1977).

2.7.2. The Aids Risk Reduction Model

The AIDS Risk Reduction Model (ARRM) provides a framework for explaining and predicting people’s efforts to change sexual behaviour related to HIV/AIDS transmission (Cantania, Kegeles & Coates, 1990). The model posits that change is a process, and that individuals move step by step to a level of avoidance of risk to contract HIV/AIDS. The ARRM is premised on the assumption that in order to avoid disease, individuals must perceive that their sexual behaviour places them at risk of HIV/AIDS infection, that they need to make a commitment to behaviour change, and that they take action to change (Cantania et al., 1990). The model appropriately organizes the concepts involved, which include knowledge, response efficacy, perceived susceptibility to HIV/AIDS, decision-making, partner relationship and sexual behaviour. Several studies have examined people’s AIDS risk perceptions in relation to their sexual behaviour (Aggleton, et al., 1994; Akwara et al., 2003; Nzioka, 2001; Lawrence, et al., 1995).

Using the ARRM, Akwara et al. (2003) examines the association between people’s perceptions of risk of HIV/AIDS and their sexual behaviour. Although the ARRM serves as an effective construct for understanding psycho-social and psycho-educational factors that influence peoples risk perceptions and risk avoidance, it does not take into consideration the socio-cultural issues that may facilitate or hinder the individual’s efforts to change behaviour (Cantania et al., 1990). In a study such as that of Akwara et al. (2003), while it reveals an awareness of a mix of cultural beliefs and practices of over 41 ethnic groups and the diverse levels of interaction that may influence the participants’ behaviour, it does not examine participants’ perspectives on the
spread and prevention of HIV/AIDS and the impact of cultural practices on these perspectives. Sorensen et al. (1992) concurs that the model does not capture the implications of the individuals’ embeddedness in a complex and contradictory social environment. UNAIDS (1999) contends that like other individual-based theories, the ARRM pays little attention to cultural aspects. Therefore, in the context of this thesis, I argue that neglecting such complex interactions between contextual factors and individual behaviour renders the ARRM inadequate in effectively guiding a perspectival study related to the spread and prevention of HIV/AIDS and the impact of cultural practices on participants’ perspectival stances.

2.7.3. The Health Belief Model

The Health Belief Model (HBM) is a health specific social cognition model designed to explain the intentionality of individuals’ engagement in actions that put their health to risk (Ajzen, 1998). According to the HBM the individual’s likelihood to prevent him/herself from contracting HIV/AIDS depends on his/her perception of vulnerability, the consequences of contracting the disease, the precautional behaviour to engage in and the benefits of reducing the threat to contract the disease (Rosenstock, 1990). Taylor et al. (2006) observe that the model examines the context of cognitions, which act as predictors and precursors to health behaviour. The model premises that health-related behaviours are determined by the concepts of perceived susceptibility, perceived severity and perceived threat. The concept of threat is central to the HBM. Based on the belief that a strong sense of efficacy enhances human accomplishment and personal well being, Bandura (1977) adds the concept of self-efficacy in order to strengthen the explanatory power of the HBM. Self-efficacy is considered to take into account the external physical and social structures as well as the internal cognitive processes.
Abraham et al. (1995) used the HBM and the Theory of Reasoned Action [TRA] in an integrative manner to understand students’ HIV-preventive cognitions. The study specifically investigated students’ basic transmission knowledge and the correlation between their HIV-preventive intentions and their behaviours. Given that the concepts involved in the HBM mainly relate to cognition and perceptions that result from individuals’ responses to their environment, the model may be regarded as a good fit for understanding people’s perspectives. However the model’s emphasis on the concept of perceived threat tend to suggest that people are rational actors and that health behaviours can best be understood as being willfully controlled rather than being determined by combinations of circumstantial realities and individuals’ habitual, emotional, conscious and other non-rational reactions to the external world (Taylor et al., 2006). In this way, in the context of this thesis the model could not be relied upon to understand the social realities involved in understanding people’s perspectives on the spread and prevention of HIV/AIDS and the impact of cultural practices on such perspectives.

2.7.4. The Theory of Reasoned Action

The Theory of Reasoned Action (TRA) provides a framework for understanding and predicting behaviour intention (Fishbein & Ajzen, 1975, 1980). There is an inherent link between the TRA and the HBM. Although the HBM was developed much earlier, the TRA has tended to overtake it and advance its approaches (Taylor et al., 2006). Like the HBM, the TRA is premised on the assumption that behaviour is under willful control. The theory posits that a person’s behaviour is determined by his/her intention to perform the behaviour, influenced by one’s attitudes and societal norms. In this case the immediate cognitive originators of behaviour are not attitudes but the behavioural intentions (Taylor et al., 2006). The theory explains the relationship between the individual’s beliefs, attitudes, intentions and behaviour. Other concepts addressed by
the TRA include intentions, subjective norms and normative beliefs all of which are believed to take place in the mind (Ajzen & Fishbein, 1993). The theory suggests that intention is influenced by attitudes and self-efficacy, which are in turn influenced by the individual’s beliefs (Fishbein, 1994). In the TRA framework the individuals’ perceptions of what the significant others think about them also influence their behaviour. Therefore used together in a study that aims to understand students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on such perspectives, the TRA and the HBM become complementary.

While inclusion of such concepts as norms, actions and reason strengthen the appropriateness of the TRA to investigate people’s perspectives, in the context of this thesis its negation of the social nature of human actions would render it inadequate. Since action is constituted with reference to shared meanings, without social relations and interactions behaviours are rendered meaningless (Kippax & Crawford, 1993). Norms as shared expectations that signal the appropriate forms of behaviour for a group need to be jointly shared. If the model is to adequately predict what an individual will do on the basis of his/her perspectives and beliefs, then it should take into consideration the social interactions that accrue from the individual’s interactions with others who may be in a similar situation. The same also applies to change of behaviour. Kippax and Crawford (1993) contend that change cannot be examined in an individual and then aggregated to a group. This is simply because social change occurs through a large number of people who change individually in ways similar to each other. Given that the model is inherently biased towards individualistic interpretations of human behaviour, and negates the social nature of human action, in the context of this thesis, I would not consider it adequate for understanding students’ perspectives on the spread and prevention of HIV/AIDS and the influence cultural practices exert on such perspectives.
2.7.5. The Affect Heuristic Model

The Affect Heuristic theoretical framework originates in the cultural understandings and hierarchical arrangements of a particular society or social group (Douglas, 1985). Although there is a diversity of heuristic models, this thesis is concerned with the Affect Heuristic model that relates to people’s perspectives on the spread and prevention of HIV/AIDS. In this context, “affect” means the specific quality of “goodness” or “badness”. The Affect Heuristic theoretical framework describes the importance of affect in guiding judgments and decisions, experienced as a feeling state and distinguishing between positive and negative stimulus (Slovic, Finucane, Peters & MacGregor, 2004). The model provides a framework for understanding people’s perceptions of risk and the way feelings about a risky object, event or person shape an individual’s decision either to negate the risk or to take it on (Fischhoff et al., 1978). This is because the motivation to engage in risky behaviours is shaped by both feelings and emotions an individual holds towards the foreseen risk. The model is therefore seen as reason-based since a decision is normally reached by focusing on reasons that justify the selection of one option over the other (Shafir, Simonson, & Tversky, 1993). Zajonc (1980) contends that affective reactions to stimuli are often the very first reactions that occur automatically and subsequently guiding information processing and judgment. Besides, the model emphasizes reliance on feelings and emotions as a quicker, easier and more efficient way to navigate in a complex, uncertain and sometimes dangerous world sea.

The Affect Heuristic model is premised on the social constructionist assumption that risk can only be experienced in one’s specific location in a particular socio-cultural context (Lupton, 1999). However, the understanding and perspective always differs from one individual to another depending on the context in which they are located. Ward et al. (2004) draw on Kowalewski et
al. (1997) and Prohaska et al. (1990) and to use the heuristics model (drawn from the discipline of psychology) to understand risk perception. Ward et al. (2004) investigated older adults’ perceptions of HIV/AIDS risk guided by the Heuristic model in order to establish whether informed awareness of risk influences participants’ adoption of preventive measures. Given that the model examines perceptions of risk, in relation to HIV/AIDS, it helps to understand how such constructs as sexual practices, moral evaluation of people with HIV/AIDS, emotional response to HIV/AIDS, protective actions in response to HIV/AIDS, worry about one’s health and feelings of shame associated with having HIV/AIDS are connected (Prohaska et al., 1990). Prohaska et al. (1990) further observe that the heuristic model, based on diverse factors such as social class, sex, race/ethnicity, education and sexual orientation, show how different people experience and understand risk.

Although the model demonstrates a clear understanding of how socio-demographic factors shape peoples’ perceptions of HIV/AIDS, its concentration in the psychological realm in areas of feelings and emotions render it a mismatch model for investigating students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives. Besides, the important interplay between feelings and cognition cannot guarantee appropriate decision making for one’s behaviour in all circumstances and this could prove problematic in an effort to understand why people behave the way they do. Based on this argument therefore, I found the model informative but not adequate to investigate students’ perspectives on the spread of HIV/AIDS and prevention of HIV/AIDS and the influence of cultural practices on these perspectives.
The Rapid Assessment Response Model was revised from a primary quick approach for data collection to a Rapid Assessment Response Model in the mid-1980s alongside other evaluation models (Bantley at al., 1988; Scrimshaw, Carballo, Ramos, & Blair, 1991). Unlike other theoretical models, the Rapid Assessment Response Model serves a dual purpose in a study. Although used predominantly as a data collection process, the Rapid Assessment Model also provides a framework for a quick understanding of the phenomenon in question (Trotter II, 1999). The model is premised on the assumptions of pragmatism, which posits that choice of approach to a study is directly linked to the purpose and nature of the research question (Creswell, 2003). This is in consonance with the view that choice of methodological approach does not depend on the philosophical commitment, but on a belief of a theoretical framework and methodology deemed best suitable for the study (Darlington & Scott, 2002). Thus the model provides a framework for understanding what supplementary methods and inclusions can be used to ensure increased triangulation or quantitative confirmation of the different data sets collected.

The model is meant to carry out comprehensive assessment of a phenomenon (Darlington & Scott, 2002). It focuses on the characteristics of the phenomenon, groups of the population that are affected, key settings and contexts, health and risk behaviour as well as social consequences. On basis of data collected, the model provides a means of quick response with appropriate program measures and interventions through identification of existing resources and opportunities. The model takes into consideration such factors as community involvement, a holistic and systematic approach to information gathering, multidisciplinary and interactive methods, and flexible responses from the participants, and emphasis on communication and listening. Key to the Rapid Assessment Response model is the structural, social and cultural
contexts within which specific groups of people live and the influence these contexts have on their understandings of risk and vulnerability (Birks, Powell, Thomas, Medard, Roggeveen & Hatfield, 2011). The model calls for high-level target population participation in the examination of a phenomenon (Trotter II, Needle, Goosby, Bates, & Singer, 2001).

Sabone, Ntsayage, Brown, Seboni, Mogobe, and Sebego (2007) draw on the Rapid Assessment Process [RAP] as a methodological and theoretical framework to both understand and to investigate students’ perceptions of the effectiveness of two HIV/AIDS programs in a University in Botswana. As the name Rapid Assessment model suggests, the researchers begun by considering all aspects of a local situation that are likely to impact students’ perceptions of the effectiveness of the programs, but quickly shifted to focus on only the most important elements and their relationships to each other from the participants’ perspectives. Such factors included the ABC (Abstain, be faithful, condomize) messages, campus environment, and lack of entertainment and students’ perceptions of HIV/AIDS.

Although these factors are social and are by all means inherently influenced by participants’ socio-cultural backgrounds, and in addition would be very instrumental in forging a creative methodological design, as the researcher, in the context of this thesis, I did not consider the model most appropriate for investigating students’ perspectives on the spread and prevention of HIV/AIDS and the influence cultural practices exert on these perspectives. This is because the model is predominantly meant for complementary data collection. The question of students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on such perspectives has not been previously investigated and therefore does not call for supplementary data for understanding what would be emergent issues.
2.8. Summary

The reviewed health and behaviour models/frameworks have been successfully used to variously examine how people perceive HIV/AIDS and their risks of susceptibility to HIV/AIDS. The models provide useful linkages between beliefs and behavioural intentions. Azjen (1991) asserts that behavioural intentions are influenced by attitudes. Although each model or theory provides a different framework for understanding people’s risk perceptions and health behaviours, the constructs in each model are fairly similar. Major constructs of health behaviour models/frameworks include: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, internal and external cues, health motivation and self-efficacy (Rosenstock, 1990). Others include behavioural beliefs and attitudes, subjective norms and behavioural intentions as well as perceived behavioural control (Azjen, 1991). These models could be useful in investigating people’s perspectives as long as they are situation specific and that attitude and intention measures are employed to specify congruent target, context and time, and as well, that interactions between persons and situations are emphasized. While these models are useful in explaining HIV/AIDS risk behaviours, they need to be conceptualized and presented within the appropriate sociocultural contexts (Dowsett’s (1999).

Therefore, for such studies as this one, which involves proximity to a context promoting physical and cultural wellbeing, combination of both health/behavioural and socio-cultural theoretical models could best provide a fuller understanding of the phenomena under study. This is because culture plays a major role in shaping people’s construction of the meaning of illness and disease, which they are trying to perceive and design interventions. If individuals do not perceive themselves to be at risk, which appears to be the case with many young people, application of these models/frameworks becomes questionable.
Also, some of the reviewed health behaviour models/frameworks do not consider individuals’ socialization within the family and community. The family is the earliest context where the individual learns and experiences day-to-day beliefs and practices. People begin learning right from birth, and this learning consists of the construction of ideas that define them as belonging to a particular cultural group. Gradually, as they grow into youthful adolescence, they begin to shift from accepting cultural ideals indisputably and to look to peers for information and advice. They then question the originally held ideals and begin constructing new perspectives. Henceforth, their ideas continue to shift from the ideals as they advance in age, understanding, and broadening of environmental interaction. The value of communitarianism is evident in the contextual nature of African people’s identity. As the African proverb stipulates, “Go the way that many people go; if you go alone, you will have reason to lament” (Davidson, 1969, p.31), the idea of security and its value depends on personal identification with and within the community. Thus, a study targeting perspectives and the cultural influence on these perspectives may need to focus on this cultural dimension that places precedence on the community rather than on the individual since this may play a key role in influencing individuals’ perspectives.

Thus, in assessing a complex sociocultural issue like perspectives on the spread and prevention of HIV/AIDS and the cultural practices that influence them, it is essential to consider the cultural aspect of family and community socialization. The issue of identity includes family relationships and environmental factors. In this study, manifestations of students’ perspectives are searched for in a specific social classroom-learning context. The learning activity involves such concepts as guided construction of knowledge, language use to create joint knowledge and understanding, the students’ experiences and the joint school and home environments or contexts
in which the students live and form their experiences. Within the sociocultural framework, knowledge exists as a social entity and the essence of human knowledge is that it is shared (Mercer, 1995). Mercer further explains that individually and collectively we use language to transform experience into knowledge and understanding.

Although available literature reveals that several studies have been carried out in relation to people’s perceptions of HIV/AIDS related risks and the role of cultural practices, literature on students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives continues to be scarce. The area continues to be under-researched and poorly understood. Unless a better and clear understanding of students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices is attained, enacting HIV/AIDS literacy that can effect transformative change will remain a challenge.

This study seeks to answer the questions: What are Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS? And, What core cultural practices have the greatest influence on Ugandan high school/Form 5 students’ understanding of the spread and prevention of HIV/AIDS? Overall, for each of the models reviewed, key aspects of them are embedded in both the sociocultural and practice frameworks. They offer important and deeper insights into how people deploy perspectives to understand and interpret social phenomena around them. Moreover, these models are encompassed within the larger social constructivist-socio-cultural-practice theoretical framework. Thus, in this study, I largely employed sociocultural and practice theories to understand and interpret the Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS. Hence, in the ensuing discussion, I will draw on appropriate aspects of these models to elucidate some of the study’s results.
Chapter Three: Methodology

If you visualize a continuum with qualitative research anchored at one pole and quantitative research anchored at the other, mixed methods research covers the large set of points in the middle area; … categorically, mixed methods research sits in a new third chair, with qualitative research sitting on the left side and quantitative research sitting on the right side (Johnson & Onwuegbuzie, 2004).

This thesis investigated Ugandan high school students’ perspectives on the spread and prevention of HIV/AIDS and the influence cultural practices have on the students’ perspectives. As well the thesis reports on the implications of these on high school curriculum and instruction. The primary research questions addressed in this thesis are: 1. What are Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS? 2. What core cultural practices have the greatest influence on Ugandan high school/Form 5 students’ understanding of the spread and prevention of HIV/AIDS? 3. How might the study’s findings inform policy and practice, theory, and research and methodology?

Based on the dynamic relationship between people’s perspectives and sociocultural practices, a combination of the socio-cultural and practice theory (Bourdieu, 1977; Giddens, 1979; Vygotsky, 1987) framed the research design of this inquiry. Out of these perspectives, a creatively designed approach was constructed, techniques selected to provoke and characterize students’ perspectives and an analytical framework drawn for how to make sense of the data obtained. Thus, in this chapter I present the research design followed by a description of the study context and participants. I then detail the data collection and analysis methods, trustworthiness and credibility of the study and conclude with ethical considerations.
3.1. **Research Design**

This is largely an interpretive case study (Merriam, 1998) that used a mixed methods design (Tashakkori & Teddlie, 2003) by employing both quantitative (Likert scale questionnaire) and qualitative (phenomenological & ethnographic – interview and classroom observation) methods (Creswell, 2003). The research problem and questions of interest played a central role in the process of selecting this research design. The mixed methods design recognizes the importance of both the natural and physical world as well as the emergent social and psychological world that includes language, culture, human institutions and subjective thoughts (Johnson & Onwuegbuzie, 2004). Used within a combination of the practice and sociocultural frameworks, it views knowledge as being both constructed and based on the reality of the world the participants experience and live in. Its allowance for an eclectic movement between different methodological approaches was particularly useful as it acknowledges that observation, experience and lesson instruction are all useful ways of gaining understanding of people and their world (Tashakkori & Teddlie, 2003). Based on the research questions, it necessitated a research design in which some stage in the research process would not only draw on the qualitative and quantitative data collection methods, but also integrate the results in order to understand the research problem more comprehensively (Creswell, 2002).

Students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these students’ perspectives is a multifaceted issue that involves culture known to be critical to social order and stability, and HIV/AIDS known to be a complicated global social problem. By themselves, neither the quantitative nor the qualitative methods could sufficiently capture the details and different perspectives of such a diverse and complex issue (Clark & Creswell, 2011). When used in combination, quantitative and qualitative methods
complemented each other to construct a holistic understanding (Creswell, 2003) of students’ perspectives on the spread and prevention of HIV/AIDS and cultural practices that influence them. In this way, the mixed design also served the purposes of complementarity and triangulation as it was helpful in having the qualitative data explain the quantitative data and provided a basis for triangulating the findings by corroborating results obtained through different methods (Johnson & Onwuegbuzie, 2004).

Within this design, the survey questionnaire served as a stimulus to evoke students’ perspectives on the spread and prevention of HIV/AIDS, which were further interrogated through use of qualitative methods during HIV/AIDS-focused lessons. The same questionnaire was re-administered after HIV/AIDS-focused lessons to check for any changes in students’ perspectives. A quantitative framework views the world as quantifiable, computable and measurable (Myres, 2009; Paly 2003) and human behaviour as regular and predictable (Golafshani, 2003), hence its appropriateness in measuring the students’ knowledge levels and determining what views they held. Thus in investigating social phenomena such as the students’ perspectives and the spread and prevention of HIV/AIDS, a quantitative questionnaire offered a window into students’ perspectives.

On the other hand, qualitative methods that included observations of students in a classroom context and focus group discussions were meant to facilitate an in-depth understanding of the problem/phenomenon through the participants’ voices consistent with the contextual and interpersonal nature of the issue under study (Yin, 2009). Phenomenological methods were key in uncovering participants’ meanings of the complexity of the spread and prevention of HIV/AIDS, and the cultural practice-related dynamics that impact student perspectives, which manifested during observation of the HIV/AIDS-focused lessons and focus
group discussions. Fundamental to the interpretivist assumption and consistent with the
sociocultural framework, is the belief that knowledge comes from human experiences and is
gained through interaction and social constructions such as language and shared meanings within
naturalistic settings of the participants (Bruner, 1986; Denzin & Lincoln, 1994; Schwandt, 1994;
Palys, 2003).

Phenomenological concerns are often researched using qualitative methods to explore the
intentional relationship between persons and situations, and to disclose the essence of meaning
immanent in human lived experiences through reflective interpretation (van Manen, 1990). In
other words, it seeks to understand participants’ perspectives as they might have experienced or
lived with those in experience and understood the phenomenon (Giorgi, 1985). On the other
hand, the ethnographic perspective aimed to understand the meanings participants attach to their
perspectival knowledge, behaviour and activities (Germain, 1993). Ideally, the ethnographic
perspective emphasizes the relationship between culture and behaviour (Goetz & LeCompte,
1984), which was a major focus in investigating students’ perspectives on the spread and
prevention of HIV/AIDS and the cultural practices that influence them. However, each approach
brings its own perspective to the study and sheds distinctive light on the problem (Peterson &
Spencer, 1993).

Given that individuals’ knowledge of their perceived world can only be understood
through careful use of interpretive procedures, the qualitative philosophical framework dictates
that in order to employ the phenomenological approach to investigate a study, the research
should be interpretivist, related to a social phenomenon and without existing theory (Carson, et
al., 2001; Patton, 1990). The question under study among other things also seeks to understand
students’ experiences and their interactions and actions that result from these experiences.
However, this study only employed phenomenological methods that were deemed appropriate for eliciting and interpreting the students’ perspectives.

3.2. **Context of the Study**

The geographical location of this study was the Central Region of Uganda, selected because of the high prevalence of HIV/AIDS in the area (UNAIDS, 2010) and the need to incorporate in the study students from a wide range of cultural backgrounds. The location and specific sites as well as the participants were purposefully selected in the view that they are capable of providing important information that may not be easily obtainable elsewhere (Patton, 1990). This is because a purposefully selected study site does not only enable the researcher to achieve results representative of a purposefully selected population, but also allows the researcher to capture the heterogeneity of the selected participants (Maxwell, 1998). Patton (1990) contends that selection of study sites cannot be done in isolation from the study participants, feasibility of data collection and analysis, validity concerns, as well as the conceptual framework of the study. The region has a diverse ethnic population mix. Although the local ethnic group (Baganda) makes up over 60% of the region’s population (Statistics, U. B. O., 2012), the presence of other ethnic groups of 40% (that include Bagishu, Banyankole, Luo, Madi, etc) could not be underestimated. Seven high schools were carefully selected to represent the different high schools in the region and a continuum of ethnic diversity among students. Based on three geographical settings two schools were urban, two semi urban and three rural.

For purposes of this thesis, I describe urban schools as those located within a radius of 5 kilometers from the urban center, in areas with high population density, with all basic amenities for a higher standard of living and paved roads. Schools in the semi-urban category are those located 10-20 kilometers from the urban centers, in areas with basic facilities, reasonable
standards of living, and are generally well connected to their nearest local urban centers with paved roads. Schools in the rural category are located between 35-50 kilometers from the urban centers, in predominantly agricultural areas, with little facilities, low standards of living, unpaved roads and limited means of transportation.

For easy identification, privacy and confidentiality I gave schools code numbers and pseudonyms. While the code numbers were used for easy identification during the fieldwork process, pseudonyms made it easier to characterize them during the writing process. As indicated in Chapter 4, under Section 4.1 computation of Analysis Of Variance (ANOVA) test indicated that despite the different school locations (urban, rural semi-rural), there were no statistical differences between mean scores of these schools, since no school student populations were strictly urban or rural.

Although this study did not focus on gender differences among the participating students, the schools were well spread out to include schools for girls only, boys only and those mixed with both girls and boys. They were: 1). Buddu Secondary School - rural/girls only (n=12), Busujju Secondary School - semi-urban/mixed with more urban population (n=17; 3). Busiro Secondary Schools - urban/mixed (n=36), 4). Kyaggwe Secondary School - urban/boys only (n=88), 5). Kyaddondo Secondary School - semi-urban/mixed, with more rural population (n=29), 6). Buvuma Secondary Schools - rural mixed (n=7) and 7). Mawokota Secondary School - rural/mixed (n=9).

3.3. Study Participants

Phenomenological approaches maintain that participants are selected on the basis of their knowledge and experiences of the phenomenon being studied (Agar, 1983; Leinger, 1985; Spradley, 1979). A purposeful sample of 198 high school/Form 5 students was selected to
participate in the study. Study eligibility criteria consisted of students in Form 5 (A’ Level), aged between 17 and 19 years, enrolled in the RE/Moral education class. This age cohort was considered particularly appropriate. They are capable of engaging in conversation with adults; known for having increased independence and a more realistic sense of themselves as adults; and characteristically capable of making independent decisions, acting independently, relying on themselves; they are also capable of refining and clarifying their values and seeing the bigger societal picture (Rice & Dolgin, 2005). Moreover, they understand cause, effect and consequences and are capable of extending their vision beyond their immediate community (Hardy & Zabin, 1991). Developmentally, they think logically and concretely, with a focus on the present and a growing awareness on the future (Rice & Dolgin, 2005). In addition to these characteristics, their intricate connection to the social issue being investigated (Simons, 1980; Stake, 1995; Yin, 1984) and their ability to articulate their opinions and attitudes make these students at the senior level of high school the ideal profile for this research. The study was limited to a small number of schools and participants in the region because of the need to grasp an in-depth understanding of the students’ perspectives. Besides, the central region is known to have high prevalence of HIV/AIDS.

3.4. Methods

Interpretive studies involve using issues, language and approaches to research, which empower the participants, recognize their voices, honour their individual differences and position both the researcher’s and the participants’ views in a historical perspective (Creswell, at al., 2006). Phenomenological and ethnographic approaches present multiple strategies for data collection (Brewer, 2000; Hammersley & Atkinson, 1995). In this way, I drew on different data sources that enabled me to triangulate findings and interpretations (Hammersley & Atkinson,
The use of multiple methods of data collection facilitates a relationship between the researcher and the participants and provides a deep insight into the complex world of the participants’ experiences from their point of view (Schwandt, 1994). It also allows more personal and in-depth analytical description of the participants’ views that recreate the shared beliefs, practices, knowledge and behaviours (Goetz & LeCompte, 1984). Given that the primary source of data were the individuals being studied, such methods as survey questionnaire, HIV/AIDS-focused moral education class discussion, participant observation, and focus group discussions were used to generate rich and detailed data, to understand the meanings participants assign to the phenomenon and to elucidate the factors that underlay participants’ thoughts and behaviours in relation to the phenomenon (Myers, 2009).

3.4.1. Questionnaire

Quantitative data were collected through use of a questionnaire. A questionnaire is a data collection method that asks participants to give written or verbal responses to a written set of questions (Parahoo, 2006). The data source was a 37-item questionnaire (see Appendix 2) adopted from (Balogun et al., 2010). I found the questions to be appropriate for stimulating students’ understandings of the spread and prevention of HIV/AIDS. The items were designed to obtain students’ opinions about the spread and prevention of HIV/AIDS. Also, the items had been constructed in English language and were positively and negatively worded. This was a specially validated True/False HIV knowledge questionnaire to which I applied a Likert scale with eleven different response options ranging from strongly disagree to strongly agree.

According to Parahoo (2006) a Likert type questionnaire comprises of statements that the researcher considers to represent the concept being measured without going through the validation process again. Participants assigned each statement a rating number between -5
(where -5 meant strongly disagree) and +5 (where +5 meant strongly agree) depending on the degree of agreement. Zero stood at the center of the Likert scale and meant that the participant sometimes agreed and at other times disagreed. Participants completed the questionnaire prior to and after the HIV/AIDS-focused moral education lesson for 25 to 30 minutes outside the classroom routine. Participants’ questionnaire responses were also used to determine the factors that underlay their opinions about the spread and prevention of HIV/AIDS.

Perspectives are better detected based on knowledge questions. However, True/False responses have a higher degree of guesswork (50%) and are not sensitive to a variety of perspectives (Peşman & Eryılmaz, 2010; Urban-Woldron (n.d.). Peşman and Eryılmaz’s (2010) suggest that when a questionnaire is designed to elicit students’ perspectives, stretching the scale enables the researcher to detect perspectives that could not have been detected on a true/false questionnaire. Thus, applying a likert scale to knowledge based items can elicit a wider range of perspectives (Peşman & Eryılmaz (2010; Urban-Woldron (n.d.). Given that I was interested in students’ perspectives, and not in the truthfulness or falsity of the items, a likert scale served this purpose whereby I used this instrument as a stimulus to the perspectives that the participating students applied in understanding the spread and prevention of HIV/AIDS. Therefore, in this study, the instrument was only used for purposes of detecting perspectives students held through Principle Component Analysis (PCA) and interrogated in details through qualitative methods.

3.4.2. Classroom Discussion

Critical to this thesis was the acquiring of verbal data from the students about their understandings of the spread and prevention of HIV/AIDS, of the influencing cultural practices and of their world. It was assumed that student perspectives on the spread and prevention of HIV/AIDS and the influencing cultural practices are contingent on the way they understand
issues that arise during HIV/AIDS-focused lessons. In the context of this thesis, HIV/AIDS-focused moral education lessons were meant to provide students with an understanding of how HIV/AIDS is spread and prevented from a moral perspective. Usually information is drawn from scientific sources and sociocultural practices with the hope of influencing the way they understand and interpret HIV/AIDS related information and knowledge. Li (1999) observes that students’ attitudes, roles, expectations, cultural values and knowledge as well as shared beliefs influence what they perceive and how they perceive. Since teaching and learning are the heart of a school, the HIV/AIDS-focused lesson instruction and discussions provided the most ideal context in which students’ diverse perspectives could manifest and be tapped. This was also in consideration of the fact that diverse mixture of different ethnic groups within the same classroom alone was not without influence on students’ understandings of the spread and prevention of HIV/AIDS and the impact of cultural practices on these understandings.

My technique for classroom discussion draws on Tharp and Gallimore’s (1988) notion of instructional conversation. According to Tharp and Gallimore (1988) classroom discussion is a teacher-facilitated discussion, designed to maximize student participation and learning through assistance by both peers and the teacher. A number of studies reveal that researchers draw on class discussions as part of a social meaning making process (Green, 1983; Tharp & Gallimore, 1988). From a perspective that values the notion of shared identity, perspectives and shared meanings, the HIV/AIDS-focused moral education lesson was a reliable means of eliciting students’ thoughts within the classroom context and obtaining a rich source of data on a complex topic (Tuckett & Stewart, 2004).

Within a sociocultural framework, the assumption is that an understanding of one’s world is not developed in isolation, but through interaction with others (Firestone, 1987; Howe, 1985;
Paly, 2003; Smith, 1984). As a researcher I was not only interested in what students thought, but also in how they thought and why they thought the way they did. I was also interested in how their perspectives on the spread and prevention of HIV/AIDS were impacted by their cultural practices. Thus, my interest in the social context of collective understandings was the basis for use of HIV/AIDS-focused moral education class discussions. This is in agreement with Lindlof and Taylor’s (2002) view that group discussion enables a researcher to come up with data that would be less accessible without interaction in a group setting. Like any other group discussion, the HIV/AIDS-focused moral education lesson generated information on collective views and offered opportunity for individual participants to voice understandings of their experiences collectively. This is consistent with Brewer’s (2000) assertion that this kind of ethnographic approach is used to permit access to people’s social meanings and activities, and to allow the researcher close association with the participants’ within their social and natural setting.

In the HIV/AIDS-focused moral education lessons, the topic of study was “Sex education”, which falls under Section A: Sex, marriage and family of RE/Moral education curriculum. Although all schools covered sex education in the second term of Form 5, the timetable differed from one school to another. While some schools covered sex education early in the term, others had it later as indicated in the data collection schedule Table 1. Class periods were double lasting 90-minutes. Consequently, the lessons did not differ significantly from the everyday lessons in the school program. I made two sets of observation in each HIV/AIDS-focused moral education class for a total of three hours. Overall, I had 21 hours of class observation across the seven schools of study.

Given that interaction is key to successful class discussion, I co-facilitated classroom discussion with the class teacher and tried as much as possible to keep it natural. HIV/AIDS-
focused moral education lessons were conducted in English language, which is the medium of instruction in Ugandan schools. The class teacher and I also ensured that all students had an opportunity to participate actively in the discussion. We often started with what students knew and used the information to propel the conversation and to draw information from them. What one participant said ignited others’ responses and any participant was free to lead the conversation.

The teacher and I as a researcher made sure that the conversation remained focused. The HIV/AIDS-focused moral education class discussions comprised of the participants who were classmates in the same school, enrolled in the same subject and of the same age group, but not separated by gender. This was in consonance with Morgan’s (1988) recommendation that in order to engage participants in the discussion fully and successfully, groups should be homogeneous. The fact that participants already knew each other had the additional advantage that they interacted freely and were capable of challenging each other’s views. Thus participants’ shared experiences and familiarity with each other made it possible for them to interact and challenge each other more easily and comfortably during class discussions.

3.4.3. Participant Observation

Since data collection in this thesis was meant to capture the social meanings and ordinary activities of the participants in their natural settings, commonly referred to as the field, participant observation was considered the most appropriate technique. Myers (1999) asserts that a participant observation technique pays attention to the contextual conditions of the study. In addition, participant observation enables the researcher to gain perspective on human behaviour within a naturalistic setting (Denzin & Lincoln, 1994). Participant observation was particularly useful, since it enabled me to capture all components of non-verbal communication within the
study context, which were an integral part of the participants’ sociocultural environment (Denzin & Lincoln, 2003). This is consistent with Spradley’s (1980) view that what participants believe, understand and undertake cannot be detached from their sociocultural context. In this way, participant observation provided opportunity to take into account the expressed participants’ beliefs and actions within the context in which they were enacted (Spradley, 1980). As a participant observer, my role comprised of actions that included observing, listening, asking questions, audio recording, writing field notes and taking care of social relations in the different environments. It is these activities together that culminate into a detailed description of the environment where the study took place (Hammersley & Atkinson, 1995; Spradley, 1979).

During the observation process within the normal classroom setting, I focused on students’ interpersonal interactions and narratives with the aim of gaining meaning about each situation.

3.4.4. Focus Group Interview Discussions

Being a largely qualitative study, I aimed at collecting rich and detailed information (Kitzinger, 1994) about the participants’ experiences, feelings, thoughts, understandings, perceptions and impressions about the spread and prevention of HIV/AIDS. Focus group discussions are a means of collecting data in one go from several people who usually share common experiences that concentrates on their shared meanings. They are valuable for obtaining in-depth understandings of numerous interpretations of research participants of a particular issue (Morgan, 1997). Conradson (2005) observes that focus group interview discussions are particularly appropriate “for exploring issues where complex patterns of behaviour are expressed and diverse views held” (p. 131). It was in this spirit that I held focus group discussions with students in all the participating schools. As with the HIV/AIDS-focused moral education class, focus group interview discussions were also conducted in English language within the school.
In this thesis, focus group interview discussions were complementary and were intended to provide additional in-depth insights into the participants’ perspectives since I did not know them (Stewart et al. 2007; Morgan, 1997). The idea behind was to explore participating students’ thoughts about the spread and prevention of HIV/AIDS and to assess if they ever changed after the HIV/AIDS-focused moral education class experience. Also, they were meant to tap into the participating students’ different forms of communication that they use in the day-to-day interactions that include jokes, teasing, metaphors and arguments (Kitzinger, 1995). Generally, focus group interview discussions were held within the respective school premises either in the classrooms out of class time, or in the school compound, in most cases under tree shades.

<table>
<thead>
<tr>
<th>School Pseudonym</th>
<th>Questionnaires before lessons Date/Time</th>
<th>Method, dates and time</th>
<th>Focus group discussions Date/Time</th>
<th>Questionnaires after lessons Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddu S.S.</td>
<td>Sept 6, 2012 (25-30 minutes)</td>
<td>Sept 6 / Sept 13, 2012 (3 hours)</td>
<td>Sept 13, 2012 1½ hours</td>
<td>-</td>
</tr>
<tr>
<td>Mawokota S.S.</td>
<td>Oct 29, 2012 (25-30 minutes)</td>
<td>Oct 29 / Nov 2, 2012 (3 hours)</td>
<td>Nov 2, 2012 1½ hours</td>
<td>-</td>
</tr>
</tbody>
</table>
3.5. **Trustworthiness and Credibility of the Data**

From a qualitative perspective, trustworthiness and credibility is derived from the rigorous techniques and methods for data collection, which, from a quantitative perspective is validity. Trustworthiness is to support the argument that the research findings are credible and worth (Lincoln & Guba, 1985, p.290). The process denotes a possibility for triangulation of the findings during data analysis.

In order to address the question of credibility, in designing the research procedure, I deliberately included the concurrent triangulation design (Creswell, 2003), which generally involves concurrent, but separate collection and analysis of quantitative and qualitative data. This was done to enable me best understand the study problem. I employed multiple data collection techniques. My intention here was to generate four data sets, two quantitative and two qualitative. Although multiple data collection techniques in themselves do not meet the technical definition of ‘triangulation’ (Lincoln & Guba, 1985), they provided a richer, more multilayered and more credible data corpus than one technique would have generated. The HIV/AIDS-focused moral education class, class observation and focus group interview discussions all served as a way of corroborating the quantitatively identified themes, interpretations and any derived meanings, assertions or claims. After transforming the quantitative data into themes, during interpretation and discussion, I merged all the four data sets as I compared, validated, confirmed, and corroborated quantitative results with qualitative findings. This is consistent with Creswell’s (2003) view that the researcher attempts to merge the data sets typically by transforming data to facilitate integrating the different data sets, and by bringing the separate results together in the interpretation during further analysis.

During the entire fieldwork and particularly during observations, I endeavoured to
understand and report participants’ viewpoints, thoughts, intentions and experiences as accurately as possible. In this case, member checks, interpreted and used by researchers as verification of overall results with the participants was not called for. Since results were synthesized, decontextualized and abstracted from and across individual participants, there was no reason for individuals to be able to recognize themselves or their particular verbatim expressions and experiences (Morse, 1998). Besides, evidence indicates that defining verification in terms of whether or not the participants of the study judge the analysis to be correct may be more of a threat to credibility than would be imagined (Guba & Lincoln, 1981; Hammersley, 1992; Morse, 1998).

Under this premise I ensured objectivity as participants expressed their views and any other information. Also use of a combination of theories, the practice theory and sociocultural theory, contributed to ensuring validity and credibility in as far as the data obtained fitted the theoretical explanation that guided the study. Given that it is not possible to specify procedures for systematically eliminating bias (Norris, 1997), as the researcher, I was constantly alert about my own beliefs. This necessitated me to remain open minded, self-critical and detached. Norris (1997) suggests that research requires detachment from one self, a willingness to look at the self and the way it influences the quality of data and reports” (p.173). All these factors interacted to guide me appropriately to ensure non-bias and that data was interpreted to contribute accurately to the existing body of knowledge (Morse, Barret, Maya, Oslon & Spiers, 2002).

3.6. Data Analysis

In order to analyze the data of this study, I creatively employed an integrated analytic mixed-method framework (Caracelli & Green, 1993; Onwuegbuzie & Combs, 2011), which involved the use of both quantitative and qualitative analytical techniques. Evidence indicates
that a mixed-method analytic framework can be used effectively and at times creatively to integrate quantitative and qualitative data during data analysis, interpretation and reporting (Hall, Hord, & Griffin, 1980; Louis, 1981; Schermerhorn, Williams, & Dickison, 1982; Talmage & Rasher, 1981). Onwuegbuzie and Combs (2011) observe that an integrative analytic mixed-method framework involves some form of crossover analysis, where quantitative data is converted into qualitative data. The purpose was to achieve triangulation and corroboration of results from different methods (Greene, Caracelli, & Graham, 1989). In addition, the framework also served for complementarity and clarification of the results (Caracelli & Green, 1993).

The process involved data reduction, transformation, correlation, comparison and integration.

Data reduction aimed at reducing the dimensionality of the quantitative data via Principal Component Analysis, descriptive statistics and cluster interpretation (Onwuegbuzie & Combs, 2011). Two sets of quantitative data (responses to survey questionnaire before and after HIV/AIDS-focused lessons) were analyzed using Principal Component analysis to look at possible perspectives that underpin participating students’ understandings of the spread and prevention of HIV/AIDS. Data transformation involved conversion of the quantitative data into qualitative data. Caracelli and Green (1993) suggest that one means by which quantitative and qualitative data can be integrated during analysis is to transform one data type to the other to allow for statistical or thematic analysis of both data types. In this study, I transformed factors extracted through Principal Component analysis from the initial quantitative data set into qualitative themes. Subsequently, I used these themes (perspectives) to code the qualitative data and to interrogate them in details.

The motive to elicit and analyze data obtained after HIV/AIDS-focused lessons was to determine if there were any changes in the perspectives that underpin students’ understandings of
the spread and prevention of HIV/AIDS. Data correlation occurred at the coding level. After extracting the factors/perspectives by use of Principal Component analysis, I characterized them and organized them into themes. Based on these themes, I then used the coding method to make sense of the qualitative data by searching forth and back for manifestations of the perspectives in the qualitative data that was obtained through the HIV/AIDS-focused RE/Moral education class, observation and focus group interview/discussions. This process also constituted the data integration phase as it amalgamated the quantitative and qualitative data.

3.7. Ethical Considerations

Of primary concern was the participants’ awareness about what was expected to ensue right at the inception of the study and what effects would accrue if any. In respect to the participants’ rights and privacy, I obtained approval for this study from the University of British Columbia Behavioural Research Ethics Board (BREB) as indicated in the preface (Certificate Number H12-01028). Also, the Uganda National Council for Science and Technology responsible for research in Uganda approved of the study (Reference Number: SS 2930). This was particularly important as it officially granted me permission to do the study in Uganda. Before entering into fieldwork and engaging with the participants, I made pre-visits to the schools involved in the study to establish initial contact with the principals and to obtain official permission at local level to access the schools and to interact with the students within the school boundaries. Prior to commencement of data collection, and in compliance with the ethics regulations, as a researcher I ensured the following:

i) I explained to the students fully the purpose of the study and the uses of their contributions
ii) All students who agreed to participate in the study gave their consent/assent by signing (see copies of these in Appendix 2).

iii) Parents of students under 18 consented on behalf of their children by signing (see copy in Appendix 3).

iv) Courtesy was exercised while conducting the questionnaires.

v) Pseudonyms were used in order to keep students’ names anonymous.

vi) Also pseudonyms were used to shield the school names.

vii) All sources used in the study were fully acknowledged.

Right at the start of the study, I fully explained to the participants the details of the research study and its intentions in order to enable them make informed decisions whether or not to participate in the study. This allowed the participants to make informed decisions to participate or not to participate based on full appreciation of what the research was about, and the expectations it had of them (Connolly, 2003). Corti, Day and Backhouse (2000) warn that participants should be made aware of their right to refuse to participate, the extent to which confidentiality will be maintained, the potential use of the data and where need be, their right to re-negotiate consent. The participants were made aware that participation in the study was voluntary, and that they were free to refuse to participate or to drop out in process of the study. To this effect, participants were given opportunity to review consent/assent forms while their parents reviewed the consent forms and all were made to feel free to sign or not to sign them.

In order to secure confidentiality, the questionnaire, the assent and the consent forms were identified by unique codes and pseudonyms instead of the participants’ names and the names of their schools. Each participant’s code included a school code of one digit (e.g., pseudonym1, 2, 3, 4). It was these numbers that were translated into school pseudonyms during
the analysis process. This is similar to Corti, et al’s (2000) recommendation that strict confidentiality of all information obtained during a research study should be maintained. In addition, the participants were encouraged to feel free about what information to provide during the HIV/AIDS-focused moral education class and the focus group interviews. Connolly (2003) suggests that the researcher should make it clear to participants that they are free to choose which information they wish to share with the researcher, and that they should not at any one point in the process of the research feel pressurized or obligated to discuss matters they would not want to.

The chapter that follows presents and analyzes data obtained through use of the above-mentioned data collection techniques. It also presents key perspectives extracted from the students’ responses to the survey questionnaires. As already indicated above, I was mainly interested in the perspectives that influenced their understandings of the spread and prevention of HIV/AIDS and how these manifested in the class and focus group interview discussions.
Chapter Four: Findings and Data Analysis

The greatest moments are those when you see the result pop up [...] in your [...] analysis - that moment you realize you know something no one else does and you get the pleasure of thinking about how to tell [it] (Emily Oster, n.d.)

This study is an attempt to understand Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS and how these are influenced by cultural practices. The study’s analysis reported in this chapter attempts to offer responses to the following research questions: 1) What are Ugandan high school/Form 5 students’ perspectives on the spread and prevention of HIV/AIDS? 2) What core cultural practices have the greatest influence on Ugandan high school/Form 5 students’ understanding of the spread and prevention of HIV/AIDS? 3) How might this study’s findings inform policy and practice, theory, and research and methodology?

These involve analyses of both the quantitative data, which are survey responses of students to a questionnaire that assessed their knowledge about HIV/AIDS and qualitative data comprising class observation and focus group interview/discussions during and after a class on HIV/AIDS respectively.

Analysis of the quantitative data provided the initial identification of the perspectives (factors) that underpin the students’ questionnaire responses regarding their knowledge of the spread and prevention of HIV/AIDS. Characterization and interpretations of the perspectives or factors through participant and classroom observation and interviews/discussions, were based on how they manifested in initial interviews, HIV/AIDS-focused lessons as well as focus group interview/discussions. The process involved extraction of factors (perspectives) from questionnaire data (quantitative) before and after classroom discussions on HIV/AIDS through
the use of Principal Component analysis. The process further involved several rounds of listening to recorded classroom discussions, focus group interview/discussions, as well as reviewing of transcripts of these data sets. Extraction of perspectives was meant for use in further analysis, a strategy intended to combine quantitative with qualitative data (Caracelli & Greene, 1993), to further explicate how the predetermined perspectives manifested in the HIV/AIDS-focused moral class context and later in the focus group interviews and discussion contexts.

This process of seeking more specific qualitative information to elucidate the extracted perspectives on the spread and prevention of HIV/AIDS represents a particular link between the quantitative and qualitative data sets. By way of coding, under each perspective I had statements that reflected the perspective while aligning the data with field notes and commentaries. Integrating quantitative and qualitative data at this analysis stage was meant to help to explain and to elucidate the statistical results from the quantitative data (Bryman, 2006; Greene et al., 1989). Besides, deriving corroborative evidence from data obtained through qualitative methods, also served as an attempt to validate the findings obtained from quantitative data, serving as what is known as a methodological triangulation (Bazeley, 2006). Overall, the process was helpful to build a more comprehensive picture of the issue under study.

The questionnaire instrument data, which is quantitative in nature, were analyzed to determine the key perspectives that governed the students’ responses. The responses to instrument items were expressed in terms of degree of agreement on a Likert scale (-5 to +5 as strongly disagree to strongly agree respectively).

4.1. Instrument (Questionnaire) Data Analysis

In order to explore the students’ perspectives, an HIV/AIDS knowledge instrument (Balogun et al., 2010) (see Appendix 2) was administered to 198 students in seven purposefully
selected schools before and after participating in HIV/AIDS-focused moral education lessons. The instrument is a Likert scale and comprises 37 items rated from Strongly disagree (-5) to Sometimes agree and other times disagree (0) to Strongly agree (+5). I used the instrument to determine the key perspectives that governed their responses. This by implication is what governed their knowledge of the spread and prevention of HIV/AIDS.

Given that the instrument included a mixture of both positively and negatively stated items, I began by reverse-coding the polarity of scores for the negatively stated items. For example, negatively stated items that had been scored +5 were reverse-coded to -5 and vice versa. Following on this, I transformed all the scores on the two data sets (before and after) to non-zero values since zero on this scale does not mean “nothingness”. The scores then turned out as follows:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td>-4</td>
<td></td>
</tr>
<tr>
<td>-3</td>
<td></td>
</tr>
<tr>
<td>-2</td>
<td></td>
</tr>
<tr>
<td>-1</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Agree/disagree</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1 Questionnaire Rating Scale

### 4.1.1. Cronbach’s Alpha Reliability for initial questionnaire data

Thus, in order to determine if the HIV/AIDS knowledge instrument (Balogun et al., 2010) reliably assessed students’ knowledge of the spread and prevention of HIV/AIDS, I computed Cronbach’s alpha. Tavakol and Dennick (2011) posit that Cronbach’s alpha is
generally used to measure the internal consistency of an instrument or scale to determine the extent to which all items in the instrument measure the same concept. This agrees with Gliem and Gliem’s (2003) view that Cronbach’s alpha is a test reliability technique that requires only a single test administration to provide a unique estimate of internal consistency reliability of a given instrument. This implies that Cronbach’s alpha is connected to the inter-relatedness of the items in the instrument.

Table 2: Case Processing Summary

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>198</td>
<td>100.0</td>
</tr>
<tr>
<td>Valid</td>
<td>198</td>
<td>100.0</td>
</tr>
<tr>
<td>Excluded*</td>
<td>0</td>
<td>.0</td>
</tr>
<tr>
<td>Total</td>
<td>198</td>
<td>100.0</td>
</tr>
</tbody>
</table>

a. Listwise deletion based on all variables in the procedure.

Table 3: Reliability Statistics

<table>
<thead>
<tr>
<th>Cronbach’s Alpha</th>
<th>Cronbach’s Alpha Based on Standardized Items</th>
<th>N of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>.432</td>
<td>.442</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>---</td>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>Q1</td>
<td>4.1515</td>
<td>4.00853</td>
</tr>
<tr>
<td>Q2</td>
<td>3.5354</td>
<td>3.51159</td>
</tr>
<tr>
<td>Q3</td>
<td>3.6717</td>
<td>3.69226</td>
</tr>
<tr>
<td>Q4</td>
<td>4.4343</td>
<td>4.42113</td>
</tr>
<tr>
<td>Q5</td>
<td>2.9495</td>
<td>3.19858</td>
</tr>
<tr>
<td>Q6</td>
<td>3.0202</td>
<td>3.18620</td>
</tr>
<tr>
<td>Q7</td>
<td>2.6263</td>
<td>2.89262</td>
</tr>
<tr>
<td>Q8</td>
<td>5.6313</td>
<td>3.87369</td>
</tr>
<tr>
<td>Q9</td>
<td>8.5253</td>
<td>3.54476</td>
</tr>
<tr>
<td>Q10</td>
<td>8.3434</td>
<td>3.45871</td>
</tr>
<tr>
<td>Q11</td>
<td>7.6616</td>
<td>3.70918</td>
</tr>
<tr>
<td>Q12</td>
<td>9.7273</td>
<td>2.50813</td>
</tr>
<tr>
<td>Q13</td>
<td>9.8081</td>
<td>2.53173</td>
</tr>
<tr>
<td>Q14</td>
<td>3.9949</td>
<td>3.48091</td>
</tr>
<tr>
<td>Q15</td>
<td>8.7222</td>
<td>2.92349</td>
</tr>
<tr>
<td>Q16</td>
<td>9.4798</td>
<td>2.78449</td>
</tr>
<tr>
<td>Q17</td>
<td>3.8333</td>
<td>3.36109</td>
</tr>
<tr>
<td>Q18</td>
<td>9.7424</td>
<td>2.52888</td>
</tr>
<tr>
<td>Q19</td>
<td>6.9798</td>
<td>3.80883</td>
</tr>
<tr>
<td>Q20</td>
<td>3.3939</td>
<td>3.37298</td>
</tr>
<tr>
<td>Q21</td>
<td>8.4242</td>
<td>3.13030</td>
</tr>
<tr>
<td>Q22</td>
<td>6.5202</td>
<td>3.55052</td>
</tr>
<tr>
<td>Q23</td>
<td>9.6111</td>
<td>2.63812</td>
</tr>
<tr>
<td>Q24</td>
<td>5.7929</td>
<td>3.65276</td>
</tr>
<tr>
<td>Q25</td>
<td>7.8788</td>
<td>4.11330</td>
</tr>
<tr>
<td>Q26</td>
<td>7.9040</td>
<td>3.70017</td>
</tr>
<tr>
<td>Q27</td>
<td>5.5101</td>
<td>2.93714</td>
</tr>
<tr>
<td>Q28</td>
<td>8.7222</td>
<td>3.00061</td>
</tr>
<tr>
<td>Q29</td>
<td>9.9697</td>
<td>2.62922</td>
</tr>
<tr>
<td>Q30</td>
<td>6.0101</td>
<td>3.66627</td>
</tr>
<tr>
<td>Q31</td>
<td>2.6465</td>
<td>2.79162</td>
</tr>
<tr>
<td>Q32</td>
<td>5.0404</td>
<td>3.87343</td>
</tr>
<tr>
<td>Q33</td>
<td>8.0657</td>
<td>3.45100</td>
</tr>
<tr>
<td>Q34</td>
<td>4.0758</td>
<td>3.35332</td>
</tr>
<tr>
<td>Q35</td>
<td>9.5303</td>
<td>2.60351</td>
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<td>Q36</td>
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</tr>
<tr>
<td>Q37</td>
<td>2.5657</td>
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</tbody>
</table>
Computation of Cronbach’s alpha indicated that the instrument/scale had an internal consistency of alpha= 0.44 (see Table 3). Typically, a desirable alpha value is 0.7 or greater (Nunnally & Bernstein 1994; Field, 2009). In this study, I was more interested in the perspectives that underpin the students’ responses. The nature of items in the instrument could help determine the perspectives that the high school students applied in their responses. Schmitt (1996) argues that when dealing with multiple traits, alpha values below 0.7 can be acceptable because of the diversity or dimensionality of the concept being measured.

Similarly, Tavakol and Dennick (2011) posit that existence of multiple factors or dimensions in an instrument does violate the tau equivalent model principle, which assumes that each item in the instrument would measure the same latent trait on the same scale. Hence, alpha value 0.44 is in this case considered to underestimate the true ability of the instrument. This is further reiterated by Cortna’s (1993) assertion that when the instrument is dimensional, there can be either a substantive overestimation or under-estimation of Cronbach’s alpha. Also, the low alpha value (a=0.44) may be attributed to students’ random guessing since in the scores before HIV/AIDS-focused lessons they had not been exposed to information through classroom instruction. Thus, Tavakol and Dennick (2011) discourage judging the reliability of the instrument prematurely.

I then computed one-way ANOVA test, on the pre lesson data to determine whether or not there were any statistically significant differences between students’ responses (see Tables 6 and 7) regardless of whether or not they were urban, semi-urban or rural.
Table 5: Analysis of Variance (ANOVA)

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
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<tbody>
<tr>
<td>Between Groups</td>
<td>6.107</td>
<td>6</td>
<td>1.018</td>
<td>2.008</td>
<td>.067</td>
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<tr>
<td>Within Groups</td>
<td>89.721</td>
<td>177</td>
<td>.507</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>95.828</td>
<td>183</td>
<td></td>
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</table>
### Table 6: Multiple Comparisons

<table>
<thead>
<tr>
<th>(I) school ID</th>
<th>(J) school ID</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Upper Bound</td>
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<td></td>
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<td>-6.709</td>
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<td>-.6369</td>
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<td>-.00846</td>
<td>.30317</td>
<td>.978</td>
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<td>.433</td>
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<td>3</td>
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<td>.907</td>
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<td>.30317</td>
<td>.978</td>
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<td>6</td>
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<td>.388</td>
<td>-.7052</td>
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<td>.28185</td>
<td>.35880</td>
<td>.433</td>
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<td>.24847</td>
<td>.388</td>
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<td>5</td>
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<td>.31395</td>
<td>.852</td>
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<td>.22023</td>
<td>.385</td>
<td>-.6263</td>
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<td>.28048</td>
<td>.141</td>
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<td>6</td>
<td>.19169</td>
<td>.22023</td>
<td>.385</td>
<td>-.2429</td>
</tr>
</tbody>
</table>

*The mean difference is significant at the 0.05 level*
The ANOVA test indicated no statistical significance in the mean scores (p= 0.067) (see Table 5). I then concluded that there were no statistically significant differences between students’ perspectives in urban and rural schools. This was not surprising given that in the Ugandan context students’ populations in schools are drawn from both rural and urban. In other words, there are no school student populations that are strictly urban or rural save for the location of the school.

4.2 Determining students’ perspectives on initial questionnaire

Given the population of students in the seven schools, I was interested in exploring what perspectives influenced their understanding or knowledge of the spread and prevention of HIV/AIDS before and after participating in HIV/AIDS-focused moral education class. I used statistical methods and subsequently investigated how these manifested within the HIV/AIDS-focused moral education class and in the follow-up focus group interviews discussions. In other words I looked for the perspectives that dominated the students’ knowledge and understanding of HIV/AIDS before and after participating in moral education lessons on HIV/AIDS. I investigated this by performing Principal Component Analysis [PCA] on the pre and post HIV/AIDS-focused moral education class experience data from the HIV knowledge instrument (Balogun et al., 2010).

4.2.1. Principal Component Analysis

Principal Component Analysis (PCA) is typically used as an intermediate step in data analysis when the number of input variables is otherwise too large for useful analysis. However, in my case I used Principal Component Analysis to explore and identify key perspectives (factors) that characterized understandings or knowledge of HIV/AIDS among the
participating student population in the schools that volunteered to participate in the study. This is unlike confirmatory factor analysis that quite often is used to confirm the existence of predetermined factors. Moreover, the idea of using PCA for this kind of investigation is consistent with Reitveld and Van Hout’s (1993) view that PCA detects the factors that underlie a dataset based on the correlations between items (also see Field, 2009). Rietveld and Van Hout (1993) further argue that in order to reduce the dimensionality of the items, the researcher may employ Principal Component Analysis to bring intercorrelated items together under more general underlying perspectives. This enables the researcher to extract underlying perspectives or factors that can explain the variance in the observed items (Habing, 2003).

The validated HIV knowledge instrument (Balogun et al., 2010) used in this study was administered initially to a total of 198 students in seven schools (Busiro, Kyaggwe, Busujju, Kyaddondo, Buddu, Buvuma and Mawokota Secondary Schools), before they experienced HIV/AIDS-focused lessons.

4.2.2. Pre-HIV/AIDS-focused Lesson Factors

Five factors were extracted from data set 1 using Principal Component Analysis. While there are various criteria for determining the number of factors to extract, Fabrigar, Wegener, MacCallum, and Strahan (1999) suggest that using a combination of techniques can be helpful, since no single technique is known to be highly accurate in pinpointing the number of factors (also see Ford, et al., 1986). Therefore, after exploring with possibilities of 3, 4, and 5 factors in the questionnaire data, most items suitably conglomerated around 5 clusters whose Eigen values are greater than 1.
Table 7: Total Variance Explained

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Eigenvalues</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.882</td>
<td>7.788</td>
<td>7.788</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.315</td>
<td>6.256</td>
<td>14.044</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2.139</td>
<td>5.782</td>
<td>19.826</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2.010</td>
<td>5.432</td>
<td>25.259</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1.684</td>
<td>4.552</td>
<td>29.810</td>
<td></td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.

For the purpose of determining key perspectives through use of PCA I drew on Suhr’s (2003) interpretability criteria for extracting factors. Ford, MacCallum and Tait (1986) observe that most researchers set a minimum value above which the loading is considered significant. Based on Suhr’s (2003) criteria, I determined that acceptable clusters were a) to have 3 or more items each loading rounded up to $\geq 0.3$; b) the variables that load on a factor had to share some conceptual meaning; c) the items that load on different factors had to measure different constructs; d) an item was only considered for one cluster on which it loaded highest. In addition, I also considered meaningful and useful membership of items to a cluster by reading over the wording of each item to consider the extent to which each item made a meaningful and useful contribution to the identified factor/perspective (Bruin, 2006). In their study ‘*Using Multivariate Statistics*’, Tabachnick and Fidell (2001) indicated .32 as a good rule of thumb for the minimum loading of an item.

Thus the five factors extracted explain a total of 29.810% of the total variance (see Table 10). This means that 29.810% of the total variance of the students’ understandings of the spread and prevention of HIV/AIDS can be explained by these five extracted factors (perspectives), while the other percentage is accounted for by other factors not explored in this study.
In terms of analysis, the first factor accounted for 7.788% of variance and comprised of seven items (25, 26, 15, 12, 17, 2 and 16). The second factor accounted for 6.256% of variance and comprised of ten items (33, 32, 6, 31, 11, 5, 24, 8, 7, and 9). The third factor accounted for 5.782% of variance and comprised of five items (36, 35, 29, 23 and 14). The fourth factor accounted for 5.432% of variance and comprised of eight items (20, 13, 28, 10, 27, 34, 18 and 19). The fifth factor accounted for 4.552% of variance and comprised of six items (3, 1, 30, 37, 21 and 4). Table 11 gives the varimax-rotated loadings.
Table 8: Rotated Component Matrix

<table>
<thead>
<tr>
<th>Items</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Q25 A woman cannot get HIV if she has sex during her period</td>
<td>.588</td>
</tr>
<tr>
<td>Q26 There is a female condom that can help decrease a woman's chance</td>
<td>.569</td>
</tr>
<tr>
<td>Q13 Using a latex condom or rubber can lower a person's chance of</td>
<td>.511</td>
</tr>
<tr>
<td>Q12 Showering/washing one's genitals/private parts after sex keeps</td>
<td>.479</td>
</tr>
<tr>
<td>Q17 People who have been infected with HIV quickly show serious</td>
<td>-.430</td>
</tr>
<tr>
<td>Q2 There is a cure for AIDS</td>
<td>.374</td>
</tr>
<tr>
<td>Q16 A person with HIV can look and feel healthy</td>
<td>.322</td>
</tr>
<tr>
<td>Q33 A person can get HIV if having oral sex, mouth on vagina, with a</td>
<td>.205</td>
</tr>
<tr>
<td>Q32 A person can get HIV through contact with saliva, tears, sweat,</td>
<td>.215</td>
</tr>
<tr>
<td>Q6 A person can get HIV by sharing a glass of water with someone</td>
<td>-.285</td>
</tr>
<tr>
<td>Q31 A person can get HIV by sitting in a hot tub or a swimming pool</td>
<td>-.221</td>
</tr>
<tr>
<td>Q4 A person can get HIV if she has anal sex with a man</td>
<td>.078</td>
</tr>
<tr>
<td>Q5 HIV can be spread by mosquitoes</td>
<td>.098</td>
</tr>
<tr>
<td>Q24 Using a lambskin condom or rubber is the best protection against</td>
<td></td>
</tr>
<tr>
<td>Q8 It is possible to get HIV when a person gets a tattoo</td>
<td>.161</td>
</tr>
<tr>
<td>Q7 HIV is killed by bleach</td>
<td>.101</td>
</tr>
<tr>
<td>Q9 A pregnant woman with HIV can give the virus to her unborn baby</td>
<td>.221</td>
</tr>
<tr>
<td>Q36 A woman can get HIV if she has vaginal sex with a man who has</td>
<td>.127</td>
</tr>
<tr>
<td>Q35 Athletes who share needles when using steroids can get HIV from</td>
<td>.076</td>
</tr>
<tr>
<td>Q29 Having sex with more than one partner can increase a person's</td>
<td>.092</td>
</tr>
<tr>
<td>Q23 A person can get HIV even if she or he has sex with a person</td>
<td>.080</td>
</tr>
<tr>
<td>Q14 All pregnant women infected with HIV will have babies born with</td>
<td>-.258</td>
</tr>
<tr>
<td>Q20 There is a vaccine that can stop adults from getting HIV</td>
<td>.042</td>
</tr>
<tr>
<td>Q13 Eating healthy foods can keep a person from getting HIV</td>
<td>.131</td>
</tr>
<tr>
<td>Q28 A person will not get HIV if she or he is taking antibiotics</td>
<td>.076</td>
</tr>
<tr>
<td>Q10 Pulling out the penis before a man climaxes or 'cums' keeps a</td>
<td>.219</td>
</tr>
<tr>
<td>Q27 A natural skin condom works better against HIV than does a latex</td>
<td>.250</td>
</tr>
<tr>
<td>Q34 Using Vaseline or baby oil with condoms lower the chance of</td>
<td>-.090</td>
</tr>
<tr>
<td>Q18 Taking vitamins keeps a person from getting HIV</td>
<td>.132</td>
</tr>
<tr>
<td>Q19 A person can be infected for 5 years or more without getting</td>
<td>.278</td>
</tr>
<tr>
<td>Q3 A person can get HIV from a toilet seat</td>
<td>.003</td>
</tr>
<tr>
<td>Q1 HIV and AIDS are the same thing</td>
<td>.275</td>
</tr>
<tr>
<td>Q30 Taking a test for HIV one week after having sex will tell a</td>
<td>.094</td>
</tr>
<tr>
<td>Q27 Washing drug use equipment with cold water kills HIV</td>
<td>-.076</td>
</tr>
<tr>
<td>Q21 Some drugs have been made for the treatment of AIDS</td>
<td>.209</td>
</tr>
<tr>
<td>Q4 Coughing and sneezing do not spread HIV</td>
<td>-1.158</td>
</tr>
<tr>
<td>Q22 Women are always tested for HIV during their pap smears</td>
<td>-.055</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

All items loaded on at least one factor, except item 22, which read: “Women are always tested for HIV during their pap smears.” It turned out that students in this study were not familiar with the meaning of pap smears since it is not a practice regularly carried out on girls in the Ugandan medical services sector. Based on the students’ repeated questions asking the meaning
of Pap smear (from one school to another), I concluded that it was new to them. This clearly displayed in students’ responses which indicated that a total of 64.64% of the students in the study were not sure of the correct answer; 23.23% indicated sometimes agree and other times do not agree, while 41.41% indicated disagreement at different levels.

4.3. Interpretation of Factors

Thus, after careful inspection of the clusters and informed by literature, knowledge of context and interaction with teachers and students, I interpreted and described the factors as the key perspectives that governed the students’ understandings and knowledge of HIV/AIDS. I found that items in each factor were highly correlated. This is also evident in the inter-item correlation table in Appendix 1.

4.3.1. Factor 1

The items in Factor 1, as presented in Table 9, shared the same conceptual meaning and addressed students’ HIV/AIDS related knowledge of perceptual and behavioural risks associated with proximity to HIV/AIDS victims.

Table 9: Components of Factor 1

<table>
<thead>
<tr>
<th>Q25</th>
<th>A woman cannot get HIV if she has sex during her period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q26</td>
<td>There is a female condom that can help decrease a woman's chance of getting HIV</td>
</tr>
<tr>
<td>Q15</td>
<td>Using a latex condom or rubber can lower a person's chance of getting HIV</td>
</tr>
<tr>
<td>Q12</td>
<td>Showering/ washing one's genitals/ private parts after sex keeps a person from getting HIV</td>
</tr>
<tr>
<td>Q17</td>
<td>People who have been infected with HIV quickly show serious signs of being infected</td>
</tr>
<tr>
<td>Q2</td>
<td>There is a cure for AIDS</td>
</tr>
<tr>
<td>Q16</td>
<td>A person with HIV can look and feel healthy</td>
</tr>
</tbody>
</table>
4.3.2. Factor 2

The items in Factor 2 as presented in Table 10 shared the same conceptual meaning and addressed students’ HIV/AIDS related knowledge of Hygienic practices.

Table 10: Components of Factor 2

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q33</td>
<td>A person can get HIV if having oral sex, mouth on vagina, with a woman</td>
</tr>
<tr>
<td>Q32</td>
<td>A person can get HIV through contact with saliva, tears, sweat, or urine</td>
</tr>
<tr>
<td>Q6</td>
<td>A person can get HIV by sharing a glass of water with someone who has HIV</td>
</tr>
<tr>
<td>Q31</td>
<td>A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV</td>
</tr>
<tr>
<td>Q11</td>
<td>A woman can get HIV if she has anal sex with a man</td>
</tr>
<tr>
<td>Q5</td>
<td>HIV can be spread by mosquitoes</td>
</tr>
<tr>
<td>Q24</td>
<td>Using a lambskin condom or rubber is the best protection against HIV</td>
</tr>
<tr>
<td>Q8</td>
<td>It is possible to get HIV when a person gets a tattoo</td>
</tr>
<tr>
<td>Q7</td>
<td>HIV is killed by bleach</td>
</tr>
<tr>
<td>Q9</td>
<td>A pregnant woman with HIV can give the virus to her unborn baby</td>
</tr>
</tbody>
</table>

4.3.3. Factor 3

The items in Factor 3 as presented in Table 11 shared the same conceptual meaning and addressed students’ HIV/AIDS related knowledge of Behavioural/practice causes and transmission of HIV/AIDS.

Table 11: Components of Factor 3

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q36</td>
<td>A woman can get HIV if she has vaginal sex with a man who has HIV</td>
</tr>
<tr>
<td>Q35</td>
<td>Athletes who share needles when using steroids can get HIV from the needles</td>
</tr>
<tr>
<td>Q29</td>
<td>Having sex with more than one partner can increase a person's chance of being infected with HIV</td>
</tr>
<tr>
<td>Q23</td>
<td>A person can get HIV even if she or he has sex with a person one time</td>
</tr>
<tr>
<td>Q14</td>
<td>All pregnant women infected with HIV will have babies born with AIDS</td>
</tr>
</tbody>
</table>
4.3.4. **Factor 4**

The items in Factor 4 as presented in Table 15 shared the same conceptual meaning and addressed students’ HIV/AIDS related predictive, preventive and transmissive knowledge of HIV/AIDS.

**Table 12: Components of Factor 4**

<table>
<thead>
<tr>
<th>Q20</th>
<th>There is a vaccine that can stop adults from getting HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q13</td>
<td>Eating healthy foods can keep a person from getting HIV</td>
</tr>
<tr>
<td>Q28</td>
<td>A person will not get HIV if she or he is taking antibiotics</td>
</tr>
<tr>
<td>Q10</td>
<td>Pulling out the penis before a man climaxes or ‘cums’ keeps a woman from getting HIV during sex</td>
</tr>
<tr>
<td>Q27</td>
<td>A natural skin condom works better against HIV than does a latex condom</td>
</tr>
<tr>
<td>Q34</td>
<td>Using Vaseline or baby oil with condoms lowers the chance of getting HIV</td>
</tr>
<tr>
<td>Q18</td>
<td>Taking vitamins keeps a person from getting HIV</td>
</tr>
<tr>
<td>Q19</td>
<td>A person can be infected for 5 years or more without getting AIDS</td>
</tr>
</tbody>
</table>

4.3.5. **Factor 5**

The items in Factor 5 as presented in Table 13 shared the same conceptual meaning and addressed students’ naïve notions of prevention and treatment of HIV/AIDS.

**Table 13: Components of Factor 5**

<table>
<thead>
<tr>
<th>Q3</th>
<th>A person can get HIV from a toilet seat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>HIV and AIDS are the same thing</td>
</tr>
<tr>
<td>Q30</td>
<td>Taking a test for HIV one week after having sex will tell a person if she or he has HIV</td>
</tr>
<tr>
<td>Q37</td>
<td>Washing drug use equipment with cold water kills HIV</td>
</tr>
<tr>
<td>Q21</td>
<td>Some drugs have been made for the treatment of AIDS</td>
</tr>
<tr>
<td>Q4</td>
<td>Coughing and sneezing do not spread HIV</td>
</tr>
</tbody>
</table>

4.4. **Summary**

The first research question of this study was: What are Ugandan high school students’ perspectives of the spread and prevention of HIV/AIDS? These findings of quantitative analysis respond to research question one. Taken together, the quantitatively determined perspectives were interpreted and described as 1) Perceptual and behavioural risks associated with proximity
to HIV/AIDS victims 2) Hygienic practices, 3) Behavioural/practice causes and transmission of
HIV/AIDS, 4) Predictive, preventive and transmissive knowledge of HIV/AIDS, and 5) Naïve
notions of prevention and treatment of HIV/AIDS. Accordingly, I consider these to be the
perspectives that guided the students’ understandings of the spread and prevention of HIV/AIDS.

When I computed Cronbach’s alpha reliability on the factors, results indicated that the
clusters had low internal consistency (F1 – alpha = .341; F2 – alpha = .551; F3 – alpha = .419;
F4 – alpha = .123; F1 – alpha = .114). Given the argument used for the main instrument, and
diverse background of the participating students, there is high possibility that even on each item
in the cluster different perspectives might have applied, hence the low alpha reliability for each
of the perspectives. Nonetheless, my interest was more in using this instrument to stimulate the
students’ understandings and the perspectives they applied, which I further interrogated through
qualitative methods of classroom observation and focus group discussions with the participating
students.

4.5. Classroom Observation Data Analysis

In order to appreciate the existence of the key perspectives among the students prior to
the HIV/AIDS-focus moral education class experience, I observed the students’ participation in
the classroom discussions and noted how the perspectives manifested. In other words, I made
classroom observations of their participation in the class discussions in all the schools.
Manifestations served as validation of the statistically determined perspectives. Thus, instances
of when and how the perspectives manifested were determined through an analytical process of
coding the observation data, which was qualitative in nature. In this case, the perspectives served
as the codes.
Classroom observation data corpus comprised of researcher notes and audio records of class discussions in which I occasionally was an active participant. In this role, I simultaneously took note of the participants’ taken-for-granted actions such as interactions, body language, facial expressions as well as the general classroom context (Denzin & Lincoln, 2003). The data corpus comprised of verbatim transcriptions of audio-recordings, and my field notes, which I made during and soon after the class discussions to ensure that follow-up questions and clarifications of responses from the teachers and the students were obtained while participating students were still available. Given that all human behaviour is attributed to underlying drives (Morris, 1978), HIV/AIDS-focused moral class observation was intended to appreciate when and how the perspectives manifested during the HIV/AIDS-focused moral education class.

I observed teacher-facilitated HIV/AIDS-focused moral education class discussions to see how students’ perspectives on the spread and prevention of HIV/AIDS manifested. This is because a teacher-facilitated class provides a more natural learning context in which students freely participate, motivated by a genuine desire to learn. The method was also of greater advantage because of the way teachers arranged class discussions in the form of debates. This dialogical interaction was more ideal than an interview and motivated students to participate most actively. Besides, since HIV/AIDS is sex-related, it was easy for students to share their views in a learning classroom context.

On the one hand manifestations of the quantitatively determined perspectives during HIV/AIDS-focused class served as coding schemes for the qualitative data corpus, which was obtained through classroom observation. On the other hand, data generated from focus group discussions was used to determine the effect the experience had on the initially determined perspectives as well as serve as fodder for manifestations of transformed as well as resilient
perspectives. In other words, the quantitatively determined students’ perspectives on the spread and prevention of HIV/AIDS were clarified by observing and noting how they manifested during the HIV/AIDS-focused moral education class, and determining the effect of the experience on them from post-experience interview data using the perspectives as coding schemes. The coding involved examining and identifying statements that conveyed the manifestation of each perspective from the class discussion audio and field note transcripts (Miles & Huberman, 1994; Yin, 2003) as they showed up or appeared for the first time, and those that spoke to the effect of the experience from the focus group discussion data.

Thus, the purpose for this analysis was to locate the manifestations of the perspectives as corroborative evidence of their existence among the participating students during the HIV/AIDS-focused moral education class, and to determine what impact the experience had on these perspectives from the focus group discussions. Whereas Patton (2002) asserts that the purpose of qualitative analysis is to identify emergent themes, which is an inductive process, in this case, a deductive process was employed whereby I used predetermined perspectives to analyze the qualitative data. Essentially, as a researcher, I used the quantitatively determined factors or perspectives as coding schemes to analyse the class discussion transcripts (Spencer et al., 2003). Hence, the five initially identified perspectives: 1) perceptual and behavioural risks associated with proximity to HIV/AIDS victims 2) Hygienic practices, 3) behavioural/practice causes and transmission of HIV/AIDS, 4) predictive, preventive and transmissive knowledge of HIV/AIDS, and 5) Naïve notions of prevention and treatment of HIV/AIDS, were used to code the in-experience (observation) qualitative data.
4.5.1. **Perspective One: Perceptual and Behavioural Risks Associated with Proximity to HIV/AIDS Victims**

Societal norms, beliefs and attitudes often dictate the ways individuals behave and the extent to which they may be aware of the risks that exist within their environment. Thus, individuals’ surroundings and the peer groups they identify with tend to have the most significant influence on their behaviour. Although strong peer groups are often important for youth particularly when parental supervision decreases and interaction with peers increases, they are still expected to retain the ability to identify what puts them at risk and what does not. The AIDS Risk Reduction Model (ARRM) influenced the interpretation of this perspective. The ARRM posits that individual knowledge of HIV/AIDS transmission, and a clear perception of one’s risk to acquire HIV/AIDS is key to safer behaviour (Cantania, et al., 1990). Thus, this perspective is about students’ views regarding nearness to HIV/AIDS victims. Rosenstock et al. (1988) observe that awareness of risk indicates an individual’s susceptibility to HIV/AIDS infection as well as its severity and threat. This perspective can be a result of individuals’ responses to their own environment. The connection between what students know about HIV/AIDS and related risks resides in their understandings of and extent of experience with the spread and prevention of HIV/AIDS.

The intentionality of individuals to engage in actions that put their health at risk depends on the extent of their familiarity and habituation with risky situations and circumstances as well as the extent of perceived seriousness of its consequences. By familiarity, I mean that the individual understand the risks of exposure from particular events and activities. At the same time, by habituation the individual knowingly gets used to the behaviour that puts him/her at
risk. In this way, understanding a risk relates to the degree to which it is observable and known to the one exposed to it, and can be detected immediately.

This perspective manifested in students’ responses when the teacher was discussing the reasons for the increase of HIV/AIDS today. In their responses students drew on their everyday life situations, which I categorized in the two following themes:

**Family neglect and lack of parental guidance**

Findings indicated that students believe that lack of parental guidance and family connections facilitate undisciplined life styles and sexual promiscuity among youth, which create congenial and risky environments for transmission of HIV/AIDS. They argue that failure of parents/guardians to have substantial time with their children in order to provide them guidance motivates the youth to join undesirable peer groups, which in turn exposes them to HIV/AIDS risks. For example, this view was evidenced as one of the students, Scott, from Busujju Secondary School expressed:

> There is a new practice of “family neglect”, where parents don’t have time to counsel and guide their children because they are over-concerned about their economic gains and how to make more and more money for their families [TFC2: 573-576, September 11, 2012].

In support of the same view, Belinda from Buddu Secondary School believed that not only does parents’ failure to spend time with their children expose them to risk, but also, lack of discipline on the part of the youth puts them at risk.

> I think the increased spread of HIV/AIDS today is due to uncontrolled behaviour of the youth. First of all, parents have no time for us; when they are not at home, we do what we like and we move wherever we want, and involve ourselves in all sorts of behaviour. We make bad friends and form peer groups with fellow youth in the neighbourhood and involve ourselves in submissive behaviour including trying out sex. I think that is why
there is a high increase of the spread of HIV/AIDS today [TFC1: 54-63; 81-88, September 6, 2012].

In her statement, Belinda reveals her perception of the kinds of behavioural risks that expose youth to HIV/AIDS. Further, she believes that youth are at risk of infection when they are away from the watchful eye of their parents. Moreover, Belinda acknowledges how this situation is compounded by the youth’s involvement with peer groups that are characterized by permissiveness and lack of self-discipline. Nathan expressed a similar sentiment when he said:

Because the parents are too busy and must look for money to maintain the family, most of the time children are left on their own. They move uncontrolled and spend a lot of time on TV involved in pornography, which eventually influences their behaviour. Also because of the absence of parents from home most of the day, these children get into bad peer groups, which influence them into bad behaviour [TFC5: 83-88, October 22, 2012].

In my observation, I noted that when expressing their views about family neglect, and lack of parental guidance, there was seriousness in the students’ tones and facial expressions, which indicated that this was an issue of deeper concern to them as children.

*Peer pressure and promiscuous behaviours*

Students also acknowledged that peer pressure intertwined with behavioural factors and lack of self-discipline contributes to increased vulnerability to HIV/AIDS. In a study carried out by Dishion et al. (1991), parental neglect was found to be a correlate to adolescent susceptibility to peer pressure, a factor most responsible for youth’s vulnerability to HIV/AIDS.

In the following excerpt, this perspective also manifested when Camila expressed her belief that the spread of HIV/AIDS is enhanced by increased permissiveness that involves lack of self-discipline and engagement in promiscuous peer activities that expose youth to behavioural risks:
From what I see about people in our age bracket I think HIV has continued to spread because of permissiveness, and the freedom we have, which easily leads to misuse of the freedom our parents give us and the leisure time we have. Instead of using our leisure time meaningfully, young people go to discos and other funny places where they fall in danger of contracting HIV/AIDS [TFC3: 25-30, September 25, 2012].

She further added:

Today young people do funny, funny things [demonstrating emphasis] and they want a lot of freedom to do what they want, but not to be guided by elders. They want to move where they want without limitations from the elders or parents. So, where we move and the groups we join, or the people with whom we make friends lead us into trouble then you find that many young people are getting HIV/AIDS today more than the older people as it used to be in the past. So, too much freedom that we don’t know how to use and wanting to do things that are dangerous to us such as pornography, peer pressures, drug addiction are all leading us into dangers of getting HIV/AIDS [TFC3: 33-41, September 25, 2012].

The perspective further exhibited in Isabella’s understanding of prostitution among female youth as a transmissive behaviour of HIV/AIDS. Isabella, from Mawokota Secondary School also conceptualized female youth who engage in prostitution as agents of the spread of HIV/AIDS:

In my view the spread of HIV is mainly due to the high level of permissiveness among us, youth, […]. For example today, many girls engage in prostitution when they are still young and in some cases they acquire HIV/AIDS and become agents for spreading it from one man to another while the men spread it back to girls. In this way HIV/AIDS spreads in a kind of vicious circle among young people [TFC7: 59-66, November 21, 2012].

Isabella implies that in a “vicious circle” model, it may be difficult to tell who is infecting whom. What is clear is that all those involved in the sexual network are rendered at risk.
The perspective also manifested in Wendy’s understanding of sensuous films or videos as catalysts into practices that contribute to HIV/AIDS transmission. Wendy from Busujju Secondary School expressed this view saying:

This also includes things like obscene films. [...] The best example is that girls like watching such blue movies with men they are not sure of. [...] In the process of watching they end up losing sexual control and giving in to sex. Such people even don’t think of using condoms when they are heated [...] [students giggle] [TFC2: 464-470, September 11, 2012].

In class, all students seemed to understand what was meant by “blue movies” because none of them asked for an explanation. I speculate that their giggling was an expression of a nonchalant attitude. In order to be clear about what the term “blue movies” meant for them, while outside class I asked Wendy to explain to me what she meant by “blue movies” and she said:

Those films which show people’s nakedness. They also involve scenes of love, sex, money and deceit among lovers. Sometimes you can even see that both the man and the girl are not serious at all. But some girls are easily taken up by the promises the men make to them and they easily give in. In fact young girls are fond of watching such films with Sugar Daddies, and they imagine themselves in those situations. So they are not only obscene, but also tempting to young people (Wendy, September 11, 2012).

Results revealed that students perceive risk environments that include risk settings and groups around their neighbourhoods, coupled with a lack of adult guidance as predisposing factors to HIV/AIDS. Driven by the “Perceptual and behavioural risks associated with proximity to HIV/AIDS victims” perspective, the above statements represent students’ complex and subtle opinions about risks to HIV/AIDS. The perspective also reveals what underlie students’ understandings of the spread and prevention of HIV/AIDS. Although students in this study
seemed to be aware of the seriousness of the risks, occasionally their reactions and body language indicated that they considered some risks more serious than others.

However, given that understandings of risk are rooted in sociocultural factors, we cannot underestimate the fact that youth between 16 and 19 undergo rapid and uneven physical and social growth and development. This coupled with a group pressure and lack of adult guidance compromises their cognition of risk posing issues they may come face to face with. Douglas and Wildavsky (1982) observe that often, people acting within social groups tend to downplay certain risks and to emphasize others as a means of maintaining and controlling the group.

4.5.2. Perspective Two: Hygienic Practices

This perspective refers to health-related behaviours and practices. From common understanding, hygienic practices are understood as approach or contact behaviours performed as preventive measures against disease that spreads through contact from one person to another (Bloomfield et al., 2009). This perspective is informed by the theory of planned behaviour. A considerable body of literature reveals that the theory of planned behaviour adequately explains the intention and frequency of performing different health behaviours (Godin & Kok, 1996; Sheeran, Conner, & Norman, 2001). In other instances, the theory of planned behaviour has been used in Sub-Saharan African settings to predict HIV prevention behaviours (Gebreeyesus, Boer, & Kuiper, 2007; Kakoko, et al., 2006; Molla, Astrom & Berhane, 2007). The theory of planned behaviour assumes that a person’s behaviour is determined by his/her intention to perform the behaviour, which intention is in turn a function of the individual’s attitude towards the behaviour and his/her subjective norms (Ajzen, 1991). In this way, the individual’s attitude, subjective norms and perceived behavioural control work together to influence his or her intention to perform a behaviour (Ajzen, 2002). According to Ajzen, the theory links people’s health beliefs
directly to behaviour. Thus, as a theory of proximal cognitive determinants of behaviour, the theory of planned behaviour provides a framework for interpreting the students’ hygienic practices perspective.

This perspective manifested during the HIV/AIDS-focused moral education class when the teacher invited students to share their knowledge of the different modes of HIV/AIDS transmission. Students’ responses conveyed a belief that good hygienic practices are instrumental to the prevention of the spread of HIV/AIDS from one person to another. Similarly, they also revealed their belief that bad hygienic practices enhance the spread of HIV/AIDS. Congruent with Bloomfield et al. (2009), the student population in this study described good hygienic practices to include hand wash, restraint from communal use of eating and drinking utensils, as well as avoidance of common use of skin piercing instruments. On the whole, students consider adequate sanitization of needles and other related instruments as instrumental in the prevention of HIV/AIDS transmission. I categorized manifestation of this perspective under the following four themes that included: family sharing of incising instruments, “visiting the bush,” medicalized versus traditional circumcision devices and traditional healers’ incision practices.

Family sharing of incising instruments

Students perceived that sharing body incising instruments with infected persons is a transmissive route of HIV/AIDS. For example, Halima, a student from Buddu Secondary School, held the view that “HIV/AIDS can be prevented if people avoid sharing sharp objects like needles, razor blades, and tattooing instruments with infected people [TFC1: 49-50, September 6, 2012]. James, a student from Kyaddondo Secondary School highlighted this further when he said, I think HIV/AIDS is also spread through use of sharp and unsterilized instruments with
somebody who is infected [TFC5: 31-32, October 22, 2012]. Also Scott, a student from Kyaggwe Secondary School, expressed a similar idea when he said:

> In poor families there is sharing of sharp equipment like needles and sometimes people share injections. I think poverty also contributes to the transmission of HIV/AIDS. If the family is too poor, even if they are aware that one of their members has HIV/AIDS, they will have no alternative but to use things like the razor blades in common [TFC4: 112-116, October 12, 2012].

Scott expressed awareness of the mode of transmission, and indicated that sharing sharp instruments is further compounded by family economic constraints. However, culturally, sharing is seen as a symbol of bonding and togetherness of a family based on the concept of communal interdependence. This is also expressed through the African proverb: “A person is not a palm tree that he/she should be self-sufficient”. This means that a person’s abilities or possessions are not sufficient for survival; hence, his/her dependence on the community through sharing.

This is further expressed in the way people live in clustered homesteads. It is on this basis that cultural values of mutual helpfulness, cooperation and interdependence are emphasized. People share everything from property, to household objects, to food, to dishes (cups and plates), to cooking pots, to salt, almost everything. Thus people live and share their lives and property together in such a way that their life becomes part and parcel of each other (Murove, 2008). Besides, it is least thought of or even unimaginable for one to think their own kin are infected with HIV/AIDS. In such contexts, during this HIV/AIDS era, people still find themselves sharing razor blades and other skin piercing instruments. Although a highly valued practice, it does not mean that youth are not aware of the danger that lies in the practice.
“Visiting the bush”

This perspective also manifested when students expressed belief that a lack of hand wash coupled with the labial inflammation thought to result from the use of herbs, has implications for HIV/AIDS transmission. Two students, Halima and Olga from Buddu and Busujju Secondary Schools respectively, better expressed this as follows:

The practice of visiting the bush or “okukyalira ensiko” […] also contributes to the spread of HIV/AIDS. When the auntie\(^1\) takes a girl to the bush, the herbs she uses to pull can make bruises on the girl’s labia. If the auntie has the virus and a cut in her hands, in the process of pulling, the girl may bleed. In this way, the auntie can pass on the virus to the girl and she gets infected […] [TFC1: 211-217, September 6, 2012].

For me I think that also visiting the bush can lead to the spread of HIV/AIDS. Sometimes the girls can bleed and yet, the practice is carried out in the bush where the aunties neither wash their hands nor put on gloves. In that way, it is easy for the girls to be infected [TFC2: 176-179, September 11, 2012].

The practice of visiting the bush or labial elongation, (locally known as “okukyalira ensiko” or “pulling”), is a cultural rite of passage from childhood to womanhood that involves a form of genital modification supposed to render a woman complete (Khau, 2012; Tamale, 2005). Its local name “visiting the bush” is derived from where it is done, because girls often perform it while in the bush on errands such as collecting wood for cooking, or when purposely taken there by paternal aunties to perform it with the help of herbs from the bush.

The students’ views indicated limited knowledge about whether or not the practice is transmissive of HIV/AIDS. The study revealed that students view HIV/AIDS as a viral or bacterial disease. This meant that through “visiting the bush”, HIV/AIDS can be spread directly by touching an infected person and another without washing. In this case hand washing would help to prevent the spread of such a disease. However, some studies demonstrate that labia

\(^1\) Ssenga/paternal aunt who provides “sexual coaching”
elongation is done through massaging and stretching (Bagnol & Marino, 2008; Johansen, 2006; Koster & Price, 2008; Tamale, 2005). The herbs used are meant to promote the stretching of the labia by softening and lubricating them so that the pulling does not cause skin laceration (Khau, 2012). Thus, since the practice does not involve removal of tissue from the genitals, it does not compromise girls or young women’s health (World Health Organization, 2008). However, the students in this study appeared to be aware of a possibility of laceration due to accidental over-elongation or over stretching. Also, the students appeared to understand that although washing hands is linked to a virus, it could be a transmission method in a way that if the auntie worked on more than one niece where one bled, by touching several others, there is the possibility that transmission of the virus can occur.

**Medicalized versus traditional circumcision devices**

This perspective also showed up when students expressed a belief that traditional circumcision devices are unhygienic, risky and therefore transmissive of HIV/AIDS, as opposed to the medicalized devices that are sanitized and kept sterile. Students from Busiro and Buddu, Secondary schools respectively, demonstrated this as follows:

Lucky: Usually, [...] one blade or knife is used to mutilate a group of girls. If one of them has *HIV then the rest of them will get HIV because they do not change the blade, they don’t wash it, they don’t sterilize it [...]”* [TFC3: 94-97, September 25, 2012].

Jacy: Circumcision is a culture through which HIV/AIDS can be transmitted because of the instruments they use; they can keep them without sterilizing and circumcise other persons. That can lead to the transmission of AIDS from one person to another [TFC1: 131-135, September 6, 2012].

Jacinta: I mean traditional circumcision carried out in the villages, not in the hospitals [...] the blade or knife is used on more than two people. In case any of those people being
circumcised happens to have AIDS, it will infect all the other boys in the group [...] [TFC3: 313-317, September 25, 2012].

Fiona: I think the practice of circumcision should be carried out in hospitals, because when done traditionally, the knife for circumcision is used on more than three people. But if they are circumcised in the hospitals, medical people are more careful than people in villages [...] and yet hygienic conditions in the villages are poor… [TFC1: 96-103, September 6, 2012].

Students’ reflections emphasized circumcision devices rather than the initiation rite itself. Studies such as the one by Leclerc-Madlala et al. (2009) demonstrate that traditional male circumcision conducted by traditional surgeons in deep rural areas, using unsterilized instruments on several initiates is highly unhygienic.

This was however a point of contention since some students referred to the rite of circumcision as the cause of the spread of HIV/AIDS, while others referred to the circumcision devices used in villages where hygienic conditions are poor rather than those in hospitals where conditions are sanitized. As we shall see later on, students who advocated for medical circumcision were of the view that traditional circumcision devices were transmissive of HIV/AIDS, while clinical or medical circumcision devices were preventive of HIV/AIDS. A critical analysis revealed that students perceived traditional circumcision devices as unhygienic and therefore transmissive of HIV/AIDS, and clinical or medical circumcision devices as highly hygienic, and therefore preventive of HIV/AIDS transmission.

*Traditional healers’ incision practices*

This perspective further showed up when the teacher was discussing modes of HIV/AIDS transmission. In the process, students expressed the view that traditional healers employ bad hygienic practices as a result of economic constraints, by using unsterilized skin piercing
instruments on multiple people, which contribute to the spread of HIV/AIDS. For example, Fabian, from Buvuma Secondary School said:

When some people get HIV/AIDS, […] they go to the witch doctors to ask for herbs, which can stop the disease from spreading in the family. People think HIV/AIDS is a kind of witchcraft sent to them by enemies of their family. When the family members continue to be sick, they consult with the traditional healer who cuts them and puts medicine in their veins […] so they accept to have cuts […]. The traditional healer wants to save, so he will find it economical to use the same razor blade on all family members, and […] will use the same razor blade on another family. This is another way of spreading the virus from one person to another [TFC6: 85-95, November 8, 2012].

Drawing on Downey (2005), students appeared to be highly aware of the concept of universal precaution which maintains that all blood and bodily fluids are considered potentially contaminated, and that all invasive instruments, once used, are potentially contaminated and can be a menace in the spread of HIV/AIDS.

Culturally, peoples’ understandings of illness and disease are guided by the notion of causation, which posits that nothing happens without a cause (Sogolo, 1998). From a cultural perspective, disease is viewed and understood within the framework of toxic infection and contamination (Green, 1999). In this way, illness is perceived as infiltrating one’s body and lodging in the blood stream in the form of dangerous microorganisms, pollution or environmental hazards that are sent to penetrate one’s body and contaminate one’s blood. As a result, culturally based attitudes about seeking treatment and trusting traditional medicines and folk remedies are rooted in core belief systems about illness causation. In order for the treatment to be considered complete, it must be pursued within a cultural framework (Chipfakacha, 1997). Thus, once not satisfied with the scientific diagnosis, people seek explanation from traditional healers or medicine men that treat by cutting them in order to administer the medication to fortify the blood and make it immune to disease.
A further implication to this perspective was the way students perceived the nature of HIV/AIDS. Students’ responses revealed that they perceive HIV/AIDS to be like any other ordinary infectious bacterial or viral diseases such as tuberculosis, influenza, flu and cholera whose spread can easily be reduced through maintaining good hygienic practices. It is however difficult to tell why students did not allude to the traditional mode of sterilization in which traditional healers add salt and ashes in incisions. This might indicate that students were possibly aware that HIV/AIDS even eludes normal sterilization.

4.5.3. Perspective Three: Behavioural/Practice Causes and Transmission of HIV/AIDS

Within the sociocultural and practice frameworks, HIV/AIDS as social disease is known to be the outcome of social sexual behaviour. It is therefore known to have intricate connections with cultural norms and practices that are likely to expose individuals to the disease. This perspective is informed by the Theory of Reasoned Action [TRA], which posits that a person’s behaviour is determined by his/her intention to perform the behaviour, influenced by one’s attitudes and societal norms (Fishbein & Ajzen, 1975). In this case the immediate cognitive originators of behaviour are not attitudes but the behavioural intentions (Taylor et al., 2006). Since action is constituted with reference to shared meanings, without social relations and interactions behaviours are rendered meaningless (Kippax & Crawford, 1993). Norms as shared expectations that signal the appropriate forms of behaviour for a group need to be jointly shared. In other words, within this context it is unimaginable that an individual can obtain information and act on it without sharing it with other individuals. Thus, in order to adequately predict what an individual can do on basis of his/her perceptions and beliefs, we ought to take into consideration the social interaction that results from the individual’s interactions with others who may be in a similar situation. Only then can we explain the relationship between the individual’s
beliefs, attitudes, intentions and behaviour.

This perspective manifested in the HIV/AIDS-focused moral education class when the teacher was discussing youth behaviours that relate to the spread of HIV/AIDS. Students’ responses indicated that youth behavioural/practice patterns characterized by peer pressure, coupled with curiosity and experimental tendencies have important implications for HIV/AIDS transmission. This was better expressed by Fiona, from Buddu Secondary School when she said:

For me I think the increased spread is due to the problem of “practice makes Perfect.” Because sexual issues are not discussed with parents, the youth discuss them among themselves, and there is a tendency to want to try out with fellow peers. So when a boy tries today with one girl, next time he will try with another. If one has already caught the disease, it will keep on spreading without them being aware. And the bad thing is that people do not find it easy to go for testing as they find it easy to try it [sex] out [TFC1: 71-77, September 6, 2012].

Also Rinah, from Mawokota Secondary School expressed a similar view when she said:

… once the parents go away to work, also the children go away to visit their friends. So you find that young girls and boys get boyfriends and girlfriends very early and they begin to engage in sex. When the friendship breaks, the boy or girl takes on another one. And with the young people’s slogan of practice makes perfect, they keep on practicing sex with every other friend they get and in the end they go around spreading HIV/AIDS from one person to another [TFC7: 218-225, November 21, 2012].

Sandra, from Busujju Secondary School further emphasized this saying, “there is also a rampant practice today, the influence of practice makes perfect. The youth today have that saying of practice makes perfect, so they engage in premarital sex to gain that perfection [TFC2: 569, 571-572, September 6, 2012].

While “practice makes perfect” seems to be a new practice in school contexts, it is also a slang phrase students use to talk about engaging in sex frequently, moreover with a variety of partners, in an immoral manner disguised as affectionate or romantic. The Ugandan society
supports abstinence. From a cultural perspective, such behaviour is perversion of the cultural norm. Perversion in a sense that the students are aware that if not found virgins at marriage, they are returned to their parents/guardians. This explains why girls seek virginity restoration herbs, which showed up later during the focus group interview discussions and exhibited during the search for the post-experience “Contextual view of the nature of HIV/AIDS” perspective.

Generally, practice is key to learning. In this context, the words “practice makes perfect” seem to refer to learning how to perform sex correctly as a result of repeated practice, intended to achieve perfection. It is a deceptive means that has an end for habitual fulfillment. It also has a notion of scare embedded in it, in a sense that if one does not practice, there is an implied consequence, in which case, it is better to practice. As well, it can be inferred that the need to practice is also in order to make a perfect couple by marriage time. Probably that is why it also involves experimentation with different partners leading to increased spread of HIV/AIDS.

The above students’ statements revealed that sexual practice of “fun-seeking” boys who aim to achieve their own goals is a major mode of HIV/AIDS transmission. However, they also acknowledge that this scenario is facilitated by a lack of parental guidance that renders youth susceptible to peer pressure. Peer pressure ordinarily occurs as a result of coercion when an individual who is part of a group is coerced into doing something regardless of whether or not they want to do it. Given that the individual feels the need to belong and fears to be an outcast, peer pressure can have a powerful influence on an individual’s perspectives. A study carried out by Dishon et al. (1991) revealed that poor parental monitoring contributes to a significantly high correlation between adolescents’ susceptibility to peer pressure and frequent sexual activity.

From the students’ reflections, the notion of “practice makes perfect” is value embedded. Framed in the sociocultural context of the underlying threat that once failed in a marriage, one
may never remarry, the statement presents a benefit in a sense that if practice is initiated early, the two young people will be assured of a lasting marriage when the time comes. While the male youth aims to prove that it is worth engaging in the activity, it is up to the female youth to weigh if the benefit is worth taking the risk. This is what the students referred to as resulting in failure to adhere to abstinence as Edina from Busujju Secondary School put it:

Today very many youths do not abstain from sex because virginity is no longer highly valued. When someone says she is a virgin, she is looked upon as being backward. So in that way, virginity is no longer a value as it used to be in the African traditional society [TFC2: 520-523, September 11, 2012].

Students perceive that risk behaviours including high frequency of sexual activity facilitate the rapid spread of HIV/AIDS. It is possible that to some extent sexual promiscuity is a result of the onset of normal sexual urges among youth catalyzed by traditional rites of passage such as circumcision among boys and “bush visiting” among girls. Studies like “Boys will be boys” by Vincent (2008) demonstrates that many initiates view circumcision as a permit to practicing sex, thus encouraging frequent sexual behaviour at the expense of the girls’ virginity.

4.5.4. **Perspective Four: Predictive, Preventive and Transmissive Knowledge of HIV/AIDS**

This perspective is about students’ knowledge about the potential for when and how HIV/AIDS can be transmitted and prevented. This perspective is informed by the theory of planned behaviour [TBH], which posits that people estimate certain factors before deciding to engage or not to engage in risky behaviour (Ajzen, 1991). In other words, the theory of planned behaviour explains the relationship between one’s beliefs, attitudes and behavioural intentions (Ajzen, 1991). Thus, this perspective revealed students’ awareness of the basic information required to assess HIV/AIDS risks and their capability to identify risk-taking behaviours. I
thematically analyzed these in two categories (predictive and preventive knowledge and transmissive knowledge) as follows:

*Predictive and preventive knowledge*

This perspective manifested during the HIV/AIDS-focused moral education class when the teacher was discussing the transmission and prevention of HIV/AIDS. For example, Paschal, a student from Busiro Secondary School said:

> I think the reason why there is increased spread of HIV/AIDS among the age of 14 to 25, is because of contraceptives such as condoms and pills they use to prevent pregnancy. Today, young people fear more to get pregnant than getting HIV/AIDS. For example because these pills are readily available in the shops and pharmacies, they buy and take them, after which they go in for open sex because they know they are safe from getting pregnant but without minding about contracting HIV/AIDS. In the process of doing so they get the virus [TFC3: 57-64, September 25, 2012].

When asked what he, Paschal meant by “open sex”, in support of his effort to clarify, his entire class responded unanimously saying, “Live sex without a condom”. This was immediately accompanied by laughter, which meant that all knew and were aware of the practice. Also Valence, a student of Busujju Secondary School expressed a similar view when she said:

> Many youth today, especially girls, fear more the risk of getting pregnant rather than acquiring HIV/AIDS. So someone decides to take the pills so that she does not get pregnant, but doesn’t mind about the HIV infection [TFC2: 475-477, September 11, 2012].

The above statements clearly reveal how students associate unprotected sex with high risk of HIV/AIDS. They further show how young people’s knowledge of what consequences may result from behaviour influenced their decision whether or not to engage in the behaviour. This is well demonstrated in the responses, which indicate that school-going female youths fear
getting pregnant more than contracting HIV/AIDS. In a study carried out on the ways young people represent and respond to HIV/AIDS, Oduro and Arnot (2010) also observed that youth were worried more about teenage pregnancy than about the risk of being infected with what they recognize as a deadly and stigmatizing disease. Heather (2007) argues that while teenagers are concerned about and want to protect themselves from both unplanned pregnancy and HIV/AIDS, they are misinformed about sex and its consequences. I speculate that this knowledge gap creates a deficiency in students’ understandings of the spread and prevention of HIV/AIDS.

Culturally, premarital pregnancy particularly among school-going female youth is detested because of the shame and humiliation it brings to the girl’s family, and the horrendous consequences that include excommunication from family, dropping out of school and related economic hardships to which they are subjected (Jones & Norton, 2007). Besides, premarital pregnancy involves loss of virginity a highly delicate and valuable norm, whose consequences include social rejection, excommunication from family and a bleak future.

Also, I speculate that female youth fear pregnancy more than HIV/AIDS, possibly because of the availability of highly active antiretroviral therapy (HAART). The World Health Organization (2008) suggests that greater access to antiretroviral drug treatment (ART) reduced people’s fear for HIV/AIDS, leading to increased engagement in risky behaviour. This probably gives young people a feeling that with the presence of such drugs, HIV/AIDS can be more manageable than premarital pregnancy. On World AIDS Day 2012, a leading Ugandan medic, Dr. Lydia Mungherera observed that while initially people were scared of contracting HIV/AIDS, they have nowadays relaxed because they know they can now get treatment and no one will predict them as victims of the disease (The Daily Monitor, 2012).
The perspective further manifested when students expressed awareness and belief that although condoms could prevent both HIV/AIDS and pregnancy, their security was not 100% guaranteed. Evans, a student from Kyaggwe Secondary School better expressed this:

In my view people think that by using condoms they will have done away with AIDS but personally, I don’t think that condoms are 100% effective. I think this use of condoms to some extent also contributes to the spread of HIV/AIDS. That is my opinion [TFC4: 57-60, October 12, 2012].

Safety of the condoms became a point of contention during the HIV/AIDS-focused moral education class. Jacy, a student from Buddu Secondary School also expressed a similar belief about the safety of condoms when she said:

I mean if someone had sexual intercourse with a person who is already infected, without any protection like a condom, then that person is likely to catch the disease. Those who use condoms do not get it although you hear some people say that they used the condom but still they got the disease. It makes me feel that even condoms are not all that safe [TFC1: 139-143, September 6, 2012].

Mable, a student from Buddu Secondary School, expressed belief in a diversity of HIV/AIDS preventive methods when she said:

There are so many ways of preventing AIDS like you can use condoms although they are not 100% safe. If we have a will those other channels through which HIV/AIDS is spread, such as the African traditional cultures like widow inheritance can be done away with, which I think is also a way of preventing AIDS. But if we continue to treasure our cultures and people continue to inherit widows, then the spread of HIV/AIDS will be facilitated … [TFC1: 35-41, September 6, 2012].

However, some students like Macey from Buddu Secondary School, expressed the belief in abstinence from sex as the only preventive strategy against HIV/AIDS when she said: “For me, I think AIDS can be prevented through abstinence from sex [TFC1: 44, September 6, 2012].
Abstinence as a component of the ABC approach (Abstain, Be-faithful, and Condom use) to HIV prevention is emphasized at the expense of the latter two, both by the Uganda Government and the media (Stoneburner & Low-Beer, 2004). This is so possibly because it is in line with Ugandan communities’ sexual ethos, and initially part of HIV/AIDS eradication program. It is therefore not surprising that many students were knowledgeable about it. The students’ responses revealed that they were aware of a variety of HIV/AIDS preventive methods. Generally, students had a clear understanding that effective prevention of HIV/AIDS requires a combination of multiple efforts including good will and the ability to let go of “dangerous” practices.

However, students’ argument about the safety of condoms indicated a gap in their HIV/AIDS preventive knowledge. Besides, while they demonstrated awareness of the ability of condoms to reduce a person’s risk of acquiring HIV/AIDS, they were not aware that different types of condoms were more effective than others. This was evident from the manner in which they repeatedly asked questions that sought to clarify the meanings and differences between lambskin, rubber, natural skin, and latex condoms after administration of the survey instrument.

Transmissive knowledge

This manifested during the HIV/AIDS-focused moral education class, when students were sharing views on the main HIV/AIDS transmissive modes. For example in her reflection, Wendy from Busujju Secondary School expressed knowledge of sexual intercourse as the major transmissive mode of HIV/AIDS when she said, “I think HIV/AIDS is mostly transmitted through sexual intercourse with an infected person [TFC2: 57-58, September 11, 2012].

Carol from Buvuma Secondary School alluded to witch doctor’s deceptive treatment and healing practices also as transmissive of HIV/AIDS when she said:
The witch doctors have contributed to the spread of HIV/AIDS in a number of ways, not only through cutting medicines into people’s veins. When women go to witch doctors to be treated of their barrenness, the witch doctors tell them that the medicine can only be administered through sex. In some cases, these witch doctors can be already infected. But the women agree to sleep with them because they are so desperate for a child. In this way, the women get infected by the witch doctor. Many witch doctors use this tactic to trap women [TFCD6: 96-102].

Also Paddy from Mawokota Secondary School expressed a similar view when he said:

“I also believe that the virus is transmitted through having unprotected sex” [TFC7: 47-48].

Participating students insisted that HIV/AIDS is mainly transmitted through unprotected sex. In his reflection, Fabian, a student from Buvuma Secondary School further explained saying, “actually, [...] one can acquire it when they get in contact through sex without a condom” [TFC6: 35-36, November 8, 2012].

The above statements indicate that students were knowledgeable about the various HIV/AIDS transmissive modes, which included heterosexual practices with infected persons, avoidance of which could lead to prevention of the spread of HIV/AIDS.

4.5.5. Perspective Five: Naïve Notions of Prevention and Treatment of HIV/AIDS

This perspective refers to the students’ misunderstandings about the spread and prevention of HIV/AIDS. This perspective is informed by naïve theories. Naïve theories posit that knowledge, and understandings are organized and conceptualized under the influence of everyday culture and language into narrow coherent explanatory frameworks that are different from current acceptable scientific concepts (Driver & Easley, 1978). Also referred to as common-sense theories or folk theories, naïve theories are a coherent set of knowledge and beliefs about concepts, which entail specific causal scientific principles (Driver & Easley, 1978).
Vosniadou (2012) refers to naïve theories as students’ misconceptions that produce systematic patterns of error.

Although naïve theories provide children with abstract frameworks for interpreting concepts, they neither state them precisely nor scientifically. However, children draw on them to build new knowledge (Vosniadou, 2012). As such, students construct conceptual schemes that contain some “correct” notions (in accordance with acceptable scientific theories), connected in various ways with “incorrect” or “partially correct” ideas (Driver & Easley, 1978). This is what Smith, diSessa and Rochelle (1993) refer to as faulty extensions of productive knowledge, since it is the basis for achieving more sophisticated scientific understanding. Given that HIV/AIDS is a phenomenon that can be explained scientifically, in the context of this thesis the naïve notions of prevention and treatment of HIV/AIDS perspective refers to students misconceptions about the prevention and treatment of HIV/AIDS that tend to conflict with scientific concepts (Driver & Easley, 1978).

During the HIV/AIDS-focused moral education class, this perspective manifested when the teacher was discussing possible causes of the increased spread of HIV/AIDS, and when he invited students to share their knowledge of available treatment of HIV/AIDS. I itemized these under five themes: decent dressing as a preventive device of HIV/AIDS, circumcision as preventive of HIV/AIDS, saliva as a transmissive mode of HIV/AIDS, animal-to-human transmission of HIV/AIDS and suitable habitation for HIV/AIDS.

**Decent dressing as a preventive device of HIV/AIDS**

The study revealed that some students perceived increased spread of HIV/AIDS in the country to be due to increased rape and defilement, which results from indecent dressing
particularly among female youth. Wendy, a student from Busujju Secondary School, better expressed this when she said:

I think that today the increased spread of HIV/AIDS is mainly due to indecent dressing which has led to increased cases of defilement and rape. When girls wear miniskirts and “patras” [hot pants] and move around the roads and in the streets, they tempt men who get attracted to them. So, the men wait for a chance to catch them and defile them [...], [TFC2: 615-616; 631-632, September 11, 2012].

The student’s notion of indecent dress encompasses ideas of skimpy, short, tight-fitting and sometimes transparent dresses that leave some parts of the body like the midriff, thighs, and breasts exposed. From a cultural perspective, dressing in such a manner connotes immoral behaviour that includes being sexy, sensual, and sexually provocative towards people of the opposite sex. It is culturally understood as being done to attract attention, and is equated to giving the opposite sex impression of one’s readiness and availability for exploitation. Orakwelu (2012) refers to indecent dressing as “provoking and could trigger some immodest sexual advancement that could lead to assault and rape”, and subsequently, HIV/AIDS transmission (pp. 37-38). This is in congruent with Omede’s (2011) description of indecent dressing as a deliberate act, aimed at appearing sensuous, stimulating and tantalizing in order to draw attention of the opposite sex. Similarly, Egwim (2010) attributes indecent dressing to individuals’ attitudes that dress with the intent to show off parts of their body like the breasts, thighs, particularly those of women that need to be covered.

Students believe that the moral aspect of enforcing descent dressing can contribute positively and complement other efforts in the direction of preventing the spread of HIV/AIDS. According to the participating students, this means that decent dressing is a positive preventive strategy against the transmission and spread of HIV/AIDS. Researchers argue that the causes of defilement and rape are more dependent on one’s mental construct and lack of discipline than the
woman’s type of dressing (Amoo & Adeyemi, 2010; Egwim, 2010; Omede, 2011). Moreover, this could be due to the prevalent stereotypes that places blame squarely on the woman (The New Vision, 2013). Nonetheless, these are culturally shaped and defined. However, it is culturally believed that exposure of a woman’s sensual body parts can entice men into sex, thus calumniating in contraction of HIV/AIDS. Yet, in some communities where skimpy dresses are used, because of the secrecy and penalty that surrounds rape, it is very difficult to tell if it ever happens.

**Circumcision as preventive of HIV/AIDS**

Misunderstandings about HIV were also evident in students’ belief that HIV/AIDS can be prevented through the practice of circumcision. Mable from Buddu Secondary School expressed this when she said:

> I think circumcision is another practice through which HIV/AIDS is prevented especially among men. Once you are circumcised, it is very difficult to get HIV/AIDS. Recently, there are a lot of announcements by government for men to go for circumcision in order to reduce on the spread of HIV/AIDS [TFC1: 263-266, September 6, 2012].

In her reflection, Halima, also from Buddu Secondary School supported this view when she agreed with saying: “I agree with Mable that you cannot get HIV/AIDS once you are circumcised” [TFC1: 269-270, September 6, 2012].

In a contention that arose when Macey, from the same school expressed disbelief in this view that she does not “agree that circumcision can prevent one from getting HIV/AIDS” [TFC1: 268, September 6, 2012], majority of her classmates expressed surprise which implied that they conform to the view that circumcision prevents one from contracting HIV/AIDS.

The statements reveal that student perceptions and knowledge of prevention and
treatment of HIV/AIDS differ from that of the scientific community, media, teacher and the
textbook and connote a gap in students’ understanding of the spread and prevention of
HIV/AIDS. In Uganda, the media is the leading source of information about health issues
(Mutonyi, 2007). As a result, young people mainly learn about HIV/AIDS-related issues from
news reports (The New Vision, 2011; 2012 & 2013. Thus, while students build their views on
available public education, it is also likely that they either incorporate a considerable amount of
misconceptions in their knowledge acquisition or, miss out on important information in the
process of knowledge gathering. In this way, it is possible that students do not understand the
fact that circumcision is only an additional component to other proven methods for preventing
HIV/AIDS infection (Bailey et al. 2007).

According to Sub-Saharan Africa randomized studies, the efficacy of circumcision as an
HIV/AIDS prevention strategy was found to be at 60% (Bailey, et al., 2007; Gray, et al., 2007),
which means that circumcision remains a component of the HIV/AIDS comprehensive
prevention package and not a stand-alone. In this way, students’ perception of male circumcision
as a strategy for preventing HIV/AIDS creates a false and naïve sense of security that contributes
to an increased spread of HIV/AIDS.

It is important to note that the students conveyed two perspectives to the way they
perceived the practice of circumcision. On one hand, when taken literally they saw circumcision
as a hygienic issue. But when looked at from another perspective, students’ statements revealed
naïve understandings of the spread and prevention of HIV/AIDS in relation to circumcision.
Saliva as a transmissive mode of HIV/AIDS

This perspective further manifested in some students’ belief that HIV/AIDS is transmitted through saliva, as evidenced below by students from Buddu and Busujju Secondary Schools respectively:

Beta: There are also two ways I know HIV/AIDS spreads in our community. The first one is among young people through kissing. You know when people kiss each other they exchange saliva and if one of them is already infected then there is a possibility of the other getting the disease [TFC1: 161-162166-167, September 6, 2012].

Amanda: For me, I think that in milk there is some bit of blood and even the baby has got saliva and when the saliva combines with that blood, I think that is where the child can get the virus [TFC2: 116-118, September 11, 2012].

However, this view turned out to be controversial as some students rejected the view that kissing contributes to the spread of HIV/AIDS. For example Alana from Busujju Secondary School argued that:

For me I don’t believe that kissing can make a person contract HIV/AIDS, except when you try to either enjoy deep kissing with someone who is infected when you have some wounds in your mouth or, when you try to get sex satisfaction by kissing the private parts of your partner. That is my view; I don’t know what others think about it. But the fact is that ordinary kissing which is not deep, according to me, does not contribute to the spread of HIV/AIDS [TFC2: 141-146, September 11, 2012].

While many students believed that by avoiding kissing one can prevent the HIV/AIDS, Alana was knowledgeable of the level at which kissing can be dangerous and should be avoided. Similarly, in Mwamwenda’s (2014) study on “HIV/AIDS transmission kissing perception among American and African students”, while some students rejected the notion that an individual can contract HIV/AIDS on basis of kissing, others held on to the belief that kissing can lead to transmission of HIV/AIDS. Thus, according to some students in this study, refraining from kissing can help prevent contracting HIV/AIDS.
Animal-to-human transmission of HIV/AIDS

Another view that represents a misconception was the belief that HIV/AIDS can potentially be transmitted from animals to humans through eating animal products like raw blood. This manifested in a brief dialogue that ensued between one student and her classmates and the teacher during the HIV/AIDS-focused moral education class at Busiro Secondary School as follows:

Jacinta: I think drinking raw animal blood among the “Baruma” (not real tribe) people can also lead to the spread of HIV/AIDS in case the animal is infected.

Class: Blood from the cow?” (looking surprised)

Teacher: Jacky please, explain to us how that happens?

Camila: Madam, does it mean that animals have AIDS?

Teacher: Jacky is going to explain to us. She is trying to recollect. Let us give her time (the class laughs).


It appears that Jacinta was consumed with the idea of the unresolved issues about the origins and emergence of HIV/AIDS and the bush meat practice believed to have been the most plausible venue of transmission of HIV/AIDS from chimpanzees and monkeys to humans (Gao et al., 1999; Sharp et al., 2001). According to HIV origin theories, there is an established knowledge of evolutionary or ecological relationship between the human immunodeficiency virus (HIV) that originated in non-human primates and was transferred to humans, and the simian immunodeficiency viruses (SIVs) endemic in wild apes, particularly chimpanzees (Keele et al., 2006; Gao et al. 1999; Sharpe et al., 2001). Given that recent studies have revealed that
human infections by simian immunodeficiency viruses (SIVs) are not uncommon, Jacinta draws on the natural transfer or “bush meat theory” to advance the view that people who take raw blood must be prone to HIV infection. According to Sharp et al., 2005, the natural transfer or “bush meat theory” is the most plausible explanation for cross-species transmission of HIV/AIDS from animals to humans.

I speculate that Camila introduced the idea of HIV/AIDS transmission from animals to humans, in an effort to engage her classmates and teacher in the discussion with the hope that in the course of the discussion, her doubts or misconceptions would be clarified. It could also be that she wanted to know what her classmates’ thoughts were about this idea. Jacinta was unwilling to discuss her view possibly because she was discouraged by the laughter from her classmates. This very insightful and mythical idea, needed elaboration and clarification, not only to Jacinta, but also to the entire class to whom it appeared to be new. Instead, the teacher just clamped all students’ questioning and expectations and swept the idea under the carpet. Jacinta decided to move on without providing any clarifications, but neither did the teacher intervene. I speculate that probably the teacher was not able to come to a conclusion. On the other hand, it was a pointer to the need for ongoing training for the teachers to be abreast with current theories as they emerge?

In a private conversation outside class I asked Jacinta to explain to me why she thought that animal blood contains HIV/AIDS. She said, “The teacher told us that HIV/AIDS is inhabited in blood.” I deducted that Jacinta considers all blood, no matter whether it is of animals or humans, is potentially infected. To this effect, she could not understand why the “Baruma,” (not real tribe name) people who drink it uncooked, could escape being infected by the virus believed to dwell in it.
Although students were knowledgeable about the general preventive and transmissive modes of HIV/AIDS, data revealed that they also held misconceptions about the manner in which HIV/AIDS is transmitted and prevented.

*Suitable habitations for HIV/AIDS*

This perspective was apparent in the students’ belief that because only particular blood types are suitable habitations for HIV/AIDS, only those with a particular blood type can contract the disease. Therefore, those without vulnerable blood types are considered immune to the disease. This was clear in Lakota’s statement when she said:

> Young people even have their slogans that “kasiima musaayi”, meaning that HIV/AIDS only infects the blood that suites it, or “kasiima mubiru”, meaning that HIV/AIDS cannot infect you unless your body suites it” [TFC3: 51-54, September 25, 2012].

This view reflects the participating students’ complacent attitude, which may be used to further explain why youth indulge in “open sex” or non-use of condoms as we saw in section 4.5.4 above when searching for manifestations of the Predictive, preventive and transmissive knowledge of HIV/AIDS perspective.

**4.6. Summary on Analysis of Class Observation**

Findings from the class observation data confirmed the quantitatively determined perspectives existed in the study population. Observational evidence indicated that the dialogical/interactional experiences stimulated students to draw on their prior knowledge to reflect on what they knew about the spread and prevention of HIV/AIDS and to construct knowledge. It motivated and encouraged students to think about their viewpoints while considering what they and their fellow youth do in particular situations that ignited their
understandings of the spread and prevention of HIV/AIDS. It is hoped that the HIV/AIDS-focused moral education class provided students opportunity for deeper understanding as well as co-construction and reconstruction of their prior understandings of the phenomenon under study.

4.7. After HIV/AIDS-focused Lessons Questionnaire Data Analysis

After the HIV/AIDS-focused moral education class experience, 87 students from four schools (Busiro, Busujju, Kyaddondo and Buvuma Secondary Schools) out of the seven (Busiro, Kyaggwe, Busujju, Kyaddondo, Buddu, Buvuma and Mawokota Secondary Schools) completed the questionnaire that yielded data set 2 to check for any changes that might have occurred in students’ perspectives. This was because other schools were unavailable and only four schools allowed me back. During this time Form 5 moral education lessons in some schools had been scheduled to take place during night preps, as students were to be away on field trips during the day. In this way, I became curious to find out if the student population in these four schools could be representative of the student population in the initial seven schools. Qualitatively, this was possible because all the seven schools had students from similar diverse ethnic backgrounds, as well as from urban, semi-urban and rural. As in the initial set of questionnaire data, analysis of the post-HIV/AIDS-focused lesson questionnaire data started with computation of Cronbach’s Alpha Reliability. Then, statistically, I employed a correlation test to determine whether or not there was a high correlation between the scores of the 87 students in the four schools and the scores of the 198 students in the seven schools using the initial data set. I wish to point out that the 87 students are included in the 198. This correlation could only be determined using the pre-HIV/AIDS-focused lesson questionnaire scores.
4.7.1. Cronbach’s Alpha Reliability for post-HIV/AIDS lesson questionnaire data

When Cronbach’s alpha reliability test was computed on data set 2, alpha was 0.52 (see Table 15), which was slightly higher than the initial questionnaire data (Table 3). This is after the students had been exposed to HIV/AIDS-focused moral education lessons.

Table 14: Case Processing Summary

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- Listwise deletion based on all variables in the procedure.

Table 15: Reliability Statistics 1

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<tr>
<td>PQ28</td>
<td>8.9770</td>
</tr>
<tr>
<td>PQ29</td>
<td>9.4253</td>
</tr>
<tr>
<td>PQ30</td>
<td>6.1264</td>
</tr>
<tr>
<td>PQ31</td>
<td>2.8046</td>
</tr>
<tr>
<td>PQ32</td>
<td>5.8161</td>
</tr>
<tr>
<td>PQ33</td>
<td>8.8161</td>
</tr>
<tr>
<td>PQ34</td>
<td>3.5747</td>
</tr>
<tr>
<td>PQ35</td>
<td>9.3333</td>
</tr>
<tr>
<td>PQ36</td>
<td>9.7356</td>
</tr>
<tr>
<td>PQ37</td>
<td>2.5402</td>
</tr>
</tbody>
</table>
However, results indicated that alpha was still less than 0.7 because of the questionnaire’s multidimensionality (Klein, 1999) (see Tables 14, 15 and 16 above). Cronbach’s alpha reliability had improved by 0.08 from 0.44 to 0.52. It is plausible that after students underwent the HIV/AIDS-focused moral education class experience, the level of randomization reduced.

I then proceeded to perform a paired sample correlation test to determine whether or not the two mean scores of the 198 students and 87 students were significantly correlated.

### Table 17: Paired Samples Statistics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td>6.4577</td>
<td>37</td>
<td>2.61503</td>
<td>.42991</td>
</tr>
<tr>
<td></td>
<td>M2</td>
<td>6.5036</td>
<td>2.55642</td>
<td>.42027</td>
</tr>
</tbody>
</table>

(N = Number of items in the questionnaire)

### Table 18: Paired Samples Correlation

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Correlation</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td>37</td>
<td>.989</td>
<td>.000</td>
</tr>
</tbody>
</table>

(N = Number of items)

### Table 19: Paired Samples Test

<table>
<thead>
<tr>
<th></th>
<th>Paired Differences</th>
<th>95% Confidence Interval of the difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>Std. Deviation</td>
<td>Std. Error Mean</td>
</tr>
<tr>
<td>Pair 1</td>
<td>M1 - M2</td>
<td>-.04590</td>
</tr>
</tbody>
</table>

In Tables 19, results indicated that the correlation between the means was highly significant (p=0.00) and the mean difference was statistically not significant (p=0.468), hence the four schools were indeed representative of the initial seven schools. What this means is that we
could infer claims from data collected from 87 students as also applying to the entire sample of 198 students. Given this high correlation, it was justifiable to make statistical comparisons between data sets from the two student populations. This was further validated by the qualitative description of the location and student population in these schools. Thus the inferences obtained from the seven schools could as well be obtained from the four representative schools that were as well urban, semi urban and rural.

Having established that the student population in the four schools was indeed representative of the 198 students in the seven schools, I investigated the perspectives the students applied after participating in the HIV/AIDS-focused lessons. Similarly, as I did with the initial perspectives, I interrogated these through qualitative methods that comprised of focus group interview/discussions. As well, I compared the perspectives determined from the after HIV/AIDS-focused lessons data and pre-HIV/AIDS-focused lessons data.


In order to explore perspectives underlying the 87 students’ post-experience responses to the HIV/AIDS knowledge questionnaire I repeated the same procedure by performing Principal Component Analysis to see what changes occurred in the previous perspectives. Although 87 cases is a bit on the lower side of the number that should complete a questionnaire to enable factor analysis, in this case it was reasonable to use this number since as I have already demonstrated, this number was a fair representation of the 198 students who had initially completed the questionnaire prior to the HIV/AIDS moral education class experience. Similar procedures as used in the pre-lessons Principal Component Analysis to extract the perspectives were followed. Thus, the analysis resulted in 5 factors or item clusters.
In Table 21 below the total variance explained indicates that the five factors by the post-experience factor analysis could explain 35.187% of the total variance as indicated. The first
factor accounts for about 10.371%, while the second factor accounts for 8.568%. Each of the remaining three factors accounts for between 5% and 6% of the variation.

### Table 21: Total Variance Explained

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Eigenvalues</th>
<th>% of Variance</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.837</td>
<td>10.371</td>
<td>10.371</td>
</tr>
<tr>
<td>2</td>
<td>3.170</td>
<td>8.568</td>
<td>18.939</td>
</tr>
<tr>
<td>3</td>
<td>2.188</td>
<td>5.913</td>
<td>24.852</td>
</tr>
<tr>
<td>4</td>
<td>1.970</td>
<td>5.325</td>
<td>30.177</td>
</tr>
<tr>
<td>5</td>
<td>1.854</td>
<td>5.010</td>
<td>35.187</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.

### 4.9. Interpretation of the New Set of Perspectives

After careful inspection of the clusters I then proceeded to show the factor components and to interpret and define the new perspectives as follows:

#### 4.9.1. Factor 1

Thirteen items (36, 14, 28, 23, 10, 13, 15, 29, 25, 19, 5, 16, and 20) that shared some conceptual meaning loaded on post-experience factor/perspective 1, which I interpreted and described as the *Predictive, preventive and transmissive knowledge of HIV/AIDS* perspective. Results indicated that this perspective persisted. While in the pre-experience factor analysis this perspective was the fourth on the scale with only three items, in the post-experience factor analysis it came first on the scale with as many as thirteen items (see Table 22).
Table 22: Components of Factor 1

| PQ36 | A woman can get HIV if she has vaginal sex with a man who has HIV |
| PQ14 | All pregnant women infected with HIV will have babies born with AIDS |
| PQ28 | A person will not get HIV if she or he is taking antibiotics |
| PQ23 | A person can get HIV even if she or he has sex with a person one time |
| PQ10 | Pulling out the penis before a man climaxes or ‘cums’ keeps a woman from getting HIV during sex |
| PQ13 | Eating healthy foods can keep a person from getting HIV |
| PQ15 | Using a latex condom or rubber can lower a person's chance of getting HIV |
| PQ29 | Having sex with more than one partner can increase a person's chance of being infected with HIV |
| PQ25 | A woman cannot get HIV if she has sex during her period |
| PQ19 | A person can be infected for 5 years or more without getting AIDS |
| PQ5  | HIV can be spread by mosquitoes |
| PQ16 | A person with HIV can look and feel healthy |
| PQ20 | There is a vaccine that can stop adults from getting HIV |

4.9.2. Factor 2

Ten items (26, 6, 35, 24, 22, 7, 8, 12, 9 and 2) that shared some conceptual meaning constituted the components of post-experience factor/perspective 2, which I interpreted and described as the Taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS perspective. In the post-experience factor analysis this factor/perspective emerged as a new perspective and was the second on the scale with a significant number of items (see Table 23).

Table 23: Components of Factor 2

| PQ26 | There is a female condom that can help decrease a woman's chance of getting HIV |
| PQ6  | A person can get HIV by sharing a glass of water with someone who has HIV |
| PQ35 | Athletes who share needles when using steroids can get HIV from the needles |
| PQ24 | Using a lambskin condom or rubber is the best protection against HIV |
| PQ22 | Women are always tested for HIV during their pap smears |
| PQ27 | A natural skin condom works better against HIV than does a latex condom |
| PQ8  | It is possible to get HIV when a person gets a tattoo |
| PQ12 | Showering/ washing one's genitals/ private parts after sex keeps a person from getting HIV |
| PQ9  | A pregnant woman with HIV can give the virus to her unborn baby |

4.9.3. Factor 3

Six items (4, 33, 7, 11, 37 and 1) in Table 25 that shared some conceptual meaning constituted the components of this factor/perspective, which I interpreted as the Contextual view...
of the nature of HIV/AIDS perspective. This too emerged as a new factor/perspective on the post-experience scale and was third on the scale.

Table 24: Components of Factor 3

<table>
<thead>
<tr>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQ4 Coughing and sneezing do not spread HIV</td>
</tr>
<tr>
<td>PQ33 A person can get HIV if having oral sex, mouth on vagina, with a woman</td>
</tr>
<tr>
<td>PQ7 HIV is killed by bleach</td>
</tr>
<tr>
<td>PQ11 A woman can get HIV if she has anal sex with a man</td>
</tr>
<tr>
<td>PQ37 Washing drug use equipment with cold water kills HIV</td>
</tr>
<tr>
<td>PQ1 HIV and AIDS are the same thing</td>
</tr>
</tbody>
</table>

4.9.4. Factor 4

Three items (31, 17, and 32) in Table 25 that shared some conceptual meaning constituted the components of this factor/perspective, which I interpreted and described as the perceptual and behavioural risks associated with proximity to HIV/AIDS victims perspective. This perspective persisted. While it came first on the pre-experience factor analysis, on the post-experience scale it came fourth and with fewer items than before.

Table 25: Components of Factor 4

<table>
<thead>
<tr>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQ31 A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV</td>
</tr>
<tr>
<td>PQ17 People who have been infected with HIV quickly show serious signs of being infected</td>
</tr>
<tr>
<td>PQ32 A person can get HIV through contact with saliva, tears, sweat, or urine</td>
</tr>
</tbody>
</table>

4.9.5. Factor 5

Five items (34, 18, 30, 3 and 21) as indicated in Table 26 constituted the components of this factor/perspective, which I interpreted and described as the Naïve notions of prevention and treatment of HIV/AIDS perspective. This perspective persisted with relatively lesser items but maintained the fifth position on the scale.
Table 26: Components of Factor 5

<table>
<thead>
<tr>
<th>PQ</th>
<th>Component Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQ2</td>
<td>There is a cure for AIDS</td>
</tr>
<tr>
<td>PQ34</td>
<td>Using Vaseline or baby oil with condoms lower the chance of getting HIV</td>
</tr>
<tr>
<td>PQ18</td>
<td>Taking vitamins keeps a person from getting HIV</td>
</tr>
<tr>
<td>PQ30</td>
<td>Taking a test for HIV one week after having sex will tell a person if she or he has HIV</td>
</tr>
<tr>
<td>PQ3</td>
<td>A person can get HIV from a toilet seat</td>
</tr>
<tr>
<td>PQ21</td>
<td>Some drugs have been made for the treatment of AIDS</td>
</tr>
</tbody>
</table>

Thus the new set of factors that resulted from the post-experience computation of PCA, comprised of 1) Predictive, preventive and transmissive knowledge of HIV/AIDS, 2) Taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS, 3) Contextual view of the nature of HIV/AIDS, 4) Perceptual and behavioural risks associated with proximity and contact with HIV/AIDS victims, and 5) Naïve notions of prevention and treatment of HIV/AIDS perspectives. Although they are the same number as in the pre-experience data, the interpretations and descriptions of two of the new clusters are different. Also, the items for each of the post-experience clusters were different from those in the pre-experience clusters. Although some of the pre-experience factors or perspectives remained the same, the number of items that loaded on each of the pre and post-experience clusters were different, hence, the order changed. I considered this to be variation in the degree of dominance of the perspectives most likely due to the HIV/AIDS-focused moral education class experience.

4.10. Focus Group Interview Data Analysis

This study is about students’ perspectives on cultural practices and the spread and prevention of HIV/AIDS. This section presents the results of the focus group discussions interview data set. After the experience of the HIV/AIDS-focused moral education class, I re-administered the questionnaire to check whether or not the students’ pre-experience perspectives changed after they had undergone the HIV/AIDS-focused lessons.
In order to see how the post-HIV/AIDS-focused lesson perspectives manifested, I conducted focus group discussion interviews. The interviews were about students’ understandings of the spread and prevention of HIV/AIDS. Interview data were elicited through focus group interviews/discussions using open-ended questions. Focus group interviews and discussions were conducted in the four selected schools with a random sample of 9-15 students from each of the schools, one month after the HIV/AIDS-focused moral education class experience. The students were randomly selected because I was more interested in their insights rather than the category to which they belonged; and as well, to know if the perspectives ever changed. This is consistent with Seale’s (2012) view that focus group discussions help to explore reasons behind people’s responses, to suggest alternatives and to provide insights into if and why changes may have occurred. Interviews lasted 90 minutes, were recorded and subsequently transcribed. A sample of the interview questions is included in Appendix 4. Focus group interviews and discussions were intended to qualitatively assess if there were any changes in students’ perspectives on the spread and prevention of HIV/AIDS one month after undergoing the HIV/AIDS-focused class experience as well as see how these manifested during focus group interviews and discussions.

Thus, coding, examining and aligning perspective manifestations as well as interpreting the focus group interview data constituted the next item on the qualitative analytical agenda. In this case, the post-experience perspectives which included: 1) predictive, preventive and transmissive knowledge of HIV/AIDS; 2) the taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS; 3) the contextual view of the nature of HIV/AIDS; 4) perceptual and behavioural risks associated with proximity of HIV/AIDS victim; and 5) naïve notions of prevention and treatment of HIV/AIDS, served as the coding schemes for the focus group
transmitted and prevented. This understanding manifested in the students’ responses when I asked open-ended interview questions that included: *What circumstances do you believe to contribute most to the spread of HIV/AIDS today?*

Students appeared to imply that while peer-to-peer interaction can go beyond promoting knowledge acquisition and awareness, as well, it could instigate HIV/AIDS risk laden behaviours. For example, this perspective was evident in Mable’s interview response during focus group interview discussions when she said:

> HIV/AIDS is also spread in circumstances where peer groups gather to share about sex education and […] in the end, youth get together and experiment sex without condoms [FGD1: 158-160, October 23, 2012].

Typically, in most Uganda cultures, it is taboo to talk about sex in public spaces (Mutonyi, 2007). As a result, youth often form their own peer contextual milieu in which they draw on various sources such as family, media and textbooks to co-construct knowledge about sex-related issues including HIV/AIDS. The students exhibited understanding that while peer-to-peer HIV/AIDS information sharing can be effective in raising general HIV/AIDS transmission
and prevention awareness among youth, their coming together can easily create a hot bed for the spread of HIV/AIDS.

This perspective was also exhibited in students’ perceptions of cultural practices as HIV/AIDS risk laden and are plausible conduits of HIV/AIDS transmission. For example, Tayina from Busiro Secondary School in her reflection, expressed awareness that engaging in a practice that allows sharing of wives within the same homestead can be a sure conduit of HIV/AIDS transmission as expressed below:

Another reason why there is an increase of the spread of HIV/AIDS is the practice of wife sharing where a woman is married into a home; apart from the brothers of the groom sharing her, the father-in-law is the first “to test where his cows went.” I think, this practice has played a very big role in increasing spread of HIV/AIDS […] [FGD3: 385-390, November 26, 2012].

Benita, from Busujju Secondary School also cited another practice, which she deemed contributory to the spread of HIV/AIDS when she said:

In my view, cultural practices like widow inheritance facilitated the spread of HIV/AIDS. If the deceased husband of the widow died of HIV/AIDS, it is most likely that the brother of the deceased who inherits this widow will contract the virus, since she is likely to be already sick. Thereafter, the disease spreads to the other wives of the new husband [FGD1: 66-70, October 23, 2012].

Also Belinda from Buddu Secondary School subscribed to a similar view when she said:

Also traditional facial tattooing can lead to the spread of HIV/AIDS, particularly through sharing tattooing instruments like needles and razor blades [FGD1: 142-143, October 23, 2012].

Beta further conformed to the view when she explained the danger that lies in child deliveries under the supervision of traditional birth attendants in rural and unhygienic circumstances.
Also home deliveries under the [...] traditional birth attendants in the villages without gloves are highly risky; [...] of course the chances of contracting HIV in the village environment are high. Sometimes that is how HIV/AIDS is also passed on from the mother to baby because of poor hygienic environments [FGD1: 148-153, October 23, 2012].

Traditional birth attendants are local maternity care providers. Based on my cultural knowledge, they are usually older women, well versed in culture and birth-related taboos and are highly respected in the community for their knowledge and experience. They are often non-literate and have learned their skills through older more experienced traditional birth attendants. Limited resources, as well as traditional and cultural beliefs influence childbirth practices and the choice of the place of delivery (Kyomuhendo, 2003). Thus the students in this study appeared to understand the risks involved in traditional birth attendants’ services and the circumstances in which they are carried out.

This perspective was also expressed in Jacy’s reflection that abolishing or evading cultural practices could be a step towards mitigation of the spread of HIV/AIDS.

If cultural practices like polygamy are abolished and monogamy, which emphasizes one woman for every man is promoted, then that could help prevent this spread of HIV/AIDS [FGD1: 131-133, October 23, 2012].

Students also expressed knowledge that blood pact practices involved incisions and were therefore transmissive of HIV/AIDS. This was better expressed when Eunice said:

Then about the blood pacts, these days when young people want to seal their friendship they make blood pacts. When a boy is in love with a girl and they want to seal their friendship, they get two coffee beads, then they cut themselves anywhere and put the blood from the cuts, smear it on the coffee beads, then they exchange the coffee beads with each other and swallow them. That means that their friendship is sealed and no body should ever break it. Now this blood put on the coffee beads is fresh blood, which may be already infected with HIV/AIDS. Remember the blood is put on the coffee bead and swallowed there and then. Sometimes for me I think they are exchanging the virus with each other. [TFD1: 169-179, September 13, 2012].
In response to Eunice’s reflection, Bonny argued saying:

Some people do not make blood pacts with coffee seeds, but by directly leaking each other’s blood. I think this is equally dangerous as the other blood pact where the coffee seeds are mixed in the two partners’ blood [TFD6: 67-69, November 15, 2012].

The blood pact practice involves making incisions on the body of two individuals involved, rubbing coffee berries in the incisions and exchanging them. Culturally, blood pacts were made between adults. What students explained in the excerpts above appeared to be an imitation of what adult friends do when making an agreement between them. However, it is not permissible for children to exchange blood without knowledge of their parents.

Some students appeared to express the view that adherence to some cultural practices could be a mitigating factor against the spread of HIV/AIDS. For example, this understanding manifested in Joan response when she said:

I believe that there are so many practices that were taken as beliefs that would spread AIDS but again they contribute to the prevention of AIDS. Like virginity in the African Tradition society was highly valued. These days it is not highly valued. But in traditional society, if you were found to have broken your virginity, they would punish you like for example among the “Bashozi” they would take the girls and throw them over the cliff [FGD1: 225-227, October 23, 2012].

The above students’ responses link to the pre-experience perspective, which persisted in spite of its position on the pre and post-experience scales. This confirms the results of the paired t-test, which indicated that the mean difference between the pre and post-experience scores for the items in this cluster/perspective was not significant (p=0.802). Therefore, a similar perspective that drove students’ understandings in the pre-experience HIV/AIDS-focused moral education class discussion continued to guide students’ understandings of the spread and prevention of HIV/AIDS in the post-experience focus group discussion interviews. In this way,
the students’ pre-experience perspective was not impacted by the HIV/AIDS-focused moral education class discussion experience.


This perspective is informed by Steiner’s (1956) theory of taboo, which posits that transgression of social or cultural codes incur automatic penalty without outside intervention. Given the link between breaking of a cultural norm and its consequence, taboos are cultural prohibitions that are enforced by embedded superstitions. The notion of taboos is a vital component of African culture that represents a system of vehement prohibitions of actions or omissions based on the belief that such behaviours are either sacred or a curse for an individual to undertake or to evade (Magessa, 1997). Researchers have referred to taboos as the guiding principles that regulate and direct behaviour of individual and the community towards their gods and ancestors (Steiner, 1956; Omobola, 2013). The theory of taboo assumes that violation of social norms avenges itself (Marshall, 2010). Thus taboos are perceived to contain within them assumed danger that has repercussions against those who transgress them (Omobola, 2013).

Students in this study who participated in focus group interviews exhibited awareness of HIV/AIDS risk laden practices and fear of repercussions that are believed to result from evading such practices or negative attitudes towards them. For instance, Santa reflected:

… if we abandon a practice as youth the older people […] will think that we are showing off. For example, my community still practices the culture of wife sharing. If I decide as an individual not to take part in the practice, it will be seen as a negative reaction and will not be taken easily by members of my community. So I really don’t know how to convince them that it is a bad and dangerous practice, because for them they tell you – this is our culture. So I don’t know, this thing is kind of confusing me, and when I go home they see me as one confusing modernity with culture [FGD2: 63-73, November 6, 2012].
Sandra also exhibited awareness of the HIV/AIDS risk that lies in the practice of wife sharing but dare not talk about it to elders who are thought to be the custodians of culture, as she expressed:

I know it would be difficult […], because a culture like wife sharing has been in existence for so long. You can’t tell your Jjajja (grand father) […]. How dare you? […]. I think it will cause trouble in the community. I don’t accept [to be shared] but there is no choice (students bend over the desks and squeak while others laugh) [FGD2: 94-100, November 6, 2012].

And if you don’t accept [to be shared] you will be chased away from the family and your parents asked to pay back the bride price to the family of your husband [FGD2: 128-129, November 6, 2012].

Related to the classroom discussion, the students also appeared to express the view that prescribed sexual ritual carried out during the practice of wife inheritance were highly risk laden. Benedict better expressed this when he said:

“So, death of the husband cannot not render the widow idle. […] that is why the brother of the deceased had to take over [the widow]. So the family continues to enjoy what the deceased could have enjoyed. But of course it is not a safe practice as far as HIV is concerned [TFD2: 207-213, September 18, 2012].

Although students are aware of the danger that lies in such practices, they undertake it to appease the elders and to conform to the cultural norms in order to evade undesirable consequences that may result from non-participation in a required practice. In this case, the fear is not so much in “causing trouble” as in being despised to the extent of being disowned or suffering throughout one’s entire life. Traditionally, looking upon cultural norms could lead to being excommunicated or even disowned.

At Sandra’s expression, some students bent over their desks and squeaked, while others just laughed. This was indicative that although aware of the risks involved in taking on a
practice, students had divided opinion between being loyal to the community prescriptions and evading the practice in order to remain safe. However, the underlying interpretation is that being sent away for having refused to be shared means risk of remaining unmarried throughout one’s lifetime.

It is important to note that the students’ responses reveal a strong affinity to culture. The students’ responses indicate a transformation in the perspective used to respond to similar questions in the post-experience focus group interview context. This confirmed the results of the paired t-test, which indicated that the mean differences between the pre and post-experience scores on perspective two was highly significant (p=0.028). This meant that the pre-experience hygienic practices perspective was impacted by the HIV/AIDS-focused moral education class experience, and transformed to the Taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS perspective.

4.10.3. Post-Experience Perspective Three: Contextual View of the Nature of HIV/AIDS

In the post-experience focus group interview data, emerged as a new perspective. This perspective is informed by the contextual theory, which posits that every action is situated in and shaped by particular space and time. Within a contextual framework, perceptions are formed through social and linguistic interactions, during which individuals grasp the meanings meant by those participating in the conversation (Gumperz, 1982). As a result, students tend to use codes or metaphors, euphemisms and analogues to code switch in order to create their in-group and to keep out those older than them or do not belong to their group and age. Since the inception of HIV/AIDS, although scholarly studies on metaphors used in relation to HIV/AIDS are scarce, many allusions of metaphors have been created and used by various communities to communicate messages about the pandemic (Mutonyi, 2007; Kobia, 2008). Thus, the
participating students’ in-group context serves as a kind of “social laboratory” in which new ways of knowledge construction and behaviour are experimented. This necessitates users who do not belong to “log in” to access full meanings. This means that students’ understandings of HIV/AIDS are linked to specific contexts that are atypical and of interest to them, and therefore cannot be globally applied in other contexts.

Students in this study who volunteered to participate in the focus group interviews appeared to tailor their perceptions of the spread and prevention of HIV/AIDS to their social context in which they achieve greater understanding and acceptance of the message behind. For example this perspective manifested in Galvin’s reflection when he said:

I think HIV is also spread through promiscuous behaviour among the youth, which include virginity testing, practice makes perfect, and […] This type of behaviour encourages youth to engage in things like virginity testing and practice makes perfect, […] boys and girls, […] trying and saying they are testing their virginity. And they engage more in sex […] in order to become perfect [FGD4: 32-33; 35-47, December 3, 2012].

“Virginity testing” is used variously in different contexts. Ordinarily, virginity testing is a prenuptial practice, traditionally conducted by elderly women on girls shortly prior to marriage to ascertain whether or not a girl is sexually chaste (Erika, 2008). Virginity is tacitly embedded within the abstinence component, which has always been part of the Ugandan ABC campaign against HIV/AIDS. While students perceive abstinence from sex as the best option for preventing HIV/AIDS, they also believe that engaging in sex before marriage can be HIV/AIDS risk laden. In this context, although the use of the expression “virginity testing” is consistent with the cultural ways of expressing, the meaning implied is highly contested in the cultural context. The expression is driven by male chauvinism characterized by the tenacity to score or to win by invoking culture-related practices. This is affirmed by Benedict’s sentiment when he said:
We have a belief that a woman should refuse no man so if I need to have sex and I go to a woman and she refuses I will know she is not serious; but if I persist she will give in [FGD4: 128-130, December 3, 2012].

Culturally, girls are trained not to appear to give in. In other words, they never say yes at first approach. They have to test the resilience. Female students appeared to be aware of this male chauvinism that culturally makes men prone to use persuasive language and female students appeared to subscribe to it as indicated in Sandra’s response:

Naturally, women are supposed to be below men; and if a man says … that is all [FGD2: 104-105, October 23, 2012].

The perspective further showed up when some students appeared to express the view that young women with restored virginity are not susceptible to HIV/AIDS. Tayina best expressed this when she said:

Even this … [idea] of virginity testing is due to the belief that when you are a virgin you cannot catch HIV/AIDS. So when girls hear about herbs, which can restore virginity, they go in for sex to please their boyfriends knowing that after all they will use herbs to restore their virginity [FGD3: 107-111, November 26, 2012].

This is framed in the context of the world of dominance of herbal medicines. Note that herbs for virginity restoration are different from those used at “bush visiting” which we saw earlier. Mills et al. (2005) observe that use of traditional herbal medicines for treatment of HIV/AIDS and associated symptoms is widespread in Africa. Being a virgin and maintaining it is a way of preventing HIV/AIDS. This is similar to abstinence. However, the belief that there are herbs that can restore virginity to prevent contraction of HIV/AIDS is a naïve notion of understanding of the spread and prevention of HIV/AIDS. Therefore, it is not surprising that for the students in this study, virginity is not about abstinence, but rather, about having the hymen kept intact.
When asked to elaborate further on her reflection about restoration of virginity in order to avoid contracting HIV/AIDS, Tayina said, “These things are good when we are only girls” [FGD3: 114, November 26, 2012]. This indicated that this was an only girls practice and was therefore better understood by girls. There was a notion of gender meaning to this. I infer that students’ thinking and actions are greatly influenced by the cultural gender roles of their communities.

This perspective further manifested in Katary’s reflection when she said: I think there is high increase of the spread of AIDS today because of practice makes perfect” (rest of the group burst into laughter) [FGD3: 152-153, November 26, 2012].

Katary further adds:

Yah. This is connected to experimental sex. Some teenagers believe that when you have sex many times with different people, with time you become experienced. Many youth go in for it to prove their manhood or womanhood. In that way they can easily acquire AIDS [FGD3: 156-158, November 26, 2012].

The rhetoric of “practice makes perfect” which we also saw earlier when searching for the pre-experience Behavioural practice and transmission of HIV/AIDS perspective, is contextual to the environments of the students participating in this study.

Further to this, drawing on the metaphoric expressions, the students appeared to express awareness that the sociocultural forms and expectations of sexual practices are HIV/AIDS risk laden, but at the same time they conformed to them. Benedict better expressed this when he said:

… like in our area […] we have a belief that no man should be refused by a woman; so if I need sex and a woman refuses the first time, I will know that she is not serious. But if I persist she will give in (group members laugh) [FGD4: 128-130, December 3, 2012].
Also Jafar expressed a similar view when he said: Yes, we also have the belief that “omusajja atayangwa”, which means a man cannot be denied conjugal rights by a woman [FGD4: 281-283, December 3, 2012]. This is not alien to Haeberle’s (1983) double standard notion, which provides different sexual norms for men and women, and largely operates through indirect pressure, customs and taboos. For example, while girls are expected to remain virgins until they are married boys are expected to have sex, and get some experience. In this way, no questions are raised as to whom the boys are expected to experience with since all girls are supposed to be virgins.

This perspective further manifested in the students’ metaphor of “kasiima musaayi” that characterizes HIV/AIDS as an insect and refer to it as an “it” (“ka”), which makes a choice of its abode. The participating students argued that the nature of HIV/AIDS is such that it chooses where to “enter and live.” Students reported that youth believe that only certain people have the type of blood and body in which HIV/AIDS can be comfortably habited and enhanced to cause devastating effects. Therefore, those without such suitable blood or body never contract HIV/AIDS. Lucky expressed this view saying:

“Young people even have their slogans that “kasiima musaayi”, meaning that HIV/AIDS only catches the blood that suites it, or “kasiima mubiru”, meaning that HIV/AIDS cannot catch you unless your body suites it. Those kinds of slogans make me feel that either young people no longer fear HIV/AIDS, or they are adamant, or they are stubborn [TFC3: 49-56, November 26, 2012].

Students participating in this study expressed a belief that HIV/AIDS is on the increase in their age cohort/community because many appear to have the type of blood suitable for HIV/AIDS. The students in this study draw on their local cultural context of illness and disease that relate to the notion of causation to understand the nature of HIV/AIDS, which informs the way they understand its transmission. It is therefore not surprising that the participating students
perceive HIV/AIDS as intrusive in a sense that it enters the human body from the outside to begin “eating” from within to cause illness. The students personify HIV/AIDS as an intelligent insect, capable of making a choice of the abode in which to dwell – “kasiima” (it chooses) “musaayi” (the blood in which to dwell). The metaphor of HIV/AIDS as an insect that enters the body implies that HIV/AIDS eats from within without the knowledge of the victim. Culturally, insects that usually eat without the victim knowing come to the area as a plague, an indication that HIV/AIDS is a destructive scourge, dangerous and unpredictable killer. I speculate that this perception of HIV/AIDS as an insect is also partially deeply rooted in the complexities and vulnerabilities created by the students’ own promiscuous behaviours coupled with a complacent attitude towards HIV/AIDS about which Linda expresses concern. A complacent attitude, in which they think that their own blood may not be of comfort for HIV/AIDS to dwell in, is in itself HIV/AIDS-risk laden. I also speculate that probably explains why they may engage in unprotected sex.

Of particular importance, students also expressed awareness that the fear of dying alone as a way of vengeance is also a contributory factor to the spread of HIV/AIDS today. Jane better expressed this when she said:

"Today, if teenagers find out that they are suffering from AIDS, they want to spread it to other people. You know they say that [...] they don’t want to die alone [FGD3: 178-180, November 26, 2012]."

Tayina clarified and complemented this view when she said:

"AIDS is spread through revenge where someone knows he is infected with the virus and he or she deliberately looks out for opportune moments to pass it on to other people [FGD3: 182-186, November 26, 2012]."
Fear of dying alone connotes awareness or realization of the deadliness of HIV/AIDS, which, once contracted, one cannot survive but die. The students’ facial expressions and nodding positively as Tayina shared her reflection indicated that many of them concurred with what Jane and Tayina expressed.

The use of metaphoric expressions that sometimes included code switching may be explained by the cultural prohibitions that do not permit youth and children to talk about sex related issues openly. Amorim (2012) observes that students code switch either to show solidarity and collective understanding of what they are talking about, to express their ideas more quickly and accurately, or to exclude an outsider. It is also possible that the participating students lacked equivalent words of expression in English language.

The above students’ interview responses reveal that the students’ pre lesson behavioural/practice causes and transmission of HIV/AIDS perspective had been impacted by the HIV/AIDS-focused moral education class experience. During the post-experience focus group interviews, students changed the ways they now understood the spread and prevention of HIV/AIDS by using a new perspective.

4.10.4. Post-Experience Perspective Four: Perceptual and Behavioural Risks Associated with Proximity and Contact with HIV/AIDS Victims

This perspective persisted in the post-experience factor extraction. In an effort to probe the views students presented during the HIV/AIDS-focused moral education class experience in relation to the same pre-experience perspective, I asked the question: *What circumstances do you consider to contribute to the increased spread of HIV/AIDS in your community?* This perspective manifested when students who participated in the focus group interviews appeared to express
awareness of circumstances that are HIV/AIDS risk laden. For example, in her response, Nancy said:

Some of us acquire HIV through sharing materials like razor blades, shavers e.t.c, through which HIV is easily transmitted from one person to another [FGD3: 223-224, November 26, 2012].

The perspective further showed up when Sam in his reflections expressed awareness that sharing tattooing instruments with infected people is risk laden for youth who participate in the practice of tattooing.

I think tattooing in groups is another way of spreading HIV/AIDS through sharing the body-piercing instruments. Because the act of tattooing involves spilling of blood and use of shared sharp instruments on each other’s body, it is easy for those involved to infect each other in case one of them happens to be already infected with HIV/AIDS.

Another manifestation appeared in Pamela’s reflection on the danger that arises from uncontrolled peer group pressures when she said: I think that increase in the spread of HIV/AIDS is due to group influence among youth. Some people are easily influenced by the behaviours of their friends [FGD3: 226-227, November 26, 2012]. Achit appeared to support Pamela’s view that flawed and misleading expressions of youth influence them to engage in HIV/AIDS risk laden behaviour when she said:

Most girls are influenced by their friends. They have a saying that being a virgin is lack of opportunity. So when a girl who is virgin hears that she gets influenced and she is like Oh God I have to break it (class bursts into laughter). I think this kind of feeling is what makes girls go in for sex and the end result is acquisition of HIV/AIDS [FGD3: 282-286, November 26, 2012].

The perspective further manifested in Paschal’s reflection on lack of sexual control among youth when he said:
For me I think that AIDS is on high increase due to the high libido among the youth. For example in our class here, (class bursts into laughter), you find that the girls go in for the boys and in the process they end up having sex. This kind of lack of self-control and random friendship with different girls every other day, there is no way you can escape the virus. I believe this is another way of spreading HIV/AIDS [FGD3: 266-271, November 26, 2012].

Panya alluded to the risks embedded in unlimited freedom of movement that we saw in the pre-experience perspective when she said:

For me I think HIV is rampant because of unlimited movement of people in urban areas during awkward hours without fear of rampant sexual immorality like rape. Now when you are moving at night a person can rape you and during that process of rape a person cannot use a condom and this means having live sex and leading to the spread of HIV/AIDS [FGD3: 241-245, November 26, 2012].

The above students’ responses conveyed the same perspective I observed during the HIV/AIDS-focused moral education discussion. Although probing the same thing, students who participated in the post-experience focus group interviews drew on the same views to answer different questions. This means that the pre-experience perceptual and behavioural risks associated with proximity and contact with HIV/AIDS victims’ perspective was not impacted by the pre-experience HIV/AIDS-focused moral education class discussion.

4.10.5. Post-Experience Perspective Five: Naïve Notions of Prevention and Treatment of HIV/AIDS

This perspective also persisted after the HIV/AIDS-focused moral education class discussion experience. Responding to the question: What circumstances do you consider to contribute to the increased spread of HIV/AIDS in your community, students appeared to express the view that decent dressing can be a strategy to prevent HIV/AIDS. Kala better expressed this when she said:
I think also the indecent dressing of the youth, particularly girls, which includes mini skirts, kundi-shows, back shows and the likes attract men to them. Those men have high libido and such dressing easily leads them to rape girls, hence the spread of HIV/AIDS [FGD3: 255-258, November 26, 2012].

Some students expressed belief that circumcision can stop one from acquiring HIV/AIDS.

Mable, from Buddu Secondary School, better expressed this when she said:

I think circumcision is another cultural practice through which HIV/AIDS is prevented especially among men. Once you are circumcised, it is very difficult to get HIV/AIDS. Recently, there are even a lot of announcements by government for men to go for circumcision in order to reduce on the spread of HIV/AIDS [FGD1: 262-265, October 23, 2012].

This view provoked a contentious debate among students. For example, Macey could not agree to this view when she said:

Personally, I do not agree that circumcision can prevent one from getting HIV/AIDS [FGD1: 266, October 23, 2012].

Yet Halima subscribed to the same view as expressed in her reflection:

I don’t think circumcision would be emphasized if it were not preventive of HIV/AIDS. So, I agree with Magdalene that one cannot get HIV/AIDS once he is circumcised FGD1: 268-269, October 23, 2012].

Also Marlon from Busiro Secondary School expressed a similar view when he said:

There is a belief today in Uganda among some men, that after being circumcised one cannot acquire HIV/AIDS. So some men go in for unprotected sex thinking that because they are circumcised they cannot get the disease. Hence, spreading the disease to other people [FGD3: 305-308, November 26, 2012].

It is interesting that the same students that advanced this argument during the HIV/AIDS-focused moral education class discussion extended it to the focus group interviews discussions.
This is not unlike Driver and Easley’s (1978) observation that children bring to the learning task alternative frameworks, preconceptions or misconceptions that are robust and difficult to extinguish through teaching.

This perspective further manifested in students’ belief that ignorance about sexual issues was a preventive strategy against the risk of contracting HIV/AIDS. In this respect, Barbra appeared to commend the traditional view of keeping young people ignorant about sex and sex related issues until they were of marriageable age, as this could prevent young people from acquiring HIV/AIDS.

Also, keeping young people ignorant about sex and sex related issues can help them to grow without knowing what sex is about until they are of marriageable age. This practice can help young people keep themselves safe from HIV/AIDS, because if you grow up innocent about something you can never know when and how do it. So I think sparing young people from hearing about sex until they get married, can save them a great deal. Today young people know everything about sex much earlier than their age. That is why sex experimentation is rampart and HIV/AIDS is on the rise [FGD1: 242-244, October 23, 2012].

Also Belinda expressed a related view when she said:

In truly African traditional homes here in Uganda, there is a practice that does not permit freedom of interaction between boys and the girls. These interactions are limited […]. So I think this cultural practice can lead to or help in the prevention of the spread of HIV/AIDS [FGD1: 190-196, October 23, 2012].

Related to the aforementioned view was the belief that identifying a partner for a young man or woman saved him or her from contracting HIV/AIDS. Again, Margaret better expressed this when she said:

Another thing I see positive […] about prevention of HIV/AIDS is that the girls were never free to look for their marriage partners. This was the responsibility of their parents to determine that their daughter was ready for married and then they would look around for a suitable partner for her. This involved identifying the partner and at the same time
investigating about him, his behaviours, health, parents, home background, members of his extended family and even people he related with. If they found out that the young man was abnormal or sickly – they would cancel the idea of their daughter marrying him. If that is upheld today, such investigations can help to […] and to prevent the chances of catching or transmitting HIV/AIDS to their daughter [FGD1: 250-260, October 23, 2012].

Furthermore, students also appeared to express the view that HIV/AIDS is not different from other bacterial diseases, and that everyone must somehow contract it. Patricia better expressed this when she said:

In my view, people take HIV like any other sickness and they say whether you get it or not, it is just a disease like any other disease. This kind of belief is mainly among youth like us. We take AIDS like malaria. So we don’t fear AIDS and we go in for sex knowing that everyone will get it [FGD3: 120-123, November 26, 2012].

The above students’ responses convey the same perspective I observed during the HIV/AIDS-focused moral education class discussion. These statements indicate an extension of the students’ misconceptions about the spread and prevention of HIV/AIDS after the HIV/AIDS-focused moral education class experience.

Besides, these naïve understandings of the spread and prevention of HIV/AIDS revealed a knowledge gap of the need for sex education in the growing process of young people and the role it plays in highlighting HIV/AIDS literacy particularly in the school programs. Students also underestimated the fact that today young people have greater freedom to move and interact, as well as making appointments to meet away from the elders.

4.1. Summary

Analysis of the entire data indicated that prior to the HIV/AIDS-focused moral education class experience, five core perspectives that were extracted from the pre-experience data set through use of PCA described the participating students’ underlying perspectives on the spread
and prevention of HIV/AIDS. These included the *Perceptual and behavioural risks associated with proximity to HIV/AIDS victims*, *Hygienic practices, Behavioural/practice causes and transmission of HIV/AIDS*, *Predictive, preventive and transmissive knowledge of HIV/AIDS*, and *the Naïve notions of prevention and treatment of HIV/AIDS* perspectives. These five perspectives became the central perspectives of the participating students.

Transcripts of the teacher-facilitated HIV/AIDS-focused moral education class were reviewed to identify statements that related to participating students’ perspectives on the spread and prevention of HIV/AIDS. Through reading forth and back, over and over again, verbatim statements from students’ responses were identified. Using verbatim quotations and taking into consideration the social interactions between students, and the circumstances that occasioned their responses, provided a means of presenting participating students’ opinions and descriptions. This is because social interactions are a product of intended and meaningful behaviour that make reference to understandings of a shared social world or phenomenon (Morris, 1978).

After participating in the HIV/AIDS-focused moral education class, computation of the mean differences of the items in the pre and post-experience data sets indicated that three of these perspectives were not impacted. Therefore they manifested as such in the post-experience interview about how the students understood the spread and prevention of HIV/AIDS. These included: the *Perceptual and behavioural risks associated with proximity to HIV/AIDS victims*, *Predictive, preventive and transmissive knowledge of HIV/AIDS*, and *the Naïve notions of prevention and treatment of HIV/AIDS* perspectives. Two new perspectives were determined in addition. These included the *Taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS* and the *Contextual view of the nature of HIV/AIDS* perspectives. These also
manifested in the post-experience focus group interview discussions. The next section answers Research Question 2.

4.12. Some Core Cultural Practices

This section answers research question two: Research Question 2: What core cultural practices have the greatest influence on Uganda’s high school students’ understanding of the spread and prevention of HIV/AIDS? Making classroom observations and conducting focus group interviews key cultural practices that appeared to have influenced or to be influencing the students’ understandings of the spread and prevention of HIV/AIDS came to surface as the students shared their reflections. Thus in the above analysis, in which an attempt has been made to answer question one about key perspectives, several cultural practices have been implicitly or explicitly implicated. Key ones have been captured in the excerpted transcripts during qualitative data coding. These include: communalism and interdependence, traditional treatment and healing practice, blood pact practice, visiting the bush or labia elongation, wife inheritance and wife sharing, circumcision, abstinence, descent dressing, and traditional birth attendant practice. In a way, while the above first two practices are norms, all the rest are rituals. Based on their transformative role, rituals are rites of passage (Bell, 2003; Cushing, 1998). In this way, they facilitate an individual’s transition from one state to another, such as from childhood to adulthood.

4.12.1. Communalism and Interdependence

This practice featured in the above analysis, while searching for manifestations of the hygienic practices perspective during observation of the HIV/AIDS-focused moral education class. It also featured while searching for manifestations of the post-experience “perceptual and
behavioural risks associated with proximity and contact with HIV/AIDS victims” perspective. In both searches, the students in this study alluded to communal sharing and interdependence when they referred to: “girls sharing tattooing instruments”, and “family sharing of razorblades and needles as a result of family economic constraints respectively.

Communalism and interdependence are core values and defining characteristics of African culture (Menkiti, 1984), and in particular, of Ugandan ethnic communities. They are intrinsically intertwined with communitarianism, and together, they flow out of culture and are transmitted from one generation to another by means of oral genres such as proverbs, myths and story telling. Gyekye (1987) observes that the sense of communalism, which characterizes social relations among individuals in the African society, is a direct consequence of communitarianism. Communitarianism is a philosophy that emphasizes the social realm over the individual. Broadly speaking, African societies are communitarian in nature particularly in the way individuals think of themselves as part of a group, and consider the community first since many individuals share it. This is what Menkiti (1984) refers to when he says that in much of Africa, the community has priority over the individual. In other words, communitarianism seeks to lessen the focus on individual rights and increase the focus on communal responsibilities. Within a communitarian framework, people ideally achieve in groups, which assume joint responsibility. In this way, communalism and interdependence are embedded in a context of social relationships and interdependence, which sees the human person as an inherently communal being, linked by interpersonal bonds, biological or non-biological (Menkiti, 1984; Gyekye, 1987). Sekou Toure (quoted in Gyekye, 1987), views the African society as fundamentally communocratic, bound to live in a communalist spirit. In his description of African communalism he asserts that,
The collective life and social solidarity give it a basis of humanism […], [which] mean(s) that an individual cannot imagine organizing his life outside that of his family, village or clan (Sekou Toure quoted in Gekye, 1987, p. 209).

With this understanding, Mbiti’s (1970) statement “I am because we are, and since we are, therefore I am” is an expression of the spirit of communalism ingrained in the minds of the African people. Thus, in the African context communalism advocates a life lived in cooperation, aid and interdependence with others, a life in which one is liable to share and reciprocate the sharing when in need.

While students in this study appeared to appreciate the spirit and value of this practice, they understood that, taken out of context or when misapplied, it does pose risks of transmission of HIV/AIDS, particularly through sharing incising instruments with people who may have the virus even if they are members of their own families.

4.12.2. Traditional Treatment and Healing Practice

This practice was featured during observation of the HIV/AIDS-focused moral education class when seeking for manifestations of the hygienic practices perspective. Airhihenbuwa (2012) observes that culture plays a vital role in determining the level of health of the individual, the family and the community. As such, traditional treatment and healing practices are an integral part of the local culture and are appreciated as key components in diseases and illnesses diagnostic and treatment and healing processes. However, these treatment and healing practices involve a complex combination of activities, order of knowledge, beliefs and customs required for effective diagnosis, prevention or elimination of imbalances in physical or social wellbeing (Eisheit, 2003). According to available literature, probably the most lethal traditional treatment
and healing practices are those that involve skin incision leading to blood letting (Hrdy, 1987; Peters, Immamamagha, Essein, & Ekott, 2004; Truter, 2007).

During their reflections, the students in this study alluded to “the traditional healer who cuts them [his patients] and puts medicine in their veins”, and referred to his treatment and healing practices as unhygienic. As indicated in the analysis of the perspectives above, the students in this study perceive skin incision coupled with the use of unsterilized instruments as some of the key HIV/AIDS risk laden practices used in traditional treatment and healing. The students appeared to be knowledgeable, probably from their school learning that once a person’s skin is broken by use of a needle, knife or blade and the tissue fragments, it adheres to the implement and can easily be transmitted into another person’s blood stream if worked upon using the same implement.

Further to this, the students in this study also appeared to understand that traditional treatment and healing practices that involve the use of unsterilized instruments, particularly the reuse of contaminated blades between patients were potentially HIV/AIDS risk laden. In addition, the students were knowledgeable that the healers’ contact with the blood and other body fluids of multiple patients was a source of infection not only for the traditional healers, but also to for many other non-HIV/AIDS patients who go to them for treatment and healing.

Relatedly, also when seeking for manifestations of the pre-experience Predictive, preventive and transmissive knowledge of HIV/AIDS perspective, the students in this study alluded to healing practices of witch doctors, which they believed to be transmissive of HIV/AIDS as Catherine indicated that when women go to witch doctors to be treated of their barrenness, […] the medicine can only be administered through sex […], and that these witch
doctors can be already infected. This is consistent with the assertion of Jjemba a former witch doctor who said:

I was a witchcraft practitioner and I know everything that takes place in every corner of the shrines. These people are doing nothing apart from […] [having sex with] women under the pretext of giving them fertility, while those who are still going there are facing more problems (Lukwago, The New Vision March 17, 2014).

As we saw earlier, based on the notion of causation and influenced by superstition, people believe that sickness, barrenness or anything wrong is often a result of some form of witchcraft. This influences people to seek for witch doctors to be ridded of the witchcraft. Thus witch doctors are “healers who specialize in curing the effects of witchcraft” (Lugira, 2009, p.100). However, according to the students in this study, the witch doctors’ means of healing are deceptive and have implications for the transmission of HIV/AIDS.

4.12.3. Blood Pact Practice

This practice was featured in the focus group interview discussions when searching for the post-experience “Predictive, preventive and transmissive knowledge of HIV/AIDS” perspective. Blood pact is a traditional practice that aims to create an unbreakable bond between two parties. Obbo (1979) asserts that blood pacts are made for various reasons such as guaranteeing faithfulness, protection and unity. Sentongo and Bartoli (2012) observe that the practice symbolizes a binding lifetime assurance of mutual support, commitment to non-aggression and openness, all based on love and trust between the parties involved. According to Kenyon (1969) and Ibuot (2014), the practice is meant to provide protection or security for the physical, emotional, financial and spiritual aspects of the lives of the individuals involved. The practice involves exchanging a small amount of venous blood via the binding of excisions, and is typically prevalent among males only (Winter, 1965).
When culturally carried out, the elder makes the incisions on the abdominal and heart regions of both parties such that some blood can ooze out. He then takes a coffee bean, breaks it open, and smears it with the blood of each of the parties. He lets each of them swallow half the coffee bean accompanied by pronouncement of a kind of commitment such as this one:

As we have become friends, let the stomach of whoever cheats his friend swell. When I visit you, at any time, you will not send me away. If I become poor you will not discard me. We will never do anything to harm any of our relatives and friends. May our ancestors be our witnesses. May God approve our friendship, our brotherhood (Byaruhanga, 1989).

Once accomplished, a blood pact bound not only those involved in exchanging the blood, but also their kinsmen or extended family members. That is why blood pacts are very serious commitments that they are never broken. Recounting the explorer Stanley’s experience of the practice with the people of East Africa, Kenyon (1969) reports that,

In Africa, if one was to break the [blood pact], his own mother or wife, or his nearest relatives would seek his death, would turn him over to the hands of the avenger for destruction. No man can live in Africa who breaks the [blood pact] … he curses the very ground he walks on (Kenyon, 1969, p.12).

The students in this study said that when a boy is in love with a girl and wants to seal their friendship, they enter a blood pact. As Beta explained, “that means their friendship is sealed and no body should ever break it”. For young people, blood pacts are only one further step in their pursuit of enjoyment or of finding a purposeful empty life. What the students referred to happening between young lovers appears to be an imitation of what adult friends do when making a blood pact. Unlike the traditional practice where individuals involved are bound together with their family members, in the case of the students, it binds only the two friends leaving out the family members. This is consistent with Evan-Prichard’s (1933) view that today,
people care less for the opinions of their kin and have the courage to enter an alliance of brotherhood pact without informing their senior relatives about the matter at hand. However, the students appeared fully knowledgeable about the implications for HIV/AIDS transmission if they allowed blood to flow in one another’s vein.

4.12.4. Wife Sharing and Wife Inheritance

These practices were featured in the focus group interview discussions when searching for the post-experience “Predictive, preventive and transmissive knowledge of HIV/AIDS” and the “taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS perspectives. On one hand, wife sharing is a practice where traditionally, a new wife is considered an addition to the family and the clan and can therefore be sexually accessed by all adult males in her new home (Sengendo & Sekatawa, 1999). On the other hand, wife inheritance, also known as bride inheritance, is a practice where her deceased husband’s relative automatically becomes her new husband as dictated by the cultural protocols of the community and usually camouflaged by taboo-like pronouncements (Kisekka, 1989; (Magezi, 1990; Ntozi & Kabera, 1991; Kirumira, 1992; Gwako, 1998; Müller & Moyo, 2011). Researchers advance different reasons for the practice. For example, Gwako (1998) asserts that widow inheritance is meant to provide financial support to the widow and her children, and to keep her late husband's wealth within the family bloodline. Müller and Moyo (2011) observe that the practice is meant to appease the spirit of the deceased man and to stop his spirit from visiting and punishing the family, and as well, to help the woman avoid promiscuity.

The students in this study appeared to be clearly knowledgeable that these two practices have the greatest risk of transmission of HIV/AIDS. The students described wife sharing as the most deadly practice they have ever known in relation to the spread of HIV/AIDS and
highlighted the embedded danger. Benedict better expressed this when he said:

In this practice, a married woman belongs not only to her husband, but to the whole clan. It is something similar to wife sharing. [...] when a woman is married to a family, the father-in-law is the first to sleep with her because he contributed the bigger bride price. And then every male in the family is free to sleep with that woman, because they all contributed to the bride price. This practice is considered to be the greatest killer during this era of HIV/AIDS. The practice was there before HIV/AIDS came. But even after people realized that HIV/AIDS is transmitted through sexual intercourse, they have not stopped this practice. Even up to now this practice is highly cherished [...] in spite of the sensitization Government has done among the people. I think this is one of the die-hard cultures, because it can make everybody in the family sick with HIV/AIDS, but when the young ones come up and become of age to marry, they also feel they should fulfill the custom of their society as their elders did. Then you find the entire family is HIV positive. [TFCD4: 152-166, October 12, 2012].

The students appeared to be well informed about the practices and the dangers involved in them. They appeared to be knowledgeable that the beginning of a marriage is the basis of calculation of subsequent cause-effect correlations. I noted that the students in this study vividly imagined the possible outcome of such a marriage. I was made to understand that after marriage of a bride, family ties are believed to be enhanced by brothers having sexual intercourse with their brothers' wives and fathers with daughters in-law. This is consistent with Yeld’s (1973) assertion that once the bride arrives in the home, sexual accessibility to her is acceptable to the grooms’ father, as well as his brothers as a way of ensuring fertility (also see Kubahire, 1981). Traditionally, it is the responsibility of the father to pay the bride wealth for his son. Kubahire (1981) observes that families pool resources together to raise the bride wealth capital for obtaining a wife to one of the brothers. Thus as a cultural value, the father of the man would be the first to sleep with his daughter in law and initiate sex as a way of checking if what the bride wealth brought into the home was worth it. This is what Oberg (1938) and Elam (1973) referred to as the father of the bridegroom having the right to test where his cows went. From a cultural perspective, this is also seen as a welcome gesture to the new bride, and is as well meant to
provide a cover for his inexperienced son.

I observed that while some students knew about this practice prior to the study, other students only learned about it during the study. However, based on their predictive knowledge, all the students appeared to recognize the risks involved and the intertwined dilemma. I also observed that during interaction on the practice of wife sharing, the students in this study portrayed a sense of fear and uncertainty, a kind of cognitive dissonance or mental discomfort about the practice, and at the same time appeared to be gripped by a dilemma and a feeling of inability to disentangle themselves from it. I infer that this was possibly a result of conflict between what practice, which they perceived as “obligatory”, and what they considered to be ideal, coupled with the fear of the consequences that go with negating it. Samalie’s responses to the question of how she would react to the practice if she got married conformed to these feeling when she said:

I don’t accept but there is no choice. And if you don’t accept you will be chased away from the family and your parents asked to pay back the bride price to the family of your husband. According to that practice of […], I know it would be difficult for a young girl to convince your people to change. Because a culture like sharing wives has been around for a long time. You can’t tell your “Jajja” (grandpa) that don’t share wives!” How dare you do that? […]. I think it will cause trouble in the community [FGD3: 107, 128, September 25, 2015].

This dynamic shift between certitude and uncertainty constitutes the core of the risks involved in the practice of which the students are fully aware. Leticia confessed to this fact when she said, “If I decide not to take part in the practice, it will be seen as negative […], and […] will not be taken easily. I don’t know, […] but they see me as confusing modernity with culture.”
4.12.5. Visiting the Bush/Labia Elongation

This practice was featured during observation when searching for manifestations of the hygienic practices perspective. Culturally, visiting the bush is the traditional preparation of girls for marriage and sex related issues (Tamale, 2005). Unlike female circumcision, which is reductive through removal of some parts of the genitalia by cutting, labial elongation is expansive through stretching (Tamale, 2005; Larsen, 2010; Martine Perez & Namulondo, 2011). The practice is mandatory for girls between 10 and 15 across several communities in and outside Uganda (Larsen, 2010). A woman who did not elongate the labia minora, is traditionally despised, and at marriage, if found not to have done so, she is returned to her parents, with disgrace (Ssengendo, et. al, 1998). In the Ugandan context, the aunts or “Ssengas” as they are locally known, who are responsible for girls’ sex education, counseling and preparation for womanhood and marriage (Tamale, 2005) are the primary experts on how the practice ought to be carried out. In families where the western influence tends to dominate their lifestyles, the responsibility is relegated to school matrons and the senior women teachers as best expressed by Olivia: “For example in the school matrons or senior woman teachers prepare the girls to undergo visiting the bush. They just let girls stay in the dormitories and practice the thing there” [FGD2: 262-264]. She further clarified saying:

You know the Matron makes these girls line up. Because they are many, she cannot handle one by one. So she makes them line up and demonstrates for them how to do it. She demonstrates from one girl to another. Then she groups them to do it on each other. Remember those private parts have fluids and sometimes blood. By touching one’s fluid and another, the virus can easily be transmitted. So that is why it is a cultural practice that contributes to the spread of HIV/AIDS [FGD2: 271-277].

As we saw above in the manifestation of the hygienic practices perspective, although visiting the bush does not involve any intent of mutilation leading to bloodletting the students in
this study appeared to be more reflective about “…. the herbs she [the auntie] uses to pull” and how they “can make bruises on the labia [...] since the practice is carried out in the bush, and the aunties neither wash their hands nor put on gloves”. The students seemed to indicate that given the tender bodies of young girls aged 9 to 16, in case of accidental cuts or bruises as a result of the pulling, there would be a likelihood of passing on the virus either from aunt to niece, or from one initiate to another.

4.12.6. Circumcision

Also this practice was featured when searching for manifestations of the hygienic practices perspective during observation of the HIV/AIDS-focused moral education class. Circumcision is a form of surgical and ritual operations performed on human sex organs. There are two forms of circumcision, namely, male and female circumcision, and the ways in which it is carried out in each case differs from one community to another. The latter is also sometimes referred to as female genital mutilation (FGM), which also differs from community to community.

Circumcision, as a rite of passage to mark transition from childhood to adulthood is culturally valued. The circumcision practice is considered highly significant, not only to the individual involved, but also to the individual’s circumcision regiment and to the entire community (Mandova & Mutonhori, 2013). The basis of circumcision is its deeply embedded cultural values. Culturally, circumcision is valued as the gateway to marriage and parenthood (Adhunga, 2014). This is consistent with Kenyatta’s view that circumcision is considered to be a “deciding factor in giving a boy or girl the status of manhood or womanhood” (Kenyatta, 1979, p. 154). Also, Magesa (1998) stipulates that the most significant instruction on life of the clan, individual’s rights and responsibilities in society, and the transition from childhood to adulthood
is only achieved during the process of circumcision. The removal of the boy’s foreskin, which corresponds to the girl’s sexual organs, and the girl’s clitoris, which corresponds to the male sex organ, makes the initiates men and women, and gives them their gender role in the community. In the case of females, circumcision is associated with cultural ideals of femininity and modesty, which include the notion that girls are “clean” and "beautiful" after removal of body parts that are considered "male" or "unclean". Thus, it is believed that through clitoridectomy or female circumcision, the practice functions to eliminate the male aspect in females, reduce their libido and helps them to resist illicit sexual acts (Magesa, 1998). The seclusion period coupled with the mingling of the initiates’ blood through use of the same knife is believed to create a strong bond among initiates of the same group for a lifetime, while the spilling of the blood to the ground symbolizes a covenant between the community and the individual initiates.

However, in light of the spread of HIV/AIDS, these values seem to be threatened. While the traditional circumcision knife is valued for its bonding symbolism among circumcision initiates, some students who participated in this study appeared to perceive circumcision as a life threatening practice, and the knife as a transmissive tool of HIV/AIDS across a given cohort of initiates. The students were knowledgeable that the communal use of the knife renders it highly risk laden. Winnie better expressed this in her reflection when she said: “HIV is spread through circumcision particularly when the same instrument is used on different people that may include those infected and those not infected” [TFCD2: 156-158]. Also Jesca expressed a similar idea when she said:

In my view, if cultural practices like circumcision or female genital mutilation are practiced, let the traditional circumcisers and mutilators use different knives or objects for different people in order to avoid transmission of HIV/AIDS from one person to the other.
This is consistent with Wilcken, Keil and Dick’s (2010) observation that traditional service providers with no formal medical training usually perform the procedure generally referred to as traditional circumcision in non-clinical settings. UNICEF (2013) observes that even when performed by medically trained personnel, circumcision can also lead to bleeding during sex, thereby exposing one to the risk of HIV/AIDS.

4.12.7. Abstinence

This cultural practice was featured both when searching for manifestations of the *predictive, preventive and transmissive knowledge of HIV/AIDS* perspective before and after the experience, and the *contextual view of the nature of HIV/AIDS* perspective. Although the terms “abstinence” and “virginity” are culturally synonymous, the contexts in which the participating students used them in the manifestations of the two perspectives differed. In the manifestations of the *predictive, preventive and transmissive knowledge of HIV/AIDS* perspective before and after, both terms were used synonymously. However, in manifestations of the *contextual view of the nature of HIV/AIDS* perspective, the term virginity was used contextually in a manner peculiar to the participating students. Note that although the students in this study portrayed a contextual understanding of virginity that does not match the conventional use of the term, they were not ignorant about the cultural values of virginity and its ability to curb the spread of HIV/AIDS as Brigid expressed: “I think keeping virginity particularly by girls can stop the spread of HIV” [TFCD1: 288]. Students’ reflections expressed concern that neglect of a virus preventive culture was the cause for the increased spread of HIV/AIDS as Tayina expressed:

Today very many youths are not abstaining from sex because virginity is no longer highly considered or valued. You know today, when someone says she is a virgin, she is looked at as being backward. So in that way, virginity is no longer a value as it used to be in the African traditional society [TFCD2: 519-522].
The cultural inspection of a girl shortly before her marriage is sometimes used as assurance that
the young woman is free of HIV/AIDS. This was best expressed by Irene when she said:

Among the Baganda, when a girl is going to get married, your auntie is supposed to
supervise your initial sex activities with your new husband. She is also the one supposed
to announce to the extended family members whether you are a virgin at the time of
marriage or not. And this state of the girl’s virginity is also supposed to be revealed to the
boy by the girl’s auntie TFCD3: [290-295].

Culturally, the practice of sexual abstinence is equated to the maintenance of the virtue of
virginity. Sexual abstinence until marriage is highly promoted in Uganda as the most effective
means of preventing HIV/AIDS. The practice is considered to bring honour to the girl’s family
(Otiso, 2006). Also, because of the notion that in patrilineal societies like those in Uganda, a
chaste bride values fidelity (Martinez Perez & Namulondo, 2010), it is believed that her off
springs are highly likely to be her husband’s children. Apart from the cultural values embedded
in the practice of sexual abstinence, the students in this study appeared to view abstinence or
virginity as the most preventive cultural practice against HIV/AIDS. This is consistent with
Leclerc-Madlala’s (2009) view that cultural virginity testing was revived in the 1990s as a
cultural initiative for preventing HIV/AIDS.

Apart from their cultural understanding, the students’ knowledge about abstinence also
appears to be built on the continued emphasis on the “Abstinence only policy” of 2004 (Uganda
AIDS Commission, 2004). Over the years, an increased embrace of abstinence has been manifest
at many levels in Uganda, from the President’s office, to Primary and high school classrooms
across the country. Reflections such as that of Macey below were not uncommon during the
search for manifestations of the predictive, preventive and transmissive knowledge of HIV/AIDS”
perspective: “I mean to say that young people who are not yet of marriageable age should abstain
from sex” [TFC1: 42-44; 47-48]. As we saw earlier on, this is a view that pervaded the students’
understanding. The students in this study believed that loss of virginity could be restored by use of herbs. As such, they do not care when they lose it since they can regain it. This in itself has the potential to facilitate the spread of HIV/AIDS, since it can lead to an attitude of complacency based on the availability of restorative herbs.

4.12.8. “Decent” Dressing

This cultural practice was featured during both observation of the HIV/AIDS-focused moral education class and the focus group interviews and discussions when seeking for manifestations of the naïve notions of prevention and treatment of HIV/AIDS perspective. In the African tradition, culturally, decent dressing is applauded and is equated to morality. In the central region where this study took place, the traditional dress code for women is “gomesi”, a wide flowing dress that reaches the ankles and wraps almost thrice around the body (Otiso, 2006). Thus miniskirts in the African context are considered indecent. In a study carried out by Neema, Musis and Kibombo (2004), circumstances leading to sexual abuse that may result in contracting HIV/AIDS included dressing indecently.

Based on Hofstede’s (2003) concept of cultural dimensions, there exists a significant dichotomy between the values attached to the Western and African ways of dressing. The cultural dimensions concept describes the effects of a society’s culture on the values of its members, and how these values relate to behaviour. While decent dressing in the Western thought emphasizes modesty above the waist, descent dressing in the African context normally emphasizes covering properly the areas below the waist (Jenkins, 1991). In his study, Jenkins (1991) reports that when the missionaries on their arrival in East Africa insisted on modest dressing that emphasized covering above the waist, Africans perceived them as trying to turn
good, morally upright women, wives and mothers into prostitutes. This is because it is culturally believed that those who cover above the waist are prostitutes.

Although a naïve way of understanding HIV/AIDS prevention strategies, the students in this study appeared to be fully knowledgeable about the African traditional preventive norms, rooted in personal security. In circumstances where an individual dresses indecently and happens to be raped, she is held responsible as she is expected to be aware of time and places of vulnerability. The concept of blame the victim in such matters is rooted in the African culture, although there is usually punishment for the perpetrator. The blame is derived from the argument that although society will protect everybody, that does not take away individual responsibility for one’s safety since there will always be people with evil minds in any society. Within the African traditional society, while the community is the custodian of the individual, security of the individual rests with oneself (Gyekye, 1988). Traditionally, this is meant to be predictive/preventive, a way of taking precaution, since society comprises of good and bad people bent to committing crime. The students appeared aware that although the fellow may be punished drawing on the law, it is believed that in the process, the virus will have been passed on, and sexual debut will have occurred. Regardless of one’s freedom to choose how to dress, indecent dressing is considered to be self-exposure to possible vulnerability including risk of contracting HIV/AIDS.

Given that risk perception and concerns about one’s safety are socially and culturally framed (Johnson & Covello, 1987), within the African context, the individual is expected to be aware of the risks that may result from indecent dressing and be prepared to take the blame. Once virginity/abstinence, a highly valued practice is breached, the individual is blamed and subsequently, the parents. Hence, the African saying: “Asiyefunzwa na mamaye, hufunzwa na
ulimwengu” which means, “He who is not taught by the parents, is taught by the world”. In other words, the individual can never be forgiven, since members of the community, particularly children, are constantly mentored to dress properly and to avoid moving alone in spaces deemed to be insecure.

From the African perspective, precautional measures are preventive because the consequences are irreversible in a sense that if sexual debut occurs before formal marriage, a girl is not likely to ever get married. Relatedly, it is against this background girls also as a sign of desperation strive to “restore” their virginity by use of herbs.

4.12.9. Traditional Birth Attendant Practice

This cultural practice was featured during focus group interview discussions when seeking for manifestations of the post-experience predictive, preventive and transmissive knowledge of HIV/AIDS perspective. Traditional birth attendants [TBAs] are local self-developed community practitioners, who provide maternity care to women during pregnancy, delivery and care of the newly born baby. The World Health Organization defines them as persons who assist pregnant women during childbirth and who acquired their skills by delivering babies themselves or through apprenticeship to other TBAs (WHO, 1992). Besides, traditional birth attendants are accomplished herbalists, whose knowledge and use of herbs is often extensive (Leedam, 1985).

There is a strong relationship between cultural beliefs and traditional birth attendant deliveries. Literature suggests that the traditional birthing practices which include the cultural desire for one’s privacy and the belief that a woman should deliver alone, as well as the taboos that surround cord cutting are the driving factors that drive women to seek traditional birth attendants (Ayede, 2012; Kabakyenga, Ostedgren, Emmerin, Kyomuhendo & Pettersson, 2011). Kyomuhendo, 2003) observe that better handling of mothers, counseling, comfort during labour
and childbirth, roasting greatly needed by delivered women and postpartum care for an extended period, also encourage many women to seek TBA’s services in spite of the risks involved. Kkonde (2010) reports that cheap labour, availability and the use of non-evidence based medical practices attract pregnant women to seek the services of TBAs. Also, in spite of a lack of understanding of obstetric complications, traditional birth attendants have the ability to draw on traditional beliefs to explain childbirth complications to the satisfaction of pregnant women (Maimbolwa, 2003).

While TBAs’ services provide a sense of satisfaction to pregnant women, the students in this study appeared knowledgeable that they are highly transmissive of HIV/AIDS. For example, Eunice said that “home deliveries under traditional birth attendants are highly risky, […] that is how HIV/AIDS is passed on from mother to baby”. Delivery involves procedures aimed at speeding the expulsion of the baby, removal of the placenta and arrest of hemorrhage. Leedam (1985) observes that immediately after the baby is born, the TBA cuts the cord with any available instrument, be it “the bark of bamboo, a hard sharp stalk of a plant, two sharp stones, an old razor blade or scissors” (p.251). These items are rarely clean and never sterilized (Leedam, 1985), thus, putting both child and mother at risk of HIV/AIDS.

Based on my cultural knowledge about TBAs, often, they are called to the home of the woman who is about to deliver. However, in the event that pregnant women due for delivery go to the home of the TBA, there is a poetical that the risk of HIV/AIDS transmission is even higher. This is because there is a possibility of having attending more than one woman at a time. In case of lacerations, there a potential of transferring infection from one woman to another. Besides, it is also difficult to tell the extent to which she keeps instruments for cord cutting to individual babies, which also has the potential to transfer HIV/AIDS from one baby to another.
4.13. **Summary on Analysis and Interpretation of Key Cultural Practices**

In this section, I analyzed and interpreted key cultural practices that influence the students’ perspectives on the spread and prevention of HIV/AIDS. The analysis indicated nine key cultural practices, which included communalism and interdependence, traditional treatment and healing practices, blood pacts practices, visiting the bush or labia elongation, wife inheritance and wife sharing, circumcision, abstinence, descent dressing and traditional birth attendant practice. In the chapter that follows the results will be discussed.
Chapter Five: Discussion and Conclusion

This chapter presents a discussion of findings resulting from the analysis of data on a study that investigated Ugandan high school students’ perspectives on the spread and prevention of HIV/AIDS in seven schools within the central region of Uganda and how these are influenced by core cultural practices. Analysis of the pre and post-experience survey questionnaire data addressed the question: What are Ugandan high school students’ perspectives on the spread and prevention of HIV/AIDS? This revealed five key perspectives that governed the students’ understandings of the spread and prevention of HIV/AIDS in HIV/AIDS-focused moral education class. These included: Perceptual and behavioural risks associated with proximity to HIV/AIDS victims; Hygienic practices; Behavioural/practice causes and transmission of HIV/AIDS; Predictive, preventive and transmissive knowledge of HIV/AIDS; and Naïve notions of prevention and treatment of HIV/AIDS perspectives.

It should be noted that some brief discussion has already been offered during analysis and interpretation of these perspectives. In this particular chapter, further elaboration on the pre- and post-experience perspectives will be provided. The discussion of each perspective provides a strong basis for understanding the key issues involved with the students’ conceptions of the spread and prevention of HIV/AIDS. Although the main focus of this study was to explore the students’ perspectives on the spread and prevention of HIV/AIDS, it was important to discuss how the perspectives manifested during the HIV/AIDS-focused moral education class and the focus group interview discussions.
5.1. Pre-Experience Perspectives

5.1.1. Perceptual and Behavioural Risks Associated with Proximity to HIV AIDS Victims

Perspective

Individual’s sociocultural contexts, in which they live, play a key role in enabling or restraining people from taking control over their health. Literature reveals that essential to understanding the spread and prevention of HIV/AIDS, is the awareness of the social and cultural contexts in which decisions regarding health and health-seeking behaviours are constructed (Falola & Heaton, 2007). This study adds to our understanding of how sociocultural factors of parenting, involvement in diverse social activities, belief in traditional norms, and school climate influence young people’s involvement in risky behaviours. Reducing or eliminating high-risk behaviors from such contexts is the only way to mitigate further spread of HIV/AIDS. However, in order to avoid disease, individuals must perceive that their behaviour places them at risk of HIV/AIDS infection, and that they need to make a commitment to move away from such behaviour (Cantania et al., 1990). Concepts involved in this process include (1) recognizing that one’s activities make him/her vulnerable to contracting HIV/AIDS; (2) making the decision to avoid such risky behaviours and committing to that decision; and (3) overcoming barriers to enacting the decision, including problems in sexual communication and seeking help when necessary to learn strategies to reduce risky behaviours (Cantania, 1990). Numerous studies have reported how factors associated with HIV/AIDS transmission knowledge impact young people’s understanding of risk to HIV/AIDS and how these influence their behaviour, attitudes and efforts towards preventive strategies to the spread of HIV/AIDS (Aggleton, et al., 1994; Akwara et al., 2003; Nzioka, 2001; Lawrence, 1995).

In Chapter Four, the students participating in this study suggested that family neglect
coupled with lack of parental guidance greatly impacted their behaviour and put them at risk of HIV/AIDS infection. It is generally known that lack of parental guidance and family connections can facilitate undisciplined life styles and sexual promiscuity among youth, creating risky environments for transmission and spread of HIV/AIDS. On one hand, the ability of the students to fully comprehend the extent of their exposure to risk and the potential danger involved as a result of parental neglect makes them aware of the need to guard against such risks. In this way, this perspective can be helpful in the prevention of HIV/AIDS.

However, Cantania et al. (1990) observe that although the ARRM serves as an effective construct for understanding psycho-social and psycho-educational factors that influence individuals’ risk perceptions and risk avoidance, it does not take into consideration the socio-cultural issues that may facilitate or hinder individual’s efforts to change behaviour or to avoid risk. In his study of the association between people’s perceptions of risk of HIV/AIDS and their sexual behaviour, Akwara et al. (2003) acknowledges that a mix of cultural beliefs and practices and diverse levels of interaction influence people’s behaviour. Similarly, Sorensen et al. (1991) concurs that the Aids Risk Reduction model does not capture the implications embedded in individuals’ complex and contradictory social environment.

Holding this perspective can contribute to the spread of HIV/AIDS. Studies indicate that severing parental guidance from youth for large portions of the day due to economic or other reasons has had significant implications on the spread and prevention of HIV/AIDS, compromising the safety of youth against the spread of HIV/AIDS (World Health Organization [WHO], 2011). A growing body of evidence demonstrates how youth who feel a lack of parental warmth, love or care are more likely to report emotional distress, and sexually risky behaviours (Resnick, 1997). Thus the result of uncontrolled and unguided behaviour manifests as Margaret
put it when she said during a class discussion that, “... we do what we like and move wherever we want, and involve ourselves in all sorts of behaviour [...] including trying out sex.” Similarly, Karofsky (2000) reports that young people who have not experienced parental warmth and connectedness are likely to withhold depression and anxiety from parents and share it with their peers who they think are more understanding towards them than their parents. Although it may not be their intention to engage in actions that put them at risk of HIV/AIDS, the students in this study appeared to express the view that the circumstances around them compel them to do so. Families are both a very important factor and a risk factor that influence youth behaviour. Drimmie and Casale (2008) posit that families in all their forms are universally the primary providers of protection, support and socialization of children and youths. If parents focus on supporting and providing guidance to their children, it naturally prevents a range of problems including vulnerability to HIV/AIDS infection. Besides, the time between 13 and 19 years old is when youth try hard to define their identity (Manopaulous, 1987).

In the students’ testimonies, their peers and others around them fill any vacuum left by their parents. This is because who the students engage with and interact with shape their behaviour. This is consistent with Bandura’s (1977) social learning theory, which asserts that behavior is learned from the environment in which they reside. In this way, the students cognitive, conceptual, and affective patterns are the roots of their behaviour. This environment encompasses not only the students’ classroom and school, but also includes their family, and community. In his study on youth-parent relationships, Mutema (2013) discovered that youth responses to sexual challenges and integration of sexual feelings, attitudes and experiences into their developing selves is profoundly influenced by the social and cultural contexts in which they
live with some contexts encouraging less risky behaviour while others encourage high risk behaviours.

It is likely that in an effort to secure support, these students are in constant struggle to find and maintain a place of belonging. This desire to belong is a fundamental need that is shared by children and adults alike. The ultimate goal of youth behaviour is to fulfill the need to belong (Bandura, 1977). In their search, youth select beliefs, feelings, and behaviours that they feel will gain them significance. Moreover, whatever method each of them chooses to use in achieving the goal of belonging, either through proper behaviour or misbehaviour is determined by the individual’s sense of belonging back in his or her family. For this reason, how youth behave either at school or in the community reflect their frustration or wellbeing in the home environment and in dealing with difficult circumstances in that home environment.

The students in this study also cited peer pressure as another factor contributing to the spread of HIV/AIDS as a result of deprived parental guidance. Although peer pressure can exert both positive and negative influence on youth, the negative impact of peer pressure is one of the primary reasons for youth engaging in high-risk behaviours such as teen sex (Kiragu & Zabin, 1993). Numerous studies have reported how in peer pressure groups, conformity to group behaviour earns one membership to the group (Dishion, et al., 1991; Kinsman et al., 2000; Seloilwe, 2005). The students in this study corroborate this finding as Jesca stated that, “If I am to be part of the group, then I should be like them, in order for them to accept me in their group. The moment I don’t participate in what they do, they will chase me away from their group” [FGD1: 505-508].

Seloilwe (2005) notes that youth are often influenced by others to engage in behaviour they would otherwise not engage in. In their study, Kinsman, Nyanzi and Pool (2000) report that
early experience of sex was important for admission to membership into informal peer groups, in which they share knowledge and experiences and also developed a mutually supportive value system. Some students feel either demeaned or on the peripheries of the group if they do not engage in a similar practice as their peers. However, the desire to conform to the group culture in most cases leads to engaging in high-risk behaviour.

This perspective exemplified attributes of constructivist learning (Bruner, 1986) as the students reflected and made association with their prior knowledge and everyday life experiences in order to reach understandings of the spread and prevention of HIV/AIDS, which they presented in the HIV/AIDS focused moral education class. Given that continuing to hold this perspective can be detrimental and contributory to the spread of HIV/AIDS, it is necessary that during the class, teachers employ events that can effectively counter this perspective and instill in students the need to take responsibility for their own behaviours.

5.1.2. Hygienic Practices Perspective

The notion of hygienic practices as a mitigation measure against diseases seems to be the influencing factor in the students’ understanding of the spread and prevention of HIV/AIDS. In fact, a vast body of literature situates hygienic practices within the behaviourist theories (Whitby, Pessoa-Silva, McLaws, Allegranzi, et al., 2007). This is espoused in the view that hygienic practices in home and everyday life settings play an important part in preventing spread of infectious diseases (Bloomfield, Exner, Fara, et al., 2009). The concept relates to most aspects of living that include medical, personal and professional care, as well religious and cultural (Allegranzi, Memish, Donaldson, & Pittet, 2009). Thus hygienic practices are widely culture and context specific since what is considered acceptable in one culture or institution may not be
acceptable in another. Moreover, hygienic practices connote sterilization of shared implements, isolation and quarantining of infectious persons or materials to prevent spread of infection.

According to Bandura (1963) behavior is learned from the environment. Thus the way we behave depends on how and where we are conditioned. In this way, behaviourists advance the view that hygienic practices, particularly those related to hand washing patterns are usually established during the first 10 years of one’s life (Allegranzi, et al., 2009; Mishra, Sarkar, Srivastava, Deepthi, Chetan, Mishra, 2013). As such, knowledge of hygienic practices is instilled in individuals through everyday life experiences in home environments. This understanding is extended through the learning of home science in schools. In this way students develop the belief that preventing the spread of infectious diseases means breaking the chain of infection transmission. And so, once the chain of infection is broken, infection cannot spread.

As indicated in Chapter Four, the students in this study suggested that violation of hygienic practices leads to the spread of HIV/AIDS. The students appeared to express the view that whether or not HIV/AIDS infected persons are asymptomatic, they are infective at all stages. They corroborated this finding by highlighting some of those practices they deemed as bad hygienic practices, which included family sharing of incising instruments, visiting the bush, medicalized versus traditional circumcision devices and traditional healers’ incision practices. A growing body of literature demonstrates incidences of poor hygienic practices including low disinfection rates of re-useable implements. In their study, Arulogun and Adesoro (2009) cited the use of disinfected blades for hair shaving, hair shaping and zero-cuts, which encourage blade to skin contact and consequent skin abrasions as a risk factor that lends to HIV/AIDS transmission. Use of one blade by all family members for hair shaving or nail cutting is common.
practice in many parts of Africa and in particular, Uganda. Similar studies expressed concern that HIV/AIDS transmission through sharing of non-sterile sharp implements used for hair cutting, circumcision, tattooing, ear-piercing and acupuncture are being given less attention in the campaign against the spread of HIV/AIDS (Arulogun, & Adesoro, 2009; Bawany, Khan, Shoai, Naeem, Kazi, & Shehzad, 2014).

The suggestion of visiting the bush as one of the bad hygienic practices also indicates that the students in this study are very knowledgeable that this is a mandatory cultural practice to which all girls in communities where it is practiced are supposed to subscribe. Besides, in communities where it is valued girls find it difficult, if not impossible, to resist the powerful cultural influence of the women in their families, especially the local experts known as “Ssengas” (literally translated as paternal aunts) and peers in their social circles. Culturally, society exerts considerable pressure on girls who refuse to conform to the tradition of labia elongation, since girls who do not embrace the practice are not considered full women. It is also believed that without “visiting the bush,” marriages of such girls can never be stable. The students in this study corroborated this belief in various ways. Allen said that though one has a degree she has to fulfill that cultural expectation. Similarly, Winnie reiterated that it is rare to find someone even if she is highly educated not obeying the culture. In addition, Olivia emphasized that if you don’t “visit the bush” you will not produce, or you will not bear children, so such threats have influenced the girls to practice it.

Although “visiting the bush” does not involve cutting and bloodletting (Tamale, 2005; Katongo, 2014), the students in this study believe that use of bare and unwashed hands coupled with use of herbs is a bad hygienic practice and therefore has implications for the spread of HIV/AIDS given the potential for accidental laceration in case of over elongation and not
washing the hands, especially those who perform the act of labia elongation. Moreover, this resonates with Levin’s (2005) assertion that use of herbs can bruise and inflame vaginal flora and walls exposing girls to risk of HIV/AIDS. Traditional herbs are important to local cultural values and beliefs and an inherent part of the passage rites in traditional African society. While Tamale (2005) indicates that traditional herbs only serve as catalysts to soften the labia and enable it to elongate to the desired length, Katongo (2014) argues that use of herbs inflict pain and oppress young women.

Regarding the medicalized versus traditional circumcision devices, students advanced the view that once circumcised with medicalized devices, one cannot contract HIV/AIDS. A growing literature indicates that people increasingly believe that as a preventive measure, male circumcision is gaining favour as a large-scale attack against the spread of HIV/AIDS (Harmon, 2011). The young men who emerge from circumcision successfully, are not only seen to achieve new social status, but are also believed to be much less likely to get infected with HIV/AIDS. The students in this study corroborate this finding as Dorothy and Leticia stated that it is very difficult to get HIV/AIDS when you are circumcised. There is a likelihood that once people think they are protected against HIV/AIDS by virtue of their being circumcised, they are likely to take on more risky behaviours. As a result, circumcised persons can be more inclined to have unprotected sex or have multiple partners. In this way, this perspective can be more contributory to the spread of HIV/AIDS than preventive if these students’ views are not checked and corrected.

As in the previous perspective, students interpreted this perspective drawing on their cultural or prior knowledge and everyday life experiences, which is consistent with Bruner’s (1986) constructivist learning. Although this perspective can be helpful in the prevention of
HIV/AIDS, it indicates a gap in the students’ knowledge of the spread and prevention of HIV/AIDS. Holding to this perspective and the perception that HIV/AIDS is like any other bacterial disease and that it can as well be prevented in a similar manner, can be dangerous not only to the students in this study, but also to the entire society. This necessitates that during instruction, teachers address the gap and lay emphasis on the need for an approach founded on awareness of the chain of infection transmission and how it differs for different groups of infections. While there is a gist in the students’ views on how HIV/AIDS spreads, it is a misconception to believe that HIV/AIDS can be spread or prevented through ordinary hygienic practices. Thus, in a classroom situation, teachers need to tap into this understanding of the students’ views to highlight the difference between HIV/AIDS and those other diseases like flu or cough, and the danger of overusing and improper use of antibiotics for non-bacterial infections such as HIV/AIDS which is viral. In addition, teachers need not only to elucidate the factual transmissive routes of HIV/AIDS but also to clarify in depth how controversial cultural practices like visiting the bush are carried out and the ways in which they can be HIV/AIDS risk laden.

5.1.3. Behavioural/Practice Causes and Transmission of HIV/AIDS Perspective

Research indicates that the leading route of HIV/AIDS transmission is through heterosexual practices and one of the most vulnerable or highly affected groups are the youth (World Bank, 2002; PEPFAR, 2008). A vast body of literature reveals that a significant proportion of youth are disposed to a variety of ecologically interwoven and interconnected sexually associated behaviours driven by a web of factors at individual, family school and peer levels (O’donnell, Stueve, Wilson-Simmons, Dash, Agronick, & Jean Baptiste, 2006; Ralph, Salazar, & Crosby, 2007). Unlike other health behaviours HIV/AIDS risk behaviours directly
involve more than one person (Moris, 1997). Therefore, social norms are best understood in terms of social networks that are key to comprehending individual risk behaviour (Auerbach, Wypijewska & Brodil, 1994).

Consistent with this view, the Public Health Agency of Canada (2010) observes that youth between 15 and 29 are vulnerable to HIV/AIDS infection mainly as a result of many social factors that include peer pressure and risky sexual behaviour. Howard and McCabe (1990) observe that youth engage in behaviours including early sexual activity partly because of general societal influence, but more specifically from their peers. Gage (1998) asserts that most youth are normally keenly sensitive to opinions of fellow peers particularly the older ones in relation to sexual and other risk-taking behaviour than to opinions of parents and other adults. This is consistent with Boyer and Keggles’ (1991) view that when adolescents believe that their peers think unprotected sex is not risky they are more likely to have unprotected sex as well.

However, the nature of sexual behaviours and experiences change in accordance with the prevailing knowledge within the peer groups (Cherie & Berhane, 2012). Prevalence of such high-risk behaviours includes causal unprotected sex, heterosexual as well as sex prior to marriage (Cherie & Berhane, 2012). While there is no adequate understanding of the socio-cultural context in which young people’s sexuality is manifested and negotiated, from an African perspective, it is evident that the socio-cultural context is an essential factor in young people’s constitutions of their sexuality particularly in terms of meanings and practices (Izugbara, 2004).

In a social constructionist framework culture constructs the rules, beliefs, ideas, values and acceptable norms or behaviours that underlie discussions and regulations of sexuality (Foucault, 1978; Reid & Walker, 2005). Consequently, the socio-cultural context influences the complex meanings and power relations within which sexual practices are constituted (Foucault, 1978).
The students in this study attributed the fast spread of HIV/AIDS to risky promiscuous sexual behaviour among school going youth. Fiona, Sandra and Edina corroborated this finding in their reference to the newly coined youth slangs of “practice makes perfect” and “virginity testing” often played out in promiscuous behaviour. As indicated in Chapter four, permitting premarital sex for initiates who undergo traditional rites of passage encourages risky behaviour practices that facilitate the spread of HIV/AIDS. For example, in some Ugandan circumcising communities in order for the initiates to successfully complete the ritual, they are required to have sexual intercourse with a specific number of females. Hulton, Cullen and Khalokho (2000) observe that the practice does not forbid several male initiates to have intercourse with the same females and vise versa, something that encourages the spread of HIV/AIDS. As in the previous perspectives, also in this case, consistent with the constructivism paradigm, students drew on their everyday experiences to interpret this perspective.

This perspective is indicative of how risky behaviour practices are major hindrances to preventing the spread of HIV. While clear understanding of these practices could contribute to avoiding risky behaviour and therefore, mitigate the spread of HIV/AIDS, following its promptings and engaging in behaviours as those we saw in Chapter four is highly contributory to further spread of HIV/AIDS. This calls for a need for teachers during their pedagogical practices to pay attention to young people’s attitude in order to bring about behavioural change. Teachers also need to devise classroom messages for instilling in students the need to delay the onset of sexual intercourse until they are old enough. Kelly (2003) asserts that the responsibility of promoting change through the education system lies with the teachers. Thus, as an approach, teachers need to create awareness of HIV/AIDS risks by generating knowledge and understanding, promote attitude development and change, and ensure that students develop the
necessary skills that can enable them to be competent and assertive in managing peer-to-peer relationships and sexual issues (UNESCO, 2002). For example, teachers can frame learning activities on “practice makes perfect” as implying benefits and provide students with resources that include further knowledge and skills that can enable them to evaluate the benefit and make informed decisions. The issue of attitude and behaviour change requires time and patience. Teachers often lack the curricular time and orientation to adequately address sex-related issues within class discussions (Kelly, 2003). It is essential to note that relying on rote learning, which emphasizes facts and promotes academic and overly scientific interpretation of HIV/AIDS transmission does not ensure students’ clear understanding of the social cultural factors that contribute to the spread of HIV/AIDS. Within this context, it is also important that teachers address the predominant view in which sex is considered a taboo topic science it is the knowledge gap about sexual issues that prompt youth to experiment sex. This is most crucial particularly because of the metaphoric and analogical language often used culturally in sex related discussions. This is consistent with Bastein, Kajula and Mhwezi’s (2011) assertion that owing to the cultural norms and taboos, parent-child discussions on sex and sexual issues tend to be authoritarian and unidirectional, characterized by vague warnings rather than direct open discussions.

5.1.4. Predictive, Preventive and Transmissive Knowledge of HIV/AIDS Perspective

Literature indicates that HIV/AIDS knowledge plays an important part in HIV/AIDS prevention through the understanding of risk and the identification of necessary behavioral changes. Poppen and Reisen (1997) observe that many HIV/AIDS prevention programs have been based on the premise that changes in knowledge and risk perception can lead to behavioral change. In Uganda, interventions against HIV/AIDS focus on information and education
campaigns to promote behavioural measures that include condom use, limited sexual partners, abstinence and delayed sexual debut. The desired effect of improving knowledge levels about HIV/AIDS and its prevention is that individuals become motivated to change behaviours that put them at risk of contracting HIV/AIDS. In a study carried out in Senegal among young women, HIV/AIDS knowledge was associated with preventive attitudes (Spira et al., 2000). However, given that various factors such as self-efficacy, gender equity and cultural and community norms influence behaviour, knowledge of HIV/AIDS in itself cannot suffice to bring about change in behaviour (Hankins, 1998; Lagarde, Pison, & Enel, 1997).

The students in this study expressed awareness that while abstinence prevents the spread of HIV/AIDS, casual heterosexual behaviours and unprotected sexual relationships, as well as sharing of unsterilized instruments become fodder for its spread. Patrick and Veronica mentioned that girls are most vulnerable when they take contraceptives to prevent pregnancy and engage in “open” or “live” sex, meaning unprotected sex. The students were knowledgeable that high levels of unprotected sexual practices put them at risk of HIV/AIDS infection. Studies indicate that sexual practices among youth are a contemporary behaviour today. UNICEF/UNAIDS/WHO (2002) observe that sexual patterns of youth identified indicate that many youth are sexually active by the age of 15. In a study carried out in four Sub-Saharan countries that included Burkina Faso, Malawi, Tanzania and Zimbabwe indicates that use of condoms among youth aged 15 to 19 ranges between 2-18% (Lansdown, 2003). As already indicated in this thesis, risky behaviours of youth are determined by complex factors of socialization awareness. Given that this stage of development is a time of turmoil that involves physiological and psychological changes leading to establishment of own identity, opinions and values, many youth tend to misuse their freedom by engaging in risky behaviours without being aware.
Although studies focusing on the relationship between HIV/AIDS knowledge and risk perception indicate that premarital sex among youth has become common (Biddlecom, Gregory, Lloyd, & Mensch, 2008), youth do not seem to see HIV/AIDS as a major risk and something they should be concerned about. Yet as Cates, Chesney and Cohen (1997) observe, unprotected sexual activity among young people is very risky because members of this group often carry HIV for years without knowing they are infected. The inability of youth to fully comprehend the extent of their exposure to the risk of HIV/AIDS and the potential dangers that result from them raises concern. While unprotected sex appears to be the norm and unwanted pregnancies common, they all have implications on the spread of HIV/AIDS. Besides, it also indicates that the students’ perception and predictive knowledge of HIV/AIDS is low.

Thus holding this perspective can be highly contributory to the spread of HIV/AIDS. Knowing how much sexual activity among young people is unprotected can provide teachers a better understanding of the risks young people face. So teachers can devise strategies for integrating in their pedagogies comprehensive reproductive health information to address HIV/AIDS information. Students need to be sensitized that in ordinary life, people face issues holistically and not in isolation. In other words, consequences that result from one’s behaviour are all lived at once together with the challenges that come with them based on one’s concerns and desires that structure their daily lives and decisions.

5.1.5. Naïve Notions of Prevention and Treatment of HIV/AIDS Perspective

There is much discussion in literature of the notion of naïve conceptions. In ordinary terms, the students’ weird ways of understanding the spread and prevention of HIV/AIDS is nurtured by the misconceptions they hold about HIV/AIDS transmission based on the socio-cultural environment in which they live and learn. In this way, the notion of naivety originates
from the students’ simple ignorance and misunderstandings about scientific knowledge regarding HIV/AIDS transmission and prevention. I also infer that the students’ naivety stems from misinformation propagated by individuals and groups with ideological views that deny a causative relationship between HIV/AIDS transmission and infection.

Although some researchers refer to naïve notions as misconceptions, those who favour the Vygotskian view of situated learning prefer to refer to them as preconceptions or alternative frameworks (Spada, 1994). Empirical evidence indicates that naïve notions about HIV/AIDS transmission are widespread among young people and persist alongside accurate knowledge, potentially undermining the protective value of that knowledge where it exists (Aryanci, 2005; Fraim, 2012; UNICEF, UNAIDS/WHO, 2002). In a survey carried out in 40 countries worldwide UNICEF, UNAIDS/WHO (2002) observe that 50% of young people harbour serious naïve conceptions about HIV/AIDS transmission. Similarly, studies such as that of Thanavanh, Harun-Or-Rashid, Kasuya and Sakamoto (2013) revealed that out of 300 high school students over 50% of the youth harboured naïve conceptions about HIV/AIDS transmission. This indicates that naïve understanding of HIV/AIDS transmission is still a major hindrance to preventing the spread of HIV/AIDS.

In spite of clear knowledge of the main routes of HIV/AIDS transmission, the students who participated in this study also held substantially naïve views about the spread and prevention of HIV/AIDS. For example, Christine and Winnie reported decent dressing as a preventive device of HIV/AIDS transmission to make an argument that indecent dressing is the cause of increased rape and defilement which in turn lead to increased spread of HIV/AIDS. The participating students’ assertion speaks to a misconception of the causation of rape and defilement. Nampala (2013) in the *New Vision* reports that 45% of the victims of rape and
defilement are under age 14, girls believed to be virgins. Meel (2003) observes that the myth that sex with virgins can cure infected men of HIV/AIDS is prevalent in Sub-Saharan Africa countries including Uganda, something the students in this study do not seem to have paid attention to. However, the students appeared to draw on the common-sense socio-cultural understanding of the proverbial “there is no smoke without fire” to put forward the argument that there is always a good reason for an unusual occurrence. Viewed contextually, girls who dress indecently are generally known to be promiscuous. While promiscuity for men is culturally permissible, naturally, men would run away from promiscuous women as they consider them to be morally wanting. However, knowing how vulnerable they are, it is also possible that virgin girls may deliberately choose to dress indecently in order to appear promiscuous as a self-defense strategy from men prowling around for them. That aside, we cannot underestimate the fact that literally, the students who believe that decent dressing is protective against HIV/AIDS are more at risk because they are unaware that even the decently dressed can be raped and defiled.

The students also suggested that being circumcised prevents one from being infected with HIV/AIDS. While some participating students did not agree with this view, many emphatically corroborated this finding as Hellen, Magdalene and Jackline stated that that you cannot get HIV/AIDS once you are circumcised. Literature indicates that circumcised men who have unprotected intercourse with female infected partners have a reduced risk of acquiring HIV/AIDS by 50-60% (Auvert, et al., 2005; Gray et al., 2007; Bailey et al., 2007). This does not mean that circumcised men develop a kind of immunity as a result of the circumcision. It only means that they may take longer to be infected, but they will eventually contract the disease.
Students also exhibited naïve understandings of HIV/AIDS transmission in a disagreement where Eunice advanced the view that HIV/AIDS spread through kissing, while Vicky stated that HIV/AIDS is spread through saliva. I noted an intricate relationship between the students’ perspectives on the spread and prevention of HIV/AIDS. Although the idea of HIV/AIDS spreading through kissing and saliva manifested when searching for the naive notions of prevention and treatment of HIV/AIDS perspective, it is possible that it stemmed from the hygienic practices perspective, as the students do not deem it hygienic since there is exchange of saliva through kissing. Generally, holding this perspective gravely distorts the way the students understand HIV/AIDS transmission and can impede comprehension of the concept, leading to increased spread of HIV/AIDS.

Students may not be aware that the knowledge by which they live and understand their world is correct or incorrect. However, this perspective informs the teachers’ need to identify the students’ misconceptions in order to help them develop proper understanding of scientific concepts related to the spread and prevention of HIV/AIDS. It is critical that during classroom instruction on the spread and prevention of HIV/AIDS teachers make students aware of their own correct and incorrect ideas about the topic or phenomenon under study. Read (2004) observes that increased knowledge resulting from experience and instruction is instrumental in helping students restructure pre-existing understandings into more coherent theories. Teachers need to develop instructional strategies to address the disparity between the incompatibilities between the students’ common-sense understandings and replace them with accepted scientific explanations. This necessitates the teacher drawing on a constructivist model to create an interactive environment through which students can freely articulate and explore their views (Watts & Bentley, 1987). In this way, teachers reorganize the concepts as well as scaffold the
students’ development of logical thinking in order to bring about conceptual change in the way the students understand HIV/AIDS transmission and prevention.

5.2. Post-Experience Perspectives

Following participation in the HIV/AIDS-focused lesson discussions in Chapter 4, the post-experience data revealed collapse of two of the pre-experience perspectives (Hygienic practices and predictive, and Behavioural/practice causes and transmission of HIV/AIDS), persistence of three of the pre-experience perspectives (Predictive, preventive and transmissive knowledge of HIV/AIDS, perceptual and behavioural risks associated with proximity and contact with HIV/AIDS victims and Naïve notions of prevention and treatment of HIV/AIDS perspectives) and a detection of two new perspectives (Taboo-like prescription of knowledge of infection and prevention of HIV/AIDS and Contextual view of the nature of HIV/AIDS perspectives).

Although the new perspectives appeared separately during the computation, they manifest seeming similarities in what is obviously dissimilar. At one level, the taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS perspective are highly contextual and at another level, highly cultural and as well contextual since they are shaped within the cultures in which they particularly occur. For example, cultural practices that may lead to the spread or prevention of HIV/AIDS are contextual in as far as some cultures or communities and not others only practice and dictate them. However, the moment participation in such practices is done as a social demand and do not have to be due to personal preference, they cease to be simply cultural practices and become dictates of taboos. In this case, taboo-like prescriptions are more specific as they spell out implicit or explicit consequences.

However, the contextual view of the nature of HIV/AIDS perspective could go beyond in a sense that it alters the ordinary understanding of a cultural practice to accommodate
unacceptable concepts about unconventional youth behaviour but in a localized manner specific to a place and group. Although the contextual view of the nature of HIV/AIDS perspective may have undesirable consequences, they do not result from taboos dictates. Thus, the two perspectives though seemingly similar are dissimilar. Therefore, for purposes of discussion, I will consider the two perspectives separately.

5.2.1. Taboo-Like Prescriptions of Knowledge of Infection and Prevention of HIV/AIDS Perspective

Fear of the assumed danger of repercussions believed to result from evading certain taboo dictates is the driving force that compels people to participate in cultural practices that are HIV/AIDS risk laden despite the risks involved. A significant body of literature reveals belief in a wide range of taboo dictates that are highly contributory to the spread of HIV/AIDS. Tenkorang, Gyimah, Maticka-Tyndale, and Adjei (2011) observe that taboo dictates are central to many African conceptions of illness, disease causation and etiology. However, the manner in which they are perceived and played out varies from one community to another. For example, in communities where widow cleansing is practiced, the practice is authenticated as enshrined in “true traditional culture” of the practicing community (Agot et al., 2010). In this case, the most visible version of the ritual held by elders as indispensable necessitates that widows undergo the practice of ritual cleansing by “having sex” with a stranger believed to be insane (Agot, Stoep, Tracy, Obare, et al., 2010). Widows succumb to the practice for fear that if not sexually cleansed by having sexual contact with a stranger, the spirit of the dead husband will visit bringing a curse upon the family (Agot, Stoep, Tracy, Obare, et al., 2010; Moyo & Müller, 2011). It is important to note that although proper tradition and true customs in relation to the cleansing practice necessitate penetrative sex in order to consider the ritual complete, Nyanzi, Nassimbwa, Kayizzi,
and Kabanda (2008) assert that considering the lethalness of HIV/AIDS, some communities resorted to symbolic sex. Nyanzi et al. (2008) explains that symbolic sex is performed in a manner that bypasses the exchange of bodily fluids within genital interaction, such as jumping over legs, skipping over warm belts, sitting on the lap and urinating in the same spot.

Leclerc-Madlala (1996) and Umunna (2011) attribute the massive spread of HIV/AIDS in Sub-Saharan Africa to the cultural dictate related to the practice of virgin cleansing generally known as the “virgin cure.” Over the years, this has been the subsequent cause of massive rapes in the Sub-Saharan region leading to an increase in the number of HIV/AIDS infected persons (Leclerc-Madlala, 1996). Besides, the practice is perpetuated by deceptive witch doctors who advise their HIV infected clients to seek a virgin for cleansing (Leclerc-Madlala, 2002). In her study on the notion of virgin cleansing, Leclerc-Madlala (2002) reveals that it is believed that a man can be cleansed of HIV/AIDS through intercourse with a virgin, but in the process of doing so, the girl would not be infected. Since a virgin girl’s vaginal track is considered intact, clean and uncontaminated it is believed to be capable of healing. This is based on the understanding that the vaginal passage of a virgin girl is sealed off by an intact hymen, which acts as a barrier that prevents HIV/AIDS from getting into and settling in the girls’ womb and in her blood (Leclerc-Madlala, 2002). In addition, Groce and Trasi (2004) report that it is mostly the blind, deaf, physically impaired, intellectually disabled, or those with mental-health disabilities that are sought to be used in the practice, since it is assumed that individuals with disabilities are sexually inactive and therefore virgins.

The relationship between HIV/AIDS and the practice of “virgin cure” provides us some insights into the ways in which people culturally conceptualize and perceive the spread and prevention of HIV/AIDS. Green (1994) observed similar understandings to those of Leclerc-
Madlala (2002) about HIV/AIDS transmission “among people of West Africa who hold the belief that some sexually transmitted diseases are transmitted in form of a worm entering through a man’s urethra after sex with an infected woman” (p. 88). The dictates of the practice of virgin cleansing prescribe that prevention/treatment-cure through sexual intercourse with a virgin is believed to provide a kind of vaccination against HIV/AIDS infection (Leclerc-Madlala, 2002) in a sense that if one has already contracted it, the virus will be made inactive and therefore not dangerous. Therefore, failing to seek out a virgin for self-cleansing means death for the person infected with HIV/AIDS.

Drawing on Ngara (2007), this perspective could be understood in terms of taboos and avoidances viewed simply as superstitious myths of uneducated people. I compare taboos or taboo dictates to the mythicized version of our current legal systems, which control social behaviour. Allan and Burridge (2006) assert that infraction of taboos can lead to illness, death, as well as to the lesser penalties of corporal punishment, incarceration, social ostracism or mere disapproval. They observe that even an unintended contravention of a taboo risks condemnation and censure. It is for this reason that, people generally avoid tabooed behaviour unless they intend to violate a taboo. As Ngara (2007) explains, a taboo is simplified wisdom presented, as a law of avoidance to, direct behavior but its underlying meaning is not given. At a superficial level, taboos may just be myths of traditional culture but, behind each taboo, there is a rational, logical or possibly plausible scientific explanation that evades simplistic analysis (Ngara, 2007). Omobola (2013) refers to taboos as sacred manifestations, aimed at providing protection from any threat to social order, as well as repairing any disturbances of social order. AGHA (2013) observes that taboos are contextual and are therefore defined within the cultural context that
includes powerful forces of religion and tradition, within which they occur, and in which young people are raised.

Thus, culturally taboos are regarded as an integral part of traditional education (Agboola & Mabawonku, 1996). People learn about taboos as children from their parents and grandparents. Based on my cultural understanding when growing up, such education mostly takes place during communal initiation ceremonies such as naming a baby, marriage, and funeral rites. Also, evening time storytelling, where it is still practiced, provides children with an opportunity to learn certain taboos embedded within stories. Moreover, children are further reminded about taboos as they go about their normal day-to-day activities, particularly when about to do something that is prohibited. Thus, taboos together with other cultural practices, shape people’s experiences, behaviours, opinions, beliefs, feelings, and knowledge of particular phenomena (Stutterheim, Bos, Vankesteren, Shiripinda, Pryor, Debruin, & Schaalma, 2012).

It is therefore not surprising that the students in this study appeared to be knowledgeable about cultural norms that dictate allegiance to cultural practices that are HIV/AIDS risk laden, evasion or infraction of which is associated with a belief that they will result in undesirable consequences befalling the person concerned. For example, in Chapter Four, the students in this study referred to the taboo dictates of the practice of wife sharing where Samalie said that “if you don’t accept [to be shared] you will be chased away…,” meaning an exemplification of failure in marriage, being unable to marry again in one’s lifetime and therefore, never being able to bear a child which is equivalent to a curse. Brian, Winnie and Vicky referred to the taboo dictates of wife inheritance where Brian said, “that is why the brother of the deceased has to take over [the widow]”.
The students in this study expressed knowledge that the sexual cleansing ritual embedded within the practice of wife inheritance to remove the spirit of the dead so that the living spouse can start living a normal life again (Moyo & Müller, 2011) is HIV/AIDS risk laden. Literature indicates that cultural norms that surround widow inheritance rituals are predominantly dictates of taboos in a way that anything that deviates from the prescribed norms is considered norm violating and therefore socially unacceptable (Arthur, 1998; Stutterheim et al., 2012). Culturally, it is believed that at the death of her spouse, a woman becomes "unclean" and remains so until she has had intercourse with a sexual cleanser, ordinarily a stranger and insane, identified by the elders of the community (Moyo & Müller, 2011; Wax, 2003). Widow cleansing prescribes that the widow undergoes the sexual cleansing ritual without use of a condom to rid her of her impurities (Moyo & Müller, 2011). Use of a condom in this process is considered deviation from the prescribed norms, and therefore socially unacceptable. According to Moyo and Müller (2011), the cleansing rituals involve a sexual act believed to purify the woman through the semen entering her body, where the use of a condom is believed to obstruct the semen from getting into the woman’s body.

In this way, both the one being cleansed and the cleanser are at risk of HIV/AIDS. Given that the cleanser will have already cleansed several women since it is his job, one can say that the risk of HIV/AIDS in such a case stands at 99.9%. According to literature, the practice of sexual cleansing is believed to have led to deaths of 19.6 million people in sub-Saharan Africa (Moyo & Müller, 2011). Thus as a result of allegiance to the cultural dictates of taboos, cleansers are spreading HIV at explosive rates (Moyo & Müller, 2011). Uwah (2013) observes that due to the influence of cultural norms, adoption of unsafe sex practices including unprotected sex is not only quite normal, but is also strongly encouraged, reinforced and desired by culture. Uwah
(2013) further reports that approval and acceptance of such taboo dictates prevents communities from providing comprehensive sex education to their youth.

This perspective could be preventive to the spread of HIV/AIDS. Therefore, knowing that the students are incomprehensively informed about sexual issues should prompt teachers to include in HIV/AIDS-focused lessons deeper information on sex education. This will enable students to understand prohibitive dangerous sexual ethos so that they are able to make informed decisions. Wood (2008; 2009) observes that teachers themselves are shaped by their culture and may be too constrained by ingrained beliefs as well as social and cultural forces to question the prevailing superstitious beliefs. However, as educators, they play an influential role in challenging individual and group mindsets. Thus, teachers need to include events in their teaching that could help to sensitize students about the dangers of superstitious beliefs that are HIV/AIDS risk laden. At the same time, teachers ought to highlight the need for both behaviour and attitude change in respect to cultural practices that are dangerous taboo dictates.

5.2.2. Contextual View of the Nature of HIV/AIDS Perspective

Given the intricate connection between sexual issues and HIV/AIDS, the way HIV/AIDS is viewed, understood, treated and handled is intricately anchored in people’s cultural values and traditional practices. Within this context, communication is key to understanding the spread and prevention of HIV/AIDS, where the main tool of communication is language. However, in communicating about HIV/AIDS, various societal factors come into play, influencing the way language is used, particularly when the issue being talked about has taboo connotations. Taboos are known to have great impact on language in discussions that relate to HIV/AIDS and sexual issues (Lonyangapuo, 2014). Because of cultural demands, African languages have sociocultural peculiarities endowed with various speech forms that are
strategically used to ensure that relevant information is communicated without necessarily offending the listener or causing embarrassment. As Lakoff and Johnson (1982) explain, language as a vehicle of communication and a major tool in the dynamics of culture portrays a relationship between what is going on in our heads and bodily activities perceivable by others and interpretable by them.

Based on the insider cultural knowledge I have about use of literal language, it is taboo to converse about sex and sexually related issues, which makes it imperative to use metaphors and euphemisms. The cultural world in which we reside dictates that experiences about sex related diseases and characterization of sexual behaviours are expressed implicitly or explicitly within the linguistic repertoire depending on the given context. As such, in public places young people use metaphors, euphemisms, and slang to conceal their discussions on sexual matters. In this way, metaphoric language is used to control sexual behaviours and to express desires.

In this study, since discussions with the students involved sex related issues and HIV/AIDS, both of which are culturally highly taboo and contextual, and therefore should not be openly spoken about, the students were aware of the cultural requirement to approach the topic cautiously. This is in consonance with Ndinda, Uzodike, Chimbwete and Mgeyane’s (2011) view that sex being a taboo subject is not referred to in plain terms, and is not discussed in daily conversations. The students therefore corroborated this finding as Gerald stated that HIV is also spread through promiscuous behaviour among the youth, which include “virginity testing” and “practice makes perfect.” Tayina mentioned that this idea of ‘virginity testing’ is due to the belief that a virgin cannot catch HIV/AIDS, so girls use herbs to restore their virginity.

In order to understand the students’ metaphoric expressions, we need to delineate the complex social practices and meanings in which these behaviors are embedded and through which they
Multiple sexual partners characterize traditional sexual promiscuity. Based on their cultural knowledge, students in this study appeared knowledgeable about the potential dangers of the high-risk behaviour of sexual promiscuity. Hrdy (1987) observes that in some African communities the period following puberty and before marriage sexual relations between young men and a number of eligible women are virtually sanctioned by society as a requirement for some ritual practices. This is culturally meant for the male youth to demonstrate virility by having many partners. It is believed that by having multiple sexual partners, they eventually gain the skill. Bauni and Jarabi (2000) and Arnfred (2004) found that in Kenya and South Africa, at initiation rites occasions, cultural groups require women to express a feeling of obligation to provide sexual service to male youth undergoing the rites, which is normally granted. These culturally prescribed activities of sexual promiscuity prohibit the use of condoms and are therefore potentially HIV/AIDS risk laden. This students’ understanding of the spread of HIV/AIDS appeared to be informed by the cultural environment in which they live as they were aware that within the African context it is what it means to be male or female in society that shapes the opportunities one is offered in life, the roles one may play, and the kinds of relationships one may have. These produce social norms that strongly influence the spread of HIV/AIDS infection. In this way, the students in this study clearly perceived that sexual initiation rites that promote liberal approaches to sexuality are responsible for creating a permissive environment for promiscuity among the youth and for directly providing opportunities for HIV/AIDS transmission.

The metaphor of “virginity testing” by male youth is closely linked with that of “practice makes perfect.” As we saw in Chapter 4, male youth evoked a highly valued cultural
practice to justify their promiscuity. As indicated by Erika (2008), virginity is the country’s greatest defense against the spread of HIV/AIDS. When “virginity testing” is juxtaposed with virginity restoration by use of herbs among female youth, it presents a contradictory irony in which male chauvinism always tends to win as indicated in Blank’s (2007) assertion that a woman who loses her virginity loses her mastery over access to her own person, and yet a man who loses his virginity, on the other hand, gains mastery. While it is understandable that virginity connotes abstinence, male youth view it as an assurance that the girl they are vying for is safe. It is this same sense of safety that male youth use to convince female youth to believe that virginity testing will not inflict any harm on them.

However, the metaphor indicates a knowledge gap about the transmission of HIV/AIDS. Although virginity testing may be a developing promiscuous subculture among high school youth, it is also possible that some may resort to it by way of courting future wives and trying to ensure that the targeted partner’s fertility and capability to produce children. I speculate that the students’ metaphor of “virginity testing” is embedded in the traditional understanding of fertility guided by the African proverb “children are the adornment of the home.” Given that children are the major reason why Africans marry (Wanjohi & Wanjohi, 2005), there is no point in courting an infertile woman.

These students’ metaphoric expressions were a portrayal of a developing practice among school youth. It is safe to say that whenever youth are together for any length of time and free to pursue their own purposes, there will be a subculture by which they operate. Resorting to metaphoric expressions was a way of aligning themselves with their peers in a specific situation that defined them as members of the same group who understood the spread of HIV/AIDS in a particular way. The metaphors the students used were intelligible to all the group members this
could be seen from the way they interacted and responded with amusement, giggling and laughing at times. This is consistent with Le Page and Tabouret-Keller’s (1985) view that people adopt different speech forms to emphasize their distinctiveness or increase their social distance. As Giles, Coupland, and Coupland (1991) explain, it is also possible that the students resorted to use of metaphors to express concepts they thought should be culturally identified through the “appropriate language.” Le Page and Tabouret-Keller (1985) refer to the use of metaphors or different speech forms as an act of identity marker where speakers seek to align themselves with, or distance themselves from, certain social groups, in this case the teachers and the researcher. I speculate that the students in this study employed the use of metaphors for two reasons. Either they wanted to keep their teachers and me as a researcher out of the conversation, or, as Mukenge (2012) observes that linguistic avoidance is a response to stimulus that may be threatening to the speaker, they did do as a response to something they engaged in with fear given the resultant effects that could accrue from it. For example, “practice makes perfect” referred to experimental sex and therefore a connotation of being sexually active as children, which is culturally forbidden and is liable to punishment. The students were aware that their teachers and the researcher would not meet openly talking about sex experimentation with approval since the teachers and the researcher were looked upon as adults in their midst.

Overall, holding this perspective can clearly be a risk contributory to the spread of HIV AIDS. Given that culturally sexual matters are not explicitly discussed with parents, some of the cultural information the students hold is patchy and incorrect and therefore need reconstruction and deconstruction through HIV/AIDS focused education. According to Kelly (2000), in relation to the HIV/AIDS pandemic, one of the aims of education is to promote in students personal efficacy and a sense that one is able to control his/her own life. Thus, there is need for teachers to
devise strategies for addressing students’ cultural sexual misconceptions that play a role in misguiding the manner in which students understand HIV/AIDS transmission. For example, students should be helped to understand that once lost, virginity cannot be restored and that being a virgin cannot prevent one from contracting HIV/AIDS. In addition, teachers need to incorporate strategies in their teaching that will help instill in students personal value attitudes that support their efforts to be free of HIV/AIDS. Also, through the process of teaching and learning, students should be guided to evaluate situations that plunge them into circumstances of vulnerability to HIV/AIDS. Besides, teachers should allow incorporation of students’ related metaphors in their lessons or create their own metaphors while teaching a sensitive issue such as HIV/AIDS, use of language with multiple meanings allows for shared meanings and understandings within the youth subculture.

5.3. Perspectives that Persisted

In this section, I discuss the perspectives that persisted as discerned from the students’ responses to the post-experience questionnaire. As noted in Chapter 4, after the HIV/AIDS-focused moral education classroom experience, the questionnaire was re-administered. When Principal Component Analysis was performed on the post-HIV/AIDS-focused lesson questionnaire, results indicated that Factors 1, 4, and 5 (the perceptual and behavioural risks associated with proximity to HIV/AIDS victims perspective; the predictive, preventive and transmissive knowledge of HIV/AIDS perspective; and the naïve notions of prevention and treatment of HIV/AIDS perspective) persisted. This meant that these students’ pre-experience perspectives were not impacted by the HIV/AIDS-focused moral lesson experience. Therefore, in the post-experience focus group interviews these same perspectives continued to guide the students’ understandings of the spread and prevention of HIV/AIDS.
Various reasons could explain persistence of these students’ perspectives even after experience of HIV/AIDS-focused lessons. Key to pre-experience perspectives is the notion of preconceptions. Students’ preconceptions comprise of a rich collection of prior experiences, knowledge and beliefs that students use to construct new understandings (Brooks & Brooks, 1993). Jones and Araje (2002) observe that preconceptions are intuitive, and form a filter for later learning. Evidence reveals that student preconceptions or naïve conceptions are very resistant to change (Driver, 1989; Osborne & Freyberg, 1985). Jones & Araje (2002) suggest that in order for understanding to take place, teachers must not only provoke students’ prior knowledge or conceptions, but must also build on these conceptions during instruction. Although the strategy brings students face to face with a cognitive conflict, it promotes conceptual development and can gradual conceptual change (Atkin & Karplus, 1962; Rubba, 1992).

Also, HIV/AIDS-focused moral education classes often will involve canonical concepts. Often, these concepts may be at variance with students’ cultural norms/values and grounded in practices. This is consistent with DeCoito and Gitari’s (2014) view that culturally oriented students “are likely to possess a traditional knowledge system that is different from the conventional science typically taught in schools” (p.31). These, to the students’ cultural upbringing are considered sacred and unchallengeable. This normally requires students to mentally transition between their everyday cultural contexts to the science world of the classroom in which HIV/AIDS education is often enacted scientifically. This is what Jegede and Aikenhead (1999) refer to as cultural boarder crossing. Geertz observes that as an ordered system of meanings and symbols, in terms of which social interaction takes place, for everything students learn, they tend to look to their culture for meaning and understanding.
Thus, as Jegede (1995) indicates, for students who strongly believe in their cultures, learning canonical concepts in relation to the spread and prevention of HIV/AIDS may pose a challenge to the way they conceptualize the phenomenon. In the event that HIV/AIDS-focused moral education classes emphasize canonical concepts, the students are likely to play double allegiance (Cobern, 1996). In this way, the students will continue to construct scientific concepts about the spread and prevention of HIV/AIDS alongside their cultural understandings while ensuring minimum interference between the scientific concepts and their cultural or everyday common sense concepts (Jegede & Aikenhead, 1999). This means that they hung on to cultural concepts because of their comfort and social connectivity. Jegede (1995) describes this situation of cognitive conflict where two conflicting ideas co-exist in a learning scenario as collateral learning.

In addition, students may draw on different perspectives in a bid to protect their assumptions and worldviews. Aikenhead (1997) observes that students often view the teacher’s attempt to interrogate them as an effort to assimilate them, or to force them to replace or to marginalize their cultural notions with the canonical concepts. In order to deal with this dilemma, students tend to compartmentalize and store the canonical knowledge and only draw on it when needed or when they think it is the teacher’s expectation; so, it does not conflict with their cultural values or life-world experiences. This too explains why there is a similarity in the way students responded to the questionnaire in after HIV/AIDS-focused lessons.

This persistence of perspectives that denote a similarity in perspectives used before and after the HIV/AIDS-focused moral education class experience may also be attributed to Cobern’s (1996) concept of cognitive apartheid. As Baker and Taylor (1995) and Maddock (1981) observe, the students may have realized that taking on the new concepts would alienate from
their Indigenous life-world culture, thereby causing various social disruptions. So during the post-experience focus group interview discussions, they used the same perspectives to explain their understandings of the spread and prevention of HIV/AIDS. The notion of cognitive apartheid explains students’ disregard or refusal to take in knowledge due to a perceived conflict with their cultural beliefs. Cobern (1996) refers to cognitive apartheid as a mechanism students use to hedge off knowledge and retrieve it later when needed, while insulating their everyday lives and beliefs from its effect. When students fail to align conflicting views they tend to drop them while appearing to accommodate them. Thus, the results of the T-test computed in Chapter Four offer insight into students’ deliberate choice of what knowledge to negate or to integrate within the classroom discussions. This cognitive apartheid can also be attributed to the environment of nested cultures, which include the culture of home, the culture of peers, the culture of the moral education class as well as the culture of school in which the students live and operate (Jegede & Aikenhead, 1999).

Besides, these students as teenagers in their peer group deliberations and engagement, form what Cobern (1996) calls social stance effect. As Ausubel (2000) explains, youth peer groups are characterized by solidarity and feelings of group consciousness, which provides each member with a personal stake to enhance and safeguard the cohesiveness and influence of the group. Thus, in order for them to change their perspectives, they require long concentrated and focused efforts as well as conviction that change is necessary, and a willingness to critically examine the existing beliefs and practices. This is where individual teenagers pay allegiance to collective group decisions, irrespective of what they, as individuals may not believe in.
5.4. Perspectives that Changed

In this section, I discuss the perspective change discerned from students’ responses to the post-experience questionnaire. As we saw in Chapter 4, computation of Principal Component Analysis of the questionnaire after HIV/AIDS-focused lessons indicated change in two perspectives (hygienic practices perspective and behavioural/practice causes and transmission of HIV/AIDS perspective). This meant that the pre-experience hygienic practices perspective was impacted by the HIV/AIDS-focused moral education class experience leading to change or transformation of these perspectives. And indeed during search for manifestations of this perspective, I found that the students applied different perspectives in both the pre and post-experience responses, which contributed to the change that transformed the hygienic practices perspective and behavioural/practice causes and transmission of HIV/AIDS perspective. Unlike the initial perspectives that were more characterized by general behaviour, the new perspectives that emerged were deeply anchored in the students’ cultural world. In this section, I discuss why the two perspectives might have changed leading to emergence of two new ones.

The significant difference in the mean scores of the pre- and post-experience test may be attributed to Mezirow’s (1991) concept of transformational learning. Eyler and Giles (1999) describe perspective change or transformation as “seeing issues in a new way” (p. 171). Much of what students know and believe depends on their historical and cultural contexts in which they live. The meaning the students assigned to new information in the process of learning largely depends on the knowledge they already have from their cultural environment. In this study, the students’ emphasis on the significant impact of culture on the spread and prevention of HIV/AIDS and the subsequent perspectival change was clear throughout the data. The students’ sociocultural environment that comprises of their cultural beliefs and values appeared to create a
significant dissonance that disrupted their notion of reality, so that what was initially familiar became unfamiliar. As a result, a change in thought occurred and consequently a break away from the taken for granted initial understanding of the spread and prevention of HIV/AIDS, as a result of the experience to which the students were subjected. This is consistent with Jegede and Aikenhead’s (1999) view that when scientific concepts are generally at odds with students’ worldviews, they tend to disrupt students’ worldviews by forcing them to abandon or marginalize their worldview concepts and reconstruct new ways of conceptualizing their world.

Mezirow (2000) speculates that when students become aware that their own assumptions and expectations and those of others are a hindrance to understanding their world, they are faced with a disorienting dilemma. In this way, they become more reflective and tend to give up unquestioning acceptance of what they have come to know through experience and culture. As a result, they are prompted to self-examine their beliefs and share their thoughts with others about the issue in order to make better decisions. During this process students become more reflective and questioning. Mezirow (2000) observes students’ engagement in informed and constructive discussions leads to critical assessment of their own assumptions and their relevance to making interpretation. In an effort to overcome the disorienting dilemma, students tend to change their frame of reference and reflect critically on their assumptions and beliefs about the issue being discussed (Mezirow, 2000). Through this critical reflection and struggle to make sense of their experiences, students begin to view their world differently. Thus, in an effort to redefine their world their perspectives are transformed. It is in this view that Mezirow (2000) notes that perspective transformation is about making sense of one’s experience and is shaped by cultural values.
Collective perceptions, like culture, are a compilation of all community members’ beliefs reflected in their day-to-day behaviours, and take long to form. As a group, these students live and co-exist within various subgroups and sub-cultures that include family, language, ethnicity, the moral education class and the school (Aikenhead, 1997). Cobern and Aikenhead (1997) observe that subgroups comprise of people who generally embrace a defining system of meaning and symbols by which their social interactions take place. As they strive towards meaning making and decision-making the various sub-cultural groups influence them. As a group they tend to awe allegiance to each other and to the group’s subculture. Eventually, their decisions are dictated not only by the educational expectations but also by the societal and group expectations. Besides, these students are teenagers who, in their peer group deliberations and engagement, form what Cobern (1996) calls social stance effect. Thus, in order for them to change their perspectives, they require long concentrated and focused efforts as well as conviction that change is necessary, and a willingness to critically examine the existing beliefs and practices. This is where individual teenagers pay allegiance to collective group decisions, irrespective of what they, as individuals may not believe in.

5.5. Summary

This chapter began with a discussion of the perspectives that were the basis of this thesis. What the participating students expressed reflects views expressed in other studies undertaken in different contexts as indicated in the literature cited earlier in this thesis. However, little or no research has engaged directly with students in a way that enables them to express individually and collectively their perspectives on the spread and prevention of HIV/AIDS in relation to cultural practices. The views emerging serve to indicate that while the students were highly knowledgeable about the transmission and prevention of HIV/AIDS, they also haboured serious
misconceptions. The students’ perspectives offer important insights for the students themselves, for other students like them, for teachers and inform curricula more generally. However, misconceptions about HIV/AIDS transmission and prevention were clear indications of a knowledge gap about the nature of HIV/AIDS that need to be addressed in the curricula. For example, the concepts that once circumcised one cannot contract HIV/AIDS, and that HIV/AIDS is transmittable from animals to humans needs to be clarified to students.

Much of what the students had to say can be understood and interpreted within a constructivist paradigm. Within the sociocultural framework, the constructivist paradigm posits that humans generate meaning from an interaction between their experiences and their ideas (Wertsch 1997). During HIV/AIDS-focused moral education class, the students’ diverse, unique and complex socio-cultural backgrounds became an integral part of learning (Wertsch, 1997). Students drew on their lived experiences, social cultural environment and pre-existing knowledge as they interacted among themselves and their teachers.

The interactions within the class observed for this study were enacted within a particular social context. In the context of a teaching-learning scenario the classroom setting constituted the field of communication and interaction between the participants in which the verbal expression became the medium of meaning making and interpretation. The specific conversational group or community was made up of the teacher, students and the researcher. Evidence of manifestations of the students’ perspectives on the spread and prevention of HIV/AIDS above, suggest that the classroom provided the social context in which the students in this study interacted and constructed meanings and understandings of the spread and prevention of HIV/AIDS based on prior knowledge with which they came to the HIV/AIDS focused moral education class.
Perspectives that persisted and those that changed were a clear representation of the students’ alternative frames of reference. Persistent perspectives indicate that subjecting students to HIV/AIDS-focused lesson instruction may not always succeed in bringing about conceptual change. Although knowledge acquisition may start with narrow explanatory framework, additional knowledge acquired as a result of teacher facilitation may fail to replace initial conceptions (Vosniadou, 2002). Alternatively, perspectives that changed indicated that depending on circumstances, students are liable to change their perspectives to suit the prevailing circumstances. In the final chapter, I present the summary of the research findings, implications and recommendations for curricula, theory, research and methodology.
Chapter Six: Summary, Implications and Recommendations

This thesis investigated high school students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives. Research questions that guided the thesis were: (1) What are Ugandan high school students’ perspectives of the spread and prevention of HIV/AIDS? (2) What core cultural practices have the greatest influence on Uganda’s high school students’ understanding of the spread and prevention of HIV/AIDS? And (3) How might this study’s findings inform policy and practice, theory, and research and methodology? In this chapter, I present the summary of the research findings and in response to research question three, provide implications and recommendations for curricula and instruction, theory, research and methodology as well as the conclusion.

6.1. Summary of Research Findings

The findings of each question have been discussed above. In this section, I present the summary of these findings. To investigate students’ perspectives on the spread and prevention of HIV/AIDS, I conducted a study of Form 5 (Grade 12) high school moral education students in seven schools. I adopted a mixed methods research strategy. I used the quantitative methods to assess the students’ HIV/AIDS knowledge levels and to determine key perspectives that drive students’ understandings of the spread and prevention of HIV/AIDS. In order to establish existence of key perspectives among the students prior to the HIV/AIDS-focus moral education, I observed the students’ participation in the HIV/AIDS-focused moral education class and noted how the perspectives manifested.
6.1.1. Research Question 1

What are Ugandan high school students’ perspectives of the spread and prevention of HIV/AIDS?

Prior to the experience, analysis revealed five key perspectives that drive students’ understandings of the spread and prevention of HIV/AIDS. These included: 1) Perceptual and behavioural risks associated with proximity to HIV/AIDS victims, 2) Hygienic practices, 3) Behavioural/practice causes and transmission of HIV/AIDS, 4) Predictive, preventive and transmissive knowledge of HIV/AIDS, and 5) Naïve notions of prevention and treatment of HIV/AIDS. After the experience, I used the t-test to track and compare mean score for the same cluster (Factor) items in the pre-experience data set were compared with the means scores of the same items in the post-experience data set to determine if the experience impacted students’ pre-experience perspectives. Results revealed emergence of two new perspectives and a collapse of two pre-experience perspectives. Perspectives that emerged as new were the Taboo-like prescriptions of knowledge of infection and prevention of HIV/AIDS perspective, and the Contextual view of the nature of HIV/AIDS perspective. Those that collapsed were the Hygienic practices perspective and the Behavioural/practice causes and transmission of HIV/AIDS perspective. Those that persisted included the Predictive, preventive and transmissive knowledge of HIV/AIDS, the Perceptual and behavioural risks associated with proximity and contact with HIV/AIDS victims, and the Naïve notions of prevention and treatment of HIV/AIDS perspectives.

Perspective persistence and transformation demonstrated the transitional process students experience as they cognitively transition from their life world into a scientific world. Results revealed that at times, students’ cognitive experiences that brought into play culturally related cognitive dissonance during HIV/AIDS-focused moral education classes resulted in collateral
learning. In other words, where students might have experienced a cognitive conflict in their life world and the subject being learned, there is a high possibility that they quietly resolved to hold on to both conflicting ideas by developing a satisfactory reason for holding onto both ideas (Jegede & Aikenhead, 1999). Often, perspectives to which students held were culturally rooted. Traditions can provide comfort and a sense of belonging and are therefore not easy to let go. Alternatively, the students preferred to merge ideas resulting into a transformation of some perspectives (Jegede & Aikenhead, 1999). Given that most of the students’ held perspectives were found to be contributory to their understanding of the spread and prevention of HIV/AIDS had implications for curriculum instruction and therefore require attention.

6.1.2. **Research Question 2**

**What core cultural practices have the greatest influence on Uganda’s high school students’ understanding of the spread and prevention of HIV/AIDS?**

Core cultural practices that emerged as having the greatest influence on students’ perspectives on the spread and prevention of HIV/AIDS were identified from the qualitative data during the search for manifestations of the students’ perspectives. These included communalism and interdependence, traditional treatment and healing, blood pact practices, “visiting the bush” or labia elongation, wife inheritance and wife sharing, circumcision and traditional birth attendance which emerged as having the potential influence on the students’ understanding of the spread of HIV/AIDS. Abstinence and “decent” dressing practices appeared to influence the students’ understanding of prevention of the spread of HIV/AIDS. The thesis revealed that the conditions under which some of these practices are carried out are often unhygienic and the instruments used are crude and unsterilized. Results further indicated that establishing identity and belongingness and as well, the fear of violating taboo related rituals are the reasons why
such practices are perpetuated and hence a potential risks of HIV/AIDS infection and spread. In addition, such practices persist because they are not questioned and thus they take on an aura of morality and traditionalism in the eyes of those practicing and participating in them. They also have inherent taboo-like threats that trap the community members into the practices forever.

In the presence of cultural practices, students constantly live in two worlds; while at school they live within the very liberal setting of the Western culture, yet at home they have to conform to values held by their parents/community and passed on for many generations. Some of these values often conflict. For many youth, cultural practices are seen as problematic in relation to the spread and prevention of HIV/AIDS. These too can have implications for HIV/AIDS curriculum and instruction.

6.1.3. Research Question 3

How might this study’s findings inform policy and practice, theory, and research and methodology?

In this era, if HIV/AIDS education does not address students’ perspectives on the spread and prevention, then our view of the classroom is far from real. This study had messages for high school education where HIV/AIDS education is meant to mitigate the transmissive risks.

Because I recognize that the way education policies should be developed is context-specific, this study suggests that students’ understandings of the spread and prevention of HIV/AIDS are greatly impacted by their beliefs in cultural practices. Implications for curriculum in turn had implications for policy on what is offered in the formal curriculum and outside curriculum. Also, this study has implications on how policy on Abstinence, Be faithful and Condom use is interpreted and implemented.
6.2. Implications and Recommendations for Policy, Curriculum and practice

Learning is not about passivity and order, but about discovery and construction of knowledge. It provides students with an opportunity to construct their own understanding of the world in which they lives. To the extent that HIV/AIDS literacy is contained within a subject area (RE/Moral Education), there is a likelihood that the links between it and broader social concerns, are often left unexplored. Yet, where the personal dimensions of HIV/AIDS prevention are stressed, interpersonal and sociocultural concerns are likely to come to the fore, most usually with respect to prevention. I interrogate whether or not issues related to the spread and prevention of HIV/AIDS should be taught didactically as a set of facts, or through use of more student-centered models? This section includes implications and recommendations for teaching and learning arising from this thesis.

My first recommendation is for students to be engaged in socially shared metacognition. Typically, metacognition is viewed from an individual standpoint and is primarily understood as awareness, monitoring and regulation of one’s cognitive process (Anderson, Nashon & Thomas, 2008; Cross & Paris, 1988; Flavell, Miller, & Miller, 1993; Nashon, 2007; Nashon, & Anderson, 2009; Nashon & Nielsen, 2011; Thomas, Anderson & Nashon, 2008; Nielsen, Nashon, & Anderson, 2009). Coming together as peers to solve their cultural dilemmas can be very helpful, since socially shared metacognition requires intentionality on the part of the participants and engagement of each other in order to solve a problem (Claxton, 2002). Socially shared metacognition has to do with teaching students to think critically. A thinking person takes charge of his/her own behaviour. He/she determines when it is necessary to use metacognitive strategies, and selects strategies that define a problem situation while searching for alternative solutions. When life presents situations that cannot be solved by learned responses,
metacognitive behaviour comes into play. Metacognitive skills are needed when habitual responses are not successful. This is similar to Claxton’s (2002) view that with shared metacognition, students learn what to do when they don’t know what to do (also see Nielsen, Nashon & Anderson, 2009).

In a classroom scenario, the teaching/learning process is a complex social situation that involves multiple actors, each with his/her own intentions and interpretations that influence one another’s knowledge, opinions and values (Iiskala, Vauras & Lehtinen, 2004). When trying to understand particular issues as a class, the students’ ability to understand each other’s thinking and interpretive framework is particularly important in collaborative learning. Thus, guidance in recognizing, and practice in applying, metacognitive strategies, will help students successfully solve problems throughout their lives. Also, through metacognition, mutual responsibility for learning, which draws on students’ family and local community’s experiences, is necessary. In addition, when faced with cognitive conflict, socially shared metacognition, helps students to become aware of their thinking processes, to recognize when meaning breaks down and to understand what strategies can work best for them (Iiskala et al., 2004).

Second, perhaps the most obvious question this thesis raises concerns HIV/AIDS education delivery mode. How is HIV/AIDS information delivered within RE/Moral Education? Given that in Uganda’s school curriculum HIV/AIDS education is integrated across a number of subjects, there is a likely tendency that subject matter content dominates based on the prevailing assumption that students have already learned basic HIV/AIDS transmission knowledge in other subjects. According to Grunseit and Kippax (1997) and WHO/UNAIDS (1997), it is generally agreed that HIV/AIDS education should include information on the nature of the virus, its modes of transmission, the consequence of infection, and the steps that can be taken to protect oneself.
against HIV/AIDS infection. However, there is no agreement on how instruction aiming towards these complementary goals should be organized and delivered. Curriculum integration embraces not just the interweaving of subjects such as HIV/AIDS education and RE/Moral education, but also of the curriculum elements involved (such as skills, content and perspectives) that might be taught more effectively in relation to each other than separately.

Third, learning about the spread and prevention of HIV/AIDS may be more successful when educators become aware of the extent to which dominant cultural understandings influence students’ understandings about the phenomenon. This thesis revealed that students’ perspectives often embodied prior knowledge and experiences from which learning is believed to proceed. In addition, the thesis clearly showed that cultural practices as a source of the students’ prior knowledge deeply influence how students filter in and interpret what they learn. Therefore, teaching effectively about HIV/AIDS requires educators to understand how prior knowledge and cultural practices affect learning. This they can do by tapping into students’ prior knowledge and relate students’ thoughts to the most valued cultural practices to elucidate and guide students on misconceptions they harbour. Tapping into students’ prior knowledge is very important because when sufficiently accurate and activated at the appropriate time, it provides a strong foundation for building new knowledge (Roschelle, 1995). However, when insufficient and inaccurate for the task and inappropriately activated, prior knowledge hinders effective learning (Roschelle, 1995). Strike & Posner (1985) observe that prior knowledge also forces a theoretical shift to viewing learning as conceptual change (also see West & Pines, 1985).

In addition, there is also a need for educators to assume the role of “culture brokers.” Learning about HIV/AIDS constitutes for the students what Jegede and Aikenhead (1999) refer to as a form of border crossing, a transition between the students’ everyday lifeworld and the
world of school science. Such a scenario can prove to be highly incongruent for students with epistemic differences and contradicting worldviews. How students deal with cognitive conflicts between those two worlds, and what this means for effective teaching of HIV/AIDS as a scientific issue has implications for the approaches educators employ in the delivery of HIV/AIDS literacy. Jegede and Aikenhead (1999) suggest that as culture brokers, teachers mentor students into multiple identities to live in a world of border crossings, and at the same time hold on to a variety of narratives that define reality. In other words, in spite of cultural influences, students should be guided on how to hold onto narratives that sustain their home culture while accommodating and participating in the world of science.

Further to this, particular attention on part of educators needs to be devoted to the thoughts the students hold about the spread and prevention of HIV/AIDS in relation to cultural practices and the dilemmas they generate in the students day-to-day-lives. In this respect, I advocate for a student-centered curriculum model. A “student-centered curriculum model” connotes a student focus. The model posits that learning requires the student’s positive and active engagement, and that the responsibility for learning lies with the student who is central to his/her own learning process (Johnson, 2004). It emphasizes the centrality of the student through its focus on the student’s learning needs, abilities, interests and learning styles in programming the student’s pursuit of knowledge (Skilbeck, 1985). In this case the needs of the student are of major significance. Marsh and Heng (2009) contend that a student-centered curriculum model is especially relevant to students in a local context, built on local resources and students’ interests.

In a student-centered curriculum model, teachers do not only perform diagnosis of students’ needs, identify learning objectives, and select content, but also ensure that organization of content, selection and organization of learning experiences address students’ sociocultural
dilemmas and misconceptions (Dolence, 2004). Dolence (2004) further observes that the dialogical and interactive nature of a school-centered curriculum model works for the good of the student as it addresses the challenges that face the teachers in the classroom, the administrators in their quest for efficient and effective operations, the policy makers in their efforts to provide adequate resources, and the community in their efforts to improve their environment. It is against this background that the student-centered curriculum model is expected to be sufficiently flexible to respond to the student’s learning needs of HIV/AIDS transmission in relation to cultural practices and to understand new and different ways in which students can learn (DeRoma & Nida, 2004; Elliot, 1997) and deconstruct prior misconceptions.

Given that the model is greatly influenced by the mental, physical and emotional requirements of the student (Dolence, 2004), it takes into consideration the students’ level of development and maturity with caution that the depth and quantity of learning experiences suit the student’s different levels of learning. The curriculum works to ensure that the student’s capacity, manipulative skills, attitudes and values are appropriately developed (Dolence, 2004). In this way, the model is premised on the psychological principles that address the cognitive and metacognitive, motivational and affective, developmental and social as well as the individual and difference factors of the student’s development (King, 2003).

Also, of great benefit is that the model views the student and teacher as partners where the teacher is seen to control the classroom and facilitate the learning, while the student constructs his learning as he accesses information, interprets it, organizes it and uses it to solve his problems (Candela, Dalley, & Benzel-Lindley, 2006). Although the teacher is the principal agent of curriculum, in this model, both the student and the teacher share the responsibility (Nunan, 1988). Achievement of the goals of a student-centered curriculum model is manifested
through the student’s behaviour change, development of mental capacity, acquisition of skills and emotional balance.

In addition, the way educators design learning, select and organize learning experiences is also of great importance. Essentially, learning takes place through experience (Baker, 1995; Kolb, 1984). In the case of social and cultural issues arising from HIV/AIDS, educators should endeavour to select not only experiences that demonstrate understanding of the varied cultures, but also those that promote cultural awareness and their impacts on mitigation of the spread of HIV/AIDS. While the objectives might include the development of students’ skills in HIV/AIDS prevention, the learning experience may include events that help students to understand better those cultural practices that may be considered most contributory to the spread of HIV/AIDS. Lunenburg (2011) stipulates that in some cases, multiple learning experiences could be used to achieve the same objectives since there are many ways of learning the same thing. Besides, a wide range of learning experiences provides more effective learning than a limited range. It is important to note that identification and selection of learning experiences alone cannot suffice without their proper organization given the role they play in achieving the curriculum objectives. Posner (1982) stipulate that since learning experiences create a cumulative effect on the students, they must be organized in such a way that they reinforce each other. In this way they create an interconnection between the different concepts (Marsh & Willis, 1999).

For effective HIV/AIDS education, I also recommend that educators adopt an interdisciplinary type of curriculum enactment since in Uganda, at secondary school level HIV/AIDS literacy is integrated in various subjects, this also helps students to experience the continuity of particular concepts as they move from one subject to another, and to deepen their understanding of the concept. For that matter, it is important that in enacting HIV/AIDS
curriculum, educators ensure continuity, sequence and integration. According to Tyler (1974), continuity provides for recurrence, while sequential development of a concept facilitates students’ understanding of concepts with greater breadth and depth. From an integrative perspective, the learning experiences help students to increasingly get a unified view of the learning concepts. This is because an integrated HIV/AIDS curriculum draws on an interdisciplinary approach, which provides connections across disciplines to real life situations (Drake & Burns, 2004). Bean (1997) observes that often people draw on numerous areas of knowledge in a seamless manner in order to solve their life’s problems. Within a learning context, this can only be facilitated through a form of interdisciplinary curriculum since the aim of interdisciplinary curriculum is to link the apparently disparate types of information into a continuous coherent knowledge structure, whose links are essential for creating an interdisciplinary learning process (Lattuca, Voigt, & Fath, 2004). If students are only taught to think about the spread and prevention of HIV/AIDS in particular disciplines without integrating what they learn into a coherent framework, it is unlikely that they will truly develop interdisciplinary thinking and a corresponding outlook to life’s challenges. Yet, through an interdisciplinary curriculum students are likely to integrate their learning, have the opportunity to connect and to see the relationships between various disciplines and HIV/AIDS phenomenon.

Overall, being knowledgeable about what to teach is only one part of how prepared a teacher is to address HIV/AIDS as an issue for the classroom. Given that HIV/AIDS is not just a health issue, but also a sociocultural issue, its implications extend into the realms of social values. As such, how the students, as members of the community behave in their relationships, and how they view the disease have implications on society. Thus, rather than teachers primarily focusing on the cognitive domain (e.g. ensuring that students know the ways HIV/AIDS is
transmitted and can be prevented), there is a strong need to emphasize the affective domain as well (e.g. examining personal values) and change behaviours (e.g. making good decisions). In this case, this is clearly indicative of the need for teacher education to prepare teachers to address HIV/AIDS in the classroom.

6.3. Implications for Theory

In this thesis I employed the sociocultural and practice theoretical frameworks. In this section, I interrogate how an integrated sociocultural-practice theoretical framework informs students’ perspectives on the spread and prevention of HIV/AIDS and the influence of culture on these perspectives.

Understanding students’ perspectives on the spread and prevention of HIV/AIDS and the impact of cultural practices on these perspectives involves social beings and their distinctive ideas, beliefs, values and knowledge, which concepts UNAIDS (1999) believes are central to culture. Gibson (2003) speculates that belief and knowledge are closely related to the extent that beliefs represent some kind of knowledge. Other concepts included in perspectives and cultural practices are attitude, interaction and behaviour. The concept of human centeredness and the need to explore perspectives, perceptions, attitudes and experiences in part situates this study within phenomenological and ethnographic approaches, which appropriately blend sociocultural and practice theoretical frameworks. The naturalistic-ecological hypothesis contends that human behaviour is significantly influenced by the setting in which it occurs, and that settings generate regularities in behaviour that surpass differences among individuals (Denzin & Lincoln, 1994; Wilson, 1997). Methodologically, both sociocultural and practice theoretical frameworks facilitate cause and effect explanatory science. This is “a science that emphasizes the emergent
nature of the mind in activity and acknowledges the central role for interpretation in its explanatory framework” (Cole, 1996, p. 104).

The belief that combination of sociocultural and practice theoretical frameworks could offer insights into conceptualization students’ perspectives on the spread and prevention of HIV/AIDS and the influence cultural practices exert on these perspectives was based on the assumptions that: (i) perspectives are a social phenomenon; (ii) in a school context students come together from different cultural backgrounds that continue to influence the way they perceive and interpret the world around them; (iii) students bring with them their cultural views and biases and (iv) that reaching the students in their naturalistic school setting minimized biases, enhanced freedom and contributed to more accurate responses. Such a framework was very helpful in analyzing students’ perspectives on the spread and prevention of HIV/AIDS and how these perspectives are influenced by cultural practices.

Besides, learning within a combined sociocultural-practice framework was seen as a changing pattern of engagement in collective activities and social practices. Thus, I viewed the participating students as cultural beings embedded within and constituted by a matrix of social relationships and processes (Lim & Renshaw, 2001). In the classroom context, the HIV/AIDS-focused moral education class discussion connoted communication that was both dialogic and linguistically based. The classroom discussions on the spread and prevention of HIV/AIDS and cultural practices were used as a means of carrying out an activity in which the participants were jointly involved. The HIV/AIDS-focused moral education class discussion was therefore best understood as functioning within a larger framework of mediated social activity (Wertsch, 1994). This is in consonance with McNaughton’s (2005) view that the classroom as a cultural site
provided opportunity of participation and interaction in the construction of knowledge and personal identity.

Based on this background, investigation of the students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives emphasized the need to consider students’ perspectives embedded in everyday practices in both their home and school settings. Thorne (2005) observes that the sociocultural theory provides a framework through which cognition can be investigated systematically without isolating it from the social context. The sociocultural theory acknowledges that cultural, social and historical elements have a bearing on human cognition, as they use such tools like speech, written language and signs to mediate their social environment (Lantolf, 2004).

However, given that the students’ perspectives were related to health perceptions and behaviour, used together, the sociocultural and practice theoretical frameworks could not adequately provide a lens for interpreting all of the students’ perspectives on the spread and prevention of HIV/AIDS across the different contexts of home and school. In this case, I drew on various health behaviour models (such as the Health Belief Model [HBM], AIDS-risk reduction model [ARRM], theory of reasoned action [TRA] and the Social Cognitive Theory [SCT], to interpret the students’ perspectives as indicated in the qualitative analysis section in Chapter four. In so doing, the health behaviour models further complemented the sociocultural and practice theoretical frameworks. Thus, while practice theory sought to explain the relationships that exist between human relationships and their world/environment (Reckwitz, 2002), the sociocultural framework encompassed traditions, beliefs and practices specific to particular groups and the health models informed the interpretation of the perspectives.
The socio-cultural perspective not only views learning as a cognitive process, but also examines how social, cultural, and community contexts impact people’s learning and understanding (Rogoff, 2003). Focusing on the role participation plays in social interactions and culturally organized activities such as rituals in influencing individuals, the sociocultural perspective explains how individual mental functioning is related to cultural, institutional and historical contexts (Chaiklin & Lave, 1993; Leontiev, 1981). Although in this thesis, practice and socio-cultural theoretical frameworks were deemed appropriate for assessing students’ perspectives on the spread and prevention of HIV/AIDS, they served the purpose appropriately only after complementing them with the health models.

6.4. **Implications and Recommendations for Research and Methodology**

This thesis investigated students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices on these perspectives. The mixed methods design was very helpful as the qualitative data provided a deep understanding of the survey responses and the statistical analysis provided detailed assessment of the students’ responses (Caraceli & Green, 1993). Although the research methods used in this thesis were not new, they were combined in ways that had not been done before. In particular, the analysis started with testing the internal consistency reliability of the survey instrument used, to determine if it reliably assessed the students’ knowledge of the spread and prevention of HIV/AIDS. It then proceeded to transform quantitative data into themes that were further analyzed qualitatively. There was a degree of illogic in the way I dealt with the issue of integration of data sources and analysis, particularly where it may be considered epistemologically unacceptable to combine. However, from a pragmatic perspective my primary concern was to determine what data and analysis were needed
to meet the goals of this study and answer the research questions. Note that there was an intricate relationship between the different data sets that resonated with Woolley (2009) explanation that:

Quantitative and qualitative components can be considered “integrated” to the extent that these components are explicitly related to each other within a single study and in such a way as to be mutually illuminating, thereby producing findings that are greater than the sum of the parts (p.7).

Although in most cases mixed methods research integrates data as a conclusion to analysis rather than through analysis (Bazeley, 2009), integration of multiple data sources during analysis is usually less common (Woolley, 2009). In this thesis, integration of the various data sets was the key to unfolding the complex relationships in the topic of study. Based on the richness I drew from integration of the different data sets, one of the major implications of data integration during the analysis process is that such integration encourages creativity, theoretical imagination and initiation of new ideas (Brewer & Hunter, 2006; Greene, 2007).

This study provides insights into high school students’ perspectives on the spread and prevention of HIV/AIDS. In terms of implications and recommendations for research, there is need for further research among students at higher levels of education, in colleges and universities to comparatively determine how perspectives of students at different levels are similar or different. Since the majority of students at these levels are within the youth bracket, it would be important to unravel how different or similar are the perspectives they hold.

Through data analysis, it was clear what influence learning has on students. This necessitates teachers to rethink curricular approaches that can support students in the learning of HIV/AIDS in relation to cultural practices. It requires teachers to treat contentious HIV/AIDS and culture related issues not in a purely academic manner, but as social science issues within the
realm of sociocultural values. Available literature suggests that within the learning context, addressing an issue like HIV/AIDS in relation to cultural practices is different from addressing other issues (Mathews, Boon, Flisher, & Schaalma, 2006; Mwebi, 2007).

Given that the study focused on curricula and instruction, it would also be of interest to carry out an investigation on teachers’ views about students’ perspectives on the spread and prevention of HIV/AIDS in relation to the influence of cultural practices on these perspectives and what strategies they would propose for better HIV/AIDS education delivery.

6.5. Conclusion

This thesis has contributed to understanding students’ perspectives on the spread and prevention of HIV/AIDS and how and what cultural practices influence these perspectives. I have extended understanding of people’s perspectives by applying a combination of the sociocultural and practice theoretical frameworks while drawing on various health behaviour models to understand the perspectives. The sociocultural theory explained human action by pointing to collective norms and values, indicative of how social order is guaranteed by a normative consensus (Reckwitz, 2002). The practice theory explained action and social order embedded in collective, cognitive and symbolic structures, engaged in a shared knowledge that enabled a socially shared way of ascribing meaning to the participants’ world (Reckwitz, 2002). The social context provided multiple layers to group interaction.

I also illustrated the value of employing mixed methods to investigate the students’ perspectives on the spread and prevention of HIV/AIDS with a focus on the students while maintaining the importance of both the participants’ natural and physical world as well as the emergent social and psychological world that includes language, culture, human institutions and subjective thoughts (Johnson & Onwuegbuzie, 2004). Finally, I have also provided important
implications for curricula and instruction, theory and research methodology. Implications include the importance of understanding and paying attention during enactment of HIV/AIDS curricula to students’ perspectives that could influence students’ understanding of the spread and prevention of HIV/AIDS.
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Appendices

Appendix 1: Inter-item correlation matrix

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Appendix 2: HIV/AIDS Knowledge Questionnaire

July 28, 2012

Dear Student,

Re: QUESTIONNAIRE

We invite you to participate in Questionnaire 1 of our study titled “Cultural Practices and the spread and prevention of HIV/AIDS in Uganda: Students’ perspectives and curricular implications”. This questionnaire is part of a study aimed at understanding Uganda’s high school students’ perceptions of the spread and prevention of HIV/AIDS and the influence of cultural practices. The questionnaire will help us determine your initial knowledge of HIV/AIDS. There are no right or wrong answers to the questions. However, determining your view of HIV/AIDS/Moral Education will help us in consultation with your teacher to develop meaningful activities during the R.E classes.

You have been selected as a potential participant because you are a Form five R.E/Moral Education student in your school. Your voluntary participation will be an invaluable contribution to the understanding of Uganda’s high school students’ views on the spread and prevention of HIV/AIDS and the influence of cultural practices.

Before completing the questionnaire, pick a number code randomly from the box in front of the classroom and record it on the questionnaire. Do not disclose this code to anyone else except yourself. Hand the completed questionnaire to your subject teacher who will in turn pass it on to Elizabeth Namazzi.

IT SHOULD TAKE YOU ABOUT 30 MINUTES TO COMPLETE THIS QUESTIONNAIRE. No identification mark(s) should be put on this questionnaire.

The contact information you provide at the end of the questionnaire will be kept confidential. This information will be used to arrange for the follow-up interview only. Once the interview arrangement is made, the information regarding your identity will be shredded. We will use a pseudonym when referring to you as a way of protecting your identity.

Thanks.

Elizabeth Namazzi

Dr. Samson M. Nashon

_________________________________________

Personal Information:
Name of the School _________________________ Your Number Code _____ Form/Grade____
Date _________________
Views on the spread and prevention HIV/AIDS Assessment instrument

Read each of the statements below and assign each statement a rating number between -5 and +5 depending on the degree of agreement, where “−5” means strongly disagree and “+5” means strongly agree. If you assign a zero it means sometimes you agree and other times you disagree.

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<tr>
<th>#</th>
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<td>1.</td>
<td>HIV and AIDS are the same thing</td>
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<tr>
<td>2.</td>
<td>There is a cure for AIDS</td>
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<td>3.</td>
<td>A person can get HIV from a toilet seat</td>
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<td>4.</td>
<td>Coughing and sneezing do not spread HIV</td>
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<td>5.</td>
<td>HIV can be spread by mosquitoes</td>
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<td>6.</td>
<td>A person can get HIV by sharing a glass of water with someone who has HIV</td>
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<td>7.</td>
<td>HIV is killed by bleach</td>
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<td>8.</td>
<td>It is possible to get HIV when a person gets a tattoo</td>
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<td>9.</td>
<td>A pregnant woman with HIV can give the virus to her unborn baby</td>
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<td>10.</td>
<td>Pulling out the penis before a man climaxes or ‘cums’ keeps a woman from getting HIV during sex</td>
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<td>11.</td>
<td>A woman can get HIV if she has anal sex with a man</td>
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<tr>
<td>12.</td>
<td>Showering/ washing one's genitals/ private parts after sex keeps a person from getting HIV</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Eating healthy foods can keep a person from getting HIV</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>All pregnant women infected with HIV will have babies born with AIDS</td>
<td></td>
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<tr>
<td>15.</td>
<td>Using a latex condom or rubber can lower a person's chance of getting HIV</td>
<td></td>
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<tr>
<td>16.</td>
<td>A person with HIV can look and feel healthy</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>People who have been infected with HIV quickly show serious signs of being infected</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Taking vitamins keeps a person from getting HIV</td>
<td></td>
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<tr>
<td>19.</td>
<td>A person can be infected for 5 years or more without getting AIDS</td>
<td></td>
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<tr>
<td>20.</td>
<td>There is a vaccine that can stop adults from getting HIV</td>
<td></td>
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<tr>
<td>21.</td>
<td>Some drugs have been made for the treatment of AIDS</td>
<td></td>
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<tr>
<td>22.</td>
<td>Women are always tested for HIV during their pap smears</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>A person can get HIV even if she or he has sex with a person one time</td>
<td></td>
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<tr>
<td>24.</td>
<td>Using a lambskin condom or rubber is the best protection against HIV</td>
<td></td>
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<tr>
<td>25.</td>
<td>A woman cannot get HIV if she has sex during her period</td>
<td></td>
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<tr>
<td>26.</td>
<td>There is a female condom that can help decrease a woman's chance of getting HIV</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>A natural skin condom works better against HIV than does a latex condom</td>
<td></td>
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<tr>
<td>28.</td>
<td>A person will not get HIV if she or he is taking antibiotics</td>
<td></td>
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<tr>
<td>29.</td>
<td>Having sex with more than one partner can increase a person's chance of being infected with HIV</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Taking a test for HIV one week after having sex will tell a person if she or he has HIV</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>A person can get HIV through contact with saliva, tears, sweat, or urine</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>A person can get HIV if having oral sex, mouth on vagina, with a woman</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Using Vaseline or baby oil with condoms lower the chance of getting HIV</td>
<td></td>
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<tr>
<td>35.</td>
<td>Athletes who share needles when using steroids can get HIV from the needles</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>A woman can get HIV if she has vaginal sex with a man who has HIV</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Washing drug use equipment with cold water kills HIV</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 3: Students’ Assent/Consent Form

Department of Curriculum and Pedagogy
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4
Tel: (604) 822-5422
Tel: (604) 822-4714

June 22, 2012

Dear Student,

We are carrying out a study on “Cultural Practices and the spread and prevention of HIV/AIDS: Students’ perspectives and curricular implications”. The purpose of this letter is to invite you to participate on this study as member of Form 5 (senior 5) R.E/moral education class in your school.

This study will investigate Ugandan high school students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices during R.E/moral education classroom lessons. Cultural practices will refer to those traditional and customary practices of the different societies or ethnic groups that relate to the spread of HIV/AIDS such as polygamy, wife inheritance, early marriage, circumcision, female genital mutilation (FGM), etc. Insights into students’ perspectives will be obtained through observation and listening to classroom conversations between the teacher and the students during the normal lesson delivery. We have chosen the R.E/moral education subject because it is the subject through which social topics like marriage, sexuality, polygamy, circumcision etc. are handled. Besides, R.E/moral education is an evaluative subject that involves the exploration of beliefs and values and how such beliefs and values are expressed.

This study aims to understand students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices within R.E/Moral Education classroom discourses.

Your participation and involvement in the study will take place during the school hours in classrooms at your school. If you provide written assent by signing this form, you will participate by doing the following in collaboration with your R.E/moral Education teacher and Elizabeth Namazzi of the University of British Columbia in order to better understand your views about the spread and prevention of HIV/AIDS and the influence of cultural practices during the learning process:

(i) Complete a short pencil and paper questionnaire about your views on the spread and prevention of HIV/AIDS (30 minute)
(ii) A whole class attendance of R.E/moral education lessons (4 hours/throughout this term)
(iii) Participate in classroom discourses on the spread and prevention of HIV/AIDS and cultural practices and
(iv) Audio-taped face to face talk with Elizabeth Namazzi of the University of British Columbia about your understanding of the world and views about cultural practices and related norms of your community both in the class and in a focus group interview setting (1hour 30 minutes).
There are no known risks to participation in this study. Instead, the study will provide experiences that are intended to enrich your understanding of the spread and prevention of HIV/AIDS and cultural practices and how they impact on the spread and prevention of HIV/AIDS.

Data collected in this study will remain confidential between the investigators, research assistants (who will sign a confidentiality memo), and yourself. After the study results are compiled, we will ensure that data obtained from you remains anonymous. Although some of your verbatim comments and excerpts from audio data may be used to clarify findings of the study in forums such as the final report, scholarly conferences and journal articles, your identity will be concealed by use of a pseudonym, as will the name of your school.

Participation in this study is voluntary. You are free to decline to participate in, or withdraw from the study at any time without consequence to your classroom standing. If you decide that you do not want to participate in the study, or decide to withdraw from the study at a later date, you will continue to attend R.E/moral education classes and will participate regularly in classroom discourses, but your responses to the questionnaire and interviews will not be used for the study.

In case of any concerns over your participation or rights in this study you may telephone the University of British Columbia office of Research Services, at (604) 822 8598, or email RSIL@ors.ubc.ca.

Thank you.

Elizabeth Namazzi
Dr. Samson Nashon

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Re: Student’s Assent/Consent Form

TO PARTICIPATE IN CULTURAL PRACTICES AND THE SPREAD AND PREVENTION OF HIV/AIDS: STUDENTS’ PERSPECTIVES AND CURRICULAR IMPLICATIONS, PLEASE SIGN AND RETURN THIS COPY OF THE CONSENT FORM

Please check the box indicating your decision

☐ I ASSENT (I say “yes”) to my participation in the above stated study and agree to my participation in the pencil and paper questionnaire, audio-taped interviews and meetings. The investigators have informed me this study and I understand the nature of my participation in this study. With my assent I acknowledge receiving a copy of the study information.

☐ I DO NOT ASSENT (I say “no”) to my participation in the study activities described in the attached form. I understand that if I say no or withdraw from participating in the study at a later date, my decision not to take part in the study will not affect my school experience and classroom standing in any way, and I can be part of the classroom discourses but not the research study.

Your Full Name (please print): __________________________________________

Signature: __________________________________________ Date: ________________
Appendix 4: Parents’ Consent Form

Department of Curriculum and Pedagogy  
2125 Main Mall  
Vancouver, BC, Canada V6T 1Z4  
Tel: (604) 822-5422  
Tel: (604) 822-4714

July 22, 2012

Dear Parent or Guardian,

Your child is part of a study investigating “Cultural Practices and the spread and prevention of HIV/AIDS in Uganda: Students’ perspectives and curricular implications” among Form 5 (Senior 5) R.E/moral education students. We are writing to request your permission for your child to participate in our study.

This study will investigate Ugandan high school students' perspectives on the spread and prevention of HIV/AIDS and cultural practices during R.E/moral education classroom lessons. Cultural practices will refer to those traditional and customary practices of the different societies or ethnic groups that relate to the spread of HIV/AIDS such as polygamy, wife inheritance, early marriage, circumcision, female genital mutilation (FGM). Insights into students’ perspectives will be obtained through observation and listening to classroom conversations between the teacher and the students during the normal lesson delivery. We have chosen the R.E/moral education subject because it is the subject through which social topics like marriage, sexuality, polygamy, circumcision etc are handled. Besides, R.E/moral education is an evaluative subject that involves the exploration of beliefs and values and how such beliefs and values are expressed.

This study aims to understand students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices within R.E/Moral Education classroom discourses.

Your child’s participation and involvement in the study will be harmonious with normal educational experiences encountered in the Form 5 (grade 11) R.E/Moral Education classroom and the curriculum. If you provide written consent by signing this form, your child will participate by doing the following in collaboration with his/her teacher and Elizabeth Namazzi of the University of British Columbia in order to better understand his/her views about cultural practices and the spread and prevention of HIV/AIDS and learning processes:

(i) Complete a short pencil and paper questionnaire about your views on the spread and prevention of HIV/AIDS (30 minute)  
(ii) A whole class attendance of R.E/moral education lessons (4 hours/throughout this term)  
(iii) Participate in classroom discourses on the spread and prevention of HIV/AIDS and cultural practices and  
(iv) Audio-taped while in the classroom and in a focus group interview setting about his/her understanding of the world and views about the spread and prevention of HIV/AIDS and cultural practices as well as related norms of his/her community (1hour 30 minutes).
There are no known risks to participants in this study. Instead, the study will provide experiences that are intended to enrich your child’s understanding of the spread and prevention of HIV/AIDS and cultural practices, and to relating his/her classroom learning to his/her local community. Data collected in this study will remain confidential between the researchers and your child. After the study results are compiled, we will ensure that the data obtained from your child remains anonymous. Although we may use some of your child’s verbatim comments to clarify findings of the study in forums such as the final report, scholarly conferences and journal articles, your child’s identity will be concealed by use of a pseudonym, as will the name of your child’s school.

Participation in this study is voluntary. Your child is free to decline to participate in, or withdraw from the study at any time without consequence to his or her classroom standing. Students who choose not to participate in the research may still attend class regularly and participate in classroom activities related to cultural practices and the spread and prevention of HIV/AIDS. In case of any concerns over your child’s participation or rights, in this study you may telephone the University of British Columbia office of Research Services, at (604) 822 8598, or email RSIL@ors.ubc.ca.

Thank you.

Elizabeth Namazzi

Dr. Samson Nashon

________________________________________

Re: Parent’s Consent

IN ORDER FOR YOUR CHILD TO PARTICIPATE IN THE STUDY ON CULTURAL PRACTICES AND THE SPREAD AND PREVENTION OF HIV/AIDS: STUDENTS’ PERSPECTIVES AND CURRICULAR IMPLICATIONS, PLEASE SIGN AND RETURN THIS COPY OF THE CONSENT FORM

Please check the box indicating your decision

□ I CONSENT to my child’s participation in the above stated study and agree to his/her participation in the pencil and paper questionnaire, audio-taped interviews and meetings. I have read the attached form and understand the nature of my child’s participation in this study. With my consent I acknowledge receiving a copy of the study information.

□ I DO NOT CONSENT to my child’s participation in the study activities described in the attached form. I understand that my decision to not allow my child to take part in the study will not affect his/her school experience in any way.

Child’s Name (please print): ____________________________________________

Parent/Guardian Full Name (please print) __________________________________

Signature: ___________________________________ Date: _________________
Appendix 5: Interview Protocol

Dear Student,

Re: Focus Group interview Discussion

This interview is part of our study on “Cultural Practices and the spread and prevention of HIV/AIDS in Uganda: Students’ perspectives and curricular implications in which we aim to understand students’ perspectives on the spread and prevention of HIV/AIDS and the influence of cultural practices as R.E/Moral Education students in Form 5 (Senior 5). The interview will help us determine the students’ views about the spread and prevention of HIV/AIDS and the manner in which cultural practices influence your views on the spread and prevention of HIV/AIDS. There is no right or wrong answer to the interview questions. However, your views will help us to develop meaningful learning activities to bridge classroom knowledge and cultural practices, and you to better understand the factors that influence the spread and prevention of HIV/AIDS and those cultural practices that contribute and those that do not contribute to the spread and prevention of HIV/AIDS.

During our discussion, we will audio-record your responses so we can make sure we have captured the thoughts, opinions, and ideas we hear from you. No names will be attached to the interview and your information will be kept private and confidential. Also note that your participation in this interview is strictly voluntary. During the discussion, feel free to refuse to answer any question or to withdraw from the study at anytime. During this process of this interview, we shall have a few questions to guide our discussion:

Expectations and motivations

1. Tell us why you chose to participate in this study.
2. What do you expect to learn from sharing about cultural practices and the spread and prevention of HIV/AIDS?

Spread of HIV/AIDS

3. What are your views about the spread and prevention of HIV/AIDS?

Core cultural practices

4. In your view what cultural practices of your community do you consider to influence the spread and prevention of HIV/AIDS?
5. In which way do you participate in cultural practices of your community at home and in your larger community?
Content knowledge

6. How do these cultural practices contribute to the spread of HIV/AIDS?
7. How do these cultural practices contribute to the prevention of HIV/AIDS?
8. How does the learning of R.E/moral education influence your understanding of your community’s cultural practices and the spread of HIV/AIDS?

Conceptual framework

9. How has your background influenced your understanding of cultural practices of your community?
10. How has your understanding of cultural practices and the spread of HIV/AIDS influences your behaviour?

Attitudes and feelings

11. How has your attitude towards the spread and prevention of HIV/AIDS changed since you started doing R.E/moral education at your school?

Thanks for your cooperation.

Elizabeth Namazzi