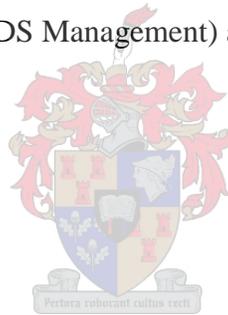


**PERCEPTION OF RISK OF HIV/AIDS AMONG WIDOWS USING THE NDLOVU
MEDICAL CENTRE, ELANDSDOORN, LIMPOPO PROVINCE**

Durotolu Motunrayo Amosun

Assignment presented in partial fulfillment of the requirements for the degree of Master of
Philosophy (HIV and AIDS Management) at Stellenbosch University



Africa Centre for HIV/AIDS Management
Faculty of Economic and Management Sciences
Supervisor: Dr Thozamile Qubuda

March 2011

DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.



Signed: D. M. Amosun

Date: March 2011

ACKNOWLEDGEMENT

It is a deep word of appreciation to my indefatigable study leader – Dr. Thozamile Qubuda. Thank you for believing in me and for pushing me to success.

To Ms. Arlene Willets of the Africa Centre for HIV/AIDS Management – you carried me on your back since 2009 and you have made sure that I cross the finish line. You are a Star!

To my gorgeous and adorable little Princess - Oluwanifesimi. Indeed, the Lord takes delight in you.

To my beautiful Niece –Oluwadarasimi, who was born while I was finishing up this study. Thank you for making me an Aunty for real!

To My Manama...you inspire me! I still want to 'grow up' and be like you. Thank you for ever being so selfless. You are a courageous widow.

To My Brother – Oluseyi...I still can't thank you enough for footing the bill and making this MPhil possible. You are just not my brother and my friend...you have become my father!

To My Barribarri Brother – Fujababa...thanking you again and again for all you have been. Were it not for your gentle and subtle push, I still wonder where I would have been.

To My godfather – Prof. Elijah Oladunni Kehinde, who bought me the scientific calculator that I used for my secondary school education and the laptop that I have used for this postgraduate programme.

To the Ilemobades – My Parents in South Africa. You are My Sunshine!

ABSTRACT

The research was conducted at Ndlovu Medical Centre, Elansdoorn; Elias Motswaledi municipality district in the Limpopo Province of South Africa using a semi-structured questionnaire. Data was collected from 30 widows. It is wrong to assume that decision-making and behaviour are always rational. The study finding shows that risk perception is influenced by social and economic factors such as relationships, community expectations, and access to resources. These have a major impact on behaviour, and may prevent individuals from adopting safe sex practices that prevent HIV/AIDS transmission; thereby making risky behaviour a social rather than an individual issue.

Public health measures to combat the spread of HIV/AIDS must be re-evaluated with consideration for ways in which factors beyond the individual shapes risk perception. In using the Pressure and Response model as a guide, vulnerability among widows can be managed and reduced by addressing root causes, dynamic pressures, and unsafe conditions that contribute to the HIV/AIDS pandemic.

OPSOMMING

Die navorsing is uitgevoer by Ndlovu Mediese Sentrum in Elanskroon wat in die Elias Motswaledi munisipale distrik in die Limpopo Provinsie geleë is. 'n Semi-gestruktureerde vraelys is gebruik om data in te samel van 30 weduwees. Die studie-uitslag dui aan dat risiko-persepsie beïnvloed word deur sosiale en ekonomiese faktore soos verhoudings, gemeenskapsverwagtinge en toegang to hulpbronne. Dit het 'n groot invloed op gedrag en kan voorkom dat individue veilige seksuele praktyke sal aanneem wat MIV/VIGS verspreiding kan verhoed. Hierdie gevaarlike gedrag is 'n sosiale eerder as 'n individuele problem.

Openbare gesondheidsmaatreëls om die verspreiding van MIV/VIGS te bekamp, moet herevalueer word, met inagneming van maniere waarop faktore buite die individu risiko persepsie vorm. Deur die "Pressure and Response" model te gebruik as 'n gids, kan kwesbaarheid onder weduwees bestuur word en verminder word deur die aanspreking van orderliggende oorsake, dinamiese druk en onveilige toestande wat bydra tot die MIV/VIGS –pandemie.

TABLE OF CONTENTS

CHAPTER ONE

Introduction and Background.....	4
Epidemiology.....	5

CHAPTER TWO

Literature review.....	10
Conceptual Framework.....	21
Figure 1.....	22

CHAPTER THREE

Research Design.....	22
Study Site.....	23
Measuring Instrument.....	24
Validity and Reliability.....	25
Informed concern.....	25
Ethical consideration.....	26

CHAPTER FOUR

Results and Discussion.....	26
Figure 2.....	27
Figure 3.....	27
Figure 4.....	28
Figure 5.....	29
Table 1.....	30
Figure 6.....	31
Figure 7.....	31
Figure 8.....	32

CHAPTER FIVE

Recommendations.....	35
Conclusion.....	35
References.....	35
Appendices.....	43

CHAPTER 1: INTRODUCTION AND BACKGROUND

The HIV/AIDS epidemic has had its most profound impact to date in sub-Saharan Africa (<http://www.kff.org/hivaids/upload/7391-02.pdf>). Two-thirds of the world's HIV/AIDS epidemic is in Africa (<http://www.avert.org/hiv-aids-africa.htm>). This has resulted in the death of 22 million Africans – most of them aged 15 – 49, people in their potentially most productive years, the effect of which has continued to echo over continuing generations. These are not statistics – they are fathers, mothers, brothers and sisters, doctors and nurses, primary school teachers, electrical engineers, community leaders, finance managers, entrepreneurs, students, researchers and farmers trying to lift their families out of poverty.

In South Africa, HIV/AIDS is currently the greatest cause of death among these most productive workforce between the ages of 15 and 49. According to the Joint United Nations Programme on HIV/AIDS in 2006, life expectancy would have declined in Botswana, South Africa, Zambia and Zimbabwe to 30 – 45 years by 2010. The incidence and prevalence of HIV and AIDS will not be significantly reduced unless the gender dimensions in the risk transmission are fully recognised and comprehensively addressed including the prevailing norms that are associated with widowhood (Kessy, et.al;2010). HIV is predominantly transmitted by heterosexual activity and women, on average, are infected at a significantly younger age than men (TACAIDS et.al; 2008). For sociological and biological reasons women are twice as likely to contract HIV through vaginal intercourse as men. Young women are particularly vulnerable because their vaginal tracts have not fully matured, are easily torn and offer less protection from disease (Sleap; 2001). In sub-Saharan Africa the rates of infection for young women between 10 and 24 years old are up to five times higher than for young men (Sleap; 2001). Since disease related to HIV infection tends to progress more rapidly with age (Baylies et.al; 2000), older HIV positive husbands are more likely to die before their younger wives, creating a new generation of young widows.

Indeed, the dangers faced by women from the HIV and AIDS pandemic have been described as “triple jeopardy”. That is, the disease potentially threatens women as individuals, as mothers and as carers (Baylies, 2004). In the context of HIV/AIDS, women have borne the worst burden of the pandemic and emerged as the social ‘shock absorbers’ to deal with its worst consequences.

Notwithstanding this burden, women who lose their husbands as a result of AIDS may also be stripped of their inheritance and property rights due to the stigma associated with the disease and the customary rights prevalent in different societies (Muchunguzi, 2002).

Furthermore, becoming a widow may entail being:

- Inherited by one of the husband's relative, typically a brother
- Forced to have sex with one of the husband's relatives in order to be cleansed;
- Blamed for the husband's death;
- Accused of witchcraft; and / or
- Disliked by the family or community as a result of the stigma attached to AIDS.

(Kessy, et.al; 2010)

The HIV prevention strategies and programmes that are widely promoted in sub-Saharan Africa in large part target HIV awareness and individual behavioural modification – conventionally through the ABC and recently D (Abstain, Be faithful, use Condom and anti-retroviral Drugs) approach to prevention (Byron et.al, 2006). However, barriers remain to the successful implementation of such an approach / strategy at the individual level because of the realities of customs and traditions, economic empowerment and social class, gender norms of behaviour, levels and types of resource access and control (Byron et.al, 2006); that all interplay in the dynamics of perception of risk to HIV/AIDS.

Prevention remains the key in the fight against HIV/AIDS; however prevention requires an understanding of the socio-cultural context in which HIV risk behaviour is perceived and occurs (McCreary et.al; 2008). Ingrained socio-cultural practices such as female circumcision, lack of male circumcision, the permissiveness of concurrent multiple partnerships by men, widow inheritance as it is done in the South Eastern and South Western parts of Nigeria (Fasoranti et.al, 2007) and the Luo of Western Kenya (Luke, 2002) is putting a clog in the wheel of current efforts to combat HIV/AIDS through behavioural change.

EPIDEMIOLOGY

One area in which widows have been marginalised is that of epidemiological studies which ignore them. The Joint United Nations Programme on HIV/AIDS (UNAIDS) epidemiology team is unaware of any statistics available on the number of women who have been widowed due to an AIDS death, or of the number of widows themselves living with HIV or AIDS (De Santis, 2000). The Indian Census of 1991 revealed 35 million widows, but very little statistical data has been collected for other developing countries. The statistics remain invisible and until more information from studies is available on the scale of the effect of AIDS on widowhood, generalizations cannot be made because every person and every community differs.

Statistics South Africa published a report called "Adult mortality (age 15-64) based on death notification data in South Africa: 1997-2004" (Anderson et.al; 2006). These data shows that between 1997 and 2004, the death rate among men aged 30-39 more than doubled. Over the same period there was relatively little change in the death rates among people aged over 55 and those aged 15-20 (which is in keeping with current demographics of the HIV epidemic). In their report, Statistics South Africa called such developments "astounding", "alarming" and "disturbing". The head of the Medical Research Council has stated that AIDS killed around 336,000 South Africans between mid-2005 and mid-2006 (South Africa Panel; 2006). The computer model of the Actuarial Society of South Africa, called ASSA2003 calculates that 345,640 people died because of AIDS in 2006 - comprising 47% of all deaths. Among adults aged 15-49 years, it estimates that 71% of all deaths were due to AIDS (Dorrington et.al; 2006). UNAIDS/WHO estimate that AIDS claimed 350,000 lives in 2007 - nearly 1,000 every day (UNAIDS/WHO Report; 2007).

These statistics other than the increase in the number of orphans and vulnerable children give some indication of the scale of the number of women being widowed by HIV/AIDS, however, it does little to show how being widowed in this way compounds the already traumatic experience of widowhood (Sleap, 2001). A widow is a woman married to a man under the statute, customary law or religious law, who has the misfortune of losing her husband through death (Sako-John, 2004).

In many traditional communities of developing countries especially in Africa, widowhood represents a "social death" for women. It is not merely that they have lost their husbands, the main breadwinner and supporter of their children, but widowhood robs them of their status and consigns them to the very margins of society where they suffer the most extreme forms of discrimination and stigma (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>).

Widows who have survived terrible hardships are often abandoned or ostracized by their relatives who refuse to support them. The shame of rape, the competition for scarce resources such as the family land or the shared house, places conflict widows in intense need. They are unable to prove their title to property and typically have no documentation and little expert knowledge about their rights. They bear all the burden of caring for children, orphans, and other surviving elderly and frail relatives without any education or training to find paid work. Widows in third world nations have the potential to play a crucial role in the future of their societies and the development of peace, democracy, and justice, yet their basic needs and their valuable contributions are mostly ignored. Where progress has been made, it is due to widows working together in an association.

The loss of a loved one is a source of emotional stress (Fasoranti et.al; 2007). The bereaved needs to express and deal with their feelings of loss before they can reorganize their lives (Fasoranti et.al; 2007). The grief that many third world widows experience is not just sadness of bereavement but the realization of the loss of their position in the family that, in many cases, results in their utter abandonment, destitution and dishonor (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>). This is often times, the point of vulnerability. The widow is blinded by grief; her inhibition is low and often makes decisions based on poor judgment. The disorganization and trauma that follows the death of a spouse seems to be greater on women than men when either of them loses his or her spouse (Fasoranti et.al; 2007).

In many districts of the indigenous African societies, special attention and care are expected to be given to widows. Under normal circumstances, a widow is entitled to either of two types of protection - she can either be remarried to the nearest male relative of her husband, in which case, she enjoys all the protection and care normally enjoyed by his wives. Or if she is not re-married, she can be given collective protection and care by the relatives of her deceased husband. In this case, help of a financial and labour nature is rendered to the widow by the relatives of the deceased husband (Fasoranti et.al; 2007). With this attention, care and protection comes the difficulty in negotiating safer sex with either the nearest relative of her husband or in the case of the more independent widow, the 'outside' male partners.

There are a few actual statistics for individual countries on numbers of widows, but it is estimated that, for example, in Rwanda, following the genocide of 1994, over 70% of adult women were widowed. In Mozambique, following the civil war, over 70% of children were said to be dependent on widowed mothers (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>).

South Africa is one of the top countries in the world with the highest burden of HIV/AIDS with heterosexual intercourse being the major route of transmission (<http://www.avert.org/women-hiv-aids.htm>). HIV/AIDS has resulted in a huge increase in widows especially in sub-Saharan Africa (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>). The poverty of HIV/AIDS widows, their isolation and marginalization, impels them to adopt high-risk coping strategies for survival (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>).

Perception of risk is the key component that drives behavioural change and informs the design of HIV prevention programmes. This research project will help in highlighting the perception of risk of HIV among widows using the Ndlovu Medical Centre and identify obstacles to lowering susceptibility and prevent infection. It will also assess

the perception of existing prevention approaches, identify gaps in the current prevention strategies and importantly provide guidelines for the improvement of prevention programmes in gender based HIV/AIDS development non-governmental organisations in South Africa.

CHAPTER 2: LITERATURE REVIEW

There is a correlation between gender equity and economic development. The wider the gender gap in all spheres of society, the slower the pace of economic growth (King et.al; 2002). There is a link between gender relations and a lack of access to productive resources. Women's lives are defined by a historically constructed ideology of domesticity, which is closely linked patriarchal gender power relations, and by an artificial private public distinction (Hansen, 1992). Patriarchy defines women in such a way that their full and wholesome existence depends on getting married, producing children and caring for the family. Thus, the domestic roles of mother, wife and homemaker become the key construction of women's identity in Africa. While patriarchy defines women in terms of domesticity, it simultaneously draws an artificial line to separate the domestic (private) arena from the public one. The public sphere represents men while the private is representative of domestic activities centred on the family. Thus, the domestic roles of mother, wife and homemaker become the key construction of women's identity in Africa. While patriarchy defines women in terms of domesticity, it simultaneously draws an artificial line to separate the domestic activities centred on the family. Women are confined to the domestic arena – a space where men rule over them as “heads of the family” and own and control all productive resources, including cash and no-cash resources – while men spend most of their time in the public realm, which is the locus of socially valued activities such as politics and business. The rationalisation for this dichotomy is that women's reproductive role makes them biologically and ‘naturally’ predisposed to rearing children and taking care of the domestic sphere.

Biology, instead of gender, is therefore used to explain social differences between men and women. Gender differences are reduced and justified by biological differences. The distinction between the public and private serves to ensure that women lack both the capacity and the means to access and control material resources. This has serious consequences on the life-cycle of women, particularly when they become widowed. The ideology of domesticity is so well-organised that the majority of African women have internalised it. This ideology informs their self identity. Domesticity confines African women both conceptually and practically in ways that limit their access to resources and increases their vulnerability to the context of HIV/AIDS. The already precarious socio-economic position of women has been exacerbated by the HIV and AIDS pandemic. Patriarchy uses several tools including culture, the law and religion to safeguard the public sphere as a domain of male hegemony and relate women to the status of second-class citizens. Because of the marginalized nature of the physical and symbolic space that women occupy in society, their legal and social status is subordinated to that of men. Where roles are divided into breadwinner and homemaker, the customs decree that the breadwinner (normally the man) is owner of

resources and in the event of the demise of the breadwinner, the consequences are telling for the homemaker, usually the woman.

The position of women in Africa adds another burden to the spectrum of complexities that confronts the continent when trying to deal with HIV/AIDS (van Niekerk, 2002). A complexity refers to a kind of problem that not only has no clear-cut or self-evident answer, but is also often thus constituted that an analytical approach wherein we distinguish parts and whole, often with the expectation that addressing the parts will fix the whole, is not always successful either. In complexities or complex systems, the whole is more than the constituent parts; the approach to the solution of complex problems often requires a problem consciousness and a sense of interactive influences that defy our natural intuitions or analytical prowess (Cilliers; 1998).

The situation in Africa has shown definitively that AIDS flourishes most demonstrably in a society where women are particularly vulnerable (van Niekerk, 2002). What can be done about these problems that breed vulnerability? They are complex, because both social roles and perceptions are deeply ingrained in the psyche of the individual. Not only are women physically more prone to become infected than men during normal sexual encounters, but their status and role put them at considerably greater risk. Women, because of their devalued status in the traditional African homestead, have significantly less control over the nature and frequency of their sexual contacts than their normal Western counterparts. They are, typically in underdeveloped societies, much more likely to be illiterate. Before and after marriage, they are perceived to be, and often also perceive themselves to be, totally dependent on men. In the advent of widowhood and with no male to depend on and limited livelihood means, women may be forced to resort to income-generating activities that are considered immoral by society, such as commercial sex work or beer brewing and selling, which place women and others at further risk of infection (Sleap, 2001; Kessy et.al., 2008). Few women are commercial sex workers as such, but often sex is seen as a commodity to be exchanged for some form of support, financial or other (Sleap; 2001).

Van der Vliet also points out how vulnerable monogamously married women are: raised in [a] strongly patriarchal society, with a tradition of polygamy, macho ideas of masculinity, and an emphasis on her duty to bear children to ratify bride-wealth contracts, [the married woman's] rights to demand fidelity or the use of condoms, or to refuse sex, are, for most women, not negotiable. Economic dependency on her partner weakens her position further. (1999, pp.3)

Widows constitute a large proportion of the adult female population in many African communities (Fasoranti et.al; 2007). Significantly so common is widowhood to women and uncommon to men that no word exists in the

vernacular languages of Southern Africa to describe a man whose wife has died (Owen, 1996). Arguably, the reasons for this is the frequent age gap at marriage, longer life expectancy of women, widower remarriage, polygamy, and the high risk of early death among men in consequence of accidents, crimes of violence, war and HIV/AIDS (Owen, 1996).

Death is always shocking to those closely associated with the dead person. Whether it comes after a long illness, or is sudden and violent, it is an awesome event - a challenge to one's emotional and spiritual understanding. But for all women, the death of a husband has an extra significance because it represents not simply the departure of a partner, protector and breadwinner but also heralds a radical change in her social status and lifestyle (Owen, 1996).

Bereavement is a social fact in any culture but reactions and practices relating to this vary from culture to culture (Fasoranti et.al; 2007) "Culture" is often portrayed in the social sciences as a historical, rigid collection of habits that plays on passive actors to influence their behaviour (Hammel, 1990; Potash, 1986). This view has been criticized by anthropologists, who underscore a more active construction of culture, where societal members continually reshape and adapt social norms and institutions to modern realities. One very significant modern reality in sub-Saharan Africa is the HIV/AIDS epidemic (Luke, 2002). The widow in this context is the local actor and their perception of risk in sexual relations in this era of HIV/AIDS is being examined.

The emergence of the AIDS epidemic in Africa has led many observers to take the instrumental view of culture, which emphasizes the role traditional cultural institutions and practices play in shaping behaviours that lead to rapid infection rates (Luke, 2002). It is argued that particular rites and ceremonies are incongruent with the modern way of life and observance of which tend to enhance the contraction, containment and spread of AIDS (NASSOP 1999, MOH 1997). For example, Widow inheritance or the levirate, arose among the Luo in Western Kenya to ensure that adult women remained under the guardianship of a man in the event of a husband's death (Luke, 2000). Widows are "inherited" by one of their husband's brothers or other male relative (Kirwen 1979, Ndisi 1974). The new union is not a remarriage; more accurately, the inheritor serves in the deceased husband's place, both physically and sexually. Thus, the inheritor serves as a widow's sole legitimate sexual partner (Luke, 2002). Within the new union, young widows are expected to continue childbearing with the inheritor, and any new children born held the name of the deceased husband (Obbo 1986, Potash 1986, Ocholla-Ayayo 1976). It is required by the customary law and in many African societies being inherited is not a matter of choice but convenience. The levirate system represents a sort of social security system within the African tradition which was instituted to protect the spouse and the children after the death of the husband.

The practice also involved ritual sexual intercourse, known as “cleansing,” between the widow and her inheritor at the onset of the arrangement. Cleansing occurs in conjunction with other observances, such as shaving the widow’s head (Luke, 2002). In some parts of Nigeria, a widow may be forced to have sex with her husband’s brothers, ‘the first stranger she meets on the road’ or some other designated male. This ritual ‘cleansing by sex’ is thought to exorcise the evil spirits associated with death, and if the widow refuses this, it is believed that her children will suffer harm (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>). In Zimbabwe, amongst the Ndaou, Tonga and Shangani, the act of sexual cleansing is said to be flourishing (Shoko; 2001) but in the neighbouring Zambia, there has been official condemnation of sexual cleansing and grabbing of property (Baylies et.al; 2000) and a wider use of alternative rituals to sexual cleansing have been observed (AF-AIDS; 1999). Due to the fear of contracting HIV/AIDS, some relatives of the deceased hire professional cleansers to engage in sex with widows (Ambasa-Shisanya C.R; 2007). These professional cleansers move from village to village transmitting HIV infection from one widow to another (Ambasa-Shisanya C.R; 2007).

In some cases men are said to have refused to inherit a widow if there was any doubt about the cause of her husband’s death (Bujra; 2000). In some parts of Tanzania, men are openly questioning widow inheritance and other indigenous customs (Baylies et.al; 2000). Women who lose their husbands may also be stripped of their inheritance and property rights due to the customary rights prevalent in different societies (Muchunguzi; 2002).

Widowhood experiences are generally a trauma but in some African societies, they are considered more as an experience of deprivation, subjugation and humiliation (Fasoranti et.al; 2007). The void left by the death of a spouse is felt after the funeral of the deceased, when relatives have departed and the bereaved is alone. In many instances the bereaved becomes pre-occupied by memories of the deceased, sometimes even talking to the departed person as though he or she were still alive. The widow is not only isolating herself from the living but is making it harder for herself to face the reality of the spouse’s death (Fasoranti et.al; 2007). One group of researchers (Clayton et.al, 1971) identified the symptoms that characterize the mourning process. In their study of 109 widows during their first month of bereavement, the symptoms most frequently reported by over 80 percent of the respondents include crying, depression, and difficulty in sleeping. Nearly half of those interviewed claimed difficulty in concentration, lack of appetite and reliance on such medication as sleeping pills or tranquillizers.

Some investigators have attempted to outline the stages of mourning during bereavement. One of such researchers was Bowlby (1960), who isolated five fairly distinct stages as being: concentration directed towards the deceased, anger or hostility towards the deceased or others appeal to others for support and help, despair, withdrawal and general disorganization and reorganization and direction of the self toward a new love object.

Another researcher (Kavanaugh, 1974) suggests that there are seven stages involved in the grieving process. These stages include, shock, disorganization, violent emotions, guilt, loss and loneliness, relief and re-establishment.

Another problem is economic hardship. With the husband as the principal breadwinner, the widow now becomes deprived of his income and the nucleus of the family is destroyed; even where both had been employed, the loss of one income is often major. The loss of a husband, even in cases of financially independent widows decreases access to cash (Fasoranti et.al, 2007). For widows who are illiterate, untrained and without land and who do not succumb to the demands of male relatives, widow inheritances, remarriage, household slavery and traditional burial rites, their options are few and far in between (<http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html>).

The HIV/AIDS epidemic in Africa is reshaping the way traditional cultural institutions and practices play in shaping behaviours that lead to rapid infection rates. In Kenya for example, the elders wish to take away the sexual cleansing element of the practice and to rename it “symbolic inheritance” (Schoofs, 1999). Widow inheritance may localize the infection to a few households, as the infected woman would be attached to a single male (the inheritor) rather than circulating freely among men in the community (Adetunji et.al, 1999). While the custom is risky for an individual inheritor, the practice contains the spread of disease within the entire population (Luke, 2002). A ban on widow inheritance, on the other hand, could actually accelerate the spread of HIV/AIDS. In the contemporary African context, unmarried or “unattached” women (such as divorced or separated women) are more likely to have numerous sexual partners, as they are often dependent on men for financial support, and these partnerships frequently involve unsafe sexual behaviours (NACC 2000, NASCOP&MOH 1998, Caldwell; et al. 1994, Doyal; 1994). A 1997 study in Tanzania revealed that those women widowed or divorced were three times as likely to be HIV positive as those who were single or currently married (Baylies et.al., 2000).

Widows who are no longer inherited and no longer receive traditional means of assistance would likely engage in high-risk behaviors with “outside” male partners in order to support themselves economically (Luke, 2002). For rural widows, many are forced to migrate to towns once they lose their right to cultivate family land (Owen, 1996). This has implications for HIV/AIDS risk perceptions among widows.

WHAT DOES WIDOWHOOD MEAN IN THIS ERA OF HIV/AIDS?

A clear understanding of underlying factors at the level of the individual and the community that influence HIV risk perception; is essential in order to strengthen prevention efforts. People respond differently to loss and grieve in their own time. Frequently, the hardest time for new widows is after the funeral. Young widows often have no

peer group and generally are less prepared emotionally and practically than older widows to cope with the loss (Scannell-Desch; 2003). Young widows have to cope with issues facing all widows: Intense isolation and loneliness and sometimes the sense of losing their “womanhood”, of being seen as sexless. They have to deal with the grief of losing their husband, or sometimes dealing with the relief of being released from that relationship. In certain communities, they may fear having their property grabbed or seized aside from the issues of levirate marriage, widow inheritance, by one of their husband’s relatives (Sleap, 2001)

Widowhood often causes financial stress because a major income source is lost with the death of a husband (Scannell-Desch; 2003). Several key factors believed to be driving the epidemic and affecting the perception of risk of the individual and the communities are as highlighted in the issues mentioned above – loneliness and the grief process with or without alcohol abuse that cuts across the financially dependent and independent. Financial constraints that lead to transactional sex with the relatives of the family of the deceased or complete ‘strangers’ in order to make ends meet – ‘falling in love’ for the sake of being supported, custom / tradition such the cleansing ritual in the Siaya district of Kenya which has a sexual component where women are supposed to have penetrative unprotected sexual intercourse following the deaths of their husbands in order to make his soul rest in peace, free the widow from taboos and release her from the spirit of her dead husband. It is also said to enable the deceased’s sons to marry and build houses (Luke, 2004).

In this era of AIDS, there are fears that these customs are costing lives, with the widow at risk of either becoming infected or herself transmitting the virus to her inheritor who may in turn transmit it to his other sexual partners. These may include new co-wives, if the new marriage is polygamous, thereby affecting a potential source of support for the widow.

Will there be an impending change as more economically secure and resource-owning widows become increasingly assertive of their right to make independent decisions about what to do with their lives? (Edwins; 1998)

For the high-net worth widows, the death of a husband equally leaves many widows in a fragile emotional state that requires special sensitivity when discussing financial issues.

While the death of a long-term spouse may be enough of an emotional challenge, many "wealthy" widows discover that they must confront underdeveloped financial plans that leave them feeling unsure and insecure. Widowhood also requires a different approach to navigate a path to financial stability that will support emotional recovery. The

lack of advanced planning by high-net-worth couples contributes to this tumultuous state in which widows find themselves.

With recent widows, the biggest obstacle to solutions is the state of mind. They are not only trying to settle the estate, but they're trying to get their own financial independence up and running — and confronting survivorship issues at the same time. They face a lot of paperwork for many different kinds of transactions in a relatively short amount of time.

Jan Geiger of Long View Wealth Management in Atlanta, Georgia notes that "the technical solutions like figuring out the estate planning, the taxes, the investments, the cash flow — that's usually the easier part, it's the psychological part that's usually hard. My experience after 20 years has been that about 20 percent of the decision-making is logical and 80 percent is emotional."

"Widows are in a position of trauma, they tend to just go along with whoever is being nice to them" says Helen Modly, the Vice President and Director of Investment Services for Focus Wealth Management.

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 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/AIDS is so varied in many regions of the world. Perhaps, the issue lies in understanding risk and how it interplays with HIV/AIDS. A wide range of risk theories developed over the past decade have incorporated the influence of varying ideologies in explaining the way we perceive risk (Wildavsky, et.al. 1990; Elliott, 2002; Douglas, 1982 & Harthorn et.al.; 2003). 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/AIDS. The association between HIV infection and the perception of risk in different regions of the world has emphasised the need to re-evaluate the public health measures being implemented to control the spread of HIV/AIDS, particularly for those people most at risk – in this case, Widows.

This paper looks at HIV/AIDS and the devastating effects the pandemic is having on populations with diverse risk perceptions of the disease, and makes the case that HIV/AIDS can be characterized as a slow onset disaster.

RISK PERCEPTION AND HIV/AIDS

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 (Wildavsky, et.al. 1990).

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 in widowhood, the individual may lack the ability and opportunity to decide which risks affect them and to what extent. Often the public (in this case, the widow) is forced to place their trust in social structures that are viewed as acting in their best interests (Elliott, A. 2002). 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 (Douglas, M; 1982). Both social institutions and social structures thus harbor the power to shape risk perception (Douglas, M; 1982). 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 (Wildavsky, et.al. 1990). These biases cause selective attention to risk and preferences for different types of risk taking behaviors, informed by an inherent compulsion to defend one's way of life (Wildavsky, et.al. 1990). 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 (Harthorn et.al.; 2003). 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 (Lupton, D; 1996).

One of the peculiarities of risk is that the knowledge of risk is not in-sync with the actions that should be taken (Douglas, M; 1982). 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 that is (1) involuntary, (2) unfamiliar, and (3) potentially catastrophic is the most difficult for people to accept (Harthorn et.al; 2003). Acquiring HIV/AIDS 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 behavior that leads to the transmission of HIV/AIDS. In many cultures, for example, women have little power over their sexuality and the sexual practices in which they engage (Bloor, M. 1995). In addition, poverty can lead to female prostitution. In these cases, individuals place themselves at high risk for acquiring HIV/AIDS in trying to avoid social exclusion, violence, and poverty (Bloor, M. 1995).

The risk of contracting HIV/AIDS may also be unfamiliar to many. The perception that HIV/AIDS occurs only amongst homosexuals is still prevalent (Barnett, et.al; 2002 & Petchesky, R; 2003). In addition, because the symptoms of AIDS do not take full effect for as many as 8 to 10 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. Within the discourse of public health, health risks have been individualized such that it is an individual's choice to engage in certain behaviors that cause the individual to acquire HIV/AIDS (Harthorn et.al; 2003). This view has led to the labelling of particular groups of individuals and populations as "at-risk" (Harthorn et.al; 2003). Populations deemed at-risk for HIV/AIDS include sex workers, men who have sex with men (MSM), and injection drug users. This narrow definition of those at-risk can also be misleading considering that heterosexual and mother-to-child transmission of HIV/AIDS is increasing rapidly across populations (Beck, et.al; 2006). As a result this has led to a limited focus on awareness and education as solutions, and has allowed those in power to dehumanize, blame, and avoid responsibility for those suffering from HIV/AIDS (Schoepf, B; 2003).

MODELLING THE HIV/AIDS DISASTER

Disasters are often referred to as unplanned, socially disruptive events with extreme effect (Shaluf, et.al; 2003). The characteristics common to environmental and natural disasters mirror the ways in which HIV/AIDS destroys and impacts communities. These characteristics include a high impact on individuals or populations; the spanning of spatial and temporal boundaries; large-scale damage to human life; and root causes that are complex (Shaluf, et.al; 2003). With regards to the latter, disasters are triggered not by a single event, but rather through the interaction of a multitude of factors and a buildup of unnoticed events. This is particularly true for HIV/AIDS. The vulnerability of a population to HIV/AIDS is rooted in social processes and underlying causes that may actually be quite unrelated to the end result itself, namely the contraction of HIV/AIDS (Wisner, et.al 2004).

Vulnerability to risk is shaped by three factors. First is the resilience of a population or the capacity of the people to resist and recover from the outcomes of a disaster (Cannon; 1994). Livelihood assets and the institutions that provide access to these assets are parts of the livelihood system that provides people with 'layers of resilience' to cope with various disturbances (Glavovic, et.al; 2002). The second component is the health of the population, or the robustness of individuals, which is most influenced by 'livelihood' and the availability of social operations such as healthcare services (Cannon; 1994). The final factor determining vulnerability 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 (Cannon; 1994).

THEORETICAL FRAMEWORK

Theories that deal with people and their interaction in the society are relevant for the background to this thesis. However, the theory of symbolic interactionism is adopted here -

Symbolic Interactionism

Blumer (1962) who coined the term symbolic interaction presents three principles as its foundation. These principles and their implications for the purposes of this study are:

- “Human beings act towards things on the basis of the meaning that things have for them” To convey this, considerable ethnographic detail is usually presented about the range of ways in which people see themselves, others and their situation.

- “The meaning of such things is derived from or arises out of the social interaction one has with one’s fellow”. The interaction pattern among the participants in the activity in question is presented in such a way that people’s activity can be seen to support the way they interpret the situation. The focus here is on those aspects of the interaction that promote stability.

“These meanings are handled in, and modified through an interpretative process used by the person in dealing with the things he encounters”. The focus here is an activity that foster change in how people see the situation and themselves. The symbolic interactionist’s rationale for focusing on concrete activities is the view that a person’s behaviour “is not a result of such things as environmental pressure, stimuli, motives, attitudes and ideas but arises instead from how he / she interprets and handles these things in the action which he / she is constructing.

CONCEPTUAL FRAMEWORK

The investigation of risk is both a scientific activity and an expression of culture. One of the most perplexing problems in risk analysis is why some relatively minor risks or risk events, as assessed by technical experts, often elicit strong public concerns and result in substantial impacts upon society at levels unanticipated by conventional risk analysis.

Several difficult issues require attention:

- The technical concept of risk focuses narrowly on the probability of events and the magnitude of specific consequences. Risk is usually defined by multiplication of the two terms, assuming that society should be indifferent toward a low-consequence/high-probability risk and a high-consequence/low-probability risk with identical expected values. Studies of risk perception have revealed clearly, however, that most persons have a much more comprehensive conception of risk. Clearly, other aspects of the risk such as voluntariness, personal

ability to influence the risk, familiarity with the hazard, and the catastrophic potential shape public response (Slovic et.al; 1982 & Renn; 1986). As a result, whereas the technical assessment of risk is essential to decisions about competing designs or materials, it often fails to inform societal choices regarding technology (Rayner et.al, 1987).

- Cognitive psychologists and decision researchers have investigated the underlying patterns of individual perception of risk and identified a series of heuristics and biases that govern risk perception (Slovic; 1987 & Vlek et.al; 1981). Whereas some of these patterns of perception contrast with the results of formal reasoning, others involve legitimate concern about risk characteristics that are omitted, neglected, or underestimated by the technical concept of risk. In addition, equity issues, the circumstances surrounding the process of generating risk, and the timeliness of individual / family response are considerations, important to people, that are insufficiently addressed by formal probabilistic risk analysis (Doderlein; 1983 & Kasperson; 1983).
- Since the resolution of social conflict requires the use of factual evidence for assessing the validity and fairness of rival claims, the quantity and quality of risk are major points of contention among participating social groups. As risk analysis incorporates a variety of methods to identify and evaluate risks, various groups present competing evidence based upon their own perceptions and social agenda. The scientific aura surrounding risk analysis promotes the allocation of substantial effort to convincing official decision makers, and the public, that the risk assessment performed by one group is superior in quality and scientific validity to that of others. Controversy and debate exacerbate divergences between expert and public assessment and often erode confidence in the risk decision process (Otway et.al; 1982 & Wynne et.al; 1984).

This article sets forth a conceptual framework that seeks to link systematically the technical assessment of risk with psychological, sociological, and cultural perspectives of risk perception and risk-related behaviour. The main thesis is that hazards interact with psychological, social, institutional, and cultural processes in ways that may amplify or attenuate public responses to the risk or risk event. A structural description of the social amplification of risk is now possible. Amplification occurs at two stages: in the transfer of information about the risk, and in the response mechanisms of society. Signals about risk are processed by individual and social amplification stations, including the scientist who communicates the risk assessment, the news media, cultural groups, interpersonal networks, and others. Key steps of amplifications can be identified at each stage. The amplified risk leads to behavioural responses, which, in turn, result in secondary impacts (Kasperson et.al, 1987).

The factors that create vulnerability in populations (in this context, widows) can be modelled to provide a visual representation of the potential negative impact of HIV/AIDS. Since risk and risk perception are a function of the degree of vulnerability and the hazard type, the Pressure and Release (PAR) model first developed by Wisner and colleagues can be used and adapted to depict the root causes and process of HIV/AIDS transmission. The PAR 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 (Wisner, et.al; 2004). This build-up of pressure is referred to as a “progression of vulnerability” that consists of three stages:

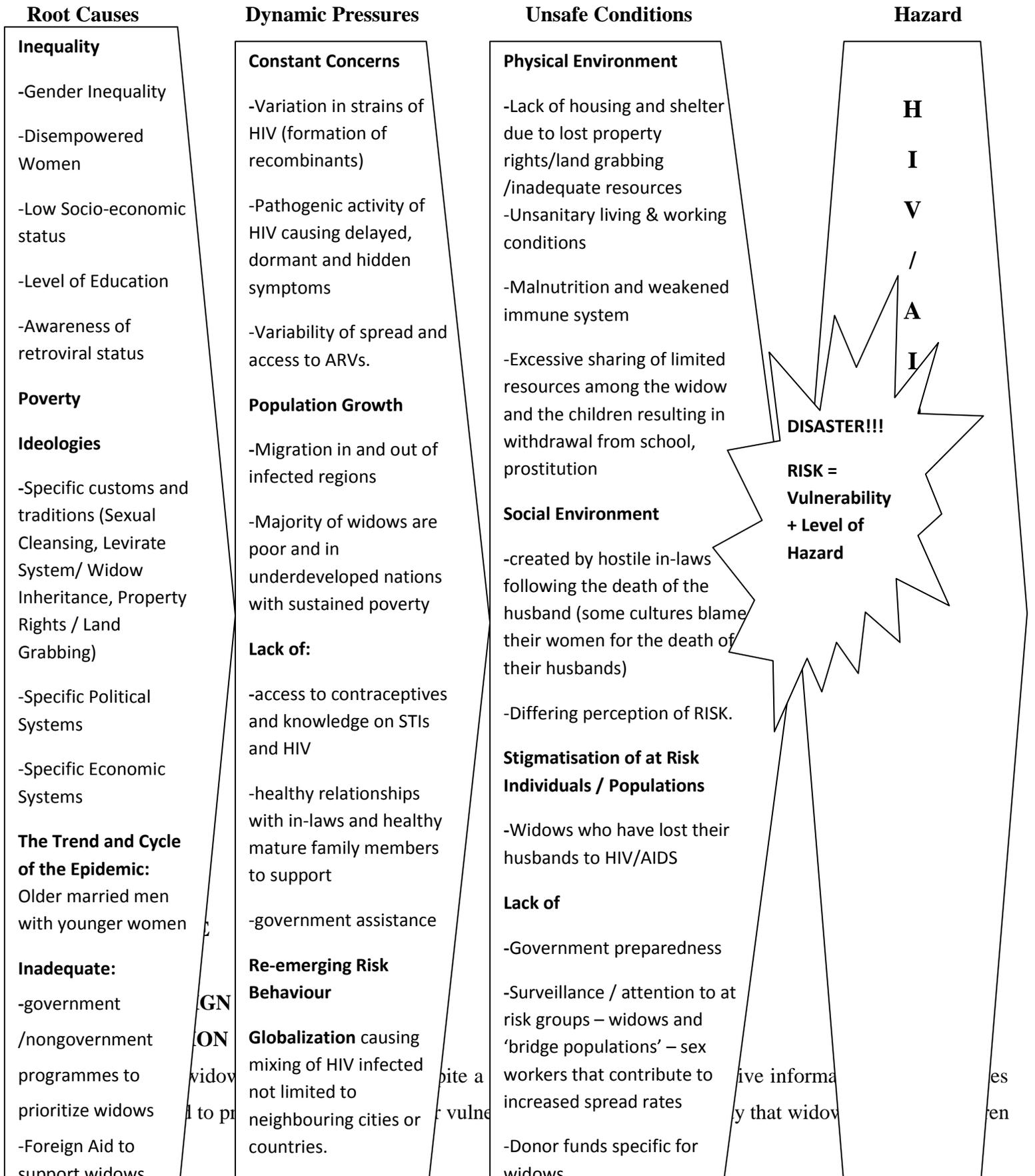
- (1) Root causes,
- (2) Dynamic pressure, and
- (3) Unsafe conditions (Wisner, et.al; 2004).

By building on the PAR model, sources of vulnerability can be identified as root causes of HIV/AIDS transmission which center round political instability, poverty, and unequal access to power and resources (Wisner, et.al; 2004). South Africa has one of the highest HIV/AIDS infection rates since the populace experience unequal access or lack of resources, poverty, social inequality, and instability (UNAIDS; 2007).

In the second stage of the model, vulnerability increases via dynamic processes that reduce the ability of the population or risk group to handle adverse circumstances. Here, local markets and fluctuating systems of labour play a major contributory role to a disaster (Wisner, et.al; 2004). Finally, vulnerability peaks due to unsafe conditions where the physical and social environment of the population is unsanitary and/or hostile. As vulnerability increases, so does the risk to the population. Figure 1 illustrates the HIV/AIDS pandemic in the context of the PAR model. The progression of vulnerability, paired with the hazard of HIV/AIDS creates the ideal setting for rapid HIV/AIDS transmission (the risk) among widows. In other words, risk equates to vulnerability (V) multiplied by the level of hazard (H) that exists. In this context, risk is defined as the probability that a person may acquire the HIV infection.

It is interesting to note that in Figure 1, factors such as poverty and inadequate government assistance act not only as root causes, but also as dynamic pressures and unsafe conditions. Needless to say, HIV/AIDS is most prevalent in populations where social inequality persists and where the disempowered are victimized (Farmer, 1996).

Figure 1: The Progression of Vulnerability to HIV/AIDS within the context of the PAR (Pressure and Release Model)



experience, organisations such as the World Bank have not yet focused on this hidden section in populations. This study's primary objective was to understand the perception of risk of the widow to HIV/AIDS, and to identify obstacles to lowering susceptibility and prevent new infections.

As the first born and only daughter of a family of six – now five (my father passed away at the age of 57). I know the burden of widowhood. I have experienced first-hand the financial stress that comes when a major source of income is lost and can confirm that the hardest time for new widows is after the funeral – when the friends and relatives are gone – the widow and her children face the reality of the loss. The violation of property rights of the widow, the bureaucratic process involved in getting the government to intervene and the incapacitating demands of culture on a widow. I have seen my mother go through a transition from risks and vulnerability to the exploration of avenues for resilience as well as her transformation and the processes that has led to a positive outcome – the improved well-being of my mum and us – the children.

In the contemporary African context, unmarried or “unattached” women (such as divorced or separated women) are more likely to have numerous sexual partners, as they are often dependent on men for financial support, and these partnerships frequently involve unsafe sexual behaviours (NACC 2000, NASCOP&MOH 1998, Caldwell; et al. 1994, Doyal; 1994). A 1997 study in Tanzania revealed that those women widowed or divorced were three times as likely to be HIV positive as those who were single or currently married (Baylies et.al., 2000).

I fall into this category of separated women and I carry the risk of ‘three times as likely to be HIV positive as those who were single or currently married. I am a professional and I do not depend on a man for financial support for myself or for my daughter but as it applies to the high-net-worth widow as described by Lewis Schiff, 2008 – I have been in a fragile emotional state and a position of trauma with the attended tendency of being scared that someone will take advantage of me and yet going along with whomever is being nice to me in the early months of the separation.

Because of these personal losses, I took on the perception of risk of widows to HIV/AIDS and during this study it was important that I did not make assumptions about the study participants' levels of stress, the depth of vulnerability and the feelings of loss. To protect this study from imposed researcher bias, I empirically examined the study participants' response using the theories of symbolic interactionism and pressure and response effect to accurately and comprehensively understand the participants' perception of risk to HIV/AIDS.

3.2 STUDY SITE

The Ndlovu Care Group (NCG) is a South African Non-governmental Organisation that provides health care and community care for people living in a rural area of South Africa, in particular the Moutse area in Limpopo and Mpumalanga provinces (Tempelman et.al; 2010). The Ndlovu Medical Centre (NMC) belongs to the umbrella of NCG.

NMC started in 1994 as a private initiative of Liesje and Hugo Tempelman (a Dutch Professional nurse and doctor) situated in Elandsdoorn next to Dennilton, thirty kilometres from Groblersdal and thirty kilometres from Loskop Dam, Limpopo Province. It functions now as a private practice and community healthcare provider taking an innovative approach towards integrated primary health care, tuberculosis and HIV/AIDS care. It combines free-of-charge services with private practice and constantly strives for interaction and co-operation with the Department of Health in order to create public-private partnerships in the provision of health care in resource-poor settings (Tempelman et.al; 2006).

3.3 SAMPLE AND ELIGIBILITY CRITERIA: The target group are the widows utilising the Ndlovu Medical Centre – a primary health care clinic in Elandsdoorn in the Limpopo Province of South Africa. Participants were HIV positive or negative, however, they all self-identified as widows. A total number of thirty participants were selected by convenient sampling – the first thirty widows over a period of three weeks.

Convenience sampling is a non-probability method. This means that participants are chosen in a non-random manner and some members of the population – in this case, the patients of Ndlovu Medical Centre has no chance of being included.

The inclusion criteria for selecting the widows who were the study participants were as follows:

- a) Widowhood (in the last five years)
- b) Un-inherited and
- c) 18 years and above.

The choice of Ndlovu Medical Centre was based on the fact that Ndlovu provides treatment and care particularly to retroviral positive clients in the rural community and suburbs of Limpopo, Mpumalanga and beyond. The sample size therefore was a good mix of the literate and non-literate, the financially dependent and the financially independent.

3.4 MEASURING INSTRUMENT: A questionnaire was used (see appendix A) as the instrument to gather information and was analysed quantitatively with fourteen closed ended questions and two open ended questions that covered the themes of:

- a) Ongoing sexual relationships
- b) Perception of risk to HIV infection through in-laws or the ‘outside’ partner
- c) Factors that contribute to susceptibility / vulnerability to HIV infection
- d) Period of vulnerability

3.5 METHOD

SUBJECT RECRUITMENT: After receiving approval from the University of Stellenbosch Ethics Committee and the Clinical Director of Ndlovu Medical Centre, the researcher then met with the designated person at the clinic in charge of patient flow from the port of entry and discussed the proposed study including its purpose, inclusion criteria and the timeline.

There were two approaches in recruiting the potential participants - at the reception which is the port of entry, the potential participants’ bio-data was screened and willingness to participate in the study was asked. Second, for the potential participants’ who missed the screening at the reception on busy clinic days, their willingness to participate in the study was sort at the consulting room with an option to opt out and a reassurance that their decision to participate or opt out would not in anyway bias the quality of care and treatment. Trust was further enhanced by giving the participant the option of having the interview before or after the consultation and the choice of picking the setting where the interview occurred.

A self – administered semi-structured questionnaire written in English was used. It was piloted and the findings in the pilot phase were put into consideration in the administration of the questionnaire while conducting the research proper. The semi-structured questionnaire with the closed ended questions guided the participants with cues / options to tap the participants’ perception of risk and provided a basis for uniform analysis. The open-ended questions allowed the participants to express their opinions and experiences.

The interview guide was in English and five out of the thirty participants had it interpreted to them – four of which was into the Zulu language; and one into Ndebele. The researcher provided assistance through empathic responses that facilitate the discussion of sensitive issues. The interpretation into English and filling of the questionnaire was immediately done by the professional counsellors. No participant required the services of the counsellors for debriefing neither did any participant present following the study with symptoms of post-traumatic stress disorder.

3.6 DATA ANALYSIS: The data was captured and analysed using the Microsoft office – Excel.

3.7 VALIDITY AND RELIABILITY: Efforts were made to ensure validity and reliability of the measuring instrument using the criteria identified by Burns & Groove (2001). External validity is concerned with the degree to which research findings can be applied to the real world, beyond the controlled setting of the research whereas Reliability is an essential pre-requisite for validity. It is possible to have a reliable measure that is not valid; however a valid measure must also be reliable. To enhance reliability, the same format of questionnaire was administered to all participants and in the few cases that needed interpretation – the same counselor was used for all the participants.

3.8. INFORMED CONSENT

Prior to beginning, a proposal was submitted to the University of Stellenbosch Ethics Committee. An informed consent process informed the participants' about the nature of the research, and protected participants' rights to confidentiality, and their ability to terminate their involvement 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: a) A full explanation of the purposes of the research; b) A clearly stated expected time commitment of the participant; c) A description of the procedures of the study

3.9. ETHICAL CONSIDERATIONS

A study of people affected and infected with HIV/AIDS needs to be approached with great sensitivity. The stigma of HIV is such that HIV positive interviewees may fear discrimination, rejection or even violence if their HIV status is revealed. Research on HIV explores the most intimate sphere of a person's private, sexual and emotional life. An interview can become a difficult and emotional experience, regardless of how well a person seems to be coping. Morse and Richards (2002, p 205) 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.
- 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.

The participants of this study were a vulnerable population; some of the participants had HIV/AIDS, a historically stigmatized illness. Therefore, I made diligent efforts to reduce risks of harm to the participants, as outlined in the sample selection and the informed consent processes, inclusive of meeting all the guidelines of the University of Stellenbosch Ethics Committee. 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 also allowing me to take notes and audiotape the interviews. I rigorously maintained confidentiality throughout the study, and potential study participants were informed of the intentions of the study. I gave the participants resources in the form of counseling, if emotional upset and unintended injury resulted. Participants were able to terminate their participation at any time, without harm. The interview questions did pose a risk of emotionally upsetting the participants. For example, there were health related questions that may have aroused anxiety or sadness within the participant.

CHAPTER FOUR

STUDY FINDINGS and DISCUSSION

HIV/AIDS and discrimination against widows are inter-related in two ways. First, HIV and AIDS significantly compounds the burden associated with the inferior status of widows. Second, this economic, social and political inferiority makes widows (and women in general) more vulnerable to HIV infection. It is a vicious circle of discrimination and poverty (Sleap, 2001). As a result, denial is one of the coping strategies used by widows with potentially destructive consequences on the lives of the women and others.

4. 1. What Do the Numbers tell us – Are the Numbers Big Enough to Act?

Statistics on the number of women who have been widowed in general from average life expectancy statistics for men in South Africa or due to specific causes like HIV/AIDS death, the number of widows living with HIV/AIDS and the poverty status of these widows are not available. According to the Survey of the South African Institute of Race Relations (SAIRR); between 2001 and 2006, the life expectancy for males was 51 years and it was expected to decrease from 2006 to 2011 to 48 years. One immediate question is, therefore, whether institutions should wait for demographic research to show that the numbers of widows are significant before they implement interventions to protect this population (Kessy, et.al; 2010).

Collecting epidemiological data on widows could be another effective step in combating HIV and AIDS and could play a significant role in creating resilience avenues in communities. Sleap (2001) pointed out that epidemiological studies have tended to ignore widows. Therefore, reaching them with effective care and treatment programmes becomes difficult.

Of the 30 widows interviewed in this study, 66% were between the age brackets of 18 – 30 and 31 – 42 years. This is in line with literature – AIDS has created a generation of relatively young and middle – aged widows. These widows, often raising young children, face the burden of discrimination on two counts – the loss of their husband and in most cases, living with the virus. Their relatively young age also increase the probability that they will be subject to the levirate system, as well as the likelihood of property grabbing (Kessy, et.al; 2010).

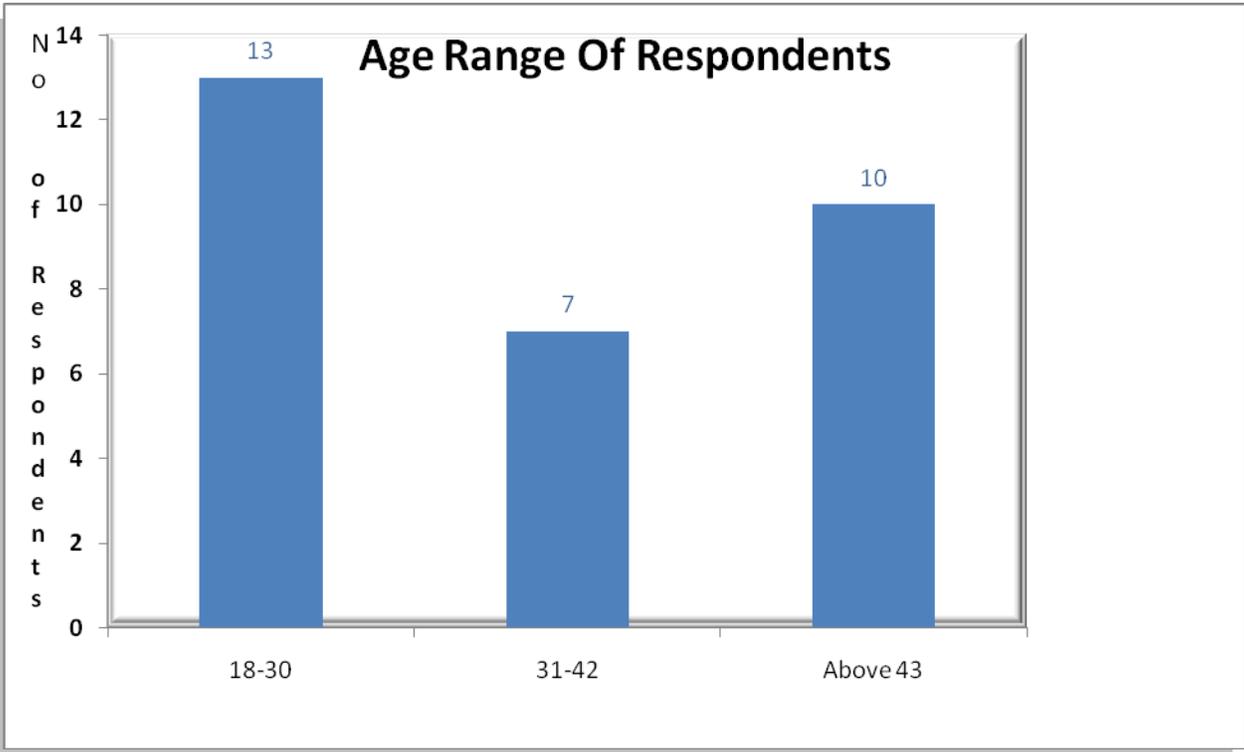


Figure 2

4.2. Destructive Coping Strategies

Self-denial and as a result, no HIV testing is done before remarrying or venturing into new relationships thereby making the widow face the risk of being infected by the ‘in-law’ or outside partner’ or transmitting the virus to the men with which they have sexual relationships and ultimately to their wives or partners unknowingly. The consequence of infecting the ‘in-law’ or ‘outside partner’ is that this source of support for the widow also becomes jeopardised (Kessy, et.al; 2010)

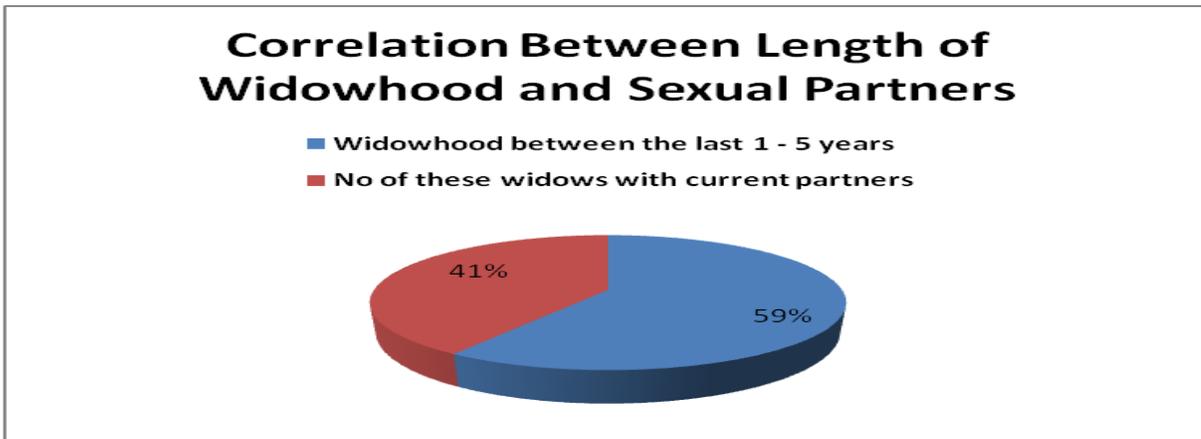


Figure 3

4.3 Perception of Risk at the Level of the “Outside” Partner

Widow inheritance is one practice that people feel (even traditional clansmen) should be revived. In Kenya for instance, the Luo elders in Kisumu where the adult rate of infection was around 20% in early 2000 wanted to identify HIV-positive women and impose restrictions on them. These restrictions would include the practice of widow inheritance as an attempt to strengthen extended families and care for the growing number of orphans in their community but the elders have stated that they seek to stop the ‘sexual cleansing’ element of the practice, and to rename it ‘symbolic inheritance’. As far as this may help stop the spread of the virus, this could have negative repercussions on widows; the fear of the widows is that the loss of these customs may penalise widows who wish to be inherited since the alternative is destitution (Schoofs, 1999).

While the custom is risky for an individual inheritor, the practice contains the spread of disease within the entire population (Luke, 2002). A ban on widow inheritance, on the other hand, could actually accelerate the spread of HIV/AIDS. In the contemporary African context, unmarried or “unattached” women (such as divorced or separated women) are more likely to have numerous sexual partners, as they are often dependent on men for financial support, and these partnerships frequently involve unsafe sexual behaviours (NACC 2000, NASCOP & MOH 1998, Caldwell; et al. 1994, Doyal; 1994). A 1997 study in Tanzania revealed that those women widowed or divorced were three times as likely to be HIV positive as those who were single or currently married (Baylies et.al., 2000).

Widows who are no longer inherited and no longer receive traditional means of assistance would likely engage in high-risk behaviors with “outside” male partners in order to support themselves economically (Luke, 2002).

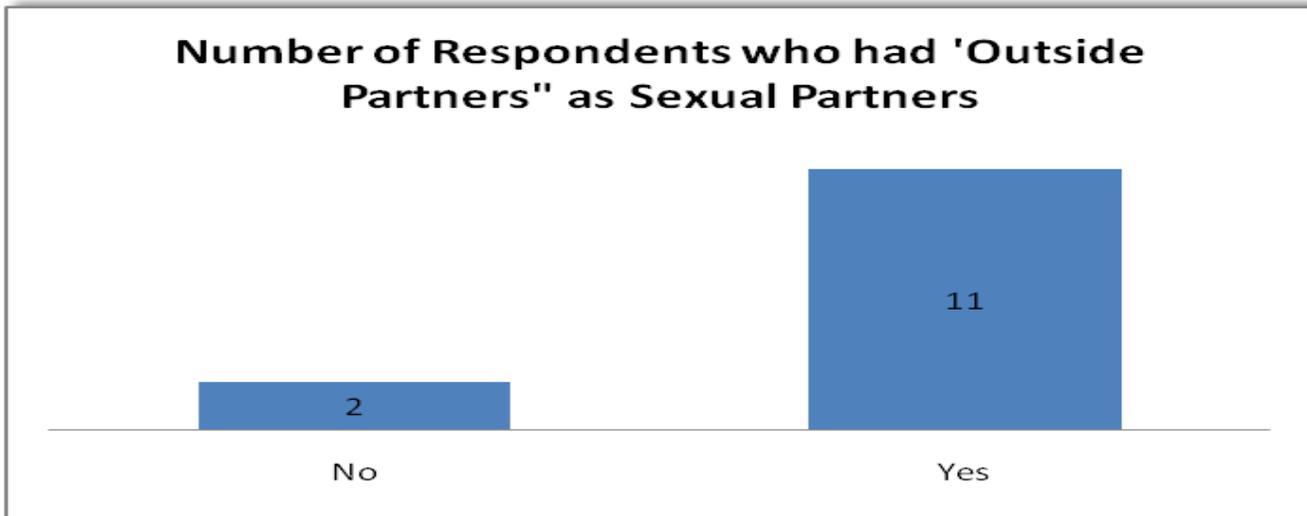


Figure 4

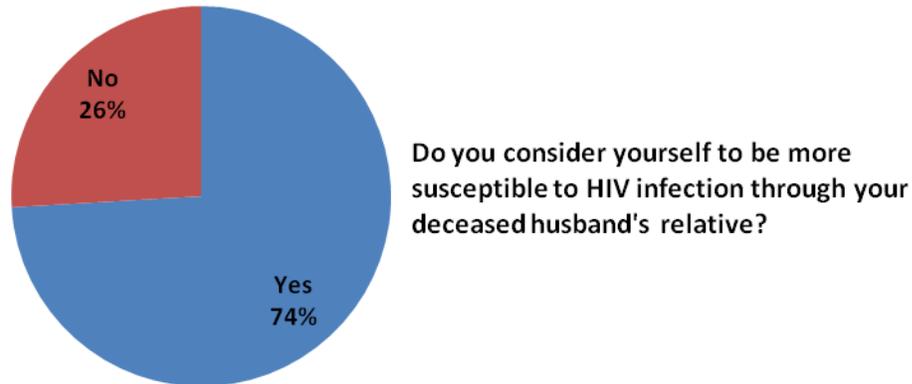


Figure 5

4.4 Obstacles to Lowering Susceptibility and Prevent Infection

Table 1:

Reasons for difficulty in negotiating condom use among widows using Ndlovu Medical Centre are:	Frequency (%)*
...it is the least of my problems for now. It's not easy to get a man who will accept one with so many issues and still take care of one. If I don't allow him, someone else will.	46.7%
...He gives me money, and pays for my children's school fees, why should I deny him what he wants.	40.0%
...Men don't like condoms, they say it takes away the fun	33.3%
...they feel one does not trust them	26.7%
...I don't like condoms, it's like eating banana with the peel	13.3%
...when I was a young girl we weren't using condoms – HIV/AIDS was not rampant at all like it is now. Now that I am much older and single again, I struggle with the condom thing.	1%

Note: *Since many widows mentioned more than one reason, the total exceeds 100%

Widowhood is oftentimes associated with vulnerability and sometimes with a downward spiral in the widow's socio-economic circumstances. The breadwinner (normally the man) is the owner of resources and in the event of the demise of the breadwinner, the consequences are telling for the homemaker, the woman (Kessy et.al; 2010). In this current study, unprotected sex is conceived as the bundle of rights held by the widow to enhance economic liberation – financial independence. Thus sexual rights are seen as a logically connected 'bundles of sticks' which include: rights to use, possess and manage new strains of relationships, and to receive 'income' from one's own 'economic activity'.

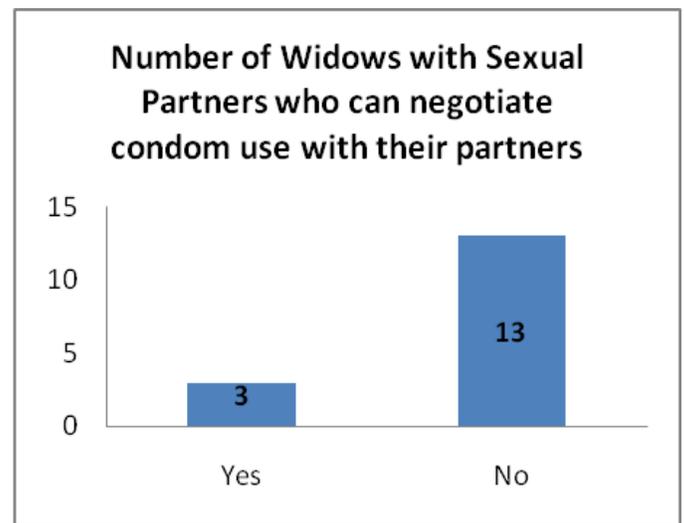
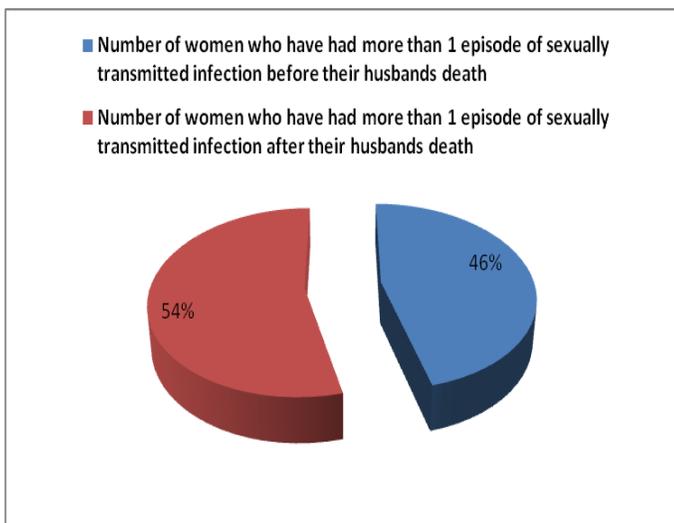


Figure 6

4.5 The High-Risk Widow – the Role of Public Health

With no male to depend on and limited livelihood means, women may be forced to resort to income-generating activities that are considered immoral by society, such as commercial sex work or brewing and selling, which place women and others at further risk of infection (Sleap, 2001; Kessy et.al, 2008).

In many African countries, sexual relationships are dominated by men, meaning that women cannot always practice safer sex even when they know the risks involved (<http://www.avert.org/hiv-aids-africa.htm>).

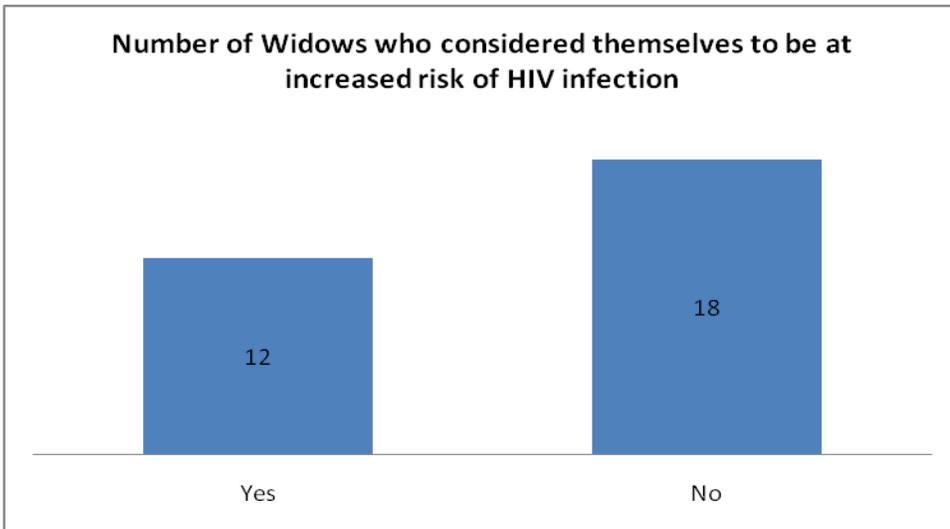


Figure 7

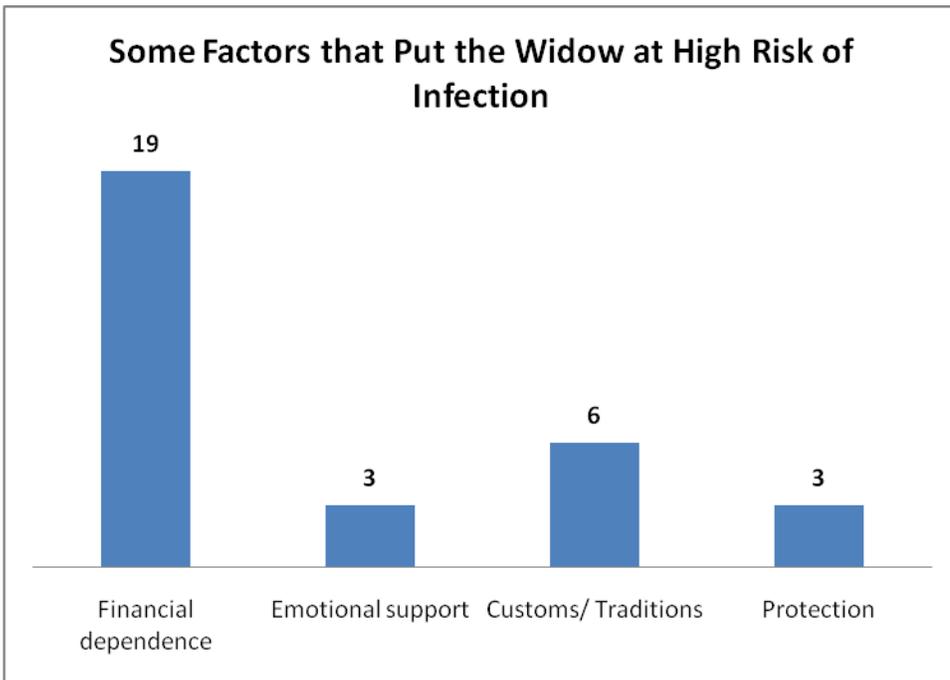


Figure 8

The spread of HIV/AIDS is exacerbated by social factors that include not only socio-economic status, political instability, and geographic location, but also gender and sexual practice (Wisner, et.al; 2004). Perceptions of risk in contracting HIV/AIDS are shaped by related patterns of social relations and cultural biases. The power to shape risk perception is usually in the hands of very few; namely those with control over social, political, and/or economic institutions.

The case can be made that HIV/AIDS causes widespread loss and serious disruption to the functioning of a community, much like an environmental disaster (WHO, 2008). Yet, despite the potential of HIV/AIDS to become a global disaster, many populations continue to neglect the risk involved in practices that make them vulnerable to HIV/AIDS. This failure to mitigate the spread of the infection may be due to the fact that perceptions of risk are shaped by patterns of social relations and cultural biases. In addition, the power to shape risk perception is usually limited to those with control over social, political, and/or economic institutions. Since the social, political, and economic context plays a role in HIV/AIDS-related risk perception, there is a need to reevaluate public health measures being implemented to control the spread of HIV/AIDS.

The purpose of public health is to manage threats to the health of a population through preventative measures and treatment. Although HIV/AIDS is not only a health problem, but also a developmental issue, attempts at mitigating the spread of the infection typically occur solely through the health sector.

Risk perception is culturally influenced and therefore risky behaviour is a social rather than an individual issue. However, the mass media often perpetuates risk as an individual issue and unique to selected populations of intravenous drug users, commercial sex workers and men who have sex with men. Therefore, 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 risk behaviour as an individual phenomenon (Black et.al; 1998 & Chatterjee et.al; 1999). Public health measures implemented to combat the spread of HIV/AIDS must be re-evaluated with consideration for ways in which culture and media shape risk perception, particularly for those groups most at-risk. In using the PAR model as a guide, vulnerability must be managed and reduced by addressing root causes, dynamic pressures, and unsafe conditions that contribute to the HIV/AIDS pandemic.

HIV/AIDS programmes must be culturally appropriate and work toward influencing risk perception, while addressing social norms and values that negatively impact vulnerable populations such as widows.

Prevention programmes typically focus on raising awareness and using interpersonal strategies, such as peer education and testimonials to influence behaviour change. These initiatives have had mixed results because often those most at risk are those in poverty, and these individuals – in this case, widows have limited means for effecting change in their circumstances (Parker et.al; 1995). For this reason, prevention programmes aimed at the level of the individual (widow) behaviour change can be ineffective in many contexts (UNAIDS, 1998). Even

awareness campaigns that are deemed “culturally-appropriate” have produced mixed results with regards to effectiveness (Parker, 1995).

These approaches to managing HIV/AIDS fail to consider the evidence that risk perception is culturally influenced and therefore risky behaviour is a social rather than an individual issue. It is wrong to assume that decision-making and behaviour are always rational. Social and economic factors such as relationships, community expectations, and access to resources have a major impact on behaviour, and at times may prevent individuals from adopting safe sex practices that prevent HIV/AIDS transmission. This indicates that attempting to reform behaviour to reduce HIV transmission risk is unlikely without structural changes – that is, public health interventions aimed at changing the environment rather than individual behaviour may be more successful in reducing the spread of the infection ((Tsasis, et.al; 2008).

Public health measures to combat the spread of HIV/AIDS must be re-evaluated with consideration for ways in which culture shapes risk perception. Societal factors, including practices and beliefs about sex, relationships, and condom-use lead to the inclusion, neglect, or exclusion of people like widows, thereby shaping individual behaviour in ways that are beyond individual control (UNAIDS, 1998). Addressing social norms and values that negatively impact vulnerable populations such as widows can effect change more rapidly than measures aimed at individual behaviour. 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 (Tsasis, et.al; 2008).

The role of public health policies and programmes cannot and should not be limited to individual health behaviours. 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 (Gillespie, 2006). 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, and development issue facilitates 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 region 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 suggests that in most cultures poverty exacerbates the spread of HIV, but there are also emerging epidemics among financially secure sectors of society partly because of the economic power to engage in risky

behaviors such as buying sex or drugs (UNAIDS, 1998). Whether safer behaviour is more likely to occur as economic status increases even for the widow depends on other factors such as social values, education and gender. This example illustrates the complexity of vulnerability, and the need to design interventions and policies that take regional variations into consideration.

Targeting interventions to the changing needs of the communities for whom they are designed is crucial to programme effectiveness. The vulnerable groups of widows – both young and old in particular demand attention in all contexts. The transition to widowhood can be fraught with difficulties such as inadequate information and financial hardship. In most societies, widows have limited rights - this can impact their propensity to take part in risky behaviors and can diminish the potentially positive effects of health and social services.

Similarly women who eventually become widows also are faced with the general issues of inequalities in access to education, in income and employment, and before the law, which places them at a disadvantage and reduces their ability to adopt safe behaviours (UNAIDS 1998). Reversing these inequalities will require cultural, legal, and policy-level changes. In the absence of policies and programmes that bridge the age and gender gaps, efforts aimed at reducing the spread of HIV/AIDS may be ineffective and short-lived.

CHAPTER FIVE

RECOMMENDATIONS

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/AIDS mitigation among widows is recommended.

Such a model involves two dimensions:

- (1) Persuading the vulnerable population groups of widows to change behaviour, and
- (2) Enabling safe behaviour by changing societal and contextual factors that contribute to HIV/ AIDS transmission (Chatterjee, 1999).

Thus far, public health measures have focused on persuasion. This narrow focus on the individual has a limited impact on communities plagued by poverty, inequality, and injustice. Public health policies and programmes must move to a paradigm of enablement and empowerment by addressing root causes. This is more challenging than behaviour change programmes because it requires collaboration across sectors and because the impact will not be evident in the near future. Cultural changes are gradual. Thus, the importance of long-term sustainable policies and programmes cannot be overemphasized. There is a clear and definite need for global cooperation on this, especially considering that the lower economic status of developing countries will result in more acute challenges to the development and maintenance of necessary programming (Tsasis, et.al; 2008).

CONCLUSION

When widows "band together," organize themselves, make their voices heard, and are represented on decision-making bodies locally, nationally, regionally, and internationally, change will occur. Progress will not be made until widows themselves are the agents of change. Widows' associations must be encouraged and "empowered" to undertake studies profiling their situation and needs. They must be involved in the design of projects and programmes and instrumental in monitoring the implementation and effectiveness of new reform legislation to give them property, land, and inheritance rights; protect them from violence; and give them opportunities for training and employment.

Widows are not exclusively victims - millions of surviving HIV/AIDS widows, especially the grandmothers, make exceptional but unacknowledged contributions to society through child care, care of orphans, agricultural work, and sustenance of the community.

REFERENCES

1. Adetunji, Jacob and Jacob Oni. 1999. "Rising Proportions of Young Widows and the AIDS Epidemic in Africa". Paper presented at the Annual Meetings of the American Sociological Association, August 6-10, Chicago.
2. AF-AIDS 430, 28th September 1999, af-aids@hivnet.ch
3. Akwara, P.A; Madise, N.J; Hinde, A. "Perception of Risk of HIV-AIDS and Sexual Behaviour in Kenya". *Journal of Biosocial Sciences* (August 2003) 35: 385 - 411 Cambridge University Press.
4. Ambasa-Shisanya, C.R "Widowhood in the era of HIV/AIDS: A case study of Slaya District, Kenya". 2007. *Journal of Social Aspects of HIV/AIDS Research Alliance*. Vol. 4 No 2 August 2007.
5. Anderson, Barbara A., and Phillips, Heston E. 2006. "Adult mortality (age 15-64) based on death notification data in South Africa: 1997-2004". Report No. 03-09-05. Pretoria: Statistics South Africa.
6. Asekun-Olarinmoye , E.O; Bamidele , J.O; Olowu ,A.O; Odu , O.O; Egbewale, B.E; and Amusan, A.O. "Sexual Risk Behaviors and Risk Perception of HIV/AIDS among a Rural Adult Population in Southwestern Nigeria". *Research Journal of Medical Sciences*.2009. Volume 3, Issue 2, Page Number 80-86. DOI: 10.3923/rjmsci.2009.80.86
7. Barnett, T. & Whiteside, A. 2002 "AIDS in the Twenty-first Century" New York, NY: Palgrave Macmillan
8. Baylies, Carolyn and Burjira, Janet. 2000. "Sexuality and Gender in Africa". Routledge. London pp. 11, 12.
9. Baylies, C. (2004). "Perspectives on Gender and AIDS in Africa. In C.Baylies & J. Bujra (Eds). *AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia*. London and New York: Routledge.
10. Black, J; Bryant, J & Thompson, S. "Introduction to Media Communication". New York. NY: McGraw Hill; 1998.
11. Bloor, M. 1995. "The Sociology of HIV Transmission". London: SAGE Publications Ltd
12. Bryon, Elizabeth; Gillespie, Stuart; Hamazakaza, Petan. September 2006 "Local Perceptions of HIV Risk and Prevention in Southern Zambia".
13. Beck, E; Mays, N. & Whiteside, A. et al. 2006. "The HIV Pandemic: Local and Global Implications. New York, NY: Oxford University Press
14. Burns & Groove. 2001. <http://hsc.uwe.ac.uk/dataanalysis/quantIssuesValid.asp> Retrieved: 08/02/2011
15. Caldwell, John C., Pat Caldwell, and Pat Quiggin. 1994. "The social context of AIDS in sub-Saharan Africa".
16. Cannon, T. "Vulnerability Analysis and the Explanation of 'Natural Disaster. In: Varley A (ed). *Disasters, Development and Environment*". 1994. Chichester: John Wiley and Sons Ltd. pp.13 30
17. Chatterjee, N. 1999. "AIDS-related information Exposure in the Mass Media and Discussion within Social Networks among Married Women in Bombay, India. *AIDS Care*. 1999; 4:443-446
18. Cilliers, F.P. (1998). "Complexity and Postmodernism. Understanding Complex Systems". London: Routledge.

19. De Santis, Dominique (Press Officer, UNAIDS). 21st November 2000. Filed Personal Correspondence of Bridget Sleap, author of “Widows and AIDS – Redefinitions and Challenges” with the Press Officer – UNAIDS.
20. Doderlein, J.M. 1983. “Understanding Risk Management” *Risk Analysis* 3, 17-21 (1983).
21. Dorrington, R.E., Johnson L.F., Bradshaw D. and Daniel T. 2006 “The Demographic Impact of HIV/AIDS in South Africa. National and Provincial Indicators for 2006”. Cape Town: Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa
22. Douglas, M & Wildavsky, A. 1982. “Risk and Culture – An Essay on the Selection of Technical and Environmental Dangers”. Berkeley, CA: University of California Press, Ltd.
23. Doyal, Lesley. 1994. “HIV and AIDS: Putting Women on the Global Agenda”. In Lesley Doyal, Jennie Naidoo, and Tamsin Wilson, eds. 1994. *AIDS: Setting a feminist agenda*. London: Taylor & Francis.
24. Edwins Laban Moogi Gwako; 1998. “Widow Inheritance among the Maragoli of Western Kenya”. *Journal of Anthropological Research*. Vol.54, No.2.pp 173-198.
25. Elliott A. 2002. “Beck’s Sociology of Risk: A Critical Assessment. *Sociology*. 2002; 36: 293–315.
26. Enel, C; Pison, G; Lagarde E. “Improvement in AIDS knowledge, perceptions and risk behaviours over a short period in a rural community of Senegal”. *International Journal of STD & AIDS*. 1997 Volume 8, Number 11, pp 681-687. Royal Society of Medicine Press.
27. Farmer, P. “Woman, Poverty and AIDS (Chapter 1). In: Farmer P, Conors M, Simmons J (eds). *Women, Poverty and AIDS – Sex, Drugs and Structural Violence*”. 1996. Maine: Common Courage Press.
28. Fasoranti, O.O; Aruna, J.O. “A Cross-Cultural Comparison of Practices Relating to Widowhood and Widow Inheritance among the Igbo and Yoruba in Nigeria”. 2007. *Journal of World Anthropology: Occasional Papers: Volume III, Number 1*
29. Glavovic, B; Scheynens, R & Averton, J. 2002. “Waves of Adversity, Layers of Resilience: Exploring the Sustainable Livelihoods Approach”. www.devnet.org.nz./conf2002/papers/Glavovic_Overton_Scheynens.pdf
Retrieved: 31/01/2011
30. Gillespie, S. 2006. “AID Poverty and Hunger: Challenges and Responses”. Highlights of the 2006 International Conference on HIV/AIDS and Food and Nutrition Security, Durban. South Africa
31. Hammel, E.A. 1990. “A Theory of Culture for Demography. *Population and Development Review*” 16(3):455-485.
32. Hansen, K.T (Ed.) 1992. “African Encounters with Domesticity. New Brunswick, N.J: Rutgers University Press.
33. Harthorn B, Oaks L. “Risk, Culture, and Health Inequality: Shifting Perceptions of Danger and Blame”. Connecticut: Praeger Publishers; 2003.
34. Kasperson, R.E. (Ed.).1983 “Equity Issues in Radioactive Waste Management” (Cambridge, Oelgeschlager, Gunn and Hain)

35. Kessy, Flora; Mayumana Iddu; Msongwe Yoswe. 2010. "Widowhood and Vulnerability to HIV and AIDS-related Shocks". Research Report 10/5. Research and Poverty Alleviation (REPOA)
36. King, E & Mason, A. 2002. "Engendering Development through Gender Equality in Rights, Resources and Voice"
37. Kirwen, Michael C. 1979. "African Widows". Maryknoll, New York: Orbis Books.
38. Luke, Nancy. 2000. "Rariu and Luo women: Illness as Resistance in Rural Kenya". Unpublished PhD dissertation. University of Pennsylvania.
39. Lupton, D. 1999. "Risk" London: Routledge.
40. Mabumba, E.D; Mugenyi, P; Batwala, V; Mulogo, E.M; Mirembe, J.; Khan, F.A; Liljestrand, J. "Widow inheritance and HIV-AIDS in rural Uganda" 2007. Tropical Doctor, Volume 37, Number 4, pp 229-231. Royal Society of Medicine Press.
41. McCreary, L.L; Kaponda, C.P.N; Norr, K.F; Jere, D.L.N; Chipeta, C.H; Davis, K.K; Batista, E. 2008. "Rural Malawians' Perception of HIV Risk Behaviours and their Socio-cultural Context". AIDS Care, Volume 20, Issue 8 September 2008 , pages 946 – 957
42. Muchunguzi, J. (2002). "HIV/AIDS and Women's Land Ownership Rights in Kagera Region, North-Western Tanzania. Paper presented at the FAO/SARPN Workshop on HIV/AIDS and Land Tenure, Pretoria, South Africa, June 24 – 25.
43. National AIDS Control Council (NACC). 2000. Kenya national HIV/AIDS strategic plan. 2000-2005. Nairobi: Office of the President and NACC.
44. Nancy, Luke. April 2002 "Widows and Professional 'Inheritors': Understanding AIDS risk perceptions in Kenya". <http://www.malawi.pop.upenn.edu/Level%203/Papers/PDF-files/luke-2002b.pdf>
45. NASCOP and Ministry of Health (MOH). 1998. Report of the second national HIV/AIDS/STD conference: Lessons learned. Nairobi, October 28-30.
46. Ndisi, John W. 1974. "A study in the Economic and Social Life of the Luo of Kenya". Lund: Berlingska Boktryckeriet.
47. Obbo, Christine. 1986. "Some East African Widows". In Betty Potash, ed. "Widows in African Societies". Stanford: Stanford University Press.
48. Ocholla-Ayayo, A.B.C. 1976. "Traditional Ideology and Ethics among the Southern Luo". Uppsala: Scandinavian Institute of African Studies.
49. Otway, H.J & D. von Winterfeldt, 1982. "Beyond Acceptable Risk: On the Social Acceptability of Technologies," Policy Sciences 14, 247-256 (1982).
50. Owen, Margaret. 1996. "A World of Widows" Zed Books.

51. Parker, R. 1995. "The Social and Cultural Construction of Sexual Risk, or How to have (Sex) Research in an Epidemic". In: ten Brummelhuis H, Herdt G (eds). *Culture and Sexual Risk: Anthropological Perspectives on AIDS*, Amsterdam. Holland: Gordon and Breach Publishers; 1995 pp. 257 - 269
52. Potash, Betty. 1986. "Widows in Africa: An introduction". In Betty Potash, ed "Widows in African Societies". Stanford: Stanford University Press.
53. Petchesky, R. 2003. "Global Prescriptions: Gendering Health and Human Rights". London, UK: Zed Books.
54. Rayner, S & Cantor, R. "How Fair is Safe Enough? The Cultural Approach to Societal Technology Choice" *Risk Analysis* 7, 3-13 (1987).
55. Scannell-Desch E; 2003. "Women's Adjustment to Widowhood. Theory, Research and Interventions". *J Psychosoc Nurs Ment Health Serv.* 41(5):28-36.
56. Schoofs Mark. "Death and the Second Sex, Village Voice". December 1 -7 1999. <http://www.thebody.com/schoofs/africa5.html> Retrieved: 29/01/2011
57. Schoepf, B. 2003 "Uganda: Lessons for AIDS Control in Africa". *Review of African Political Economy*; 2003:30:553-72.
58. Slovic, P; Fischhoff, B. & Lichtenstein, S. 1982 "Why Study Risk Perception?" *Risk Analysis* 2, 83-94 (1982).
59. Slovic, P. 1987. "Perception of Risk". *Science* 236, 280-290 (1987).
60. Shoko, Rangarirai. "Spouse Inheritance Continues in Zimbabwe Despite AIDS". Panafrika News Agency, 24 January 2001. <http://www.allafrica.com/stories/printable/20010122440258.html> Retrieved: 29/01/2011
61. Shaluf, I; Ahmadun, F; Said, A." Review of Disaster and Crisis. *Disaster Prevention and Management*" 2003:12:24-32.
62. "South Africa Panel: 336 000 Dead of AIDS". 29 August 2006. Associated Press. <http://www.avert.org/safricastats.htm> Retrieved: 30/05/2010
63. TACAIDS. Zanzibar AIDS Commission (ZAC), NBS. Office of the Chief Government Statistician (Zanzibar) (OGCS) & Macro International. (2008). *Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007 - 08*. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OGCS & Macro International.
64. Tempelman Hugo; Slabbert Mariette; Gosling Anke & Vermeer Adri. 2010. "A Model for Integrated Health, Child and Community Care in Rural South Africa - Ndlovu Care Group" VU University Press. Amsterdam 2010.
65. Tempelman Hugo & Vermeer Adri. 2006. "Health Care in Rural South Africa - An Innovative Approach". Chapter 3. Pp 51,52
66. Tsisis, Peter & Nirupama, N. 2008. "Vulnerability and Risk Perception in the Management of HIV/AIDS: Public Priorities in a Global Pandemic". Original Research submitted to the School of Health Policy and Management and the School of Administrative Studies, York University, Toronto. Canada. <http://www.dovepress.com/vulnerability-and-risk-perception-in-the-management-of-hiv-aids-public-peer-reviewed-article-RMHP> Retrieved: 30/01/2011

67. UNAIDS/WHO Report on the Global AIDS Epidemic 2010.
68. UNAIDS “AIDS Epidemic Update”. Geneva, Switzerland: UNAIDS, c2007 [cited 2008 Sep 10]. http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf.
69. UNAIDS 1998 “Expanding the Global Response to HIV/AIDS through focused action: Reducing Risk and Vulnerability: Definitions, Rationale, and Pathways. www.unaids.org/en/.
70. Van der Vliet; V. 1999. “The Ecology of South Africa’s AIDS Epidemic”. Pulse Track. July 15 1999.
71. van Niekerk, Anton. 2002 “Moral and Social Complexities of AIDS in Africa”. 27(2), 2002. “Journal of Medicine and Philosophy”.
72. Vlek, C.A & Stallen, P.J.M. 1981 “Judging Risks and Benefits in the Small and the Large” Organizational Behavior and Human Performance 28, 235-271 (1981).
73. Wildavsky A, Dake K. 1990. “Theories of Risk Perception: Who Fears What and Why? Daedalus 1990; 119: 41–59.
74. Wynne, B. 1984 “Public Perceptions of Risk in the Urban Transportation of Irradiated Fuel, J. Surrey (ed.), (Macmillan, London, 1984), pp. 246-259.
75. Wisner, B; Blaikie, P; Cannon, T; et al. 2004 “At Risk: Natural Disasters, People’s Vulnerability and Disasters”. Second Ed. London, UK: Routledge
76. World Health Organization, Disaster Preparedness and Response. WHO c2007. <http://www.euro.who.int/emergencies> Retrieved:03/03/2011
77. <http://eforums.healthdev.org/read/messages?id=3574> Article written by Rebecca Sako - John in the context Of Gender Based Violence Campaign 14/12/2004. Retrieved: 30/05/2010
78. http://www.google.co.za/search?hl=en&q=blumer+symbolic+interaction&aq=f&aqi=g3g-m2&aql=&oq=&gs_rfai Retrieved: July 2nd 2010.
79. <http://www.deathreference.com/Vi-Z/Widows-in-Third-World-Nations.html> Retrieved: January 25th 2011.
80. <http://www.avert.org/women-hiv-aids.htm> Retrieved: January 25th 2011
81. <http://www.kff.org/hiv/aids/upload/7391-02.pdf> HIV/AIDS Policy Fact Sheet. The Henry J. Kaiser Family Foundation. February 2006. Retrieved: January 25th 2011
82. <http://www.mg.co.za/article/2009-11-19-sa-life-expectancy-decreases> “SA Life Expectancy Decreases”. Johannesburg, South Africa Nov. 19, 2009 14:11 Retrieved: 02th February 2011.

APPENDIX A

QUESTIONNAIRE ASSESSING THE PERCEPTION OF HIV RISK AMONG WIDOWS

Date:

Instruction: Please tick the most appropriate answer.

1.	Age in Years	18 – 30	31 – 42	Above 43	
2.	For how long have you been widowed?	Less than 1 year	Between 1 and 5 years		
3.	Do you currently have a partner?	Yes	No		
4.	If your answer to question 3 is Yes, Is your current partner related to your deceased husband? If your answer is No, Why?	Yes	No		
5.	Do you consider yourself to be more susceptible to HIV infection through your deceased husband's relative?	Yes	No		
6.	Do you consider yourself to be more susceptible to HIV infection through someone else?	Yes	No		
7.	Can you negotiate condom use with your current partner?	Yes	No		
8.	If No why?				
9.	Have you had any episode of Sexually Transmitted Infection	Yes	No		

	(STI) before?					
10.	How many episodes of STI did you have before your husband died?					
11.	Since your husband's death, how frequently have you had episodes of STI?					
12.	Do you consider yourself to be at increased risk of HIV infection because you are a widow?	Yes	No			
13.	If your answer to Question 12 above is Yes, why?	Financial dependence	Emotional Support	Customs / Traditions	Protection	Others
14.	Do you know of any cultural practices that puts you at risk of HIV as a widow?	Yes	No			
15.	If your answer to question 14 above is Yes, kindly explain.					
16.	At what point do you think you were most vulnerable after the death of your spouse?	0 – 6 months	7 – 12 months	13 – 18 months	19 – 24 months	

Interpreted into

Name of Interpreter.....

Signature of Interpreter