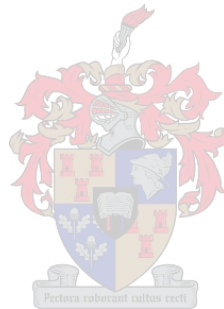


**To investigate the risk perception of rural adult population in Chikhwawa District, TA Maseya,
on wife inheritance as a driver to HIV transmission**

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**Assignment presented in partial fulfilment of the requirements for the degree of Master of
Philosophy (HIV/AIDS Management) at Stellenbosch University**



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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Chancy Alfred Nthowela

January 2012

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DEDICATION

Many people have played a great role in making this thesis a reality. Firstly I would like to dedicate the thesis to my first born son Tadala Kamanga Nthowela.

Secondly I would like to dedicate this thesis to the memory of both my late father Alford Ben Tom Kamanga and late mother Elasi Phiri, who never lived to see what has become of the words of encouragement they used to instil in me and for their daily encouragement to pursue my education at all levels possible.

Thirdly I would like to dedicate this thesis to all widows in TA Maseya, because without them this thesis would not exist. The participation of these widows gave me an insight in terms of understanding some major challenges they meet in their daily lives especially on issues related to HIV/AIDS. Their individual, but related stories did not only inspire me to write this thesis but motivated me to engage development partners in HIV/AIDS management to come up with interventions in TA Maseya in order to address the cultural practices that put them (widows) at risk of contracting the virus.

I would like to thank my supervisor Dr. Thozamile Qubuda and my promoter who assisted me in the development and finalisation of the project. I would also like to thank Dr. Thomazile for his guidance in analysing the results of my research paper and to come up with the final thesis.

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This research project would not have been successful and would have been just a dream without the tireless assistance made by the following people.

Firstly I would like to thank God Almighty for making me who I am today and by giving me strength and wisdom to never give up. I know that without His guidance, love and grace I could not have made it up to this far. Thank you Lord for your will to make me complete this research study.

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I am grateful of the timely guidance and assistance provided by my supervisor Dr. Thozamile Qubuda during this study. Your constant support, patience, and speedy feedback made this research possible. Thank you and do the same to others. Stay blessed at all times.

Many thanks should go to my wife Mwandida Lucy Chimatira for her moral support. Many thanks should also go to Mphumula Lynne Saka for her technical support. You were there for me when I needed you most. Indeed you have been another great source of inspiration. I am blessed to have you.

I want to thank my supervisor at Save the Children in Malawi for allowing me to do my research during work time. To all those whom I have forgotten to mention their names I say it is not out of bad will but it is due to the limitation of my memory; and all I can say is that may the Almighty God bless you abundantly.

ABSTRACT

INTRODUCTION: The purpose of this study was to investigate the cultural practice of wife inheritance as a driver of HIV transmission among the adult population in Chikhwawa District, TA Maseya in Malawi. Wife inheritance entails that the wife of a deceased husband marry a relative of the deceased husband.

OBJECTIVES: The objectives of the study were to assess the knowledge levels about and risk perception of *wife inheritance* as a driver of HIV transmission.

METHODS: The study adopted a qualitative approach. In-depth interviews using interview guides were employed as a method of data collection.

RESULTS: In total, 37% of the respondents indicated that they had been involved in the practice of wife inheritance. It was found that wife inheritance could be a driver of HIV transmission. Many respondents reported not using a condom in their last sexual encounter; as well as not caring whether or not they used a condom the last time they had sex.

CONCLUSION: Many respondents knew they were HIV-positive, but had not informed their spouses of their status because of fear that their partners would end the relationship. Many respondents knew that the practice of wife inheritance increased their risk of contracting HIV.

OPSOMMING

INLEIDING: Die doel van hierdie navorsing was om die verband tussen MIV-oordrag en die kultuurgebruik waar 'n weduwee met 'n lid van hul afgestorwe man moet trou, te ondersoek.

DOEL: Die doelwit van die studie was om die kennisvlakke en die risiko-persepsies oor die verband tussen MIV-oordrag en die kultuurgebruik waar 'n weduwee met 'n lid van hul afgestorwe man moet trou, te evalueer.

METODOLOGIE: 'n Kwalitatiewe navorsingstudie is van stapel laat loop en dit het persoonlike onderhoude ingesluit. Die teikengroep het bestaan uit volwasse kliënte van die Chikhwawa-distrik, TA Maseya in Malawi.

BEVINDINGE: Die studie het bevind dat 37% van respondente wel die kultuurgebruik waar 'n weduwee met 'n lid van hul afgestorwe man moet trou, beoefen. Daar is bevind dat daar wel 'n verband tussen MIV-oordrag en die kultuurgebruik waar 'n weduwee met 'n lid van hul afgestorwe man moet trou, kon bestaan. Baie respondente het aangedui dat hulle nie 'n kondoom gebruik het die laaste keer wat hulle seksueel verkeer het nie; asook dat hulle nie omgee of hulle wel 'n kondoom gebruik het of nie die laaste keer wat hulle seks gehad het nie.

IMPLIKASIES: Baie respondente het geweet dat hulle MIV-positief was, maar dat hulle nie hulle gade van hul status wou vertel het nie uit vrees dat dit die einde van hulle verhouding sou beteken. Respondente het ookaangedui dat hulle wel kennis dra dat die kultuurgebruik waar 'n weduwee met 'n lid van hul afgestorwe man moet trou, hulle risiko vir MIV-oordrag kan verhoog.

LIST OF ABBREVIATIONS

The following acronyms and terms are used throughout the thesis. They are listed here for reference and clarity.

AIDS	Acquired Immune Deficiency Syndrome
TA	Traditional Authority
HIV	Human Immune Virus
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
UNAIDS	The joint United Nations Programme on HIV/AIDS
PLWHA	Person Living with HIV/AIDS
GVH	Group Village Headman
VH	Village Headman
SPSS	Statistical Package for the Social Sciences
SEP	Socio-Economical Profile
MHRC	Malawi Human Rights Commission
PHC	Population and Housing Census
UNDHR	United Nations Declaration of Human Rights
NAC	National AIDS Commission of Malawi
PAR model	Pressure and Release Model
LGE	Local Government Elections
STI	Sexually Transmitted Infections
WWW	World wide Website
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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CHAPTER ONE: INTRODUCTION

1.1 Background

In Chikhwawa district, traditional authority Maseya, cultural practices associated with the heterosexual life of the adult population include: wife inheritance, wife cleansing, polygamy, and wife replacement. These cultural practices increase the risk of HIV infection. In particular, *wife inheritance* has an influence on the aspects of people's lives including their behaviours and perception in relation to HIV transmission among the adult population.

Wife inheritance is a process where a married woman loses her husband and is required by culture to re-marry her deceased husband's brother, nephew or uncle. The wife is required to marry the relative of the deceased husband without couple counselling to find out whether one of them is HIV positive. In this era, most deaths are linked to HIV and AIDS related illnesses (UNAIDS, 2008). In the case that the deceased husband died of HIV/AIDS, the relatives who will re-marry the wife risk contracting the virus. The situation could be that the wife to the deceased husband could be HIV positive and could possibly transmit it to the inheritor. Most of the time in *wife inheritance*, sex takes place without condom use and in the absence of HIV testing and counselling for the adults involved in the practice. The magnitude and the nature of the impact of this practice on the transmission of HIV are yet to be determined. Without a thorough understanding of how *wife inheritance* influences the transmission of HIV, it is difficult to design strategies for intervention where the impact is negative. Consequently, the rural adult population will continue to be at risk of contracting HIV because of the impact of *Wife inheritance*. However, *wife inheritance* continues to be practiced in TA Maseya because the rural adult population have low risk perception of how this practice can put them at risk of contracting HIV.

1.2 Knowledge gap

Against this background, there is a knowledge gap regarding the rural TA Maseya adult population's perception of risk of *wife inheritance* as a driver for HIV transmission.

1.3 Research question

What is the risk perception, of rural adult population in Chikhwawa district, TA Maseya, on *wife inheritance* as a driver to HIV transmission?

1.4 Aim and objectives of the research study

1.4.1 Aim

The main aim of this research is to investigate the risk perception of rural adult population in Chikhwawa District, TA Maseya, on wife inheritance as a driver to HIV transmission.

1.4.2 Objectives

- To analyse cultural practice of *wife inheritance* in relation to HIV transmission among the rural adult population.
- To assess the knowledge of the rural adult population on how *wife inheritance* can put them (adult population) at risk of contracting HIV.
- To identify the rural adult population risk perception on *wife inheritance* as a risk driver of HIV transmission.
- To provide recommendations for interventions for communities regarding the practice of wife inheritance.

CHAPTER TWO: RESEARCH DESIGN AND METHODS

2.1 Study location and target population

The study has been conducted in Traditional Authority Maseya in Chikhwawa district among the rural adult population aged 15-49 (both male and female). According to the *2008 Population and Housing Census*, TA Maseya has 38 villages with a total adult population of 12, 871 out of which 6, 184 are male and 6, 687 are female. TA Maseya consists of the following ethnic groups: Sena and Mang'anja who practice *wife inheritance* as part of their culture (there is a negligible number of Lomwe who do not practice *wife inheritance*).

2.2 Research design and data collection

The aim of the research study is to investigate the risk perception of rural adult population in Chikhwawa District, TA Maseya, on wife inheritance as a driver to HIV transmission. A qualitative method in gathering data consisted of semi-structured interviews with widows, men, traditional leaders (who are custodian of culture), and the adult community members on their knowledge about *Wife inheritance* and HIV/AIDS in the area. The researcher used an interview guide with open ended questions to achieve the aim of the study. The themes that were covered in the questionnaire include; the assessment of the rural adult population on the general knowledge of HIV/AIDS, knowledge of cultural practices that fuel HIV transmission i.e. *wife inheritance*, and the adult population perception on *wife inheritance* as a risk driver of HIV transmission.

2.3 Population and sampling

The researcher interviewed 30 participants (as the sample size). The interviews used the inclusion criteria sampling method. The researcher expected that the perceptions of the rural adult population, on knowledge of cultural practices that fuel HIV transmission, would vary with the specific gender of participants. The researcher engaged 20 widows (n=20), 10 rural adult community members out of which 5 were traditional leaders in TA Maseya (n=10). In other words, 25 farmers and 5 village headmen were subjected to the study. Written informed consent was obtained from each respondent.

2.3.1 Measuring instrument

2.3.1.1 Questionnaire.

The measuring instrument utilised was a self-administered questionnaire with limited open-ended questions. The questionnaire contained 37 open-ended questions.

2.3.2 Demographic characteristics of the sampled population

The population sampled varied from different perspective. The demographic characteristics for the sampled population took into consideration respondents: sex, highest education, village of residence, marital status, ethnic group and religion. However, reference is made to the statistical distribution of the sampled population in the **Tables 1-8** below. A quota sampling technique was mainly used.

The gender of respondents was dominated by women, who were about 67%. This was so because it is mostly women who are the victims of *wife inheritance* compared to men.

Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	20	66.7	66.7	66.7
	Male	10	33.3	33.3	100.0
	Total	30	100.0	100.0	

Table 1: Sex of Respondents

The villages studied consisted of a poor population that is heavily reliant on agriculture such that those interviewed were farmers, and some doubled with the role of the village head.

Occupation: What respondent does

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Farmer	25	83.3	83.3	83.3
	Village Headman	5	16.7	16.7	100.0

Occupation: What respondent does

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Farmer	25	83.3	83.3	83.3
	Village Headman	5	16.7	16.7	100.0
	Total	30	100.0	100.0	

*Table 2: Occupation of Respondents***Age group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-29	3	10.0	10.0	10.0
	30-39	7	23.3	23.3	33.3
	40-49	20	66.7	66.7	100.0
	Total	30	100.0	100.0	

Table 3: Age group of Respondents

Further, as is shown above, the age distribution was skewed towards the adult population as the researcher intended to tap into their experiences and determine the extent to which the *wife inheritance* practice has been entrenched in their lives.

The research was carried out in four group villages of Mbande, Josephy, Frank and Kalima. A group village headman (GVH) is a chief who is responsible for a cluster of villages that have their own headmen subject to him/her.

It was Mbande GVH area where the research was concentrated as a result of travel challenges met during the research. The area studied is a disaster-prone area subject to flooding of the Shire River, which cuts off other areas during the rainy season. This would have greatly increased sampling error had it been that there were marked demographic and social differences between the villages.

Village

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mbande	19	63.3	63.3	63.3
	Josephy	5	16.7	16.7	80.0
	Frank	5	16.7	16.7	96.7
	Kalima	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Table 4: Village of Respondents

It was determined to study according to education levels but it was seen that the area had few people who had made it to primary school and beyond. Most had received no formal education as is reflected by the table below:

Highest education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	13	43.3	43.3	43.3
	Primary School	15	50.0	50.0	93.3
	Secondary School	2	6.7	6.7	100.0
	Total	30	100.0	100.0	

Table 5: Education of Respondents

In addition, the respondents' marital status was verified and it was mostly widows who were interviewed because it was considered important that they relate their personal experiences.

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	1	3.3	3.3	3.3
	Married	9	20.0	20.0	23.3
	Married	9	20.0	20.0	23.3
	Widowed	20	76.7	76.7	100.0
	Total	30	100.0	100.0	

Table 6: Marital Status of Respondents

The respondents were either Sena or Mang'anja whose cultural practices made them relevant for study. As was already earlier explained, there are spats of Lomwe in the villages, but this tribe does not practise *wife inheritance* as part of their culture; hence, were excluded. *Table 7* is the sampling distribution according to ethnic group.

Ethnic group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mang'anja	14	46.7	46.7	46.7
	Sena	16	53.3	53.3	100.0
	Total	30	100.0	100.0	

Table 7: Ethnic Group of Respondents

Finally, the religion of respondents was established for determining the demographic pattern of the sample. The area had a heavy Christian presence with much bias towards Roman Catholic. Other denominations included Baptist, Seventh - day Adventist and Pentecostals. See below:

Religion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Baptist	4	13.3	13.3	13.3
	SDA	5	16.7	16.7	30.0
	Catholic	10	33.3	33.3	63.3
	Pentecostal	6	20.0	20.0	83.3
	Apostolic	1	3.3	3.3	86.7
	Salvation	1	3.3	3.3	90.0
	Army	1	3.3	3.3	93.3
	CCAP	1	3.3	3.3	96.7
	Evangelical	2	6.7	6.7	100.0
	Total	30	100.0	100.0	

Table 8: Denomination of Respondents

Therefore, the researcher interviewed using a wide spectrum of demographic aspects in order to improve on validity and reliability of the findings.

2.4 Data analysis

The collected qualitative and quantitative data was analysed in two ways. Firstly, the Quantitative data was nominal, discrete, and was subjected to descriptive statistical analysis. SPSS 16.0 was used in analysing the quantitative data. Secondly, the Qualitative data was interpreted through thematic content analysis and summarising. The qualitative data was analyzed with the view to gain an in-depth understanding of the adult population risk perception on wife inheritance as a driver of HIV transmission. The data from the research tool (open-ended questions) was summarized in themes that emerged.

2.5 Informed consent

Prior to the start of the study, a research proposal was submitted to the University of Stellenbosch's Ethics Committee for approval of the intended study on 18th August, 2011. The University of

Stellenbosch's Research Ethics Committee received the research proposal on 27th July, 2011 and was reviewed and approved on 28th July, 2011 for a period of one year (27th July, 2011 -28th July, 2012). An informed consent process informed the participants about the nature of the research, and protected participants' rights to confidentiality, and their ability to withdraw their participation in the study at any time. More specifically, the informed consent outlined the nature of the study, and the risks of participating in the study. It gave a full explanation of the purposes of the research; an expected time commitment of the participant; a description of the procedures of the study; a statement of potential benefits of contributing to research on adult population risk perception on wife inheritance as a key driver of HIV transmission in TA Maseya, Chikhwawa district; a statement regarding the confidentiality of participation (as described above); a listing of the researcher's name, telephone numbers, and address, as well as those of the research supervisor and the University of Stellenbosch Ethics Committee, if the respondents had any questions about the study and their rights as participants; and a clear statement that participation in the study was voluntary and participants could elect not to participate at any time without any penalty. The above protocol for informed consent was submitted and approved by the University of Stellenbosch Research and Ethical Committee.

2.6 Ethical consideration

The Ethics and research committee at Stellenbosch University approved the research protocol and study instrument. The study was dependent on the use of human subjects (widows, men and traditional leaders) for completion. The issue of ethics as well as respect for human rights and dignity were carefully considered. The HIV positive sero-status of widows were carefully considered as private in order to avoid stigma due to the participants status which may lead to fear of discrimination and rejection by community members and close relatives and friends. Morse and Richards (2002, p 205) in Qubuda (2010) identify the following ethical principles regarding participants' rights:

- The right to be informed of the purpose of the study as well as what is expected during the research process. The amount of participation and time required. What information will be obtained and who will have access to it. Finally what the information will be used for.
- The right to confidentiality and anonymity.
- The right to ask questions of the researcher.
- The right to refuse to answer questions the researcher may ask, without negative ramifications.
- The right to withdraw from the study at any time without negative ramifications.

In consideration of ethical issues related to the selection of the sample, participation was voluntary, and any of the potential participants were free to decline to take part. Participation in the study was confidential. Study participants signed informed consent forms. Confidentiality was maintained throughout the study, and potential study participants were informed of the intentions of the study. Despite the project addressing the possible psychological pain and discomfort as observed by the Research and Ethical committee, participants were ensured of addressing the foreseen challenge through counselling, if emotional upset and unintended injury resulted. Participants were allowed to withdraw their participation at any time, without harm or consequence should they feel of doing so. However, none of the approached and interviewed research participants withdrew from participating in this research due to foreseen harm or consequences, since no harm was caused.

Permission to conduct this study was approved by the Ethics committee of the Stellenbosch University and the relevant community (Chikhwawa district, TA Maseya). Informed consent was obtained from all participants before the study began. Participants had the right to withdraw from the study or stop their participation at any time during the process. This study maintained the participants' anonymity and privacy. The names of participants were coded to protect their identity in all written reports. The names were also removed from the master copy of the demographic information after being coded and only the researcher was able to identify the participant.

Only the researcher had access to the participants' names. Research participants was assured that their identity would be kept confidential and that the completed questionnaires and all collected data would be securely filed and locked (in a locked cabinet) with access limited to the researcher and the supervisor. The consent forms were filed separately from the data. The participants were assured that the data would be presented in an overall picture of the research which would be beneficial for further social science research and HIV/AIDS management practice. Data and the results were not shared with anyone except the researcher's supervisor.

2.7 Significance of the research study

The research study has been inspired by the objective to pursue an open discussion on *Wife Inheritance* that if left un-checked will have negative consequences on the rural adult population in Chikhwawa district, TA Maseya. I am interested in this research problem for the following reasons:

- The research study would provide the rural adult population with knowledge on how HIV transmission is linked to cultural practices such as *Wife Inheritance*.
- The research study on one hand would determine the level of risk perception of wife inheritance as a driver for HIV transmission and such information would provide a background on how the Government and non-state organisations would cordially network with other stakeholders in order to sensitise communities on the dangers of practicing *Wife Inheritance* in relation to HIV transmission. On the other hand the study would assist Government and organisations to analyse and estimate the damage that may be caused by the problem and later design and implement interventions in line with the needs on the ground in order to address the problem beyond culture.
- This research study is important in that it will specifically determine the role of Traditional Leaders (who are considered to be the custodians of Malawian cultures) to assume their advocacy role in bringing to an end cultural practices, such as *wife inheritance*, that promote HIV transmission.
- This study will provide a list of recommendations which could serve as guide for all actors in the field of HIV/AIDS prevention while defining programs' objectives for HIV prevention, hence the importance of this study.

CHAPTER THREE: LITERATURE REVIEW

3.1 Background information of HIV/AIDS in Southern Africa: The case of Malawi

According to the *UNAIDS, 2004 AIDS Updates*, Sub Sahara Africa represented at least 10% of the world population whilst it sheltered 64 % of people living with HIV. An estimated 3 million people became infected in 2003. It is the worst affected region by the HIV/Aids. Studies have revealed that 80% of HIV transmission in Africa is via the heterosexual route and 12% via mother to child route. Blood transfusion is estimated at 2.5%. Unsafe medical injections are suspected to contribute to 2.5 percent of HIV spread in Africa though this data is not certain (*UNAIDS, 2004*).

The high prevalence of HIV infection in Africa compared to other regions tends to suggest that different dynamics came into this region. Although it is often controversial and sometimes misleading to make generalisations, Africa, and Malawi to be specific, has a wide range of beliefs, habits, religious and healing practices. Some of these practices and beliefs date back several centuries. It is also true that cultural differences are evident within and between countries. While it is important to recognise that traditional practices are important in maintaining cultural identity and continuity, but some have harmful aspects and voices have been raised to discontinue such practices. Other voices argue for a harm reduction approach, to reduce harms but seek to maintain the culture.

Since 1983, the HIV/Aids pandemic has added a very significant new harm to a number of practices, but it is usually feasible to eliminate this particular harm completely through basic infection control procedures. Though it is assumed that some traditional practices promote HIV transmission, specific studies have not often been conducted to establish the linkage. Such practices may be so rooted in the culture that it seems impossible to stop them.

However, we do know it is possible to change behaviour but because of cultural differences, accepted norms by societies in different settings, this may be difficult in practice. For example, safer sex practices have not been accepted by all throughout the world, but evidence shows it is possible to change the attitude and behaviour of the society through intensive sustained education and empowerment of vulnerable communities.

3.1.1 New HIV infections are declining in Southern Africa

In 2009 the UNAIDS reported that there were an estimated 2.6 million [2.3 million–2.8 million] people who became newly infected with HIV. This is nearly one fifth (19%) fewer than the 3.1 million [2.9 million–3.4 million] people newly infected in 2004, and more than one fifth (21%) fewer than the

estimated 3.2 million [3.0 million–3.5 million] in 1997, the year in which annual new infections peaked (*UNAIDS, 2009*). In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009. 22 of these countries are in sub-Saharan Africa. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million [1.6 million–2.0 million] people became infected in 2009; considerably lower than the estimated 2.2 million [1.9 million–2.4 million] people in sub-Saharan Africa newly infected with HIV in 2001. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural causes of HIV epidemics.

Tsunamis, earthquakes and other natural disasters throughout the history of civilization have captured worldwide attention, demanding an immediate response. Increasingly with sophisticated technology, a global response to disasters has been comprehensive with immediate aid and prevention plans made against further catastrophe. Yet, the human Immuno-deficiency virus (HIV), which causes the slow deterioration of the immune system leading to an acute immune deficiency syndrome (AIDS) has created chaos within social structures, devastated communities, and killed millions without receiving the same swift response as earthquakes. According to the Joint United Nations Programme on HIV/AIDS (*UNAIDS, 2009*), approximately 33.2 million people are currently infected with HIV, which makes HIV/AIDS a pandemic.

Against that background, Malawi is among other Southern African countries which continue to suffer from the connecting problems of poverty, famine and HIV/AIDS. In the recent years, intensive efforts have been made towards increasing awareness about HIV and to prevent its spread, and these efforts appear to have had a positive effect. This is evident in the reduction of the Malawi national HIV/AIDS prevalence rate from 14% in 2007 to 10% in 2011. However, AIDS epidemic is responsible for eight deaths every hour in Malawi. Out of a population of nearly 14 million, almost one million people in Malawi were living with HIV at the end of 2007 (*UNAIDS, 2007*). It is also AIDS which is the leading cause of death amongst adults in Malawi, and is a major factor in the country's low life expectancy of just 43 years (*UNAIDS, 2007*).

HIV has spread rapidly in Malawi over the past two decades. The prevalence of infection among adults is estimated to have grown from 1.7% in 1987 to 12.1% in 2008 (*UNAIDS, 2008*). This is reflected in the increase in AIDS death of over 80,000 people who are dying yearly and as many as 100,000 new infections occur, at least half of which are among young people between the age group of 15-24.

According to the *UNAIDS 2008 Update Report*, statistics of women living with HIV and AIDS is at 59% while the rate of men is at 41%. While adults have been the most affected, it is important to note that there has been a large increase in infant and early childhood mortality linked to AIDS (*UNAIDS, 2008*). There are a number of factors that explain the higher percentage of women living with HIV/AIDS, which includes the larger number of women than men in the population and physiological differences and susceptibility. However, cultural and socio-economic factors are likely the most important influences on the marked differences in age specific patterns of infection. Infection among women begins earlier in the 15-24 years group. Women are 4-6 times as likely to be infected as men of the same age (*UNAIDS, 2008*).

HIV/AIDS presents particular challenges because it is in the majority of cases transmitted sexually and has profound effects on not only individual physical health, but on all aspects of social life as well. Sexuality itself is culturally bound, making behaviour change efforts particularly challenging in the sphere of HIV/AIDS prevention. The complex nature of HIV/AIDS epidemic requires multidimensional strategies for prevention. Particularly in a resource constrained communities such as Malawi, public health prevention efforts need to be based on a better understanding of the social-cultural dimensions of the spread of HIV.

3.2 Chikhwawa District: Traditional authority Maseya

Chikwawa District is located in the Southern Region of the Republic of Malawi. It is bordered with four districts, namely, Mwanza to the North, Blantyre to the North East, Thyolo to the East, Nsanje to the South and it also shares an international border with Mozambique to the West. The District Headquarters is approximately 54 km away from Blantyre, the Commercial City of Malawi. There are two main ethnic groups: Mang'anja, and Sena and they cover the following Traditional Authorities (TA's) of: Ngabu, Ngowe, Masache, Lundu, Chapananga, Katunga, Makhwira, Mulilima, Kasisi, Ndakwera, and Maseya¹ (*Chikhwawa District Socio-Economic Profile (SEP), 2006*).

According to the *2008 Population and Housing Census (PHC)*, Chikwawa District has a total population of over 438, 895 which is about 3.4 % of the national population. The average annual population growth rate is estimated at 1.1%, lower than the population growth rate in the country of 2.0 %. The *2008 Population and Housing Census* projection shows that 220, 914 (representing 50.03%) is female population while male population is 217, 981 (representing 49.97%).

¹ Traditional Authority Maseya was the focus study area of this research study

Based on the objectives of this study, the literature review will focus on the analysis of *wife inheritance*, assessment of the rural adult population knowledge of *wife inheritance* as a driver of HIV transmission, an explanation of risk perception and provide recommendations to improve cultural practice of *wife inheritance* in order to reduce HIV transmission.

3.3 Culture and cultural practices in TA Maseya

3.3.1 What is culture and how does it relate to HIV/AIDS management?

Heggenhougen defined ‘Culture’ as one of many factors influencing human behavior; it is a determinant of socially accepted behavior, value systems, beliefs, and practical knowledge (*Heggenhougen, 1991*). Culture in the broader sense, includes also traditions and local practices such as amongst others, *wife inheritance*, taboos, religious affiliations, gender roles, marriage and kinship patterns. Therefore, culture is deeply rooted in all aspects of a society, including local perceptions of health and illness and health seeking behaviors.

However, *Heggenhougen* further argued that culture does not exist independently of individuals. On the one hand it is by means of their own culture that social actors interpret and shape their life and environment, and on the other hand, culture is a dynamic construct which can also be subject to change. Cultural determinants go hand in hand with individual behavior that can favour risk taking and with other factors (such as amongst others gender, age group, and social status) that may increase vulnerability. It would therefore be simplistic to try and explain sexual behavior by using culture as the sole determinant.

To respond appropriately to the health needs of a community, “it is important to gain an understanding of the social and cultural contexts of people’s lives and to identify needs within, and in terms of, such contexts” (*Heggenhougen, 1991*). Accordingly, a cultural approach in health utilizes culture as a lens through which one can gain a greater understanding of individual and collective health behaviors, and a means to formulate prevention programs within a specific cultural context. If we understand that,

Culture provides people with a way of perceiving the world at large and with ways of coming to terms with the problems they face: [including] attitudes about the body and ways in which a person should be treated when ill, (Heggenhougen, 1991)

Then bringing the cultural approach into HIV/AIDS work allows for prevention efforts not to rely solely on the import of foreign and biomedical concepts as a means of prevention, but also to utilize

local knowledge for sustainable and appropriate health programs and prevention efforts. Because health is something that “cannot be given to people” (*Heggenhougen, 1991*), it has to be realized through a process which begins with prevention at the local level, on distinctly local terms. For example the use of a cultural approach to HIV/AIDS will be desirable and sustainable.

Heggenhougen further argues that the cultural approach to HIV/AIDS prevention must also address the reality of those traditional cultural practices that promote the spread of the epidemic. An effort should be made to identify those practices that endanger the health of a community such as wife inheritance, certain initiation rites that includes the circumcision of boys and girls, polygamy, wife sharing, the exchange of wives for land or cattle or the belief that unprotected sexual intercourse with a virgin will cure HIV/AIDS (*Heggenhougen, 1991*). Gender relations, as well, are deeply ingrained cultural values that in some cases define sexual behavior. In many cultures all over the world especially in Malawi, the multitude of a man’s sexual partners is rewarded with enhanced social status, and expression of a man’s sexual prowess is encouraged and an expected behavior. These learned behaviours and practices not only aggravate the spread of HIV/AIDS, but also underscore the subordinate status of women often making it difficult for them to insist upon safe sexual practices such as the use of condoms, or to refuse those cultural practices that can put them at risk such as widow or wife inheritance. The cultural approach to HIV/AIDS prevention aims to tackle these issues at a local level by stimulating community members to engage in a process of critically analyzing these traditional practices and beliefs to seek local solutions that encourage risk reduction.

Like any other society in the world, Malawi is governed by a culture whose beliefs, values, customs, and a host of social practices have a powerful influence on community life. Culture is very important for national identity. Culture is at the root of national development, and for that development to be sustainable that culture must be vibrant (*Malawi Human Rights Commission, 2005*). At the same time it is worth noting that, some elements of culture can be obstacles to development. It is in recognition of the important role that culture plays at all levels of society, including the personal level, that Section 26 of the Malawi Republican Constitution regards culture as a human rights issue. It says:

Every person shall have the right to use the language and to participate in the cultural life of his or her choice.

There are many cultural practices practiced in Chikhwawa district, TA Maseya that has been documented. However, most of the cultural practices such as *wife inheritance* have not been investigated thoroughly to determine how they possibly facilitate the spread of the HIV. Although

information on how HIV is transmitted and could be prevented was known early on in the pandemic, the spread of the disease increased unopposed. Bringing the infection under control would have demanded unique, effective and efficient national and cultural response, one that would have required policy makers in Malawi to address sensitive cultural practices that affect transmission such as among others, *Wife inheritance*.

3.3.2 Cultural practice of wife inheritance

Wife inheritance is also locally known as *Chokolo*. In this practice, when a husband dies, his brother, cousin, or nephew inherits the surviving wife. According to *Malawi BRIDGE I, End of Project Report, 2004* there are several reasons why *wife inheritance* is practiced in the district: first, some women enter into *Chokolo* because they fancy the brother to their deceased husband. This usually occurs when the husband's brother is wealthy. Second, women enter *Chokolo* to make it possible for the deceased relative(s) to inherit the property left behind, if he is believed to have amassed property. Third, some men do *Chokolo* because they want to offer security to the surviving wife in order to easily assist her and her children in a family union. With this arrangement, children are accorded the opportunity to continue growing up in a family setting with a father figure, which is considered desirable for proper upbringing of the children.

However, *Wife inheritance* contributes to the spread of HIV based on the fact that men inherit wives without ascertaining the cause of death of their relatives. As testified by Traditional Authority Maseya, he narrated that

Two brothers in the same family died one after the other in a period of less than three years after they each inherited a certain woman. The general society in general thought that the brothers died because of other natural causes, but I believe that it was because of the HIV/AIDS considering how they suffered and the signs and symptoms they developed during the time (Malawi BRIDGE I, End of Project Report, 2004).

3.3.2.1 Gender inequalities and the HIV/AIDS epidemic in Africa

The impact of the AIDS epidemic on women and girls is acute. Out of 23 million infected adults in sub-Saharan Africa, 57 percent are women. Women are becoming infected with HIV at an earlier age than men. In several countries across the globe, more than three quarters of all young people living with HIV are women, while in Sub-Saharan Africa overall, and Malawi in particular young women between 15 and 24 years old are at least three times more likely to be HIV-infected than young men

(UNAIDS Updates; 2009). While consensual sex is certainly part of this picture, sexual violence and other forms of injustice against women contribute directly to this disparity in infection and subsequent mortality.

There are a number of factors that contribute to the increasing feminization of the AIDS epidemic. The extensive and fragile tissues in the sexual areas of the female body, and their greater exposure to large volumes of high risk body fluids, makes women more vulnerable to HIV infection than men. The vulnerability of a teenage girl is further aggravated by the ease with which her immature genital tract can be lacerated and become infected (*Malawi BRIDGE Project Report; 2004*).

But apart from these biological factors, the risk of HIV infection for women and girls is also, compounded by a wide array of social, cultural, economic and legal factors, all of which are embedded in extensive theoretical and practical gender inequalities. The gendered aspect of almost every one of these factors implies denial in practice of the first article of the 1948, Universal Declaration of Human Rights which states that:

...all human beings are born free and equal in dignity and rights...

Most African cultures express subordination of women in their relationships with men. These cultures degrade women. Instead of making women's essential equality with men a lived reality, they deny this by proclaiming that in the practical situations of life women are inferior to men. And as they do so, they heighten women's risk of becoming infected with HIV (*MHRC, 2004*).

Several established practices in society also have the twofold outcome of demeaning women and enhancing their risk of HIV infection. These include various forms of sexual violence in the home, community and workplace; indulgence towards men who take sexual liberties; and the practice of older married men of having a "girlfriend" on the side. Further, some customary practices, such as early marriage, widow/wife inheritance, ritual cleansing, and dry sex, have the same double effect of treating women as chattels and making them more vulnerable to HIV infection (*Malawi BRIDGE Project Report; 2004*).

The message that women are there to be at the service of men, in sexual and other ways, is transmitted from an early age through child-rearing practices that form girls to be non-assertive and to accept

subordinate status in relation to men. The insistence at times of initiation and pre-marital “kitchen parties” that the prime responsibility of a woman is to please her husband at all costs reinforces the message of her inferior status. Effectively this leaves many women psychologically powerless to take steps to protect themselves against possible HIV infection from their husbands, even if they know that the consistent and correct use condom can protect them (*Malawi BRIDGE Project Report; 2004*).

In African society, as in many other parts of the world, married women often face violence and abuse if they demand condom use or refuse sex from their husbands or long-term partners. While many women are vulnerable to HIV because they are single or without a partner the disturbing fact is that more of these women are vulnerable to HIV infection because they are married and remain faithful to a partner who does not reciprocate this trust. The adverse situation for women is aggravated by the fact that, with few exceptions across Malawi, marital rape is not recognized as a crime, and domestic violence is seen as a right of married men (*Malawi BRIDGE End of Project Report; 2004*).

Economic factors further accentuate women’s vulnerability to HIV infection. A woman’s access to property usually hinges on her relationship to a man. When the relationship ends or when the husband dies, the woman stands a good chance of losing her children, home, land, livestock, household goods, money, vehicles, and other properties. They (woman) have limited access to capital or credit. Some societies do not allow women to own land. Because they receive inadequate financial support from their spouses, many women must apply their own ingenuity and resources to maintaining their household. All too frequently the sale of sex becomes the only way to meet household survival needs (*Malawi BRIDGE End of Project Report; 2004*). Although the law may offer them nominal protection, many widows experience considerable violations of their property and inheritance rights. Relatives may grab the property of the deceased husband, evict them from their homes, strip them of their possessions, or force them to engage in risky sexual practices if they are to keep their property. *Human Rights Watch* in collaboration with the *Malawi Human Rights Commission* has aptly summarised the situation that exists in Malawi:

A woman’s access to property usually hinges on her relationship to a man. When the relationship ends or when the husband dies, the woman stands a good chance of losing her home, land, livestock, household goods, money, vehicles, and many other properties that they may have acquired while together. These violations have the intent and effect of perpetuating women’s dependence on men and undercutting their social and economic status.

As well as failing to protect the property and inheritance rights of women and children, justice systems may also be weak in responding to cases of sexual abuse. Regrettably, the attitude of the legal and law enforcement agencies in cases of alleged rape frequently reflects the way of thinking of a male dominated society. The courts often do not take the case seriously and, in the case of an older girl with a complaint of sexual abuse, the case may hinge on whether or not the judge believes she 'asked for it'. The poor protection offered by the courts increases the reluctance of families to seek justice for crimes of sexual abuse against women and children. The light sentences that courts frequently hand down also proclaim the very degrading message that these are not regarded as serious offences and that officially the state takes them quite lightly (*MHRC, 2004*).

These violations have the intent and effect of perpetuating women's dependence on men and undercutting their social and economic status. Compounding all these restrictions and limitations is the heavy HIV and AIDS burden that women must bear. The burden of care that they already carry is greatly increased by additional responsibilities in caring for sick family members and for orphans from their own or their husbands' extended families. Even if personally HIV infected, or ailing from some other illness, women must continue to manage a household, provide care, produce food and generate income. Access to antiretroviral treatment (ARVs) is problematic for many women who feel disempowered by a culture that gives priority to the health needs of men. On top of this, women are often daunted by the bureaucracy surrounding the delivery of antiretroviral therapy (*Essien et al., 2009*).

3.4 Risk perception and HIV/AIDS

The association between perception of risk of HIV infection and sexual behaviour remains poorly understood, although perception of risk is considered to be the first stage towards behavioural change from risk-taking to safer behaviour. Even though HIV/AIDS is viewed as a pandemic with potential for catastrophe, many populations around the world continue to neglect the severe risk involved in cultural practices that make them vulnerable to HIV/AIDS. Since risk perception is embedded and impacted by the various cultures of the world, it is not surprising that the spread of HIV is so varied in many regions of the world. Perhaps, the issue lies in understanding risk and how it interplays with HIV/AIDS.

Hybes (2001), defines perception as ‘how you look at others and the world around you’. But it was *Tsasis et al., (2008)*, who argued that wide range of risk theories developed over the past decade, have incorporated the influence of varying ideologies in explaining the way we perceive risk. Understanding the way perception of risk is shaped and constructed is crucial in understanding why it has been so difficult to mitigate the spread of HIV. The association between HIV infection and the perception of risk in Malawi has emphasized the need to re-evaluate the public health measures being implemented to control the spread of HIV, particularly for the rural adult population who are most at risk because of their continued practice of *Wife inheritance*.

Tsasis et al., 2008, described that risk perception varies in that risk perception is linked to an individual’s predisposition to be risk-averse or risk-seeking and to the individual’s knowledge regarding the object or situation at hand. However, the unpredictability of hazards and uneven distribution of knowledge and access to knowledge in societies means that members of the public are not always in a position to define and understand risk. At some point, individuals may lack the ability and opportunity to decide which risks affect them and to what extent. Often the public is forced to place their trust in social structures that are viewed as acting in their best interests.

Since different groups and stakeholders have different interests at the level of public debate, certain dangers are attached to particular threats when different perceptions of risk are created. Both social institutions and social structures thus harbour the power to shape risk perception. This process of negotiating risk demonstrates how people organize their universe through cultural and social biases and choose what to fear based on their way of life and patterns of cultural and social norms. These biases cause selective attention to risk and preferences for different types of risk taking behaviours, informed by an inherent compulsion to defend one’s way of life (*Tsasis et al., 2008*).

Furthermore, although it is ultimately social structures that define and shape risk perception in societies, we see that risk is usually individualized, leading to worry and anxiety among persons regarding specific threats that have yet to take place. Through this process of individualization, risk becomes associated with choice, responsibility, and blame, and the individual rather than society is held accountable for negative outcomes.

One of the peculiarities of risk is that the knowledge of risk is not in-sync with the actions that should be taken. In other words, the principle of taking the greatest precaution for the worst possible outcome is not executed. Although it is possible that this is due to lack of awareness, the more likely explanation is the lack of acceptance. Research regarding risk perception demonstrates that risk is;

involuntary, unfamiliar, and potentially catastrophic is the most difficult for people to accept (*Tsasis et al., 2008*). Acquiring HIV is an involuntary occurrence for most. Lack of knowledge, but more often, lack of control over social and economic circumstances, such as the cultural practice of *Wife inheritance*, precipitates individuals to engage in risky behaviour that leads to the transmission of HIV. In Malawian cultures, for example, women have little power over their sexuality and the sexual practices in which they engage (*Malawi Human Rights Commission, 2005*). In this case, the community puts the individuals at high risk for acquiring HIV in trying to avoid social exclusion and in the name of culture preserving.

The risk of contracting HIV, through *wife inheritance*, may also be unfamiliar to many. The perception that HIV occurs only amongst commercial sex workers, those who engage in multiple concurrent sexual partners and through mother to child is still prevalent. But the idea that HIV can be transmitted through the practice of cultural practices such *Wife inheritance* is not prevalent among most of the adult population. In addition, because the symptoms of AIDS do not take full effect for as many as eight to ten years from the time of infection, many are unaware of being sero positive, and those who do know may not fully comprehend or accept the magnitude of the disease.

Although risk perception may be clouded by the individual's inability to accept the reality of risks that are involuntary, unfamiliar, and catastrophic, the problem is not necessarily with the individual, but rather with society at large which continues to practice *Wife inheritance* as a way of living. *Beck (2002)* argued that within the discourse of public health, health risks have been individualized such that it is an individual's choice to engage in certain behaviours that cause the individual to acquire HIV. This view has led to the labelling of particular groups of individuals and populations as "at-risk". Populations deemed at-risk for HIV include commercial sex workers, men who have sex with men, people who engage in multiple concurrent sexual partners even if they are married and injection drug users. This narrow definition of those at-risk can also be misleading considering that some cultural practices such as *Wife inheritance*, heterosexual and mother-to-child transmission of HIV is increasing rapidly. As a result this has led to a limited focus on awareness and education as solutions, and has allowed Traditional Leaders who are the custodians of culture to blame, and avoid responsibility of changing *Wife inheritance* (which is deemed to be the driver of HIV transmission) and eventually for those suffering from HIV/AIDS.

Nonetheless, Risk perception in this research study shall be referred to as two sets of beliefs perceived susceptibility, which is the belief that one could be vulnerable to a disease or event, and perceived

severity, the perceived noxiousness of the event. I will operationalise perceived risk in terms of perceived susceptibility to acquiring an HIV infection and perceived severity of the disease.

3.5 Knowledge on HIV/AIDS

A number of HIV transmission research studies conducted in Chikhwawa district have shown that the rural adult population has information and knowledge on HIV/AIDS. For instance *Malawi BRIDGE II Project End of Project Evaluation* and *Munthali et al., (2004)*, of Center for Social Research conducted a study in the southern region of Malawi (and Chikhwawa district was one of the areas where the study was taken). One of the objectives of the research studies was to assess the level of awareness and knowledge regarding issues of HIV/AIDS among adult population. Their findings demonstrated that approximately 87% of the respondents said that they had ever heard about HIV and AIDS while only 13% said that they had not.

One factor that has contributed to the increase of HIV cases in Malawi is the practice of cultural practices such as, among other wife inheritance (*Munthali et al., 2004*). This behavior is not only knowledge related because the practice is done with the sole intention of preserving culture and maintaining family structures. The initiators and actors normally do not often know the consequences of the practice in regard to HIV transmission.

Essien et al., 2009, argued that knowledge of HIV/AIDS is significantly associated with the level of education of an individual which might protect against HIV infection through information of the danger of practicing certain cultural practice. This study will also access the level of education of participants in order to determine their ability to understand and comprehend the knowledge and information they get in HIV/AIDS.

Differences exist between and within cultures. While some traditional and cultural practices and beliefs within a society might discourage certain risk behaviors (*Archibald, 2007*), others might advertently encourage risk behaviors. As a result culturally sensitive prevention approaches are to be identified and implemented so those culture-specific causative agents are curtailed.

3.5.1 Knowledge of HIV/AIDS and risk behaviours

The essence of educating the populace about the modes of transmission and methods of prevention of HIV is to reduce unsafe or risky behavior. However, studies have revealed that knowledge does not necessarily reduce risk behaviors. Knowledge is significantly related to condom use and participating

in safe sexual behaviors but knowledge alone is not sufficient to eliminate risk behaviors (*Sowell et al., 1996*).

What people perceive to be HIV/AIDS risk behavior is an integral component of any attempt to reduce risk taking and this can be influenced by knowledge. Knowledge about HIV/AIDS has been found to be associated with risk perception but that men's knowledge of HIV/AIDS does not have as much impact on risk perception as do other factors. Women on the other hand who seem to have comparatively low knowledge of the disease have more of an association with individual risk perception.

A relationship has also been established between unsafe sexual behaviors and age and gender. Young men (aged 15-27) were likely to engage in unsafe sexual activities. This is because behaviors such as risky sexual experiences, partners change, peer influence and the use of alcohol and other illicit drugs they engage in can only increase their vulnerability (*Ferrer et al., 2007*).

Being educated may mean being enlightened and responsible. Knowledge of HIV/AIDS is significantly associated with level of education which might protect against HIV infection through information and knowledge that may affect long term behavioural change (*Essien et al., 2009*).

3.5.2 The need to complement knowledge

Knowledge dissemination alone has proved to be insufficient in slowing down the spread of the virus. Knowledge and other intervention methods have been suggested as a combination that could make the difference such as education and skills development, small group discussions led by peer or voluntary outreach, community discussion forum. It is also suggested that peer education is more effective when it occurs where young people live rather than in classrooms.

In addition to the knowledge campaign individuals need to be motivated towards reducing their risk behaviors. In that direction, principles that have as core bases motivational factors, problem solving and decision making competencies, behavioural skills and social responsibilities to complement the knowledge drive for reducing risk behaviors have put forward. Prevention programs should incorporate, among other things activities, scripts and should be delivered in small groups.

In the face of the inadequacies in current approaches, it has been suggested that radically different conceptualisations and prevention strategies are needed. Programs such as family wellness which can help to create health promoting communities should be in place. *Rotheram-Borus* argued that a social

space for interaction and critical thinking is needed in communities in order to build knowledge and skills in both formal and informal networks. To be very effective, knowledge should be backed up by concrete evidence in the face of denials (*Rotheram-Borus et al., 2009*). It has been found out that knowing someone who has been impeded by the disease or who has died of AIDS appears to be the most significant behavioural contributor to knowledge of HIV/AIDS for men and women. Other determinants of knowledge efficacy include having been tested for HIV and or treated for STI within a year (*Barden-O'Fallon et al., 2004*).

Archibald, 2007, argued that differences exist between and within cultures. While some traditional and cultural practices and beliefs within a society might discourage certain risk behaviours, others might inadvertently encourage risk behaviors. As a result, culturally sensitive prevention approaches are to be identified and implemented so that culture-specific causative agents are curtailed.

3.5.3 Safer sexual practices: Are they practiced in Malawi?

The greatest concern about HIV is the fact that there is no cure and no vaccine till today. In other words the cure for HIV/AIDS still remains elusive. To avoid the infection an individual has only two choices: abstinence or usage of prevention methods that means safer sex. Communication methods are helpful to fight misinformation and raising awareness on the dangers of sexual partners' network.

In Malawi, HIV prevalence declined from 16% to 12.6% from 1991-2007. The 2010 research studies, supported by the National AIDS Commission of Malawi, show that the prevalence has gone down from 12.6% to 10.6% from 2007 to 2010. Analysing how such data was recorded, researchers found first *reduction* in sexual partners is one behaviour change which leads to prevention success in the country. It is a behaviour which limits HIV infection exposure if not abstention for sex. Safer sex is sexual activities reducing or eliminating physical contact with body fluids that contain the HIV virus: e.g., semen, vaginal or cervical fluid, often by means of barriers: e.g. condoms, gloves, dental dams (*Loosli, 2004*). Safer sex practice protects, one and his or her partner from HIV infection at least at a rate of 90 per cent. The NAC report indicated a number of factors that contributed to the decline and it also indicated some few steps that need to be followed by all actors if the prevalence is to decline further.

Widows are the most vulnerable, adult literacy is ideal in curbing the spread of the virus. It was also suggested that promoting male condom use as well as female condom use can be ideal for widows at all levels. Seemly, female condom are perceived as more difficult to use and more uncomfortable than

male condoms. Nevertheless if it is well used, a female condom constitutes an efficient prevention method against HIV infection, other STI's and against unwanted pregnancy.

There is need to strengthen health education within communities and involving traditional leaders in the fight against HIV. There is also a need to make traditional leaders accountable of cultural practices that lead to intentionally transmitting the virus.

CHAPTER FOUR: RESULTS OF THE STUDY

4.1 Introduction

The aims of this qualitative research were to investigate the risk perception of rural adult population in Chikhwawa district TA Maseya on wife inheritance as a driver to HIV transmission by focusing on the following: participants knowledge on HIV and AIDS, wife inheritance, risk perception, participants history of condom use, to find out whether respondents have gone for testing and have ever told their status to their partners.

The data for this study was collected from September, 2011 to November, 2011 through in-depth interviews using a semi-structured interview guide.

4.1.1 Sample description

In order to successfully gather data from respondents, the researcher approached 20 widows, 5 traditional leaders and 5 community men and all of them met the predetermined inclusion criteria for the study. More importantly, all respondents were willing to share their experiences with the researcher. All of the participants had been widows (especially the 20 women). During the interviews, the respondents were encouraged to talk about any of their experiences that were relevant to the objective of the research study. Furthermore, respondents freely discussed all aspects of their life experiences from the perspective of their educational background, whether they have lost their husbands due to being susceptible to HIV and AIDS, whether they have gone for HIV testing and have shared their results with their partners and have ever used a condom before. The researcher also took time to discuss in detail with men in the community and traditional leaders in the community about wife inheritance and their perception of the practice as the key driver of HIV transmission.

All of the respondents were interviewed in their homes, however, all interviews were not audio taped because the respondents did not want the responses to be audio tape. The interviews ranged from 45 minutes to 60 minutes per interview.

4.2 Research findings

The researcher followed the *Wisner et al., 2004* Pressure and Release (PAR) Model which is used to depict the root causes and process of HIV transmission.

4.2.1 Pressure and release model (PAR)

Briefly this model is generally used to outline how disasters are shaped by external conditions that apply increasing pressure until a release is forced resulting in a disaster. This builds up pressure is referred to as a 'progression of vulnerability' that consists of three stages: 1) root causes, 2) dynamic pressure, and 3) unsafe conditions (Wisner et al., 2004).

By building up on the PAR model the researcher identified sources of vulnerability, such as the practice of wife inheritance, as root causes of HIV transmission among the adult population in TA Maseya. This vulnerability of women in TA Maseya who engage in wife inheritance, center around poverty, unequal access to power and resources, and lack of political will at national level to call for Local Government Elections (LGE) that will put elected Councilors at community level to work with the communities in the development of By-Laws that will deal or make to an end some ill-cultural practices that puts people at risk of contracting HIV.

4.2.1.1 Application of the PAR model in HIV/AIDS Management

The spread of HIV and IADS can be modeled much like an environmental disaster that is characterized by a slow onset and is exacerbated by human action or inaction. If humans can act as agents to mitigate the effects of hazards and disasters, accountability and responsibility must be acknowledged as not being limited to a selected group, but shared by all individuals and communities. Discourses surrounding the global HIV and AIDS crisis must move in this direction; developing recognition that HIV and AIDS is a shared responsibility requiring a coordinated response from all nations (Wisner et al., 2004).

Considering the similarities between HIV and AIDS and other natural and environmental disasters, a disaster management approach to HIV and AIDS is needed to improve global responses. A disaster management framework can act as a policy and administrative tool to assist decisions makers in determining the appropriate responses to HIV and AIDS. For example, depending on the current level of HIV and AIDS impact and the potential for future disruption based on vulnerability, societies can be classified into one of the three phases: 1) pre-disaster phase; 2) early-warning phase, or 3) disaster phase. In order to effectively utilize the PAR model within such a framework, there must be reliable and valid means for ongoing data collection in the nation, region, district or community being studied. Data on social, economic, and health indicators paired with an understanding of the social and political context is necessary (Wisner et al., 2004).

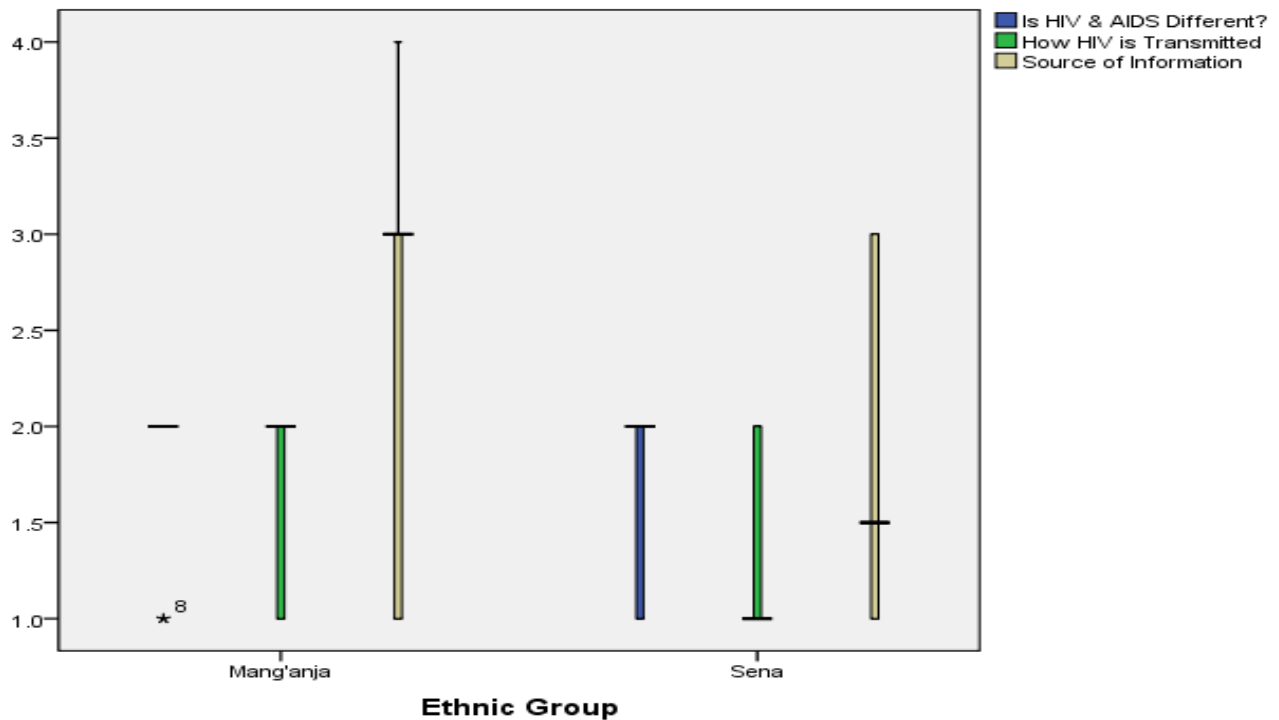
In its simplest application, the PAR model can be used as a check list in which existing factors are checked off, while factors that are not currently occurring in the target area are left blank. Used in this manner, the PAR model can indicate levels of vulnerability, or in other words the model will reveal which disaster phase the community is currently in. The model can also highlight which “pressures” should be released through addressing root causes that achieve safer conditions, thereby reducing the risk of disaster (Wisner et al., 2004).

4.2.2 Adult populace knowledge of HIV and AIDS

Essien et al., 2003 argued that being educated may mean being enlightened and responsible. Knowledge of HIV/AIDS is significantly associated with the individual level of education which might protect against HIV infection through information and knowledge that may affect long term behaviour change.

Respondent’s level of HIV and AIDS knowledge was a factor that was of importance to find out in the research. Under this theme the researcher wanted to know the respondents understanding on the difference between HIV and AIDS. In addition, the research was to find out the respondents knowledge of how HIV is transmitted; and the participants sources of HIV and AIDS information. The box plots below show the findings according to ethnic group and age. The vertical lines show the range of response while the small horizontal line drawn across each line shows the median response. **Table 9** below *Chart A* is a key table to the box plot interpretation.

Chart A: Ethnic Group Perception on HIV Basics



Code	Is HIV and AIDS different?	How HIV is transmitted	Source of information
1	No difference	Sexual intercourse	Radio
2	They differ	Variety of ways	Books
3			Public meetings
4			Government information

Table 9: Code Keys to Ethnic Group Responses

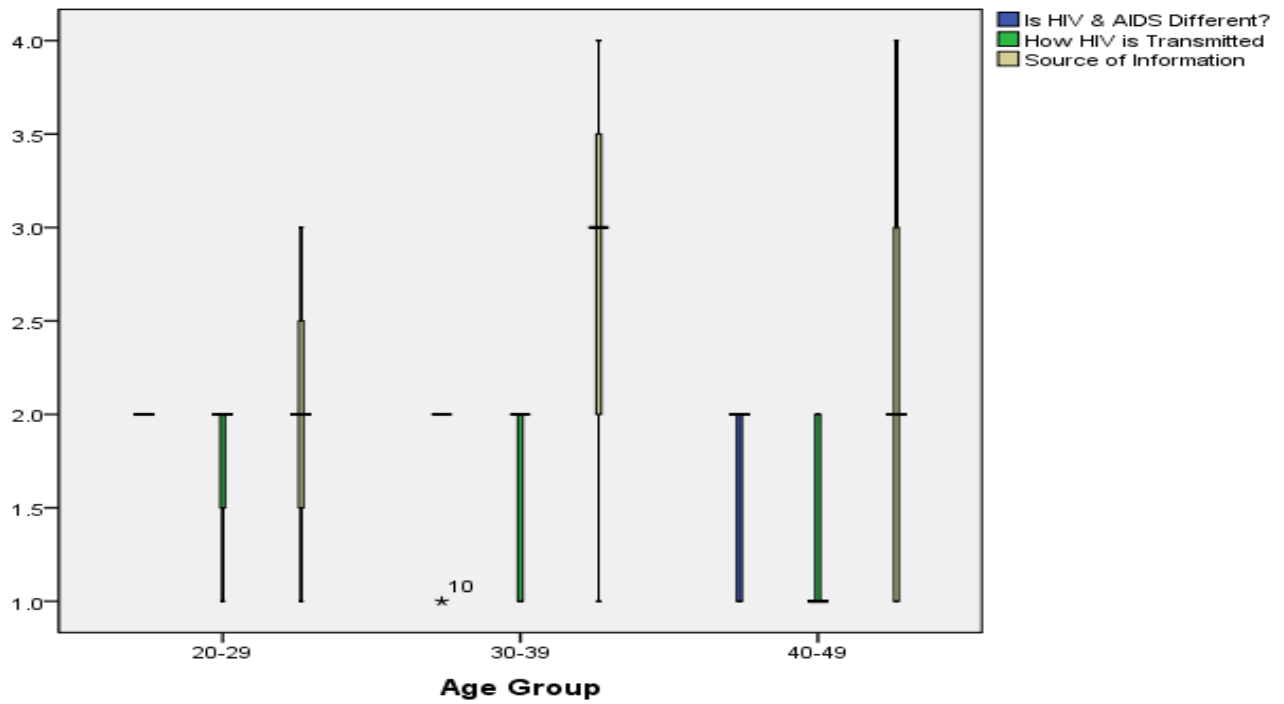
Respondents ranged from Sena and Mang'anja and the research found out that the majority demonstrated the understanding that HIV is different from AIDS. However, the median response for Mang'anja on transmission was that the virus is transmitted through sexual intercourse unlike the Sena whose median opinion was that it is transmitted through a variety of ways. The research also reviewed that the reason in the disparity might have been due to the difference in sources of HIV/AIDS information, with many among the Mang'anja hearing through public meetings such as community open days on HIV and AIDS. In contrast, the Sena heard HIV and AIDS related information through radio and books.

The essence of educating or providing the populace information about the modes of transmission and methods of prevention of the HIV is to reduce unsafe or risky behaviours. However, this study has revealed that individual knowledge does not necessarily reduce risk behaviours. The target group showed through the research that they had information about HIV and AIDS but still more they have been engaged in the practice of wife inheritance which puts them at risk of contracting HIV. Further, the research also revealed that wife inheritance might not be knowledge related because the target population often know of the consequences of unprotected sex but they choose to continue to engage the practice in the name of culture preservation.

The findings of this research are consistent with numerous others who reported high levels of risk behaviours among people with moderate or high levels of HIV and AIDS knowledge across population. For instance *Sowell et al., 1996*, in his study found out that knowledge was significantly related to condom use and participating in safe sexual behaviours but knowledge alone is not sufficient to eliminate risk behaviours. Another research by *Tanaka et al., 2008*, discovered that from an extreme angle, there was virtually no correlation between HIV/AIDS knowledge and the practice of safer sexual behaviours.

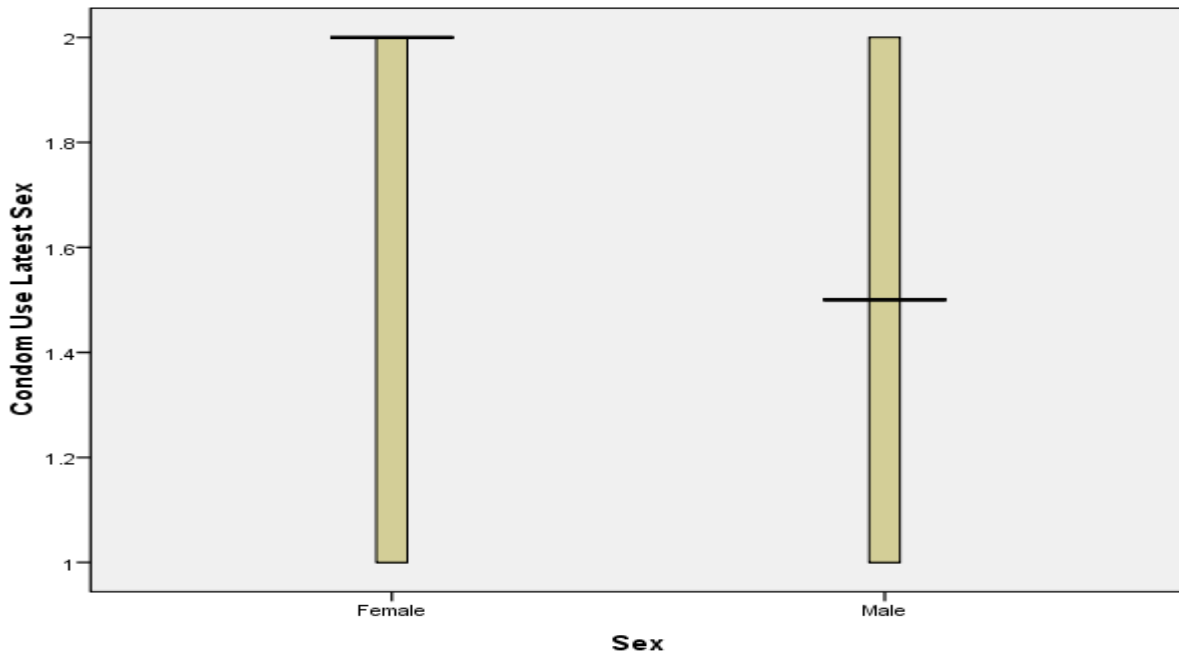
The interviewed age group of 40-49 had the correct knowledge and believed that HIV is transmitted through sexual intercourse only. See the box plot below. *Essien et al. 2009*, rightly argued that being educated may mean being enlightened and responsible. This implies that with the right knowledge an individual is expected to make responsible and informed decision. *Essien* further puts it that knowledge of HIV and AIDS is significantly associated with the level of education of the respondents which might protect them against HIV infection through information and knowledge. However, this research found out that even though the age group had the right information on HIV transmission, they failed to capitalise on their knowledge of HIV and AIDS to abstain from engaging in wife inheritance. This is also contributed by the participant's level of education. The research findings show that most of the respondents have not gone further or beyond the fifth grade of their education. In other words, most of the respondents are illiterate and this in itself puts them at risk of contracting the virus because they could not translate the information and knowledge they had on HIV and AIDS into action by refusing to engage in wife inheritance.

Chart B: Age Group Perception on HIV Basics



4.2.3 Adult populace use of condom

Respondents were also asked to indicate and explain if they had used a condom in their latest sexual intercourse and if they had ever used a condom before. The box plot below shows the median response with 1 coded for “Yes” and 2 for “No”.

Chart C: Use of Condoms by Respondents

The median and modal response for females shows that most women did not use a condom in their latest sex with a partner. In contrast half of the studied men used a condom while half did not use it.

There was an exact response on the participant's response having ever used a condom. Both the median and modal response among women was that they had never used a condom in their lives whereas half of the men indicated that they had used it before and half had never used it. Hence, it was shown that those who did not use a condom in their last previous sex had, in fact, never used it before; and that it was the women who did not much care on whether or not they used a condom. This might be attributed to lack or inadequate access to information related to correct and consistence use of condoms and the cultural dominance of giving men more power in making decisions related to sex than the women.

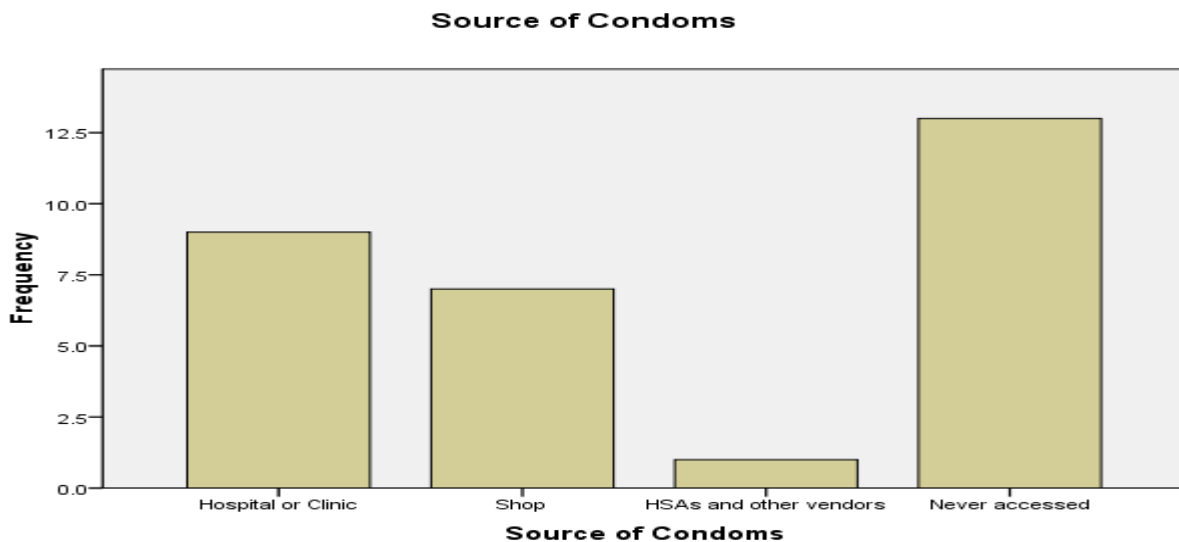
Using the Wisner's PAR model, vulnerability to HIV transmission is through one of the three factors which is the degree of preparedness of a population. The level of preparedness is shaped by societal values and beliefs, which determine what is, viewed as a risk and in turn which measures are taken for protection if any. Factors such as poverty and inadequate traditional leaders and government assistance act not only as a root cause, but also as dynamic pressures and unsafe conditions. Needless to say, basing on the PAR model HIV and AIDS is said to be prevalent in populations such as TA Maseya where social inequality persists and where the disempowered such as women are victimized through the practice of wife inheritance.

However, inquiring as to whether the respondents considered it important to use a condom or not, all respondents had the view that it was essential. The reasons given were that condoms help to prevent against unwanted pregnancies and protect against sexually-transmitted diseases, mainly HIV.

It was indeed expected that if they had the opinion that condoms are essential, they should have used them at least once, but as has already been earlier noted, more than half of all respondents indicated that they had never used a condom in their life, as such its importance is notwithstanding.

Similarly, when asked to indicate how they accessed condoms, the responses were quite revealing as shown below:

Chart D: Source of Condoms by Respondents



The above shows that (n=13) respondents have never accessed condoms in their life which is consistent with the finding that most have never used a condom before. The knowledge dissemination about HIV prevention is hinged around the ABC model. A stands for Abstinence, B for Be faithful and C for condomization, for example the use of condoms for prevention. The research reviewed and suggested that knowledge is the only predictor of condom use and the lack of understanding of the productive benefits of condom use can result in their decreased use.

4.2.4 Adult populace knowledge of HIV status

Another area of interest was finding out from respondents if they knew their HIV status, if the respondent's partners also knew their status and if the respondents knew the HIV status of their partner. The results are shown in the table and bar charts below:

Whether partner knows respondent status		
	Frequency	Percent
<i>Yes</i>	8	26.7
<i>No</i>	22	73.3
Whether Respondent knows his or her status		
	Frequency	Percent
<i>Yes</i>	22	73.3
<i>No</i>	8	26.7
Whether Respondent Knows partner Status		
	Frequency	Percent
<i>Yes</i>	21	70
<i>No</i>	9	30
Total	30	100

Table 10: Knowledge of HIV Status

Chart E: Knowledge of HIV Status by Respondent

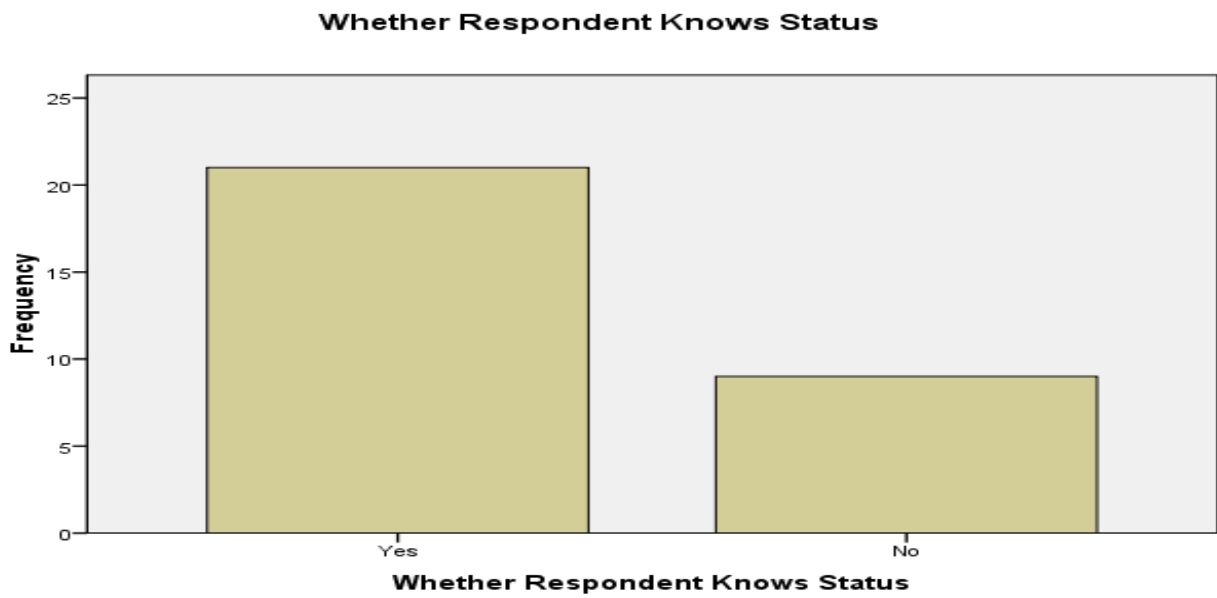


Chart F: Partners knowledge of Respondents HIV Status

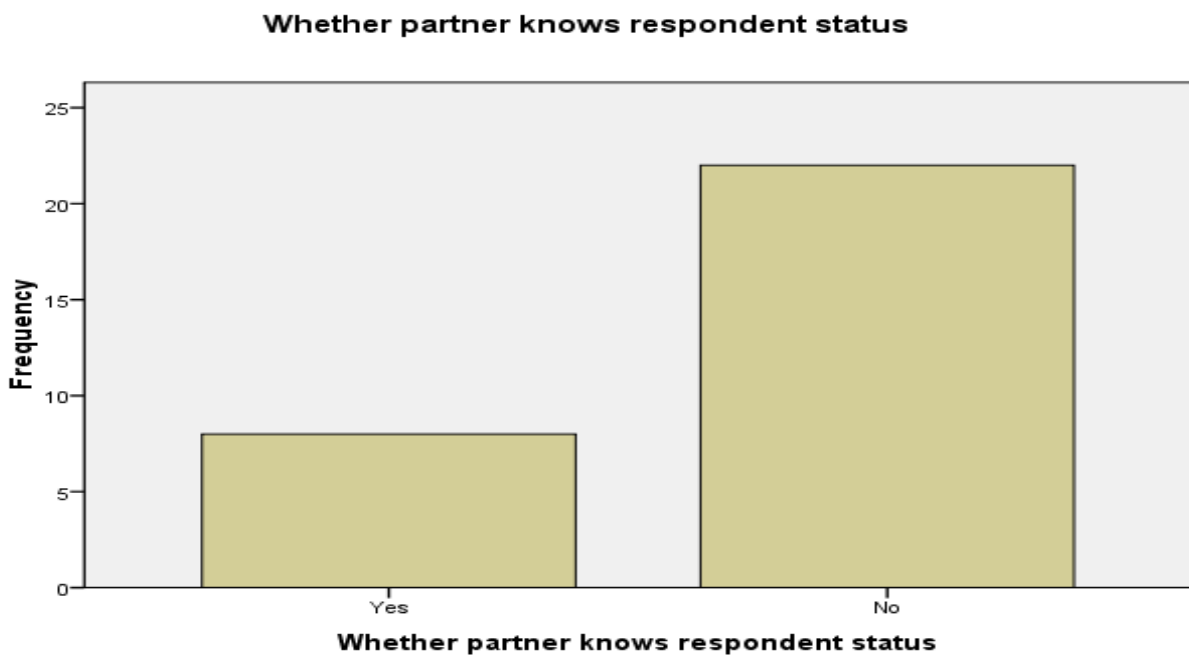
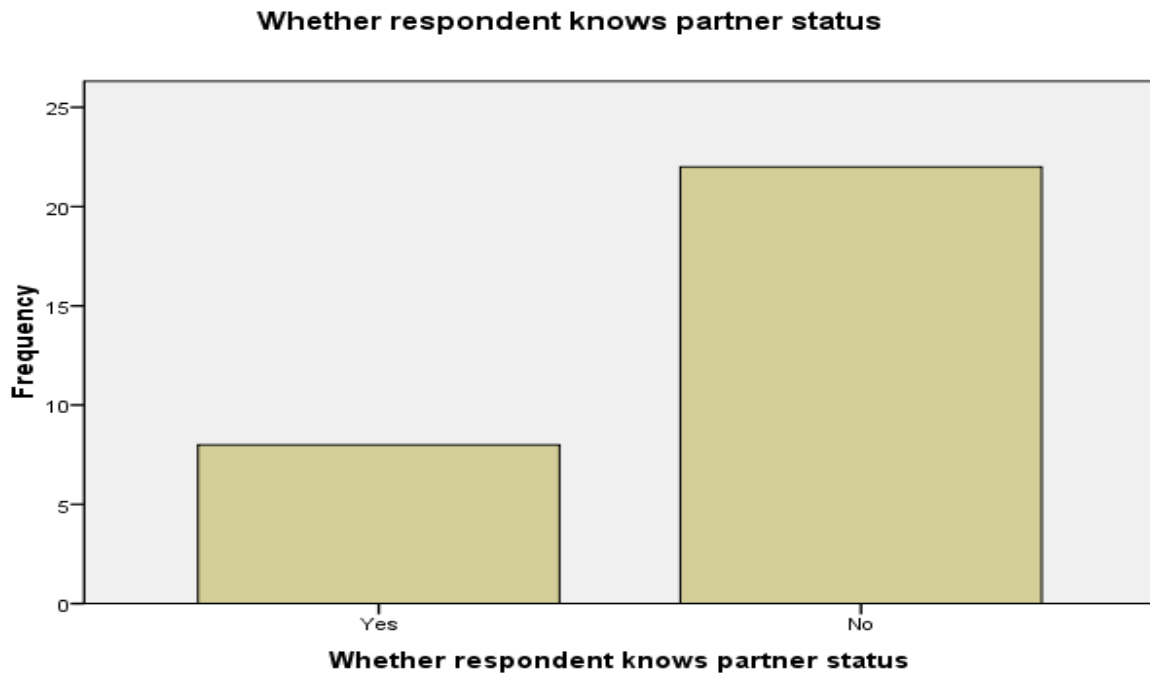


Chart G: Respondents knowledge of Partner's HIV Status

As indicated in the graphs above, the majority of respondents – more than 70% - knew their HIV status. However, asked if the spouse knew the respondent's status too, 73% said that the spouse did not know. It was important to find out the reasons behind the asymmetric information among people who are supposed to selflessly love each other. A number of reasons came out and the following were included:

- Partners not being free with each other to the extent of failing to reveal the status
- The respondent being afraid that if she/he discloses the status, the partner would call a halt to the relationship
- The respondent had never gone for testing

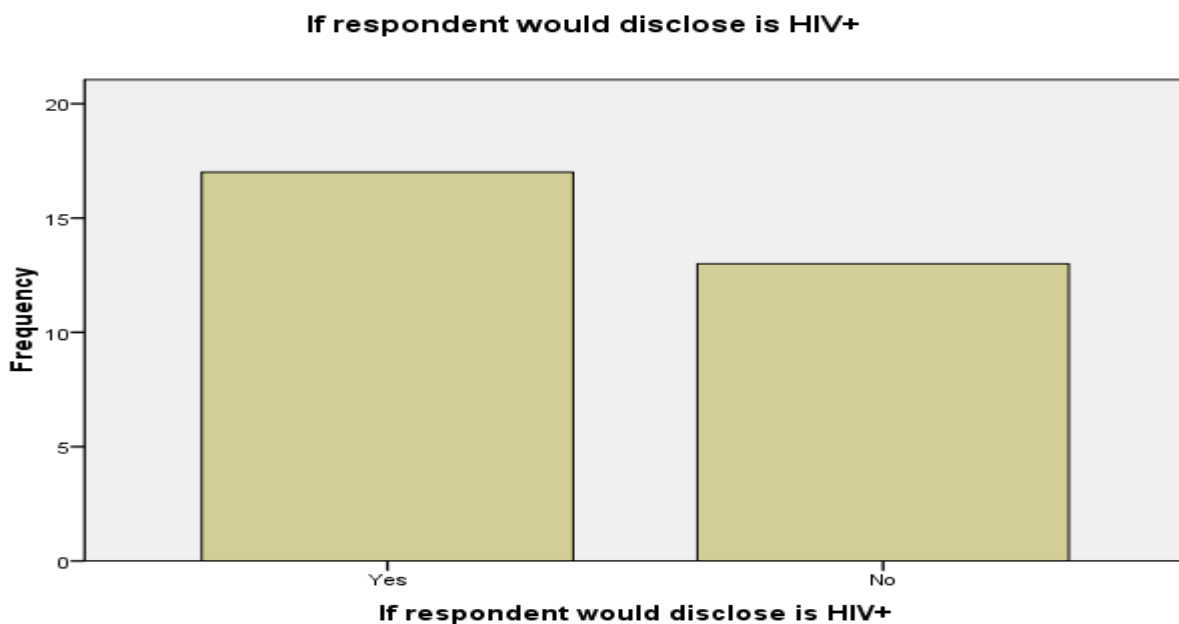
The second reason was intriguing in that if the respondent was afraid that disclosure was risky, then it could be implied that some respondents were indulging in risky behaviour (not using condoms) with full knowledge that they were HIV+. For it could be inferred that if the respondent's status was HIV-, then there was no reason to be afraid to disclose.

It was again to be established if the respondent knew the HIV status of the partner. It was shown that most respondents did not know the status of their partners and the following reasons were given:

- The respondents (especially women) were afraid to ask, fearing that the partner would end the relationship. It was noted that the question of HIV status was culturally off-limits among the respondents where male chauvinism is deeply ensconced.
- The partners had both never gone for testing
- The partners were not free with each other to talk about HIV counselling and testing.

Partners were later requested to indicate whether or not they would tell their partner if they knew that they were HIV+. The results are shown in the chart below:

Chart H: Disclosure of HIV+ status by Respondents



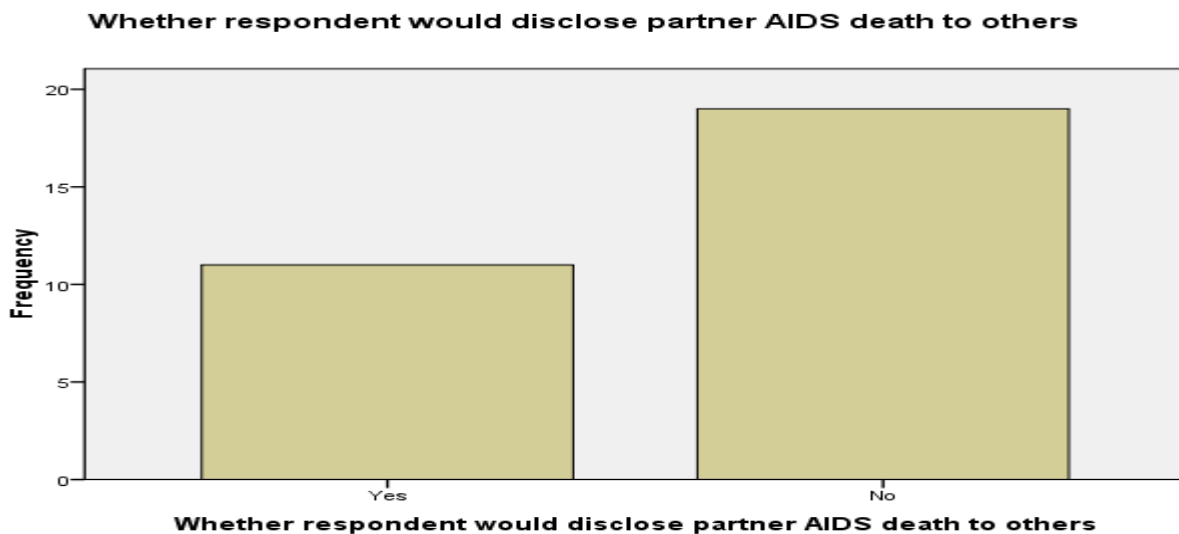
More than half of the respondents, n=17, held that they would disclose while around n=13 said they could not disclose.

Those who said they would not disclose said that they were afraid the partner would call it quits. Nonetheless, those who would disclose said it was because they believed disclosure would be beneficial to both themselves and the partner. They would get counselling quick enough, shape their future and determine how the partner would take care of them as life progresses.

It was noted that all the n=30 respondents, widowed or not, were sexually active with regular or non-regular partners. It seemed also that being in a sexual relationship was important to their lives, for example outweighing the perceived and actual risks of unprotected if non-marital sex.

As to whether they would disclose to relatives and close friends if their partner had died of AIDS, the chart below shows the response summary:

Chart I: Disclosure of AIDS death of Partner



Most respondents specified that they would not disclose that their partner had died of AIDS. Those who would not disclose said they would take such a course due to the following two main reasons:

- They feared discrimination thereafter. People would accuse the respondent of being responsible for infecting the deceased, hence for their death.
- They feared stigma

“Ndikuopa anthu azidzangondiseka” (I fear people would be laughing at me),” said one respondent.

However, some respondents said they would disclose because the revelation would open the way for getting help and care, from family members and friends, they would necessarily need thereafter.

Furthermore, although it is ultimately social structures that define and shape risk perception in societies, we see from the findings of this research that risk is usually individualised leading to worry and anxiety among persons regarding specific threats. Respondents could not share their HIV sero status to partners even if they know that they were HIV positive. Respondents expressed worry and anxiety with their relationships because they fear that the same relationships would come to an end as soon as they declare their HIV positive status to their partners and when they try to know the HIV status of their partners.

This research finding are in consistence with the findings of other researchers such as *Dr. Tsasis et al, 2008* who argued that one of the peculiarities of risk is that the knowledge of risk is not in sync with the actions that should be taken. Respondents in this research knew of their HIV positive status but they ignored that knowledge and even failed to use the same knowledge to inform their partners they engage in sex with during wife inheritance so that the other partners make informed decision before they engage in the practice. Although it is possible that this is due to lack of awareness, the more likely explanation is the lack of acceptance among respondents who are HIV positive but continue to engage in wife inheritance.

Dr. Tsasis et al, 2008, further states that researches regarding risk perception demonstrate that risk is; 1) involuntary, 2) unfamiliar, and 3) potentially catastrophic and is the most difficult for people to accept. Acquiring HIV is an involuntary occurrence for most. Lack of knowledge, but more often, lack of control over social and economic circumstances precipitates individuals to engage in risky behaviour that lead to the transmission of HIV. In Malawian cultures, especially the TA Maseya cultures for example, women have little power over their sexuality and the sexual practices in which they engage. In addition, it is poverty that pushes widows to engage in wife inheritance because they want to meet their basic needs in life. In other words, widows and the men who are involved in wife inheritance seem to place themselves at a high risk for acquiring HIV in trying to avoid social exclusion and poverty. However, because of increased stigma attached to being HIV positive in many communities, it is likely that cases of HIV and AIDS are underreported and thus these numbers may actually be considerably higher.

4.2.5 *Wife inheritance and other risky cultural practices*

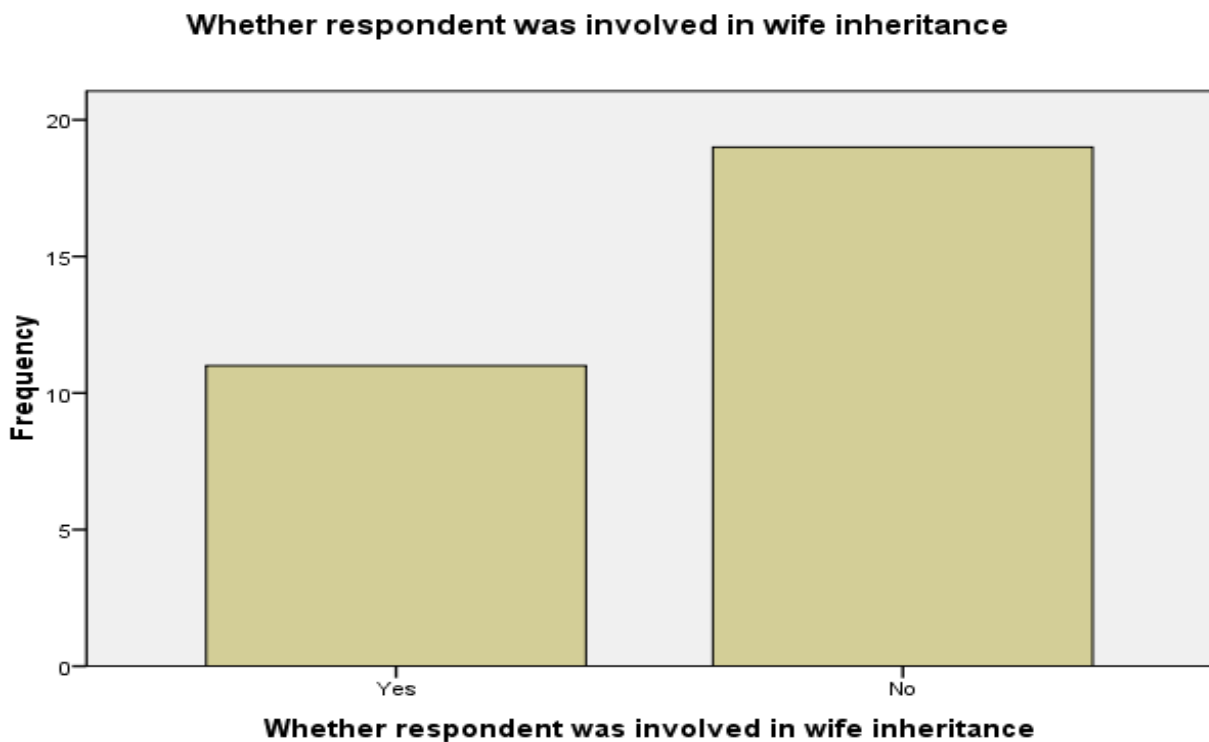
HIV and AIDS cases in Malawi are on the decline of 10% from 12%. However, despite this decreased figure, women and children continue to be affected. The adult population in TA Maseya, Chikhwawa district also have an increased risk of acquiring HIV due to cultural factors such as the practice of wife

inheritance that contribute to sustained participation in risky behaviours. The preceding findings were leading to the main focus of the research, which was determining the extent to which the adult population under study perceived *wife inheritance* as a risk key driver to HIV transmission in Traditional Authority Maseya, Chikhwawa District.

Respondents were first asked to recall any cultural practices they were aware of that could be drivers in spreading HIV. Respondents shared that the following cultural practices were prevalent in their area: *mitala* (polygamy), *kulowa dzwide* (wife cleansing) and *kulowa kufa* (wife inheritance). All respondents knew of at least two of these cultural practices.

Then the researcher investigated further to establish if the respondents had ever been involved in the practice of *wife inheritance*. 37% responded that they had been involved, all being widowed women. See chart below:

Chart J: Respondents involvement in wife inheritance practice



In all cases, the women who were involved in wife inheritance responded that it was *akuchimuna* (relatives of the deceased husband) who had pressured them to go by the tradition. The practice is observed to mark the closure of the mourning period and give the woman an opportunity to be sexually

engaged with the deceased husband's relative for help or any other financial support. Asked whether they had accepted or not, a few women said they refused; but those that accepted said they were involved in the practice out of fear of being an outcast in spite of their knowing that the practice was risky to their health in relation to HIV transmission.

The respondents were, nevertheless, unanimous in condemning the practice of *wife inheritance* and called for it to be terminated. Both male and female respondents acknowledged that wife inheritance is a cultural practice that could spread HIV and that it fell short of respecting the rights of the bereaved.

Of special interest were GVH responses. All the village headmen interviewed said that they were aware that *wife inheritance* was being practised in their area. They said that it was a tradition inherited from time immemorial. But they concurred with their subjects that the practice should be halted. What was intriguing was that the headmen, who have power to make or change village by-laws and customs, held the power to stop the practice but were not exercising it because of the absence of elected Councillors. Malawi is a decentralised state that has been operating without elected Councillors, since 2005, who would help in community development especially in developing, approving and enacting By-Laws for example that would help in HIV prevention at community level.

4.3 Discussions of the research findings

The respondents group showed that they were aware that the major transmission factor for HIV is sexual intercourse. The research, however, revealed that there were respondents who could not differentiate between HIV and AIDS and those who did not know that HIV could be spread through means other than sexual intercourse. This could make them and others more vulnerable to infection; for example, mother to child.

The actual population divide was poor and might not get access to quality information about HIV. This could explain some of them not even making the effort to access condoms from nearby shops or health centres that were admittedly near.

Most respondents, it was noted, indulged personally in risky sexual behaviour by:

- Not using condoms when having sex with a partner
- Not going for VCT despite being sexually active

- Failing to disclose their HIV status to their partner, much less determining to not tell them if they were HIV+
- Failing to find out the HIV status of their partner
- Not willing to tell others if their partner had died of AIDS
- Failing to stand up against risky cultural practices, such as *wife inheritance*, albeit realising that it infringes the rights of the bereaved and is a key driver in the spread of HIV

This should be coupled with the educational levels of the respondents and the areas in general. It was found out that most of the villagers never received formal education. This could augment the argument that education was a key factor in seeking, comprehending and acting upon knowledge. The residents looked resigned to their custom and it would take a massive campaign to prise them out of this cultural cocoon.

In addition, it was recognised that the culture was discriminatory against women than against men. Most practices favour men and limit freedom of women. These included: polygamy, wife cleansing and wife inheritance. In all cases, the man would be allowed to exult as he would please, but women would not be allowed to do the same because societal norms would not accept such ‘lewd’ behaviour.

Most women, as a result, were at pains to solicit a straight answer from their partners on their HIV status, much as they would wish to know. Their seeking to know their own status demonstrated their willingness to know their partner’s status. However, the cultural practice prohibited them from finding out. Neither could they garner the courage to tell the partners of their status for fear that the partner would end the relationship. Thus, it was shown that culture was indeed a driving factor to spread of HIV because had it not been for such practices, partners would freely share information and make informed choices.

The key custodians of the culture, it was revealed, were *makolo* (village elders), *anamkungwi* (counsellors) and *anyakwawa* (headmen). These opinion leaders, most of whom are male, would require targeted sensitisation if the risky factors are to be eliminated.

In conclusion, the research revealed a vicious cycle in which elements of education and ignorance, social roles, poverty and culture played a crucial in exacerbating the spread of HIV in Chikhwawa, T/A Maseya.

4.4 Study limitations

Despite the fact that this study has provided important recommendations, knowledge and insight into the investigation of the experiences and risk perception of adult population in Chikhwawa district, TA Maseya on wife inheritance as a key driver of HIV transmission, few limitations deserve mention.

Some of the possible interventions that were not included in this analysis may be effective strategies. The interventions that I included in this analysis have been formulated in a small number of ways among the many possibilities. For example, this research considered and recommended the development of By-Laws as one way to bring to end ill cultural practices such as wife inheritance that fuel the spread of HIV in the rural communities. However, the recommendation of the development of By-Laws falls short of elected Councillors to guide the process and give legitimacy to the process of developing By-Laws. Although the analysis is intended to provide broad guidance to decision makers such elected Councillors (in the case of Malawi are not in place), many factors can cause the failure to achieve this due to lack of political will at national level to call for Local Government Elections that would legalise local councils to develop By-Laws for the benefit of the communities.

Due to time constraints the population sample was relatively small and this may partially account for the discrepancy between the findings of the questionnaire. Due to time constraints a sample of convenience was selected based on availability. Consequently, the sample results may not be representative of the thoughts of all community members in Chikhwawa district, TA Maseya. The study was conducted in five villages of Kalima, Maseya, Mbande, Josephy and Frank only that limits the ability to generalise the results for the whole traditional authority Maseya which has six GVHs.

Many important uncertainties remain about the trajectory of HIV and AIDS epidemics and the potential effectiveness of interventions when expanded to full scale (Daniel et al., 2005). Developing a better understanding of sexual behaviours such as wife inheritance in a different setting will be critical, as it will strengthen the empirical link between behavioural and epidemiological models. In considering the likely impact of interventions I extrapolated most assumptions from a limited number of a relatively small sample, however a large sample will be required to estimate and determine the risk perception of adult population on wife inheritance as a key driver of HIV transmission so that large scale prevention programmes are still needed.

It is worth mentioning that similar and important study findings have already been documented. Consequently, the findings from this research confirmed findings from previous risk perception on

wife inheritance as driver of HIV transmission among the sexually active adult population in Africa and many more of the issues identified in this analysis were also identified in other studies such as the following: Abdulai et al, 2007; Tsasis, 2008; Douglas, 1982; Parker, 1995. Therefore, it is evident that the findings of this study are linked with previous studies and these linkages provide some detailed perspectives on the experiences of the adult population on the risk perception of cultural practises such as wife inheritance as a driver of HIV transmission in Chikhwawa district TA, Maseya. For the project to carry on it needed a lot of money to print out research questionnaires for each respondent and fuel to travel to the villages of the targeted respondents and the researcher incurred high costs.

4.5 Study implications

4.5.1. Implications on public policies

The findings of this research have some implications to Government of Malawi and other actors in public health responsible for the development of public health police and programmes. This research implies that when Government is developing public health policies the role of public health policies and programs should not be limited to individual health behaviors. Despite the knowledge and experience in the field of public health with regards to the social determinants of disease, including food and nutrition, shelter, and employment, there has been little impact on HIV/AIDS policy and programming in Malawi. In addition to recognizing the role of social context, policy and program implementation must also not occur in isolation. Inter-sectoral coordination is necessary to influence risk perception on a macro-level. Recognition of HIV/AIDS as not only a health problem, but also a social, economic one, and development issues facilitate collaboration between different levels of government and civil society.

However, it is important to stress that the application of public health efforts will differ from one country and district to another due to differences in demographics, political context, education levels, social service provision, geographic location, cultural beliefs and epidemic patterns, among other factors. For example, data of this research suggests that in the Mang'anja and Sena cultures of Chikhwawa district, practice of cultural practices and poverty exacerbates the spread of HIV. Whether safer behavior is more likely to occur as economic status increases depends on other factors such as social values, education and gender. This research illustrates the complexity of vulnerability, and the need to design interventions and policies that take community variations into consideration.

4.5.2 Implications on HIV and AIDS programs

The study findings imply that if actors in HIV and AIDS in Malawi do not take into consideration programs that bridge the age and gender gaps into HIV and AIDS planning, efforts aimed at reducing the spread of HIV may be ineffective and short lived. Keeping in mind the need to balance context specificity with consideration for cross-cutting issues like ageism and sexism, a multi-dimensional approach to HIV and AIDS mitigation is the recommendation of this research. Developing such a model involves two dimensions: (1) persuading vulnerable population groups to change behavior, and (2) enabling safe behavior by changing societal and contextual factors that contribute to HIV transmission. Thus far, public health measures have focused on persuasion. This narrow focus on the individual has a limited impact on communities plagued by continued practice of ill cultural practices such as wife inheritance, poverty, inequality, and injustice.

4.5.3 Implication for collective community participation

The findings of this research implies that to mitigate the ill cultural practice of wife inheritance, community participation and community led approaches to HIV/AIDS mitigation need to be popularised because they are often quite innovative in their response. The advantages of community led programs are that local knowledge is utilized and the focus is on the community as an entity as opposed to individuals. One of the models that the research findings recommends and implies is that, government and non state development organisation need to use community mobilization, paired with public health efforts to allow for a naturally evolving response to diversity and changing needs. Despite the great, untapped capacity of communities, local programs often continue to focus on behavior change out of context. However, proactive action rather than reactive action is required to ensure policy gets ahead of the epidemic.

4.5.4 Implications for the roles of community leaders

The research findings found out that most traditional, political and religious leaders are men. Men in positions of power have many advantages, including increased access to sex. Men who are community leaders may be reluctant to promote policies that will enhance the status of women, because such policies appear to threaten the status of men. Yet men also benefit from equal status with women. Most men who treat women as equals find that their lives are more rewarding and less stressed: at a personal level, instead of a servant, they have a partner for a wife, and at community level they benefit from the insights and strengths that women bring.

These research findings imply that HIV and AIDS prevention deeply depends on equal gender status, but equal gender status will result in much greater benefits. The community leaders must have the courage to place the needs of their communities above their personal desires. Steps that community leaders can take include: Publicity campaigns discouraging the continued practice of wife inheritance; Support for community policies and By-Laws that enshrine gender equality and do away with ill cultural practices; Publicity campaigns encouraging condoms within all relationships; and Widespread provision of voluntary counselling and testing facilities for HIV to all community members.

This research implies that traditional and religious leaders should also set a clear example in their personal lives, by discouraging communities not to engage in cultural practices such as wife inheritance and many other extramarital relationships. Ideally, community leaders should make a public statement to such an effect, although it is recognized that this is an extremely difficult and sensitive area.

This research implies that for the traditional leaders to be able to advocate for community change in regard to HIV/AIDS, the Government and other HIV/AIDS implementing partners need to build the capacity of community leaders in gender, human rights, and HIV and AIDS in order to lead community sensitization campaigns. Furthermore, community leaders need to be sensitized about the gender concept and the role that they can play in positively transforming gender relations within their communities; promote the empowerment of women at household and community levels to enable them to assert their sexual and reproductive rights.

This research also implies that few policies and programmes in response to HIV/AIDS are informed by the real-life situations of men and women: how they live and work in rural areas, and the complex network of relationships and structures that shape their lives. Yet, these experiences are all well known and well documented. Both men and women live in accordance with widely shared notions of what it is to be a man, or to be a woman. These ideas about typically feminine or masculine characteristics, abilities and expectations determine how men and women behave in various situations. Such ideas and expectations are learned from families, friends, schools, the workplace, religious and cultural institutions, and the media and opinion leaders. Since these are learned responses, it is evident that leaders can and should play an aggressive role in changing those norms about femininity and masculinity that support the spread of HIV and AIDS.

4.5.5 Implication for social research

The study's findings are essential in public health planning in Malawi and these findings imply a number of things. Firstly, there has been little research done to determine the risk perception of the adult population in Chikhwawa TA Maseya on wife inheritance as the key driver to HIV transmission. This study, like the study by Dr. Thomazile Qubuda (The experience of elderly African women caregivers of their children with AIDS related illness, 2011) however contributes to the literature greatly by providing detailed information about research participants who voluntarily admitted to being involved in wife inheritance and are at the same time willing to work with the relevant authorities to advocate for change on how the practice is conducted in order to reduce the spread of virus.

Secondly, the findings of this research are important in social research in that the study explores the cultural differences of people in Chikhwawa TA Maseya in the issues relating to the death of a woman's husband. Among the issues explored is the vulnerability of women to HIV transmission based on their high illiteracy level which contributes to their risk of contracting HIV. It also explains how the role of the traditional leaders is not utilised to avert the problem. The research has also provided some recommendations on the role of community leaders. The loss of a loved one is a source of intense emotional stress, yet the bereaved need to express and deal with their feelings of loss before they can reorganize their lives. Normal grief often follows a fairly predictable pattern (Schulz, 1978).

The brief reference to the state of research on widowhood practices is necessitated by the need to call attention to the limitations of this presentation and a need for a large scale study of this subject matter. Although widows constitute a large proportion of the adult female population in many African communities, systematic investigation is missing (Betty Potash, 1986; 1). The result is that much of the scanty pieces of information we have on widowhood practices are mere raw and unprocessed information. Systematic and sponsored sociological and cosmological studies are yet to be made (Afigbo 1986; 8). For the same reason of lack of analytical approach, comparative studies of widowhood practices are also conspicuously absent. There is also absence of diachronic studies aimed at showing how widowhood practices have evolved or changed over time especially as a result of religion (majorly Christianity and Islam) and modernization. It is obvious that the widowhood practices are, no doubt, a product of history intercepted by religious and cultural contacts.

The other scientific contribution that this research implies is the disorganization and trauma that follow the death of a spouse seem to be greater on the women. It was found out that in a case of the loss of a

husband, the wife becomes the primary suspect as the cause of the husband's death and is thus treated accordingly by being told to engage in wife inheritance. On the other hand, where a man loses his wife, the man is almost immediately offered a substitution to comfort him and douse the impact of the grief of bereavement. The cause of this is not farfetched. It has been rightfully observed that "The differentiation between men's and women's role in Malawi as with other societies is one of complementary and superior relationship in favour of men. It involves a hierarchy in which men are given greater leverage over decision making and resources than women. The result is a cultural setting that invariably promotes male domination and female subordination" (Ahosi 2002; 2). As it relates to certain societies in Malawi therefore, it can be observed that some of the customs relegate women to the background and clearly rob women of their rights and privileges, and puts them at risk and are vulnerable to contract HIV.

This study discovered that widows are faced with a myriad of problems such as economic, social and psychological particularly in the first year or so after the death of their spouse. Helena Lopata (1977, 1979) has done extensive research with more than 1000 widows and widowers. A major problem for both sexes is economic hardship. When the husband was the principal breadwinner, his widow is now deprived of his income and the nucleus of the family is destroyed. The freedom and independence of the nucleus of the family is suddenly lost as a result of the death of the husband.

The other aspect that this research demonstrated is the problem associated with widowhood which is loneliness. Helena Lopata (1977-1979) and Blackwell (1981) did some extensive research with widows and their findings were consistent with the findings of this research in that; as most widows nearly eight out of ten live by themselves and so they suffer the fear of being alone and loss of self-esteem as women in addition to the many practical problems related to living alone. They feel the loss of personal contract and human association therefore they tend to withdraw and become unresponsive. Most are reluctant to move in with their children and only those who are poor and frail live with some relatives, few express any interest in remarrying and so the lack of potential remarriage partners may not distress them. As a result they end up engaging in risky behaviours that puts them at risk of contracting the virus in the name of meeting their basic needs.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The concluding chapter finalizes the research study and offers recommendations that will assist the Government of Malawi, NGO's in HIV and AIDS Management and communities in Malawi in general and specifically Chikhwawa district, TA Maseya to effectively and efficiently deal with the negative impact of cultural practice of wife inheritance that fuel the spread of HIV.

5.2 Conclusion

This research report has investigated the risk perception of rural adult population in Chikhwawa district, TA Maseya, on wife inheritance as a driver to HIV transmission. The study looked at the adult population knowledge level on: the basic facts on HIV and AIDS, knowledge on wife inheritance, condom use, voluntary testing and counselling. The research study further highlighted a range of issues relating to the broader context of risk perception, cultural practices and HIV and AIDS knowledge related.

Cultural practices such as wife inheritance, in TA Maseya, demonstrated that they favour men unlike women. Men are allowed to do whatever they want but women would not be allowed to do the same because the community norms do not allow such behaviours. Most women, as a result, were at pains to solicit a straight answer from their partners on their HIV status, much as they would wish to know. Their seeking to know their own status demonstrated their willingness to know their partner's status. However, they could not garner the courage to tell their partners of their status for fear that the partner would end the relationship. Thus, it was shown that cultural practices such as wife inheritance were indeed a driving factor in the spread of HIV because had it not been for such practices, partners would freely share information and make informed choices through couple counselling and consistency use of condoms.

5.3 Recommendations

On the basis of the findings of this research, the following research recommendations are made:

- Knowledge dissemination alone has proved to be insufficient in slowing down the spread of the virus. Knowledge and other intervention methods, such as education and skills development,

small group discussions led by peer or voluntary outreach, and community discussion forum, need to be done as a combination that could make a difference in the communities.

- In addition to the knowledge campaign, the adult population need to be motivated towards reducing their risk behaviors. In that direction, principles that have as core bases, motivational factors, problem solving and decision making competencies, behavioural skills and social responsibilities to complement the knowledge drive for reducing risk behaviors have to be put forward through Community Action Groups.
- The greatest concern about HIV and AIDS in Malawi is the fact that there is no cure and no vaccine till today. To avoid infection or re-infection adult population has only two choices: abstinence or usage of prevention methods that means safer sex. This research recommends that communication methods would be helpful to fight misinformation and raising awareness on the dangers of engaging in unprotected sex through wife inheritance.
- The research observed that widows are the most vulnerable because they are involved in wife inheritance where condom use is not prioritised. In this regard, adult literacy is ideal in curbing the spread of the virus. The research suggests that promoting male and female condom use can be ideal for widows at all levels. Seemly, the female condom is perceived as more difficult to use and more uncomfortable than male. Nevertheless if it is correctly and consistently used, the female condom constitutes an efficient prevention method against HIV infection, other STD's and against unwanted pregnancy.
- The power to shape risk perception is usually in the hands of very few; namely those with control over social, political, and economic institutions such as traditional leaders. The research recommends that there is need to strengthen health education within communities and involve traditional leaders in the fight against HIV. By-Laws need to be developed to make traditional leaders accountable of cultural practices that lead to the transmission of HIV.
- The research observed that risk perception is culturally influenced and therefore risky behavior is a social rather than an individual issue. However, the mass media often perpetuates risk as an individual issue. Therefore, the research recommends that the role of media must also be recognized in terms of being an important player in disseminating information on risks as well as promoting a cultural approach to prevent further spread of HIV/AIDS among a population where social instability exists. As a result, the media plays an integral role in shaping or

reinforcing risky behavior as an individual phenomenon, where the individual chooses to be in that risk group. In addition, HIV/AIDS programs must be culturally appropriate and work toward influencing risk perception, while addressing social norms and values that negatively impact vulnerable populations such as women and children.

- Public health measures to combat the spread of HIV/ AIDS must be re-evaluated with consideration for ways in which culture shapes risk perception and wife inheritance. Societal factors, including practices and beliefs about sex, relationships, and condom-use lead to the inclusion, neglect, or exclusion of people, thereby shaping individual behavior in ways that are beyond individual control. Addressing social norms and values that negatively impact vulnerable populations such as widows can effect change more rapidly than measures aimed at individual behavior. Thus, the ultimate aim should be to enable people to exert control over their own risk and to create an environment in which safer behavior can be practiced.
- The research recommends that public health policies and programs must move to a paradigm of enablement and empowerment by addressing root causes. This is more challenging than behavior change programs because it requires collaboration across sectors because the impact will not be evident in the near future. Cultural changes are gradual. Thus, the importance of long-term sustainable programs cannot be overemphasized. There is a clear and definite need for community and district cooperation on this, especially considering that the lower economic status of communities will result in more acute challenges to the development and maintenance of necessary programming.
- The research recommends that Traditional leaders need to ensure that short and long term gender sensitive strategies are developed, from the community level all the way to the national level. Short term strategies may focus on people's immediate needs, especially those pertaining to obtaining information about HIV/AIDS, for both literate and illiterate populations, support to home-based care, and access to treatment of STDs and counselling services. Long term strategies must address the underlying cultural and social structures that sustain gender inequality. The traditional leaders should promote mutual respect between men and women and equal access to opportunities and resources, and should empower individual men and women to exercise responsible choices about their own sexual behaviour.
- The research also recommends that a disaster management approach to prevention, treatment, and mitigation can ensure that HIV and AIDS becomes priority and is addressed with the same

concern and attention as other environmental disasters. The utilisation of the PAR model can direct and enhance disaster management efforts. By using the PAR model as a guide, public health departments can work towards addressing one or more of the three features of increasing vulnerability, namely: root causes such as poverty, access to resources, and gender inequality; and dynamic pressures such as the cultural practice of wife inheritance.

- In addition to reducing vulnerability by addressing root causes, the research recommends that particular attention can be paid to developing methods for changing perception of risk. By impacting cultural and social expectations, individuals will be able to more readily adopt safer sex behaviours. The development of policies and programmes addressing the issues in context as opposed to individual behaviours alone, allows for effective public health intervention which is needed if we are to prevent the HIV and AIDS pandemic from becoming a full blown catastrophic disaster.

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APPENDICES

APPENDIX A: LETTER OF INVITATION AND INFORMED CONSENT



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

Sexual risk cultural practice and risk perception of HIV transmission among a rural adult population in Chikhwawa District: The case of wife inheritance in TA Maseya

You are asked to participate in a research study conducted by chancy Alfred Nthowela a student from the Africa Centre for HIV and AIDS at Stellenbosch University. The results of this study will anonymously be processed into the study report on **Sexual risk cultural practice and risk perception of HIV transmission among a rural adult population in Chikhwawa District: The case of wife inheritance in TA Maseya**. You were selected as a possible participant in this study as a result of being an adult community member, traditional leader, and widow in Traditional Authority Maseya where the research will be conducted.

1. PURPOSE OF THE STUDY

The main aim of this research is to investigate the extent to which the adult population perceives *wife inheritance* as a risk key driver to HIV transmission in Chikhwawa district, traditional authority Maseya.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Questionnaire

Complete a questionnaire about knowledge of wife inheritance and your perception of wife inheritance as a risk driver to HIV transmission in TA Maseya. This will take approximately 20-30 minutes of your time because this has been identified as convenient.

Interview

A short interview with the researcher will be conducted with traditional leaders, men and widows to understand how and why wife inheritance is being practiced and assess their (interviewees) risk perception of wife inheritance as a driver of HIV transmission. This will take approximately 30 minutes of your time and this time has been identified as convenient to you.

POTENTIAL RISKS AND DISCOMFORTS

Information required by the interviewer will require prior knowledge of TA Maseya, traditional cultural practices and activities which may seem to be disrespectful to the community's cultural beliefs. However, the intention of the study is to assist communities in TA Maseya in Chikhwawa district and further reassurances will be provided if needed. The research tackles sensitive issues dealing with sexual behavior, therefore some pain and discomfort on the part of participants is expected. Reassurance will be given and the strictest confidence will be observed in order to ease the pain and discomfort which might be caused.

3. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

It is expected that the research study on one hand, can assist traditional leaders, widows, and men, to determine the level of risk perception of wife inheritance as a driver for HIV transmission and such information would provide a background on how the TA Maseya community would network with stakeholders such as the Government and non-state organisations to sensitize the general communities about the dangers of practicing *Wife Inheritance* in relation to HIV transmission. On the other hand the study would assist Government and organizations to analyze and estimate the damage that may be caused by the problem and later design and implement interventions in line with the needs at ground in order to address the problem beyond culture.

4. PAYMENT FOR PARTICIPATION

There will be non payment for participation. This is a voluntary exercise that is contingent on your participation.

5. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of storing the data collected from the community in a closed location not accessible by the public.

The information might also be inspected by the University of Stellenbosch, Human Research ethics Committee. The records will only utilized by them in carrying out their obligations relating to this study.

6. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

7. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Chancy Alfred Nthowela on +265-0-888-300-394 and +265-0-999-675-295, email: chancynthowela@yahoo.co.uk and cnthowela@savechildren.org AND Dr T. E. Qubuda on 021 8083999, email: tqubuda@sun.ac.za

8. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me.....by Chancy Alfred Nthowela in English. A translator.....was asked to explain in my own language sections that I could not understand. I am in command of this language.....and where necessary it was satisfactorily translated to me.

I.....was given the opportunity to ask questions and these questions were answered to my satisfaction. I am aware that the results of the study will anonymously be processed into a study report and that at any stage I can withdraw my consent and participation in the study.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in..... And a translator was used in this conversation. The conversation was translated intoby

Signature of Investigator

Date

APPENDIX B: Research Questionnaire

CULTURAL PRACTICES AND HIV/AIDS IN MALAWI

District:.....

Target Area:.....

Location : Rural

Name of Interviewer:.....

Interview Number:

Date of Interview:...../...../2011

Checked by:.....

For Respondents/Key Informants

SECTION A: RESPONDENTS BACKGROUND

Name of Respondent/Key informant:..... (Optional)

Sex: 1. Male () 2. Female ()

Age group: 15-49 years ()

Occupation:.....

Education

Highest Education 1. No Formal Education () 2. Standard 1-8 () 3. Form 1-4 () 4. Post Secondary ()

Denomination:.....

Marital status: 1. Never Married () 2. Married () 3. Widowed () 4. Divorced ()

Original home district:.....

Ethnic group.....

SECTION B: BASIC AWARENESS AND KNOWLEDGE ON HIV/AIDS

1. Have you ever heard about HIV?

.....

2. What is HIV?

.....
.....
.....

3. Have you ever heard about AIDS?

.....

4. What is AIDS?

.....

5. What is the difference between HIV and AIDS?

.....
.....

6. What are your sources of HIV/AIDS information?

.....

SECTION B: CONDOM USE

1. The last time you had sexual intercourse with a non regular partner did you use a condom?

.....

2. Have you ever used a condom before?

.....

3. Where do you access condoms from?

.....

4. Are both male and female condoms helpful?

.....

5. If yes, how helpful are they?

.....

6. If NO, how un-helpful are they?

.....

SECTION C: VOLUNTARY COUNSELLING AND TESTING

1. Do you know your HIV status?

.....

2. If NO why have you not gone for VCT?

.....

3. Do you know the HIV status of your partner?

.....

4. If you do not know the statuses of your partner explain why?

.....

5. Does your sexual partner know your HIV status?

.....

6. If your partner does not your status explain why so?

.....

7. If you were HIV positive, would you tell your partner and why?

.....

8. If the above answer is NO, why would you not tell your partners about your HIV status?

.....

9. Is it really necessary to know your HIV status and why?

.....

10. If you and your partner were HIV positive and your partner died as a result of AIDS, would you disclose your partners' cause of death to your relatives and friends and why?

.....

11. Do you know where one can go for HIV testing and counselling in your area?

.....

12. Mention any two places in your area where you can go for HIV testing and counselling.

.....

SECTION D: PREVAILING CULTURAL PRACTICES AND HIV/AIDS IN CHIKHWAWA DISTRICT

1. Are there any cultural practices, in your area, that predispose people to HIV?

.....

2. If yes what are these cultural practices?

.....

3. Is Wife inheritance practiced/ found in your home area?

.....

4. If yes how does the practice of wife inheritance predispose people to HIV?

.....

5. Have you been involved in the practice of wife inheritance?

.....

6. Who initiated the practice?

.....

7. Should Wife inheritance be retained in your community and why?

.....

8. As a Traditional Leader, who is the custodians of culture, are you aware of Wife Inheritance being practised in your area?

.....

9. If the above answer is YES, for how long has Wife Inheritance been in practice in this area?

.....

10. It is said that Wife Inheritance fuel the transmission of HIV. Is this true?

.....

11. In your own opinion how does Wife Inheritance fuel the spread of HIV in your area?

.....

12. What do you think is the role of Traditional Leaders in preserving culture amidst HIV in your area?

.....

13. Any other comments

.....

Thank You Very much for taking part by responding to questions in this questionnaire.

APPENDIX C: ETHICAL CLEARANCE BY RESEARCH ETHICAL COMMITTEE



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvenoot • your knowledge partner

STELLENBOSCH UNIVERSITY

Approved with Stipulations

New Application

18-Aug-2011

NTHOWELA, CHANCY CA

Dear CHANCY NTHOWELA,

The **New Application** received on **27-Jul-2011**, was reviewed by Research Ethics Committee: Human Research (Humaniora) via Committee Review procedures on **28-Jul-2011**.

Please note the following information about your approved research protocol:

Present Committee Members:

Van Wyk, Berte B

De Villiers, Mare MRH

Hattingh, Johannes JP

Theron, Carl CC

Somhlaba, Ncebazakhe NZ

Viviers, Suzette S

Bitzer, Elias EM

Van Zyl, Gerhard G

The Stipulations of your ethics approval are as follows:

1. Possible psychological pain and discomfort is foreseen as sensitive issues are addressed by the project. Indications of ‘reassurance’ are given in the application, but it is not spelt out what the ‘reassurance’ might entail. The researcher needs to spell out clearly in a note to the REC what ‘reassurances’ will be provided to participants given the sensitive nature of the research

Please remember to use your **protocol number (HS651/2011)** on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a progress report should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number projects may be selected randomly for an external audit.

Translation of the consent document in the language applicable to the study participants should be submitted.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 0218089183.

Sincerely,

Protocol #: HS651/2011

Title: Sexual risk cultural practice and risk perception of HIV transmission among a rural adult population in Chikhwawa District: The case of wife inheritance in TA Maseya

Protocol Approval Period: **28-Jul-2011 -27-Jul-2012**

Included Documents:

PARTICIPANT INFO SHEET

APPLICATION FORM

CHECKLIST

RESEARCH PROPOSAL

QUESTIONNAIRE

CONSENT FORM

INTERVIEW SCHEDULE

Sidney Engelbrecht

REC Coordinator

Research Ethics Committee: Human Research (Humaniora)