Myths, Facts and Misconceptions about HIV and AIDS

PART 1

For nearly 30 years HIV and AIDS has been shrouded in myths and misconceptions. In some cases, these mistaken ideas have prompted the very behaviors that cause more people to become HIV positive.

Myth 1
There is no need to use a condom during sexual contact if both partners already have HIV.

Fact:
There are different strains of HIV. If a condom is not used during sexual contact, HIV-infected partners may exchange different types or strains of HIV. This can lead to re-infection, which will make the treatment of HIV infection more difficult. The new HIV strain may become more resistant to the current treatment taken, or cause the current treatment option to be ineffective.

Myth 2
Homosexual men and drug users are more likely to get infected with HIV than other people.

Fact:
In Singapore, 90% of all HIV infections occur through sexual intercourse. Out of these, 60% result from heterosexual intercourse. HIV is spread mostly through unprotected sexual contact and does not discriminate against anyone. It is not who you are but your risky behaviours which put you at risk of HIV infection. Regardless of your personality or sexuality, you will be at risk if you don't take protective measures.

Myth 3
Getting HIV/AIDS is a death sentence.

Fact:
Although HIV/AIDS has no cure, it can be treated. There has been tremendous progress in treatment for HIV over the years. A person living with HIV/AIDS can now continue to live a strong and productive life for many years.

Myth 4
My partner tested negative for HIV. That means it is safe for us to have sex.

Fact:
An HIV test works by detecting the presence of antibodies in the body that develop when HIV infects the body. But it takes about three weeks for there to be enough antibodies for detection. In addition, to be sure that the individual is completely HIV-free, it is not enough to have one negative HIV test result - the individual would need to take another HIV test at least 3 months after the first one. He or she must also avoid any risky sexual activities in that whole period. If the second test result is negative, the individual is HIV-free and able to have sex without spreading HIV.

Myth 5
An HIV-positive person who receives antiretroviral treatment will not spread the virus.

Fact:
Antiretroviral therapy can reduce the amount of HIV in the body. However, HIV remains in the body and can be transmitted to others.

Myth 6
Faithful and loving partners do not spread HIV.

Fact:
You may think that your partner has been faithful and loving to you, and will not spread the virus. But what if your partner doesn't know that he already has HIV? A person can be HIV-positive for years without symptoms. Besides, how sure are you about your partner's sexual history? Also, HIV can be transmitted through non-sexual activities -- such as blood transfusions and the sharing of injection needles -- regardless of whether he or she has remained faithful. To be safe, use a condom during sex, and get your partner and yourself tested for HIV.

Myth 7
HIV infections can be cured by having sex with a virgin.

Fact:
There's no cure for HIV/AIDS. However, HIV can be treated and a person who goes on treatment will be able to live a strong and productive life. By having unprotected sex with a virgin or anyone else for that matter, the person with HIV/AIDS can transmit the virus, which is irresponsible. In Singapore, it is against the law for someone with HIV/AIDS not to inform his or her partner of their risk of HIV infection.

Myth 8
HIV/AIDS cannot be transmitted during oral sex.

Fact:
Transmission of HIV occurs when there is an exchange of body fluids (such as semen, vaginal fluids, breast milk, blood or pre-ejaculatory fluids), and this is possible during oral sex when there are open wounds. These include cuts, sores or abrasions in the mouth or gums, or infections in the throat or mouth that are inflammed. There may also be abrasions or sores on the penis or vagina. It is best to avoid oral sex if you have any cuts, sores or abrasions, or if you have a sexually transmitted infection. Otherwise, it is advisable to use condoms when engaging in oral sex.

Myth 9
HIV can be spread during contact with saliva, such as through kissing or the sharing of utensils.

Fact:
HIV may be found in saliva, but it is in too small an amount to infect anyone.

Myth 10
HIV can be spread through non-sexual physical contact such as hugging, handshakes, sharing toilet seats, and from mosquito bites.

Fact:
HIV can only be transmitted through an exchange of body fluids. It cannot be spread through physical contact unless you have an open wound which comes into contact with the body fluids (semen, vaginal fluids, breast milk, blood or pre-ejaculatory fluids) of an HIV-positive person. Body fluids such as saliva, sweat and tears cannot transmit HIV. Also, as the virus cannot survive in insects, HIV cannot be transmitted through mosquito bites.

PART 2

MYTH 1: I can get HIV by being around people who are HIV positive

Evidence shows that HIV is not spread through touch, tears, sweat or saliva. You cannot get HIV by:

1. Breathing the same air as someone who is HIV positive.
2. Touching a toilet seat or door knob handle after an HIV positive person.
3. Drinking from a water tap/fountain.
4. Hugging, kissing or shaking hands with someone who is HIV positive.
5. Sharing eating utensils with an HIV positive person.
6. Using exercise equipment at the gym.

You can get it from infected blood, semen, vaginal fluid or mother's milk.

MYTH 2: I don't have to worry about becoming HIV positive…new drugs will keep me well

Yes, ARV drugs are improving the lives of many people who are HIV positive. However, many of these drugs are expensive and produce serious side effects. None yet provides a cure. Also, drug resistant strains of HIV make treatment an increasing challenge.

MYTH 3: I can get HIV from mosquitoes

Because HIV is spread through blood, many people have worried that biting or blood sucking insects spread HIV. Studies show no evidence to support this – even in areas with lots of mosquitoes and cases of AIDS. When insects bite, they do not inject the blood of the person or animal they have last bitten. Also, HIV Lives for only a short time inside an insect.

MYTH 4: I am HIV positive, my life is over

In the early days of the disease/epidemic, the death rate from AIDS was extremely high. But today ARV drugs allow HIV positive people – and even those with AIDS- to live much longer. In fact, from 2004, the number of people living with AIDS increased by 30%.

MYTH 5: AIDS is genocide

In one study, as many as 30% of Afro-Americans and Latinos expressed the view that HIV was a government conspiracy to kill minorities. Instead, higher rates of infection in these populations may be due, in part, to a lower level of health care.

MYTH 6: I would know if my partner had HIV

People can live with an HIV infection for years, or even decades, without showing symptoms. The only way to know if someone is HIV+ is to ask if they have been tested.

MYTH 7: I am straight and I don't inject drugs intravenously - I won't become HIV+
Most men become HIV + through sexual contact with other men or through injection drug use. However, about 16% of men and 78% of women become HIV+ through heterosexual contact.

MYTH 8: If I am receiving treatment, I can't spread the HIV virus
When HIV treatments work well, they can reduce the amount of virus in your blood to a level so low that it doesn't show up in blood tests. Research shows, however, that the virus is still 'hiding' in other areas of the body. It is still essential to practice safe sex so you won't make someone else become HIV+.

MYTH 9: My partner and I are both HIV+ - There is no reason for us to practice safe sex
Practising safe sex e.g. wearing condoms or using dental dams, can protect you both from becoming exposed to other strains of HIV.

MYTH 10: You can't get HIV from oral sex
It is true that oral sex is less risky than some other forms of sex. But you can get HIV by having oral sex with either a man or woman who is HIV+. Always use latex barrier during oral sex, eg dental dams.

Voluntary medical male circumcision for HIV prevention

Fact: ***Medical male circumcision reduces the risk of female-to-male sexual transmission of HIV by about 60%.***

There is compelling evidence from three randomized controlled trials in Africa that medical male circumcision reduces the risk of female-to-male sexual transmission of HIV by approximately 60%[1,2,3]. Thus, WHO and UNAIDS recommend voluntary medical male circumcision (VMMC) as an additional efficacious intervention for prevention of heterosexually acquired HIV, particularly in settings with generalized HIV epidemics[4]. The most recent data from Uganda show that, in the five years since the Uganda trial was completed, high effectiveness has been maintained among the men who were circumcised, with a 73% protective effect against HIV infection[5].

VMMC is safe when provided by well-trained health professionals in properly equipped settings. Health messages should be carefully tailored, culturally sensitive, draw on local language and symbols, and be appropriate to the particular level of education and understanding of the population groups that they address. Messages should address both men and women[4].

Recommendations and guidance for all key population groups

i. VMMC is recommended as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic and generalized HIV epidemics and low prevalence of male circumcision[4].

ii. VMMC service provision should serve as an opportunity to address the sexual health needs of men; such services should actively counsel and promote safer sexual behaviour[4].

Men who have sex with men

i. VMMC is not recommended to prevent HIV transmission in sex between men, as evidence is lacking that VMMC is protective during receptive anal intercourse[5].

ii. Men who have sex with men may still benefit from VMMC if they also engage in vaginal sex. Men who have sex with men should not be excluded from VMMC services in countries in eastern and southern Africa where VMMC is offered for HIV prevention.

People in prisons and other closed settings

i. VMMC is **not** one of the recommended interventions in the prison package. If VMMC is offered to men in prisons in priority countries in eastern and southern Africa with generalized epidemics and low rates of male circumcision, it is crucial that it is provided with full adherence to medical ethics and human rights principles.

ii. Informed consent, confidentiality and absence of coercion should be assured.

Sex workers (and clients of sex workers)

i. Health messages and counselling should emphasize that resuming sexual relations before complete wound healing may increase the risk of HIV acquisition among recently circumcised HIV-negative men and may increase the risk of HIV transmission to female partners of recently circumcised HIV-positive men[(4)].

ii. "Men's health services" offering VMMC to clients of sex workers or other men at higher risk (such as in serodiscordant couples) may be a promising approach in the high-priority countries of eastern and southern Africa to reach men at greater risk of HIV infection. This approach has not been systematically reviewed and evaluated, however.

Transgender people

VMMC is not recommended for HIV prevention among transgender women[(5)].

Adolescents from key populations

Countries with hyperendemic and generalized HIV epidemics and low prevalence of male circumcision should increase access to male circumcision services as a priority for adolescents and young men[(4)].

Implementation considerations

Partial protection: Male circumcision provides only partial protection against female to male HIV infection. Therefore, male circumcision services should not be delivered in isolation but rather as part of a recommended minimum package that also includes information about the risks and benefits of the procedure, counselling on safer sex practices, access to HIV testing, condom promotion and provision, and management of STIs[(4)].

Opportunity to expand services: Introduction and expansion of VMMC services in high-priority countries of eastern and southern Africa should serve as an opportunity to expand HIV services to all males.

References

1. Auvert B et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med, 2005, 2(11):e298.

2. Bailey R et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet, 2007, 369:643–656.

3. Gray R et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. Lancet, 2007, 369:657–666.

4. Technical Consultation on Male Circumcision and HIV Prevention: research implications for policy and programming. Geneva, World Health Organization, 2007 (http://libdoc.who.int/ publications/2007/9789241595988_eng.pdf, accessed 27 February 2014).

5. Gray R et al. The effectiveness of male circumcision for HIV prevention and effects on risk behaviors in a posttrial follow-up study. AIDS, 2012, 26(5):609–615 610.1097/ QAD.1090b1013e3283504a3283503f.

6. Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach 2011. Geneva, World Health Organization, 2011 (http://www.who.int/iris/ bitstream/10665/44619/1/9789241501750_eng.pdf, accessed 25 February 2014).

Cultural Practices that Enhance the Spread of HIV and AIDS

Culture: An Introduction

Seeking to influence cultural norms and practices to reduce people's risk of HIV will inevitably result in some kind of cultural adaptation. The Committee on Economic, Social and Cultural Rights views culture as a "…a living process, historical, dynamic and evolving, with a past, a present and a future."[1] Rites and ceremonies, customs and traditions, are included in this definition by the Committee.[2] In a paper commissioned by the UN Economic and Social Commission for Asia and the Pacific, Goonesekere argues that human rights norms can have a transformative effect on culture, helping to reinforce positive aspects of tradition and culture, and undermining harmful elements. Given that all cultures change over time, the introduction of new human rights norms into a culture can have a positive and transformative effect, so that the human rights norms eventually become internalized into refined traditional cultural practices.[3] Further, new human rights norms can contribute to a positive change in attitudes towards key populations whose marginalization has previously increased their vulnerability to HIV.

1. Traditional cultural practices that affect HIV responses

1.1 Cleansing Rituals

Cleansing rituals involve a sexual act which is believed to purify the recipient through the semen entering the woman's body. The practice is common for widows after the death of their husband when the widow has sex with a man identified by the elders of the community. Such cleansing rituals stem from the belief that a widow becomes unclean after burial ceremonies of her late husband.[4]

This practice therefore makes women and at times men more vulnerable to HIV infection and re-infection, since the cleansers have had many sexual partners in the process of cleansing others. This is further aggravated by the fact that sexual cleansing calls for unprotected sex. Culturally, it is strongly believed that condoms cannot be used to effectively cleanse a person because it is semen that does the cleansing.[5]

This practice is documented in a number of African countries such as Kenya,[6] Malawi,[7] Zambia[8] and Botswana.[9] In Malawi, sexual cleansers are hired to have sex with widows before they return to their home. This practice is also used in many other contexts in Malawi, such as: after the baby's birth when the mother of the baby, irrespective of her marital status, has unprotected sex with a man in the belief that the sexual act will cleanse the baby and enable it to grow with healthy and strong bones; after miscarriage, when a hired man sexually cleanses the mother by

having unprotected sex with her; and where a man has bought or made a boat to be used for "shing or sailing in the river, a woman has sex with the person who will use the boat – whether his wife or not – to cleanse away evil spirits which may potentially capsize the boat. In most cases the sexual cleansers are men, but in some cases women are also used. Some cultures have people who have now become professionals in this area; sexual cleansers hence perform sexual cleansing exercises with many unidentified women.[10]

Sexual cleansing is also alarmingly used to 'cleanse' people living with HIV and acquired immunodeficiency syndrome (AIDS). In Isiolo in North-western Kenya it is believed that sex with a virgin can cure the disease. Nassir, a man living with HIV interviewed by Reuters said, "I was given a girl of nine years to sleep with for a week … I took pity on her but if it wasn't for this disease I wouldn't have slept with her... I had to do what the elders had said."[11] After the ceremony, the community reportedly engages in an orgy to complete the cleansing process.[2] A local charity called Tumaini is working to stop the customs and report the abuse of young girls in this process, as well as offering alternative purifying rituals for men with HIV.[2]

Belief in the so called 'virgin cure' has been found to exist in numerous countries with a high prevalence of HIV, including in South Africa, India,[12] and Thailand.[13] Interestingly, the phenomenon has been traced back to Victorian Scotland when virgin sex was believed to cure syphilis and gonorrhoea.[14]

1.2 Dry Sex

Dry sex involves vaginal penetrative sex with reduced lubrication, natural or otherwise, and usually without the use of a condom. Women will often insert drying agents into their vagina, such as dry cloth, herbs, and even chemicals including bleach, toothpaste, and antiseptics, to create the required tight, dry and hot vagina.[15] Dry sex is associated with heightened sexual pleasure for the male during intercourse.[16]

For women, dry sex causes friction and sometimes tearing of delicate membranes and micro-lacerations. The chemicals used to dry out the vagina cause inflammation and lesions and alter the natural pH level, increasing the risk of numerous infections, including HIV. In addition, the fact that dry sex also usually involves having unprotected sex increases the vulnerability of the woman to HIV infection.[2]

The practice of 'dry sex' is common throughout Sub-Saharan Africa,[17] Latin America,[18] the Caribbean42 and South Asia.[19] In one study, eighty six per cent of women in Zambia and 93% of women in Zimbabwe reported having practiced dry sex, and similar practices have been described in Malawi, Botswana, and South Africa.[20] In the Caribbean the practice of dry sex has

been found to be widespread in the Dominican Republic, Haiti and Hispaniola.[21] In South Africa a wet vagina is associated with infidelity, sexually transmitted diseases and dirtiness.[22]

In combating dry sex, women's vulnerability to HIV is reduced, and condom use can be encouraged as part of the solution. In addition, women will no longer be required to suffer pain during and after intercourse, and may find empowerment through gaining back some of their bodily integrity.

1.3 Unprotected Sex Amongst Married Couples

Condoms, both male and female, are the single most effective available technology to reduce the sexual transmission of HIV.[23] The Joint Action for Results UNAIDS Outcome Framework 2009-11, includes reducing sexual transmission of HIV as the first of its ten priority areas and cross-cutting strategies, and states that "we can reduce sexual transmission of HIV by promoting social norms and individual behaviours that result in sexual health."[24] There is perhaps a worldwide resistance across cultures to condom use amongst heterosexual couples, however, throughout Asia and Africa there appears to be a particularly strong cultural resistance to condom use amongst heterosexual couples, particularly within marriage.[25]

Unprotected sex between married couples is such a strong traditional practice throughout these regions, that many people do not see condom use as an option.[26] A report by UNAIDS explains that condom use amongst the general population is very difficult to measure.[27] In India, if women suggest condom use within their marriage and appear to have knowledge about HIV transmission, they are often assumed to have engaged in premarital sex,[28] or to be suspecting their husband of intercourse with sex workers.

Condom use is also associated with contraception, rather than HIV protection, and conflicts with the strong cultural importance attached to procreation, and in particular the pressure to bear sons.[2] The resistance to condom use also goes deeper than this, and touches on more complex cultural beliefs about health.

According to Bhattacharya[2], the use of condoms is believed to interrupt the natural flow of body fluids, and to prevent the necessary transmission of semen from the man to the woman. Bhattacharya states that throughout India, semen is seen as belonging to the natural element of metal, and its blockage through condom use is seen to cause an unnatural rise in body temperature for the man and burns for the woman, causing sickness. For this reason women will often undergo sterilisation after they have completed their families rather than use condoms as contraception.[2] For many women, this belief is so strong that they would prefer their husbands to use sex workers whilst away for long periods of time, rather than risk getting sick by storing too much semen in their bodies without the release involved through sex.[2] Bhattacharya notes that

sex is a completely taboo subject throughout India, and any HIV intervention must work within this cultural constraint. However, she suggests drawing on the strong family network which is so core to Indian culture, to promote HIV awareness through the involvement of HIV-positive family members. Although challenging in the context of extreme stigma around HIV, the use of elders in the family who have strong influence and control over the younger generation, could be a powerful tool to disseminate the necessary health messages.[2]

In many countries in Africa, the resistance to condom use amongst married couples is similar to those in India, but for slightly different reasons. The same suspicions about the suggestion of condom use being a sign of infidelity are prevalent in many countries of Africa, and there is also a strong desire to have multiple offspring, as there is in Asia. Loosli[29] suggests that semen is also valued in many African countries, and that a woman's desire to use a condom is taken as rejection of the man's semen,[2] although not on the same 'health' basis as in India.

As is the case all over the world including North America and Europe, in many parts of Africa, Asia, and the Middle East, traditional cultural practices are intertwined with religious beliefs, and often efforts to promote condom use are met with objections on religious grounds.[30] Throughout Africa, the Christian evangelist message on HIV and AIDS stresses abstinence in place of condom use. In addition, in many parts of Africa people with HIV are encouraged by religious 'healers' to pray for their recovery,[31] and in many cases this has involved ceasing taking their prescribed anti-retrovirals as a demonstration of their faith.

1.4 Female Genital Mutilation

Female Genital Mutilation (FGM) is defined by the World Health Organization (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."[32]

The practice of FGM has no health benefits, causes severe pain and has several immediate and long-term health consequences.74 FGM may also contribute to the risk of HIV infection among women and girls. This is because of the unsterilised instruments such as kitchen knives, razor blades, and pieces of glass, or even sharp fingernails, which are often used to perform such procedures, sometimes on several people with the same instrument.[33]

A submission from Nigeria to the Africa Regional Dialogue of the Global Commission on HIV and the Law shared the case study of a mother, whose daughter was taken to be circumcised following pressure from the woman's husband. The girl contracted HIV during the circumcision, following which the woman's husband abandoned her, and due to the stigma associated with HIV in Nigerian culture, the woman did not feel able to disclose her daughter's status and therefore did not seek treatment or warn other mothers about the dangers of FGM.[34]

Furthermore, FGM can bring problems later in life when the scarred or dry vulva of a woman who has undergone FGM is more likely to be torn during intercourse, which can facilitate transmission from an infected partner.[35]

FGM has been recorded historically in ancient Rome, tsarist Russia, and in nineteenth century England, France and North America.[36] FGM is widely practiced today in 28 countries in Africa, in some countries in Asia and the Middle East,[37] and in the Arabian Peninsula, Australia and Latin America.[38] The practice is associated with purity and cleanliness, and in countries where the practice is deeply rooted in the culture it is usually a prerequisite for marriage, as the uncircumcised vagina is viewed as being ugly, by both men and women. FGM is also reported to be a form of control over women, as it can be used to repress their sexual desire and is believed to preserve their virginity.[39] WHO estimates that in Africa 91.5 million girls and women have been subjected to the practice, in most cases before the age of 15.[40] The United Nations Population Fund and the United Nations Children's Fund are currently working on a joint programme to eliminate the practice, and an Interagency Statement was produced in 2008 involving most of the UN agencies, with the goal of eliminating FGM on the grounds that it is discriminatory against women.[41]

FGM was banned in Kenya in September 2011, making it illegal to practice or procure it, or to take somebody abroad for the procedure. The challenge now will be to implement the ban. The Maasai Education Discovery (MED), an organization created and operated by the Maasai community in Kenya and Tanzania, has worked to promote alternatives to FGM.

Unlike many non-Maasai anti-FGM activists, MED have chosen to open dialogue between community members and discussed possible alternatives, noting that confrontational ways would not work.[42] They have additionally encouraged young girls to speak out about their true feelings on the practice; a method that has been suggested in other jurisdictions. In cases where a girl is being forced into FGM against her will, they ensure that the girl is taken away from her family to a safe house. After some time, they initiate a reconciliation process to bring the girl back together with her parents and community. MED has also initiated a programme to involve the men which targets young Maasai men who are not educated and are planning to marry young Maasai girls.

Because circumcision goes hand-in-hand with marriage, they ask these men to refuse to marry circumcised girls.[43] This change in practice has implications beyond addressing the spread of HIV, as the girls are empowered by being allowed to express their views and have them heard, and the inclusion of men helps to increase men's awareness of women's rights in general. This, of course, may not be the ideal solution as encouraging men to refuse girls who have already been circumcised further marginalizes these girls.

1.5 Wife Inheritance

Wife inheritance is a traditional practice whereby when a woman's husband dies, she is 'inherited' by her husband's brother. It is a practice that was historically aimed at protecting the widow and her children from economic hardship upon the loss of her husband[44], and is referred to in the Bible.[45] It was largely viewed as a form of social protection where one of the brothers of the deceased would be identified to take care of the immediate needs of the widow and the orphans.99 The basis of wife inheritance was never related to sexual intercourse, but, in many countries in Africa the practice has changed over the years, and now women are often coerced into a sexual relationship with their inheritor.[46] For example, in the Kenyan context according to Luo tradition widows were not forced into inheritance, rather the elders would inquire whether the woman was willing to be inherited. This, in a way, respected the widow's right to autonomy.[47]

The risk factors posed by this practice, in the context of HIV, include the fact that if the widow is HIV-positive and engages in unprotected sexual intercourse with a male relative who is HIV-negative, then it puts the inheritor at a high risk of contracting HIV. Equally where the inheritor is HIV-positive and the widow is HIV-negative, a risk of infection is also posed to the widow.[48]

Wife inheritance practices have been recorded in other African countries including, Zimbabwe,[49] Malawi,[50] Zambia,[51] Namibia[52] and Uganda,[53] as well as parts of India.[54] The practice, known also as levirate marriage, took place in the ancient Israelite and Near East societies, but seems to have more or less died out in that region.[55] In Kenya, the Luo Council of Elders have formulated culturally appropriate solutions on how to perform the rites of wife inheritance without the need of having sexual intercourse. The symbolic dressing by the widow in the coat of the man who will take care of the widow and the children (the inheritor), is now considered to be enough and no sexual act is required. Another solution is the symbolic patching of the roof by the inheritor by removing a section of it and replacing it. In both cases, the widow can seek consultations with the inheritor without having sex with them,[56] thereby preserving the original value of the traditional custom, while eliminating the risks of HIV. Emphasis is also put on community literacy on the dangers of the practice and the harmful effects of HIV.[57] The Luo Elders have demonstrated their capacity to adapt their own culture in light of new information regarding the risks of HIV, in a way that could only come from within their own community.

1.6 Land Inheritance

Disinheritance of property has become an acute problem for widows and orphans in light of HIV. Disinheritance entails the unlawful appropriation of property of a widow and her children.[58] Emerging legal and social trends relating to the ownership and inheritance of property especially land, indicate a practice that has worked to the detriment of women in virtually all communities and social classes in Africa[59] and South Asia.[60] There is evidence that increased land scarcity has

made the situation worse in recent years, so that in Tanzania widows who were previously allowed to stay on their husbands` land have been dispossessed as the land has increased in value.[61]

Property grabbing from widows is common in Kenya, Uganda, and Zimbabwe,[62] and land ownership by women in the region is rare, at only 5% in Kenya, less than 10% in Cameroon, and until 2005 women were not allowed to own land at all in Lesotho and Swaziland.[63]

The effect of HIV is worse on women than men, as there is a higher prevalence of HIV amongst women worldwide.[64] Much of the disinheritance is done in the name of culture. The inability to inherit the land results in an economic dependence on men and a power relationship in which women are unable to negotiate the terms of sex, including consent, fidelity and condom use, and their risk of HIV is increased. In many developing countries access to the formal legal system is difficult as it is lengthy and expensive which exacerbates the violations by effectively denying redress in the event of property grabbing. When evicted, most of the women and orphans unwillingly move to urban areas where they are exposed to circumstances that increase their vulnerability to HIV, and are often drawn into sex work. When women and children lose their land, homes and other assets, destitution and hence greater vulnerability to exploitation follow.[65]

1.7 Virginity testing

Virginity testing is a practice involving a physical examination of girls and women to ensure that their hymen is still intact as evidence that they have not yet had sexual intercourse with a man. Rather than being a cultural practice that directly increases the risk of HIV, virginity testing has been justified in terms of HIV prevention in South Africa and Uganda, on the basis that it ensures abstinence in girls, and proves to the new husband that she is not yet sexually active. The Special Rapporteur on violence against women referred to Human Rights Watch evidence documenting the practice in Turkey.[66]

Apart from the fact that enforced virginity testing amounts to a human rights abuse in itself, it is not an effective practice to prevent HIV. In Uganda, virginity testing was part of an attempt to change the cultural environment in the direction of abstinence, and was in direct opposition to condom promotion efforts. The abstinence policy was strongly backed by the United States (US) government and was driven by ideology rather than science.[67] Abstinence programmes are unrealistic and ineffective, and because they go hand-in-hand with a resistance to condom distribution, the implications for HIV are serious.

In South Africa, virginity testing was found to put girls at greater risk of sexual violence because the public testing advertised the ‘availability’ of virgins to men who seek out virgin girls as sex

partners.[68] In many communities in Sub-Saharan Africa there is a belief that sex with a virgin cures HIV,[69] and there are accounts of this belief persisting in other regions as well including Asia, Europe and the Americas.[70] There are also concerns that people may be more likely to engage in riskier practices such as unprotected anal sex in order to pass virginity tests.[2]

In South Africa, virginity testing was a traditional practice that although popular in the past, was much less common prior to the HIV epidemic. In the past the practice was common to test a woman's virginity prior to marriage, as this was a factor that would favorably increase the bride price.[2] The practice saw resurgence as a public health response to HIV, in an attempt to promote abstinence amongst girls. The virginity test, carried out by traditional 'testers' involved an examination of the vagina, and also an assessment of the girls' breasts, which should be '"form and taut', and of her eyes which should 'look innocent'.[2] Many rural women and even members of South Africa's political elite saw the practice as a positive return to traditional cultural values of chastity before marriage, modesty, self-respect and pride.[2] The South African government responded by attempting to ban the practice, and it was widely denounced as a human rights abuse.

1.8 Male Circumcision

According to the WHO, male circumcision is the surgical removal of all or part of the foreskin of the penis. It is one of the oldest and most common surgical procedures worldwide, undertaken for religious, cultural, social or medical reasons.[71]

In adult men, a four-to-six week period is required to fully heal the wound. Healing is usually complete after about one week when circumcision is performed for babies.[72] Male circumcision is almost universal in the Middle East and Central Asia and in Bangladesh, Indonesia and Pakistan, and the WHO estimates there to be 120 million circumcised men in India. Male circumcision is also common throughout Africa.[73] The WHO found that the major determinant globally of this practice is religion, but that a large number of men are also circumcised for cultural reasons.[2] Traditionally this practice is undertaken as a rite of passage within many African communities. It is done by a specific traditional healer, during a particular season, and in most cases, with one unsterilized knife to circumcise an age set of boys.[74]

Male circumcision is an example of a traditional cultural practice that has a positive effect on reducing HIV infection in men. It only poses a risk to HIV infection when it is done in unhygienic conditions and one instrument or knife is shared. When circumcision is performed in a clinical setting, under aseptic conditions, by well-trained, adequately equipped health care personnel the level of risk is low, and the concomitant benefits in terms of long-term HIV prevention are high.[75]

There have been numerous studies and debates as to whether circumcision helps reduce the risk of HIV transmission among heterosexual men.[76] Some of the studies have put forward arguments that circumcision and HIV claims are based on insufficient evidence.[77] A survey undertaken in South Africa demonstrates that circumcision had no protective effect on HIV transmission.[78] On the other hand the WHO documents the results of three randomized controlled trials that have provided evidence that male circumcision reduces the risk of HIV acquisition in men through heterosexual sex, demonstrating at least a 60% reduction in risk.[79] The UNAIDS Global Report on the AIDS Epidemic 2010 recommends the scaling up of male circumcision in areas of high prevalence and low rates of male circumcision, noting success in the Nyanza area of Kenya.[80] The scale up has also been based on the initiation of male circumcision as an additional tool for prevention in 13 African countries that "t the criteria for scaling up.[81]

The involvement of cultural leaders in the intervention is important and has proven effective in Kenya, where HIV prevalence among uncircumcised men in 2007 was found to be three times higher (13.2%) than among men who were circumcised (3.9%). Though male circumcision has not been traditionally practiced in the Nyanza region, with the involvement of elders in partnership with government officials, there has been an increased demand for service, with over 20,000 men having undergone voluntary male circumcision. The elders have been instrumental in promoting and generating this demand.[81] UNAIDS notes that in order to increase the practice of circumcision, it is important to work with cultural structures as catalysts for behavioural change in communities where circumcision is not already a cultural norm.[2] The Luo Council of Elders in Nyanza managed to introduce the practice into their culture, creating a new cultural norm.

References

1. Committee on Economic, Social and Cultural Rights, General Comment No. 21, Right of everyone to take part in cultural life (art. 15, para. 1 (a), of the International Covenant on Economic, Social and Cultural Rights), p.3.

2. Ibid, pp 3 & 4.

3. Goonesekere, S., Harmful Traditional Practices in three Countries of South Asia: culture, human rights and violence against women, UN Economic and Social Commission for Asia and the Pacific, Gender and Development Discussion Paper Series No. 21, (2009) p.6.

4. Malawi HIV and AIDS, Monitoring and Evaluation Report: 2008-2009, UNGASS Country Progress Report, Reporting Period: January 2008-December 2009, Submission Date: 31 March 2010 available at http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/ 2010progressreportssubmittedbycountries/malawi_2010_country_progress_report_en.pdf [accessed 15.06.2011].

5. UNAIDS, UNFPA, UNIFEM, Women and HIV/AIDS Confronting the Crisis available at http://www.unfpa.org/hiv/women/report/chapter7.html.

6. Shisanya C.R.A., Widowhood in the Area of HIV & AIDS; A case study of Siaya Distirict (2007) Journal of Social Aspects of HIV 4:2.