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TRADITIONAL PRACTICES
AND HIV PREVENTION IN
SUBSAHARIAN AFRICA

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PREFACE

This discussion paper has been following a request of the HIV Governance Group for the Secretariat to assist Red Cross National Societies to explore how to utilise harm reduction principles to manage HIV transmission risks associated with traditional practices. This extends on the harm reduction tool “Spread the light of science” to cover practices not addressed in that document focused on IDU.

Discussion of traditional practices require a great deal of cultural sensitivity, and it is acknowledged that only people within cultures can fully appreciate the role and importance of each practice, and lead the process of identifying and implementing changes in ways that maintain and even strengthen the culture. It is hoped some careful consideration of issues will help prepare leaders for their role, particularly when silence and taboo needs to be challenged.

This paper has been prepared by Bertille Loosli, a Benin woman, graduated at Geneva’s University and nurse from Geneva Nursing School who works for Swiss Red Cross in prevention outreach with African communities in Geneva. The Swiss government support for Ms Loosli to spend months work experience with the Federation in Geneva is much appreciated.

Dealing with harmful traditional behaviors and practices could meet interest or rejection because it approaches contents that are not often subject to writing. The idea which leads this writing is to name and explain openly a number of traditional practices. It is not possible to avoid something you can even afford to talk about. Rise people aware of their daily risky behavior that could promote HIV infection and suggest a starting reflection on them. Behavior changing is not something that happens overnight, it is a long-lasting process. But it is necessary to start thinking of it one day or another otherwise change cannot occur.

The paper is a starting point only. Every attempt has been made to draw on the limited literature research available on these topics, and to contact experts at UNAIDS and others agencies, but it is acknowledged that local knowledge of National Societies staff and volunteers is likely to be able to enrich and improve on the findings presented.

INTRODUCTION

In 2004 Sub Sahara Africa represented a bit more than 10% of world population whilst it sheltered 64 % of people living with HIV. An estimated 3 millions people became infected in 2003. It is the worst affected region by the HIV/Aids. Studies have revealed that 80% of HIV transmission in Africa is via the heterosexual route and 12% via mother to child route. Blood transfusion is estimated at 2.5%. Unsafe medical injections are suspected to contribute to 2.5 percent of HIV spread in Africa though this data is not certain¹. The high prevalence of HIV infection in Africa compared to other regions tends to suggest that different dynamics came into this region. Although it is often controversial and sometimes misleading to make generalisations, Africa has a wide range of beliefs, habits, religious and healing practices. Some date back several centuries. It is also true that cultural differences are evident within and between countries. Traditional practices are important in maintaining cultural identity and continuity, but some have harmful aspects and voices have been raised to discontinue such practices. Other voices argue for a harm reduction approach, to reduce harms but maintain culture. Since 1983 the HIV/Aids pandemic, has added a very significant new harm to a number of practices, but it is usually feasible to eliminate this particular harm completely through basic infection control procedures. Though it is assumed that some traditional practices promote HIV transmission, specific studies have not often been conducted to establish the linkage. Such practices may be so rooted in the culture that it seems impossible to stop them. However, we do know it is possible to change behaviour but because of cultural differences, accepted norms by societies in different settings, this may be difficult in practice. For example, safer sex practices have not been accepted by all throughout the world, but evidence shows it is possible to change the attitude and behaviour of the society through intensive sustained education and empowerment of vulnerable communities.

Body cutting practices e.g. scarification, tattooing, male circumcision, and female genital mutilation are risk factors for HIV transmission when the tools are reused without sterilisation. The efforts of good public health interventions have been undermined by beliefs that drive the practices. It is now time to stop trivializing the risk linked to such practices and adopt safer practice from public health campaigns to involve the partners and address the beliefs and concepts. Top down campaigning is poor public health practice and it should be no surprise it has limited effect. Obviously, it is proven that very often, endeavours to put a halt to risky customs failed. Why? Reasons are many, but include:

1- Usually, people are reluctant to adopt another behaviour because it is easier to continue to do what they used to do than comply with new things. Requiring an individual or group of persons to do new or unusual practice will produce certain anxiety and resistance before being accepted.

2 - Reformers failed to understand '*Why people do what they do, what may persuade them to act in a different way.*' Before tackling problems through reform, it is advisable to explore why they exist and find out the communities understanding of the potential harm. Then, by a new approach, we have to facilitate maintenance of good culture and avoidance of harmful practices. Behaviour change that originates with the peoples cooperation is more likely to be sustainable.

3 - The greater resistance for affecting change in cultural practices is from men and women who are playing the role of tradition-keepers. Who are the tradition-keepers?

Traditional healers, mural chiefs, community and political leaders, faith-based leaders, families' elder (men and women) have a great role to play in HIV/Aids prevention and care because people trust them within the societies. Their social power enables them to promote behaviour change as well as HIV prevention in general. Therefore, their involvement in

community's response to HIV is a first step toward an original way to tackle HIV/Aids issues in Africa. Some of those tradition-keepers who are against change in tradition are certainly worried about the loss of their power upon the societies. Performance of traditional activities also provides income to tradition-keepers, so an assent to abolishing some practices could mean an economical gap for them. One of the approaches for changing the role of this tradition-keeper is to educate them based on acceptable language and use them to educate the community on the prevention of HIV/Aids. Giving them such responsibility can give them respect of the community because the society wants the prevention of HIV/Aids.

Rape, especially of virgin in the mistaken belief it can cure HIV infection, sex cleaning ritual, multi-partnership network: polygamy and polyandry, wife inheritance, wife exchanging, cross generational sex, incestuous, transactional sex, etc are important risk factors in many areas. The practice of dry sex which creates an entry point for HIV is still ongoing hitherto. Some practices such as incestuous, anal sex or declared homosexuality in Sub-Sahara Africa are not approached in this paper because of a lack of reliable documents. A resounding silence around sexual issues hamper open discussion thereby hindering the behaviour changing process. As Lucius Phaiya argues: 'There is no valid excuse for continuing with these customs? What is a custom for if it stands to kill you? What logic lies in clinging to it? It is high time we reviewed some traditional practices.'²

A hypothesis assumes that cultural behaviours and beliefs may contribute heavily to the spread of HIV infection in Africa. It is a fact that African people are vulnerable to health disaster giving the lack in health and care system. Poverty combines with the climatically conditions further the apparition and the development of micro organisms such as: Ebola, cholera, malaria, tuberculosis, etc. Some attribute the magnitude of HIV/Aids disaster in Africa to the fact the virus had appeared there, thus it had had time to spread before human being been aware. Surprisingly, HIV comparative prevalence seems also high among Sub-Sahara African who are living on others continents. In Switzerland, France, Belgium, Portugal, etc epidemiological data suggests migrants, and particularly Sub-Sahara African are more vulnerable to HIV than other populations³. It has also been documented that HIV infection of African origin is higher than the remainder of the population in USA despite the fact the life conditions are not similarly to Africa. According to the Center for Disease Control and Prevention⁴ in 2002, African-American women had a 23 times greater chance of being diagnosed with HIV than white woman.

What do Sub-Sahara African populations, migrants or autochthones have in common which induces their vulnerability to HIV infection wherever they are living? May cultural practices increase the likelihood of HIV transmission? What are the core issues which need to be approached for successful behaviour change strategies facing HIV threat?

This paper has been inspired by the objective to pursue open dialogue on a number of traditional practices on which the discussion on HIV prevention was put on side despite its cause the highest route of contamination. Identify and understand the interaction between the virus and traditional practices may lead to perform prevention programs and policies.

Thus, the first part highlights shortly the link between customs, tradition and culture. The second part presents some theories and models of behavior change applicable for HIV/Aids programs. The third identify cultural beliefs that may facilitate HIV spread. Traditional surgeries, multiple sexual partnership and dry sex practices which could lead to HIV transmission/reception are explained in the parts four, five and seven. The part eight names a list of recommendations which could serve as guide while defining programs' objectives or making-decision for HIV prevention.

1 CUSTOMS, TRADITION, AND CULTURE

Custom is a 'habitual group pattern of behaviour that is transmitted from one generation to another and is not biologically determinant. Since societies are perpetually changing, no matter how slowly, all customs are basically impermanent. If short-live, they are more properly called fashions. Customs form the core of human culture and are stronger and more persistent in pre industrial societies than in industrial ones, in rural than in urban areas. When formalized in the social or religious sphere it leads to ethics, and when enforced in the sphere of rights and duties, custom leads to law.'⁵ A custom or tradition could vanish from a culture if population decide to give it up. A tradition is 'a story or custom that is memorized and passed down from generation to generation, originally without the need for a writing system.' Thus, tradition seems a fixed link between us and our ancestors. This reason imply traditions should be conserved to save mankind origin. Though tradition is presumed to be ancient and deeply rooted than custom, in this paper: the words custom and tradition will be use as synonym.

The word culture comes from the Latin root which means *colere* referring to human activity such as to cultivate or habit use etc. The anthropological concept of culture evolved through centuries and has today many usages. 'Culture ...is that complex whole which includes knowledge, belief, art, morals, custom and any other capabilities and habits acquired by man as a member of society.'⁶ Culture seems something fixed and bound to untouchable component as well as something dynamic in continuous change.

Apart from a society, culture could involve groups within communities, for instance age and class culture, gay culture, or gender culture which are not specific for a society but universal. In that case culture could be understood by considering three elements: values, norms and artefacts⁷. Values are ideas or philosophy about what in life is important, they lead the culture. Norms are expectations of how partisans would act in different situations. Artefacts are things or material culture stem from the culture's values and norms. Therefore, sometimes the members of the same society have strong contrast values and behaviours' code. Meaning culture can be created by a individual or a group following a need of identity recognition. So, researchers proved that culture could it be traditional or modern evolves in the present time accordingly to human decision under internal influences.⁸

The way people behave is largely influence by the culture in which they had grown. Health issues are also affected by culture since culture influences the day-to-day decision one has to get through. Most people do thing because that is the 'the way they do things around there' till the day something happens to appeal a change. Stemming from all that, culture could be an efficient means: one on hand to innovate cultural approach in a specific cultural context of prevention projects and on second hand to seek for behaviour change.

2 BEHAVIOUR CHANGE THEORIES AND MODELS

The word behaviour will be used in this paper as its basic meaning: 'manner of acting or conducting yourself'.

A significant number of studies have shown HIV/Aids interventions which provide information and education are not efficient to induce a desirable behaviour. The classic prevention method of Information – Education – Communication –(IEC) recorded insufficient success. Denial of HIV existence continues to prevail because messages sound abstract. People likely not identify themselves with the matter giving the complexity of sex and sexuality issues. For this reason, HIV/Aids interventions attempt now to use cognitive aspects of prevention through Behaviour Change technique. Such programs are focused on different theories and models which aimed to change sexual behaviour at individual or community level. Success are noticed when methods are combined according a specific need of each context.

Countries like Uganda which have shown success in the fight again HIV spread confirm that behaviour change and communication should be highlighted when implementing prevention programs. To give an overview, a few among them are shortly summarise below.

2.1 The theory of reasoned action

It explains how attitude impacts behaviour. 'A person behaviour is determined by s/he attitude towards the outcome of that behaviour and by the opinions of the person's social environment'. It affirms that a person's intention is function of 2 basic determinants : *attitude, and subjective norms.*' **Attitudes** are made up of beliefs accumulate over lifetime whereas subjective norms are beliefs about what others will think about the given behaviour.

Thus, subjective norms are based on opinions of persons seen as significant or important. These people include friends, family, communities leaders, celebrities, peer group, etc. Laws and rules may have an impact on people's attitude because of their will to comply with others. In others words, subjective norms are a kind of others' imitation.

Intention emanates from the probability to perform or not a behaviour following a self-evaluation. **Behaviour** is the transmission of intention into action. For these correlations, it posits that individual would be receptive and does what is been promoted by others as 'norms'. This theory offers the opportunity 'to guide activities focus on attitudes about risk-reduction, response to social norms, and intentions to change risky behaviours.'⁹ However a limitation of the theory is the assumption that behaviour could always be under volitional control.

Attitude =====> Intention =====> Behavior

2.2 Sexual risk and cognitive 'escape'

This individual psychological model had been developed by D.J McKirnan & all¹⁰. This theory argues that people do not always behave as 'rational operators'. Unsafe sex behaviour is neither only the result of misinformation nor limited resources. Sexual behaviours are so linked to emotional states that risk-taking could not be accurately conceptualised as a prevention models. Authors' findings were based on observing gay people 's behaviours towards HIV risk – taking. Contrarily to the theory of *reasoned action*, the *cognitive escape*

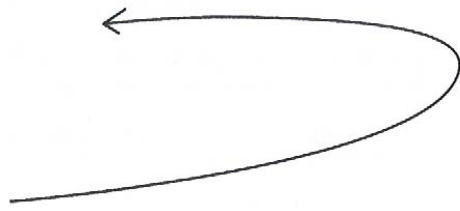
theory suggests that: ‘...Many people’s sexual risk does not stem from a lack of community norms or personal standards, but from a desire to escape cognitive awareness of very rigorous norms and standards. Being self-aware of HIV risk arouses anxiety and precludes highly-desired activities: fatigue, fatalism, or other negative affect over HIV may lead people to ‘cognitively disengage’ within the sexual situation, and not to follow their norms or intention toward safety.’ Furthermore, substance such as drug or alcohol use added to a certain setting encourage a non-rational behaviour. To overcome this difficulty of cognitive escape which undermine prevention actions, the theory recommends to:

- Make use of social norms’ influence which promote safer sex,
- favor a face-to-face which interventions are likely more effective,
- Encourage people to attend prevention activities within high risk groups during all the sexual lifespan.
- Emphasize how to recognize cognitive escape cue and maintain self-awareness in very high-risk states of mind.

2.3 Stages of change model

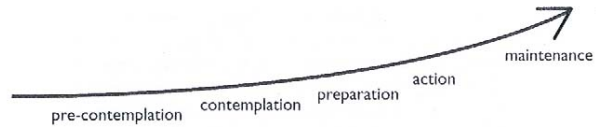
It is one of individual approach including emotions, temporal dimension, enable factors, and barriers. The model which is not design specifically for HIV/Aids prevention had been already use for several health issues such as: smoking cessation, alcohol abuse, weight control, condom use, etc. Intentional behaviour change occurs over time involving emotions and cognitions¹¹. To illustrate this reality, the model identify stages of behaviour change as followed:

- Pre contemplation: The individual is not intending to take action maybe because he is ignorant about risky behavior or discouraged about his ability to change. Prevention message produce none effect.
- Contemplation: The person is intending to change because something happened in his life resulting in the need for further change. He will be now receptive to prevention message, balancing pros and cons of adopting a new behaviour. Individual thinks about the importance of condom use to avoid risk.
- Preparation: The individual undertakes action including how to gather useful information he needs to start the change. He would like to use condom in a close future.
- Action: The person adopts a new behavior. In case of HIV/Aids prevention he will use condoms consistently for less than 6 months.
- Maintenance: At this stage, the person works to incorporate the healthy behaviour in his life, get more confident to prevent relapse. If it is concerning HIV/Aids prevention, he will use condom for more than 6 months.



The ongoing spiral of behaviour change

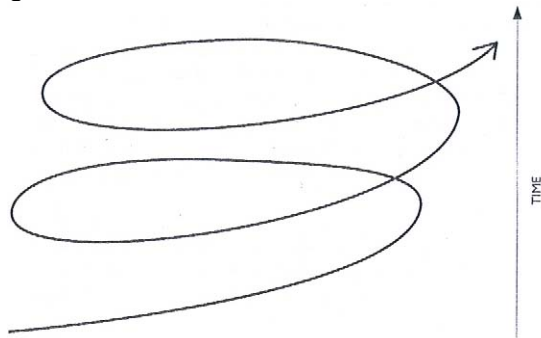
Figure: 1



The first stages of behaviour change

Figure: 2

Fi



The full spiral of stages of behaviour change

Figure: 3

Nerveless, internal feelings and external factors (such as enable factors or barriers) reacting on a individual environment represent a treat for a sustainable change. Thus, the new change acquired will hardly be definitive after one straight move. Individual is likely to return several times through stages before gains stability at maintenance stage. It is why Bruce Parnell & Kim Benton illustrated the first stages as a curved line and movements of go-back and coming through stages by spirals displayed above.

Source : Facilitating sustainable behaviour change, B. Parnell & K. Benton, 1999.

Theories recommend to assess stages people are currently evolving before implement interventions. However in the community people are not at the same stage. According to professionals, contemplation stage people are those who response most successful to address prevention programs.

2.4 Diffusion of innovation theory

It asserts people adopt new behaviours when they are convince by an idea suggested to them by other members whom they trust. 'When beneficial prevention beliefs are instilled and widely held within one's immediate network, individuals' behaviour is more likely to be consistent with the perceived social norms.'¹² It explains the process of how a new idea is disseminated throughout communities or institutions. The theory is based on 4 components: the innovation, its communication, the social system and time. It is similar to the manner advertisement companies launch new items on the market. For instance a singer wearing a new fashion of dressing, induce his fans to do so. Then starts a new fashion which will become a custom within a group over the time if the fashion long lasted. Similarly, positive sexual behaviours are more likely to be created and integrated into the social norms.

Influential people: communities, political and religious leaders, artists, and others well-known or respected people should take leaders role in HIV/Aids awareness and campaigns, show best practices with contribute to risk reducing in order to be followed by others. The method is useful to diffuse safer sex messages, some called it safer sex' 'erotization' trend within groups or communities which are resistant to condom use.

Other theories such as : theory of *gender and power*, *sexual communication*, *social and change or empowerment* model and examples of project can be read in the UNAIDS document: 'Sexual behavior change for HIV' indicated in the references.

2.5 Behavior Change Communication: a concrete example

Behavior Change communication (BCC) is a guide, a concrete example of tool in behavior change developed by FHI. The BBC is an 'interactive process with communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviors; promotes and sustain individual, community and societal behavior change; and maintain appropriate behaviors.'¹³ To change behavior, individual may be educated about HIV avoidance, accept and adopt key attitudes and need to be given appropriate products and services. The environment plays a supportive role in behavior change. It is a strategic framework which integrates most of important variables of different theories. BCC specialists are using it to skill health educators in more than 40 countries.

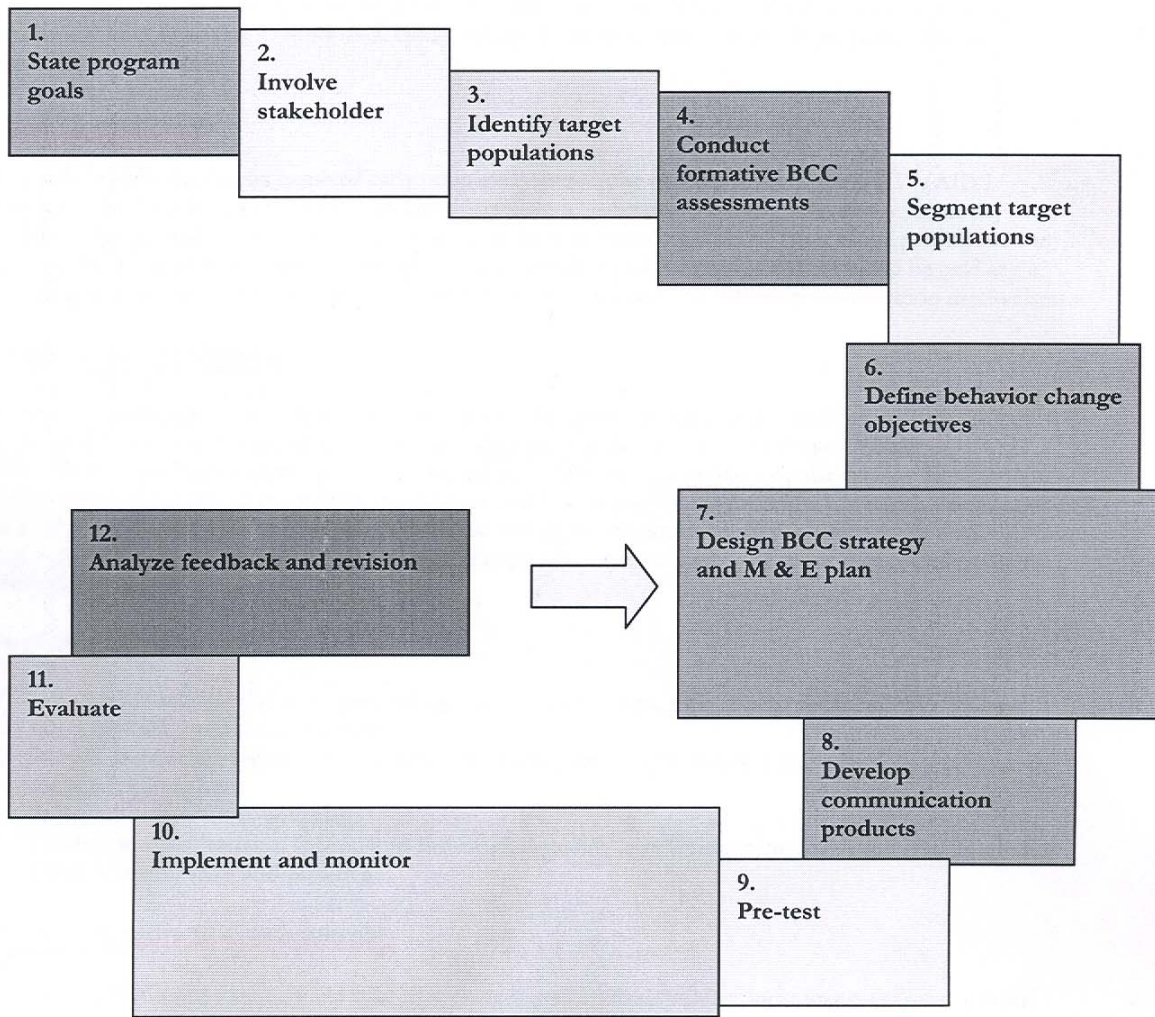


Figure 4: Steps in developing a behavior change communication strategy

Source: Behavior Change Communication for HIV/Aids, a strategic framework, FHI 2002.

BCC is based on a step-by-step methodology summarized as following: Step (1): Include BCC in a global program goals. Step (2): Implicate all concerned stakeholders including PLWHA to obtain their commitment. Step (3): Identify target population: primary and secondary population¹⁴. Step (4): Seek out and collect available information and data. Step (5): Subdivide target population basing on the group characteristics emerging from the formative assessment at the 4th step. Step (6): Specify behavior change objectives. Step (7): Design communication plan, develop themes and key messages and select dissemination channels. Decide a monitoring and evaluation plan. Step (8): Target communication according to characteristics of each population subdivision. Step (9): Verify that theme, message materials, etc have sufficient impact in the target audience. Step (10): Implement the plan and monitor it according to project management recommendations. Step (11): Assess the project success in achieving its objectives. Step (12): As people are acquiring knowledge needs should be periodically assess to modify or adjust BCC approaches.

Still carrying out prevention project in BCC manner need experts to be knowledgeable and BCC skilled because it requires a wide range of background in several fields.

3 CULTURAL BEHAVIOURS AND BELIEFS

Before attempt behaviour change, the greater need is to collect more and exact information about what are the current practices and beliefs which should be addressed, why people are doing them and what can refrain them to behave in a desirable manner. What practices are more likely to change and what may be great obstacles and how to overcome them.

3.1 Sexual rituals

▶ Motherhood's sexual abstinence

Cultural beliefs can result in exposing people at greater risk of HIV infection. In certain communities beliefs recommend husbands to not have intercourse with their wife during pregnancy and breast feeding to avoid the baby's ailments. In rural areas, women usually breastfeed their babies during an average of one year unless. This myth allows women to space births naturally. One the over hand that means spouses should avoid having sex during a relatively long period. So, meanwhile, men seek others women outside. A study in Guinea – Bissau shown that men who did not have sex with their wives during breast feeding were more exposed to risk-taking behaviour than those who did continue intercourse with their wives.¹⁵

▶ Sex cleaning

According to a cultural belief, a widow became unclean after burials' ceremonies of their late husband just as women whose child died. According to this ritual the widows should be sexually clean otherwise they will never be able to marry again.¹⁶

So women are compelled to have sex with a man called sex cleaner or "*namandwa*"¹⁷. In this practice people don't use condom. Now, in Malawi, efforts are being made to encourage sex cleaners to the use of condom while doing such a kind of ritual.

In some countries people find a way to respect the tradition without making harm. In Malawi for instance sex cleaner have to put condom on otherwise there is a punishment is planned. Cleaner may well be suspended or expelled from the healers' body if he engaged in an unprotected sex with a widow.

► Wife inheritance

Similarly, when a woman became widow in several African sub-Saharan countries, the husband's family obliges her to choose a member of the husband's family as husband. In Zimbabwe the practice is named *Nhaka* in the Shona language.

Previously, the practice intended to ensure protection and security to the widow and orphans. In addition, a partial explanation of this practice from the fact that the death's family had had paid the dowry while marrying the woman, it is somehow normal that this woman become inherited as an asset of her husband. 'In our culture if a man dies, the wife should be inherited. If you are inherited, you cannot use a condom-it is skin to skin.'¹⁸ (Kampala conference participant, 2003). However, they don't take any HIV test before starting sexual intercourse. So, if the women's first husband was died from HIV infection, the new husband is also exposed or it could be the new husband who will infect the widow. If a woman refuses to be inherited, she is outcaste since belief presumes evil befall the community if they do not inherit her.¹⁹ "Of course, if her husband died of AIDS, she might very well pass on the virus to her guardian. Millicent Obaso, a Luo public-health worker with red Cross, says: We have homes where all the males have died because of this widow inheritance."²⁰ Some consider the highest rate of HIV in western Kenya could be put down to the fact wife inheritance is especially popular in certain regions.²¹

Faced to such a heart-rending noticing, some countries are about making legislation to end this tradition officially.

3.2 Sexual violence and myths

Sexual violence means any sexual action intended against the will of a person. It covers many forms: rape is one amid sexual violence. Sexual violence does not mean necessary a rape case. Even if someone consents for a sexual activity, the brutality the partner shows might make this consent pleasure turned into coercion. Sexual violence describes an behaviour which is adopt during a consented or non-consent sexual activity, it can occur even with regular partner outside of rape situation. Rape is definite as the *offence of forcing a person to submit to sexual intercourse against that person's will*. A woman, a girl, a man or a boy can be raped by any unknown or know person including regular partner.

In Africa the trend is to not consider a forced sex with any known one as a rape. From this idea is equivalent to a partial rape acceptation, an estimation of 75% of rape case are not reported. Rape is punishable by a prison sentence.

Despite the fact that it exists for centuries within the worldwide culture, rape is neither a custom nor a tradition elsewhere. According to the law in force in each country in Africa, this practice still liable to curbing, rapists are remanded in jail. Rape is a deviant practice which is prosecuted everywhere including in Africa. Nevertheless, women are too often exposed to sexual violence in Africa and Asia.

For instance, in Africa it consider as normal that a husband is entitled to have intercourse with his wife as far as he wants, there should not have no way for the wife to escape. In

others words, violence is a part of the culture. Another disturbing finding from the PHR study of sexual violence in Sierra Leone was the women's responses to questions about marital relations. More than 60 percent stated that a husband had the right to beat his wife, and the same proportion thought it a wife's duty to have sex with her husband even if she did not want to."²² In others words, violence – neither sexual nor other forms - is an integral part of the culture. However this does not mean that people are living like in a jungle, simply they have internalized violence, use to facing and cope with it.

It is not uncommon to hear a husband has beaten his wife because she refused to have sex with him. Beating is not the only one way a sexual partner's punished thereafter a wife refuse to have sex: men can go to have sex with a girl-friend outside, then he will start coming back home later than usually to let the wife understand something is happened because of her fault, or make financial pressure on the wife by stopping giving household money, or psychological pressure by stopping to talk to the wife for a moment. The worst punishment that could also happened is the fact a man kick out his wife for refusing an intercourse. It is not a generalization, all men in Africa do not react punishing their wife following a sex refusal, particularly, and growing educated generations are giving these kinds of manners. Nonetheless, a lot of men still keep on such a mindset within Africa culture.

'Studies in Tanzania showed that compared to HIV-negative women, young HIV-positive women were 7 to 10 times more likely to have been subjected to unwanted sex through rape, beatings, or other forms of coercion.'²³ Today, sexual violence is pointed out as an important element of women's HIV risk. It is an evidence that a forced intercourse may well causes pain and injure and other damage that could facilitate HIV transmission. However, research on the link between partner violence, male dominance, and HIV infection is need.

²⁴Moreover, countries in war, parties in conflict use rape as a weapon such as in Sierra Leone, Angola, Democratic Republic of Congo and Rwanda. The United Nations reports that Hutu attackers raped 250,000 women during the last war in Rwanda, deliberately choosing HIV-positive men to act. They succeeded in infecting roughly 70% of their victims."²⁵

'Sexual violence is the most obvious distinctive experience of women in armed conflict ... It has been said that women's bodies are the fighting ground for the battle between men and since within many societies a women's chastity is a matter of family honour, rape is perceived to be the ultimate humiliation of the male enemy.' Another form of sexual violence which is actually ongoing in Asia is the fact women and girls are being forcibly enrolled in prostitution.

In others words, it means that in Africa people do not blame regular partners' rape, nor do they for someone who was knew by the survivor. This mindset becomes worryingly since a study released in British Medical Journal among South Africa school pupils underlined: Apparently, there is an expectation of sexual coercion among the youth and associated adaptive attitudes contribute to a culture of sexual violence."²⁶

Rape exist in all country however, in Africa it is seem quite bit rampant in certain regions. The incidence varies considerably from country to country. In regions where sexual violence compromises seriously the security, people tend to be resigned to the situation. It becomes almost 'normal.'

In 1993, the Un Human Rights Conference in Vienna recognized violence against women as a human rights violation and called on governments and United Nations to work towards its elimination. From this year to now, endeavors have been made to tackle the problem. However, the response to sexual violence through the world remains lower though the international Criminal Court has included rape in its list of war crimes.

▶ Virgin myth

There is currently a belief that says sex with a young girl prevent from HIV infection whilst sex with virgin including children and babies cures AIDS. According to the myth, it is seemed the younger the virgin, the more potent the cure.

Obviously this belief is untrue and scientific baseless. It is worth remembering that in the Dark Ages of medieval Europe, a similar myth prevailed in relation to syphilis and gonorrhoea²⁷. Brothels were set up in Liverpool since 1827 to provide this cure.²⁸ People believe virgins have magical powers to get ride from impurity after sexual contact.

Not surprisingly, the rate of young girls' rape is rising those latest years in some African's countries: Zambia, Zimbabwe, Nigeria, and mainly in South Africa. 'Child rape is not a new phenomenon, but recent media attention - particularly on baby rape - seems to indicate that is on the increase in South Africa.'²⁹

Each year, 20'000 out of one million rapes committed in South Africa are against minors. According to available police records, rape and attempted rape of children under 18 increased by 8.5% between 1996 and 2000 in South Africa.

After being raped person have to overcome mount problems, among them the risk to be infected by HIV or others STDs, the pain which she got through during the rape and the psychological damages which remand for a long time. 'Violent or forced sex can increase the risk of transmitting HIV because forced vaginal penetration commonly causes abrasions and cuts that allows the virus to cross the vaginal wall more easily'³⁰ Young girls are more exposed to HIV infection following sexual violence because their vaginal mucous still immature, therefore it is not an effective skin barriers against the virus' penetration. In addition, internal organs could be damaged following a sexual coercion. Low self-esteem, culpability, and long-lasting depression are other effects of rape.

To deal with the consequence of rape, PEP: PostExposure Prophylaxis is an emergency preventive method destined to face accident that occurs possibly during occupational exposure to the virus. 'PEP reduces the rate of HIV infection from workplace exposures by 79 percent. However, some health workers who take PEP still get HIV infection'³¹ This procedure, has been available since 1996. The treatment is administered as soon as possible, preferably within the 48 hours after an exposition to a high HIV infection's risk. It not means PEP is a "morning after pill." PEP is a two or four-week program of three or two antiretroviral drugs, several times a day.

The side effects are considerable. An average of one third of people who start PEP treatment had had to stop it because they can tolerate the side effects. In addition, potential toxicity and long-lasting compliance are dissent issues that make PEP complicated to undergo.

Moreover, another thing not less important is that close follow-up for clinical and serological check are required when a patient undergo PEP treatment. This medical check up is a necessity since the person needs to be monitoring to ensure the outcomes of the medication and the final HIV status after the treatment. However, a study carried out in France reveled only 25 to 30 percent of the people who undergo PEP respect this constraint of medical follow-up.³²

► How to reduce HIV infection risk related to a rape ?

After being raped it is an emergency to go to the nearest medical clinic or hospital to undergo an internal examination. The health workers have to decide if it is make sense to prescribe the PEP to the victim. Before making such a decision the level of the risk has to be assessed.

- In the same way, PEP is not recommended during pregnancy. The decision to refer to PEP during a pregnancy should be discussed carefully. The benefits of PEP's usage should always outweigh the risks.

The treatment could be also stopped if it happened to know the rapist is HIV negative. To date PEP use in other contexts than occupational is controversial because its benefit has not been proven and health workers fear it will discourage safer sex practice.

South Africa already started a policy in this view. However this treatment's availability is not yet widely known by the population.

3.3 Resistance to condom usage

Condom is an old method of contraception. Beliefs suggest condom was used already by Egyptians 1,000 B.C.³³ Many legends surround on its origin which still unknown. Anyway, the name condom derives from the Latin "condos", which means receptacle. It is seemed there was also someone named Dr Condom who had supplied King Charles II of England with animal-tissues sheaths to prevent him from having illegitimate children and getting diseases from prostitutes.³⁴ Through ages, condom's form and materiel manufactured had evolved. Today, new technologies have improved condom production. Different types of condom are manufactured in latex, multiple colours, textures and flavours. Polyurethane condoms are also available for those who are allergic to latex.

Before HIV infection occurs, condom use was somehow marginal in African. Then after 1983, HIV prevention programs focusing on condom are reaching successfully certain target audience, mainly sex workers. Owing to prevention effort that are being made by local Health departments and NGOs in each country to raise awareness, people are getting increasingly more knowledge than ever about HIV infection transmission and condom use.

Nerveless, many studies revealed that the knowledge about HIV risk does not markedly translate into modification of harmful behaviours³⁵. Condom use in Africa still very low, for instance in South Africa the rate is about 10 to 20% of the population³⁶ though South Africa is a country where the condom use is relatively high in Sub Africa. A recent study in Côte d'Ivoire concluded condom use remains low in the country despite the increasing prevalence of HIV and widespread awareness of how the virus is transmitted. In addition the study asserts 'The level of accuracy of AIDS knowledge did not predict the likelihood of recent condom use in this sample.'³⁷ However, studies found the most powerful determinant of condom usage in Africa is a perceived risk of HIV infection from the partner.³⁸

Originally, the socio-cultural context is badly predisposed to condom use since it is against basic traditional values.

Condom had never been really a strong contraceptive method in Africa given contraception is not a concern of most of African people although health department endeavour to develop familial planning. Few people used it apart from some prostitutes.

The problem is a number of researchers have found that negative attitude towards condom were significantly associated with its non-use whilst favourable attitudes towards condoms are positively correlated with firm intention to use condom during intercourse³⁹.

Certain countries like Mozambique announce the going up of condom sales data whilst others indicate that the level still low.

Despite the fact progressively the culture of safer sex is being adopted in Africa, tradition still displays many strong barriers that needed to be approach on behalf of moving forward in the fight against HIV infection. So, understanding cultural hurdles that impede condom use has the utmost importance.

Condom's rejection in Africa and also Asia is back up by traditional ideas, negative constructions against aids and strong misinformation on condoms.

▶ Progeny's need and semen value

Using condom is a preventive method against: HIV infection, STDs, unwanted and wanted pregnancy. The role of limitation of birth is a significant obstacle to safer sex in Africa. Though African culture is different from place to place, everywhere ...the high value placed on children and procreation has been transferred to the sexual act as basically an act of fecundation...The social importance attached to fertility cults, to birth, naming and initiation rituals, to marriage, death and burial ceremonies, flow from a logic of, and accord well only with, generalized fecundity and procreativity.⁴⁰

The need of progeny which is a paramount question in Africa as explained concerning polygamy. Unfortunately, the importance of procreation overweighs too often the desire to be protected against HIV infection in the feeling for both men and women. For instance, a childless woman could take the risk of unprotected sex in order to get pregnancy. The desire of child lead married and unmarried men and women to have unprotected sex. Obviously this is one reason that explains the highest rate of HIV infection between married because a absence of a child in marriage is not understandable. Consequently, it is one of the reason married people are more exposed to HIV infection than single.

The associated value of semen to procreation, renders condom use is seen as a *waste of semen*⁴¹.

Evenly, semen had traditionally another great value. It is an element of converse acceptance between two partners. If a woman decides to not receive in her body the semen of a man that could mean or interpreted as a lack of love for her partner. Conversely men need to arouse woman they love as a way to pose his signature inside the woman to mean he has conquered her body. Condom use suppresses this psychological mind state which undermines men's pride and masculinity.

▶ Masculinity concept and gender issues

According to social construction in Africa, men perceived themselves endowed with a supernatural power that put them beyond any misfortune. Regarding to this suggestion they do not feel concerned by disease or illness which are "*business of women and child.*" In this point of view, they believe do not need to avoid risk. Men are also much more likely than woman to see themselves as being invulnerable to illness or risk, which may contribute to the ineffectiveness of awareness messages. Condoms are often viewed as "unmasculine," and

sex without a condom also adds to the sense of danger that traditional concepts of masculinity encourage.⁴²

Women are already more exposed than men to contract HIV infection given their sexual anatomy: a man with HIV/AIDS has an average chance of one in 500 of passing the virus to a woman in a single act of unprotected vaginal intercourse. The odds of woman to man transmission in the same situation are about one in 1000.⁴³ Those rates assume there is absence of any SDTs else. It is due to the fact man ejaculates into a woman and also because the virus is more concentrated in semen than in vaginas' fluids.

In addition, men's virtual domination and females' disadvantaged position rendered them powerless is largely contributing to the spread of HIV infection in Africa. Women are in weak position to negotiate safer sex. Gender inequity around sexual issues is a problem that needed to be approached in the HIV infection's context. The subject has been almost exhausted. 'Essentially, widespread of stereotypes of masculinity, "machismo" and what it means to be a *real man* encourage male dominance over women, risk-taking, and promiscuous sex (*a real man* is not satisfied by one woman). In many cultures, ideals of manhood include strength, courage and dominance and critically, accept men as having an incontrollable sex drive that lets them off the hook of responsibility.'⁴⁴ Although this assertion is still being true in most situations, it will be an error to generalise. All African men are not macho, some exception exist depending on many variables. For men who do not subscribe to machismo, it is not rewarding to make a snapshot. Anyway, traditionally in Africa, women sexuality does not exist apart from giving birth and satisfied their men sexually.

To empower both men and women overcoming this issue, many solutions are about to be implemented or already implemented in local, regional and global level. At global level by United Nations bodies' and bilateral development partnership⁴⁵ attempting to fill gender inequity's gap which become development priority at global level since HIV infection's onset.

For the time being, to move forward through the global fight against HIV, efforts have to be centred on research of solution rather than continuously pointing out men as scapegoats. Men should be constantly incorporate to debate concerning HIV infection at all level as women do. It was hardly the case in the past. Failure to target men in health policies has also negative impact in programs' success. Now the objective is to gather men and women to discuss about sexuality and reproduction issues in order to adopt altogether best sexual practice.

► **Absence of Communication around sexuality**

Some African people may find this paper offensive because sex issues are not habitually discussed openly nor publicly. People who dare approach sexuality are pointed out as having received a wrong education or are associated to sex-workers. In Africa sex is the most taboo theme to be approached because the basic norm is that 'sex is something to do and not to talk about'⁴⁶. Factually, lesson learnt from Uganda efforts to stem HIV spread have shown safer sex is not a concern of one person, since it is involve partners they should communicate on the subject and make a reasoned decision based on the rule of safer sex before act.

► **Controversial prevention message**

Mixing message are been released within populations about condom efficiency. Churches are against condoms and oppose to the prevention messages that encourage and support condom use.

According to the opinion of most Roman Catholic and conservative Protestant groups condom could not be advocated as a policy to fight VIH/AIDS .Those religious think condom use - first promotes promiscuity and irresponsibility in relationship - second it is limited artificially birth - and third Vatican had convey condom use is not a efficient preventive method against HIV infection. Cardinal Trujillo incorrectly stated that the small size of the virus 'can easily pass through the net of the condom'⁴⁷ WHO has formally rejected this assertion. Such an assertion jeopardises condom promotion's programs which are being carrying out in African countries.

WHO maintains that consistent and correct condom use reduces the risk of HIV transmission by 90 %. While there may be breakage or slippage of the condoms than can lead to failure, condoms are not manufactured with netting or holes that allow viral passage.

Evidently, condom use is as far the safer way people could avoid HIV for the moment. The New England Journal of Medicine reported a survey in 124 couples in which one person is infected with HIV and the other not 'discordant couples', consistent use over a period of two years demonstrated none of uninfected partners became infected. Whereas at the same period, 12 partners became infected among 122 discordant couples who used condom less regularly.⁴⁸

However, churches' influence is strong in Africa because a lot people turn to the church hoping it will help them overcome their life difficulties. Churches' group do often take care and support the most venerable groups within communities. In addition, condom usage opponents are also the greatest contributors to implementing Emergency Plan's against Aids through the world. So, they use enhancing rather faith and abstinence only as prevention method than encouraging condom use campaign, though the evidence is clear that comprehensive approach is needed.

► **Ignorance: a great barrier to condom use**

Ignorance about condom is a major concern which is too often under estimated. As safer sex is a new practice in Africa, most people still simply ignorant of condom use and basic sexual knowledge.

- At some places in Africa and Asia: Many people still believe condoms have pores and are therefore useless - people think condoms are difficult to put on - or reduce enjoyment of sex - STIs including HIV can be prevented by taking antibiotics before or after sex, and someone's HIV status can be determined from their physical appearance, if they seem outwardly healthy condom use is not a necessity.⁴⁹

- In certain cases, people reported that condom is difficult to use because they do not have accurate knowledge about how to put it on. A District Health Educator in Uganda asserted 75% of youth in a certain district use condom, however only 2% of this percentage knew how to use it correctly.⁵⁰

- Other misinformation presumes condom use weak and asphyxiates sex since the rubber does not allow it to breathe.⁵¹ In the same way, men dislike the idea of rubber between themselves and the partner during an intercourse; this feeling is reported diminishing their pleasure or at worst making loose their virility. It is the reason that underlines the famous expression in Africa: "*skin to skin*".⁵²

- Although 90% of Nigerians have heard about HIV/AIDS, 80% do not believe the disease exists.⁵³ At certain places, people still do not believe in the existence of the virus attributing Aids to witchcraft or to a curse. In Ghana, the prevalence rate of VIH is still high and had not achieved the desired results due to apathy and disbelief⁵⁴ of the youth about the existence of the pandemic.

- A lot of people think in Africa that the virus is a 'man-made' weapon to vanish certain communities⁵⁵.

- There is a group of individuals claiming AIDS exists only in the mind of people not in reality. How someone can fight against an enemy he even not believes in its existence? Thankfully, in regions where the virus has already ravaged the population, this is no longer the case. Such a learning way is hard.

- In Africa is still embracing to buy, carry or help oneself condom, because condom is associated to promiscuity or prostitution given the fact that condom was firstly used by sex workers. Another common embarrassment is due to fact if a partner suggests condom use the second partner will interpret the request as a lack of trust, a suspicion of infidelity coming from the partner intentioned to condom use.

- Apart from religious and cultural opposition, condom use faced with parental opposition in such a way, young people feel embarrassed to carry on or use freely condom because there is a failure parents' authorization on condom use. Relatives, policy makers and most of churches leaders think that talking about condom and sexuality with teen could motivate them to start sexual activity. 'We teach students how to abstain, how to put off sex until marriage. We never talk of condoms'⁵⁶ a representative of the Ministry of Education in Zimbabwe. The result of such an assertion is clear: young people interviewed in the country are awarded of HIV infection but they did not know how to protect themselves apart from abstinence. Worse, the same research found sixty per cent of 700 teens interviewed had wrong believed that female contraceptives can cause infertility and condoms can 'weaken' sperm.⁵⁷

'Programme and policy directions in several countries have been hampered by adult beliefs of what young people should be permitted to know...However, various global studies have consistently found little evidence that sex education encourages sexual experimentation or increased sexual activities.'⁵⁸ Studies have proven that sexual and reproductive health education for young people does not encourage promiscuity rather the opposite. A study lead in several parts of the world have shown young people were more likely to delay sexual activity when they are well-informed on sexual issues.

Though invaluable prevention efforts' ignorance remains the greatest challenge that hampers condom usage in Africa and Asia. Health workers have absolutely to demise misinformation and misbelieve which are surrounding about condom. Most of the time prejudices are due

to low education level in general and specifically to lack of health reproductive knowledge since sexual issues are taboo in societies.

► **Cognitive escape and substance use**

Risky attitudes are not always stem from the lack of information or ignorance. During my own experience in HIV prevention within African people in Geneva, I had been faced with several hundred Sub Sahara African people who had enough knowledge on the virus, were well-informed, however they recognize did not use condom consistently as required. It happened that many people in a perfect mind state decide to engage in risky behaviour regardless of their knowledge about the probable consequences. None of them was able to explain the reason of such a non-rational behave. Another none sense is the fact, certain recognize the existence of the virus however they feel themselves different from others and are convinced they cannot get the virus (if not already infected) even if they disconsider safer sex. 'I have free sex, I can get HIV because I have faith in my body'. This feeling distorts the information to the contrary. So doing it satisfies the unaware desire to be free of constraint. That means sexuality is complex to be rule. People must be also empowered about those psychic aspects.

Drugs and alcohol abuse enhance this kind of cognitive distortion. In most African villages, people have facilitated access to alcohol and light drugs. Alcohol brewing is a one of income generating activities, it is easy for people to abuse its consume. In the same way, hashish is cultivated in rural areas and use by young people. Of course individuals react differently to substance. Nevertheless, studies had shown a link between substance abuse and unsafe sex. Substance effects may induce 'cognitive release' which in turn leads to a risky behaviour.

► **Which marital status is concerned by condom usage? Married or single?**

Factually numerous studies found reluctance to condom usage within marriage or cohabiting partnership in Africa. Only 14 percent of interview people men and 17 per cent of women reported consistent or occasional condom use in such relationship in South Africa ⁵⁹ where the rate of condom use is relatively higher.

Pitifully, it is shown through this writing that married or regular partners are more exposed to HIV infection's risk than single in Africa.

Furthermore, churches promote chastity until marriage and be faithful after marriage. This moralistic approach could be dangerous and lead to risk since faith is not something one should rely on. The standard profile of women who are being infected today is ones with only one regular partner whatever as marital or cohabiting partnership because... 'Between 50 and 80 percent of all HIV-infected women in Africa have had no sexual partners other than their husbands'.⁶⁰ Another study in Kigali, Rwanda, found that women with no others risk factor except their long-term partner formed the largest proportion of women with HIV/AIDS. 75% up infected-women in Thailand are probably carrying the virus from their husband.⁶¹ The faith claimed by ABC prevention programme is not humanly realistic given it convey a false sense of security in Africa and Asia.

The problem is not unknown in US where, in 2002, according to the Centers for Disease Control and Prevention, African Americans accounted for about 50 percent of the 42,000

estimated new AIDS cases diagnosed among adults in U.S.⁶² 'Keeping it on the down low is a slang term for discretion in general. But the expression now commonly refers to subculture of African-American men who lead double lives. They date or marry women but secretly have sex with men. Experts say it may explain epidemiological data that show increasing numbers of black women who aren't intravenous drug users becoming infected with HIV'.⁶³ Reportedly, prevention method based on faith seems to be HIV infection's risk factor unless within African people. Married are more exposed to HIV infection than single.

Basically about regular partners' couple: spouses, boys or girls-friends, any long-lasting sexual relationship, before the couple starts intercourse it is better for both to take a test in order to ensure each one status.

- If one of them is HIV positive the couple should always use condom for sexual activities.
- Oppositely, if the result is negative for both, they will have protected sex and remain faithful during a probation period of three months. Afterward, a second checking test is necessary to confirm their status. If the result of the test still negative for both after 3 months, they can start having unprotected sex, but at one condition: they have to maintain absolutely faith, otherwise they should not give up condom usage.

- For single who has sex occasionally with different partners it is better to use absolutely condom at each intercourse with new or known sexual partners to avoid risk. It is not a good idea to decide to have unprotected sex based on feeling about your partner rather make this decision after a testing process as describes above.

To answer the question which one of marital status is concerned by safer sex, all kind of relationship involving sex have to avoid risk by adopting safer sex practices.

► **Condom availability**

Easier access to condom is a another issue that need to be take in account in developing countries, on average, men in sub-Saharan Africa only have access to about three condoms a year.⁶⁴ Though governments, national and international NGOs' efforts, condom is not so much accessible in developing countries. Many projects are used to distributing condom over time, in most towns there are focal points where you can get condom freely. Such a free condom projects are carried out in urban areas. Rural places are too often kept away from free access to free condoms. The reason is HIV rate is generally lower in rural areas than urban regions.

Obviously, condom is always available in pharmacies at every place. However if people have a other concern more pressing as hungry problem, they will not spending money by purchasing condom whatever it is in rural or urban place.

Another misinformation in condom's lack context is about the fact condom should be use only once. A study's report in Uganda has stipulated that in Gulu, young men, particularly soldiers wash condoms and use them several times. Sometimes they even share used condoms among each other.⁶⁵

Despite many aware campaigns, people still engaged in unprotected sex. Sadly one of the reasons is because in certain cases people can not afford spending money to pay condom. The concern is those people will not abstain to have sex, they will expose themselves to risk. '...low condom sales showed that people were not so much using, the protective measures because maybe they had to deal with bread and butter issues first before they could think

about the disease.⁶⁶ Therefore, condom's price, even low is already a difficulty that could hamper safer sex success in many poor countries' context.

Female condom is less available than male one because is relatively a new-comer on the market so that means it is remain unknown by most women. In addition, it costs higher than male condom and there is only one fabricant firm through the world. Opinion or feeling about female condom usage is another concern. Some women find it very uncomfortable to use whereas others enjoy it use.

► How to reduce risk relevant to condom usage?

Interventions based on local context are likely to address specific issues relevant to condom usage resistance within a particular context. Culture is a valuable resource in this setting to direct health educators tailor the right message to target misinformation which are ongoing in each area. For instance if the belief about condom usage cause penis weakness is predominant within in a community, interventions should intend to correct the false idea by targeted messages and actions. Once more, behaviour change communication will be valuable in this context.

4 TRADITONALS SURGERIES

4.1 Male circumcision

The word circumcision comes from Latin: *circum* means "around", *coedere* is "to cut". Thus circumcision is a surgical procedure which removes some or all the prepuce or foreskin of the penis early in the childhood or later. Previously, circumcision has been cultural practice widely across African cultures, in some Pacific Island cultures, and also in Muslim and Jewish religions. Circumcision also occurs in broader population of such communities and is justified as a preventive and hygienic intervention, or just to 'fit in'.

► Could male circumcision reduce transmission/reception of VIH infection?

According to medical current knowledge, health professionals have been hesitant to integrate male circumcision as a public measure for HIV prevention because of a dearth of reliable scientific information on the issue, and because the procedure itself could facilitate transmission if equipment is not sterile, and leaves a wound that is a risk until healing have occurred. Public There is research on the linkage with HIV transmission and circumcision, but it is not conclusive about the link between circumcision and reduced spread of HIV.

Here are the main outcomes of the available research:

The scientists and clinicians who support the protective effect of circumcision against HIV infection are Dr Halperin, Fauci, Cameron and colleagues, & al. '... from over 40 studies shows that male circumcision provides significant protection against HIV infection; circumcised males are two to eight times less likely to become infected with HIV. Furthermore, circumcision also protects against other sexually transmitted infections, such as syphilis and gonorrhoea...'⁶⁷

According to them, the foreskin provides a portal of entry to HIV and other pathogens. The prepuce would contain primary target cell (Langerhans cells) for sexual transmission of HIV infection. Besides, foreskin is susceptible to traumatic epithelial disruption during intercourse,

which implies more vulnerability to HIV infection and others STDs. Keratinisation of circumcised penis would reduce chance of HIV penetration. They have also found that where most of the men are uncircumcised, STDs are common implied HIV epidemic explosion. Nevertheless, some authors assert that circumcision before age 20 years has a protective effect against HIV, but if circumcision is made later that could not reduce the risk of transmission. Kelly and colleagues' study suggest that if the procedure is performed on adults it may not reduce the risk of HIV transmission."⁶⁸ The study by Kelly and colleagues asserts that the number of populations undergoing circumcision has increased.

Others researchers (late Aaron J. Fink, MD, R.S. Van Howe & al) have an opposite point of view. Van Howe found that: 'a man with a circumcised penis is at greater risk of acquiring and transmitting HIV than a man with a non-circumcised penis...Based on the studies published in the scientific literature, it is incorrect to assert that circumcision prevents HIV infection'⁶⁹

Thus, they oppose use circumcision to control HIV infection because they think behaviour factors' are the most important risk factors in acquisition of HIV infection. Authors focus their writing on confounding factors which likely flaw the studies that found a link between less HIV infection and circumcision. The main confounding factors are: age, location of trial, socio-economic status, religion, sex behaviour, etc.

Some authors assert that an intact prepuce may offer a protective effect against HIV because Lysozyme beneath the prepuce contains an agent for killing HIV in vitro. So, circumcised men had greater chance of contracting HIV than others since their prepuce are removed.

Moreover, studies that recommended circumcision for preventing the spread of HIV infection were all almost undertaken in African countries, did not use broad samples, and were not randomised. Furthermore, there are lobbying groups through out the world against female and male circumcision advocating for the bodies integrity. Some in this group ask the question: 'If genitally mutilated females were found to be at reduced risk of HIV, would the researchers suggest promoting FGM?' to highlight the reasoning behind their opposition to all circumcision.

► What is UNAIDS' opinion concerning all these assertions?

According to Mrs. Hankins, Associate Director at the department of Strategic Information at UNAIDS : 'There is an association between male circumcision and lower HIV prevalence but this is among men circumcised at birth or prior to puberty - not in adult men where *cornification* of the prepuce may not occur in the same way it can in infants.' UNAIDS is conducting 3 randomized controlled trials of adult male circumcision. Results will be available in around 2 years. So, for now UNAIDS is not recommending adult male circumcision as a preventive intervention against HIV infection.

A key focus of harm reduction would be infection control during circumcision as well as the others traditional surgeries. People conducting such surgery need to be aware of the transmission modes for HIV infection, and use sterile instruments for bodies cutting.

In hospital and clinic circumcision children candidates undergo local anaesthesia, adult do it under general anaesthesia. When the practice is performed outside of clinics and hospitals, it is almost conducted without anaesthesia so it is very painful. This can lead to trauma with lasting psychological impact, though ritual context is a mitigating factor. In addition, the sanitary condition of the surgery is doubtful mainly with regard to safety of the implements.

Traditionally, in most of African countries healers are requested to perform circumcision at ritual ceremonies for initiation in adulthood, or circumcision for cultural habits and faith purposes. People often undergo circumcision in groups, for instance brothers and others siblings of the family used undergoing together, and if healers use with only one knife to cut everybody at the same time, there is a great risk of transmission of HIV and other blood borne infections. 'The major concern is the possibility that HIV and Aids could be transmitted during traditional circumcisions...a former district surgeon says the surgeons often carry out more than one circumcision, using the same instrument.'⁷⁰. But in some countries hard hit by HIV infection, traditional surgeries' are already changing, for instance in Uganda.

► **Reducing harm:** If circumcision is carried out:

1. Utilise a hospital or clinic by with a medical experienced physician in the procedure and infection control.

2. In the case the person has not to access to medical expert, or the ritual setting is important, a well-trained and experienced healer who practices infection control is needed. In that case we recommend the practice be conducted with sterilized or single use implements (one sterilized knife to be use for one person) to prevent transmission of HIV, Hepatitis B and C, and other blood borne infections. Medical backup should be in place in case of serious hemorrhage.

4.2 Female circumcision/genital mutilation

► **Overview**

There is a strong advocacy movement highlighting the harmful effects of female circumcision, such that the term 'female genital mutilation' is now widely used to describe the practice. "Female genital mutilation" (FGM) refer to the cultural practice of removal of part or all of the female sexual organs. There are 3 levels of FGM: type I, II, III. Type III, a procedure of clitoridectomy called infibulation or *pharaonic circumcision* where part or all clitoris, labia minora, and labia majora are cut out, then stitched or held together leaving a small exit for urine and menstruation blood, is widely considered a grave and harmful abuse that denies the fundamental human rights of the women, who are then referred to as victims or survivors of the procedure.

An estimation of 135 million women had undergone FGM through the world. In Somalia, 98% of women (5 millions) have undergone FGM⁷¹. It is estimated that 70-80% of women in Gambia⁷² undergo FGM. The type of FGM performed varies by ethnic group and region.

FGM is practiced by Muslims and non-Muslims in Egypt, eastern, central, and western Africa. A lighter form of the procedure is being practiced in some parts of Middle East and South Asia.

Females undergo FGM between the ages of four to eight. As with male circumcision, it is a group event, usually in the context of ritual ceremonies, but parents can also opt for their girl to have FGM alone, it is depend on the setting. The procedure is carried out by healers, traditional midwives, old women, at home, or at a specially designed place for initiation.

In some countries the practice is increasingly performed in a clinic or hospital by health workers (nurse or midwife), which undoubtedly reduces harm but places health workers in an

ethical dilemma as they still inflict irreversible mutilation. 'In some countries, more affluent families seek the services of medical personnel; in an attempt to avoid the dangers of unskilled operations performed in unsanitary conditions...A major effort is needed to prevent the medicalization of the practice.'⁷³

► Reasons of FGM

The main reason people often evoke to legitimise FGM is: custom and tradition. FGM is a millennia old custom and ritual, tenaciously rooted in social life of communities. Apparently, FGM could not be allotted to religious beliefs. Muslims explain that FGM it is not required by Islam as the Qur'an does not contain any appeal for FGM.

Others reasons cited are: gender identify, control of women's sexuality, hygiene and health issues. Only women who underwent FGM are considered by the society as women in FGM-practising societies where an uncircumcised girl can hardly get married.

'A girl cannot be considered an adult in FGM-practising societies unless she has undergone FGM...FGM is often deemed necessary in order for a girl to be considered a complete woman, and the practice marks the divergence of the sexes in terms of their future role in life of marriage.'⁷⁴

A common reason cited for FGM is to reduce the woman's sexual need, as a kind of 'chastity belt'. As with dry sex, FGM involves tightening the vaginal opening for men's pleasure. The idea of cleanliness as noted for dry sex is once more a focus, with FGM purported to ensure the cleanliness of the vagina.

Assertions are made about the unhappiness of the family life of uncircumcised women. Attitude and beliefs which are underlying this in practice are a major deterrent to families who wish to discontinue FGM. Direct social pressure and social exclusion is often applied.

► Practice's description and consequences

Outside to hospital or clinic FGM is performed with cutting instruments such as: broken glass, a tin lid, scissors a razor blade or other sharp tool. One Sudanese grandmother described the procedure: 'In some countries they only cut out the clitoris, but here we do it properly. We scrape our girls clean. If it is properly done, nothing is left, other than a scar. Everything has to be cut away.'⁷⁵ This refers to infibulation's description, the type III of FGM.

Article 5 of the Universal Declaration of Human rights, states that "no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment." Article 22 added "everyone as a member of society has the right to social and cultural rights indispensable for his dignity and the free development of his personality".

- Use of the same implements to perform FGM on several girls at the same time could cause HIV and infections.
- Circumcised women do report psychological troubles attached to FGM during whole life span including shock and trauma, betrayal, humiliation, anxiety.
- the surgery is performed on unanesthetized infants' bodies that imply a extreme pain ;
- Complication such as blood loss could occur immediately or shortly after the surgery causing anaemia and sometimes death;
- The non-use of antibiotic is a factor that could enhance genital infections ;
- Over the years, several long-lasting illness due to FGM occur such as : urinary tract infection, kidney damage, pelvic infection (e. g dypareunia), excessive scar tissue, etc
- Death occurs in some cases.

'Female genital mutilation of Somali women has increased the number of STDs and is a recipe for higher rates of HIV/AIDS in the country, said Hodan Farah, a Somali gynaecologist...Objects used for the excision are not sterilized and at the same time could again be used to mutilate more women, who could already be HIV-positive.'⁷⁶

▶ **What are UNAIDS' WHO, and IFRC opinions concerning FGM?**

Consistently the 3 organisations condemned and call for FGM prohibition. At the 11th General Assembly of the IFRC in 1997, the Decision 38 called on all NS to work on the 'elimination of the practice...noting that the practice of female genital mutilation poses serious threats to the safety and health of women including increasing the risk of HIV infection and other life-threatening complications...'

Even with medicalized FGMs' long-lasting illness remains and the practice itself still a violation of body integrity since is usually not the patient's free choice. WHO forbids performing FGM even if the practice is conducted by medical staff?

▶ **How to reduce risk related?**

A lot of national and international human rights' bodies are voiced to abolishing FGM. The practice of FGM should be eradicated. In September 1997, a forum which gathered 40 countries' delegate urged African legislators to enact specific and clear legislation to Abolish FGM by the year 2005.

Communities where the practice is performed should find a replacement ritual or a modified one that does not involve mutilation of the women's body. In many countries advocacy groups are already working on this objective.

In the meantime all efforts should be made to minimise the harms without condoning or encouraging FGM, even when the practice has been criminalised.

4.3 Other body cutting's practices

Scarification, tattooing and others sorts of body cutting have their origins in ancient human history across the world. 'Scarification is a permanent form of body decoration that perfects the body in much the same way as cosmetic surgery. It involves puncturing or cutting patterns and motifs into the dermis or upper levels of skin.'

In Africa, the practice dates back centuries and is popular among tribes. The practice is performed for several reasons: for beauty, costumes, to cure some illness, or to increase pleasure during intercourse'. Common facial scarification is performed by all members of a tribe to recognize each other. Today the practice is dying gradually because of the modernity and also due to the fact that in several countries it is outlawed.

In some countries like Benin, people do not continue to make scarification. However scarification story remains alive during rituals. People are used to paying for keep they child away from cutting. Whatever the purpose is, the fact is that when a sharp tool (needle, razor, knife, etc) breaks a person's skin, blood and tissue fragments will adhere to the implement. Then when the same implement is used the blood and fragment is directly transferred to the bloodstream of the next person.

In several countries, people start to raise awareness against risk that could resort out from such behaviour. To date there are no study about the specific link between those practice

and the spread of HIV given clear knowledge about modes of transmission the existence of a certain risk related to shared implements is widely acknowledged.

1.4 Some practices focus on blood

In Africa, several rituals require exposure to animal or human blood:

- Among them one practice has been reported identified as a case of possibly HIV infection.⁷⁷ It is referred to the practice called brotherhood which is widespread in East and Central Africa among pastoral groups such as Masai tribe. The practice consists of exchange of venous blood following a small cut. Thereafter people become a blood brother.

- A similar practice called blood pact exists also in some West Africa tribes. Two or many persons gather in secrecy, cut themselves slightly and suck jointly the blood of each other. This act means that they promise one another to remain faithful in love or friendship until the end of their life. Basically, the blood brotherhood and blood pact have the same meaning. This kind of friendship is nearly vanished in urban areas due to western civilisation.

In addition, the traditional way to give birth can be considered a risk unless basic hygienic rules are taken into account. Midwives need proper training in universal infection control procedures.

► How to reduce the risk related to body cutting?

All people that are involved in performing those surgeries need to be taught the basic hygienic rules about :

- their personal hygiene as performer,
- Best practice in order to work safety: instruments and surfaces that need regular cleaning, disinfection, or sterilisation.
- Aftercare problems.

To clarify the meaning of a number of words : cleaning, decontamination, disinfection and sterilisation:

- cleaning is a process to remove dirtiness and contamination. For instance we clean our bodies by bathing and our clothing by washing. However cleaning does not necessary destroy micro-organisms. Surfaces and work equipment should be regularly clean with adequate detergents.

- Disinfection is stronger than cleaning because it reduces a number of micro-organism, but all of them. So some work equipment has to be disinfected after each use.

- Sterilisation is the process than renders a tool free from any viable micro-organism. Reusable implements which are use to cut body have to be absolutely sterilized after being used on one person to avoid spread of transmissible diseases.

5 MULTIPLE SEXUAL PARTENERSHIP

5.1 Polygamy and polyandry

Polygamy and polyandry have the same consequence, they increase the number of sexual partners thereby expose people involved to risk of HIV transmission, unless condom use is consistent. However, polygamy is more common within African societies than polyandry. It is why I will pay more attention here to polygamy.

Polygamy has a great role in Africa culture and customs. Given the value of family size men marry several women to have many children. 'There is no part of Africa where children are not greatly valued and where, as a consequence, large families do not exist or polygamy is not practised Conversely, childlessness remains the main cause of divorce, as a childless marriage is considered to be equivalent to no marriage at all.'⁷⁸ As there is no social insurance system, people traditionally have a large family to ensure an adequate workforce within the family, and care when they are older.

Flowing from this view, even a man who wants to remain monogamous would likely change to polygamy if his first spouse does not give birth in the years follow marriage.

In the same way a men whose wife gives birth to daughters only will likely consider marrying another woman in order to have sons. In Africa, any baby is welcome but people think that men are much more able to lead a family.

The last important reason that fosters polygamy is the men's need to show their financial power. Some rich men attempt glory and celebrity by marrying or engaging in relationships with a lot women. According to the customs, a man who is able to maintain a lot wives is admired for his manhood.

5.2 Intergenerational and transactional sex

Both practices are reinforced by poverty, specifically women's poverty. Transactional sex means one partner has intercourse in exchange for money, material gifts or favours. The transaction could be initiated by the man or the woman. People involved in transactional sex are not necessarily defined as sex - workers even if the practices share many features. The difference is that woman can have a few occasions of transactional sex to resolve a specific problems or needs, without this becoming her job.

A study⁷⁹ found 33.3% of girls aged between 15 and 19 years in the western city of Kisumu (Kenya) were infected by HIV. Transactional sex would be partly the reason of this high HIV rate given young girls drop out school and start seeking resources to feed their destitute relatives.' *There was no other way to find money. I started to have sex with anyone who could give me money. It was not easy for me but I had to do it because I had to find food for my brothers...*⁸⁰

The "youth culture" is strong in Africa. Old men prefer to have sex with youngest girls and very often to marry them as the second, third, wife. In exchange they provide social welfare

to the girl and her family. On the other hand the practice persists because most families are in financial need.

In Zimbabwe, those much-older sexual partners are called 'Sugar Daddies'. However a wealthy person is often already old, has got already several wife. Whatever the reasons, the UN Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa has found that both transactional sex and intergenerational sex have become the norm in many countries. For example, a study in Zimbabwe found that nearly 25% of women in their 20s are in relationships with men at least 10 years older (United Nations, 2003). It is also clear that these relationships are a major factor in the feminisation of AIDS in Africa.⁸¹

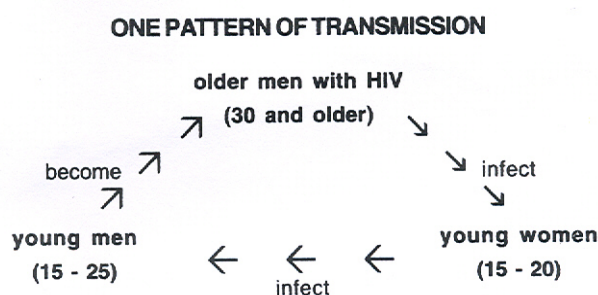
The Secretary-General's Task Force on Women has identified three factors that contribute to women's vulnerability of HIV in the region, which are: silence surrounding sexuality, transactional and intergenerational sex and violence against women within relationships.⁸²

Intergenerational sex is suspected to lead to high rates of infection among African girls. Some studies found that young women in sub-Saharan Africa are up to 6 times more likely to be HIV positive than young men.⁸³

Furthermore, safer sex has a link with age difference: 'Within relationships, the power to negotiate safe sex diminishes with the increased age of the partner; older men reportedly became violent if girls proposed condom use or refused sex.⁸⁴ Young girls reported men become violent if they suggest condom use or if they refuse sex. *One girl said: '...If you do not want this kind of relationship, you stay poor.'* Thus, it is not unusual to hear relatives encouraging their daughter to choose the richest man for marriage in order to gain welfare.

This practice is also happening in other parts of the world. Occident. Older European men engage in sexual relation and even marry young African, Latina, or Asian girls. Young women accepted the union in exchange of the possibility to stay and gain work permit in the hosted country. The result is the same as described above spread of HIV infection. Most of girls or young men who married oldest in Europe or elsewhere throughout the world have several sexual friends without their legal partners knowing. Authors practice experience with 20-40 individuals in France, Switzerland to date.

Fig: 5



Source : Men and HIV in Namibia, PANOS/NRCS/SAfAIDS, 2003.

An older HIV positive man establishes a sexual relationship or married with a young girl in exchange of material rewards and transmitters the virus to her. Afterwards, this young girl will have the desire to have sex with a young boy in the same age with her because she is not (though if she is married to the older) sexually dissatisfied with her aged partner. Therefore, she will pass the virus once more to the young men. Later this young boy will infected his wife and when getting aged will infected also others young and the cycle will start again.

In conformity with what has been explain above, this pattern show one important way of HIV infection spread which is deeply rooted in most African Sub-Saharan countries. Precisely, in Africa according to the custom, schoolgirls engage in such relation to earn money and maybe to feed all the family. Such traditional practices foster transactional and cross generational sex. The worst is the fact, in some areas it seems relatives' pride when their daughter is engaged in relationship with her teacher.

So, implicitly or explicitly cross generational sex installs a network of unprotected sex which is a hazard for all the community. HIV spreads when people have more than one sexual partner and condoms are not used consistently. Trans generational sex suggests infidelity and increases extramarital unprotected sex.

In conformity with what has been explain above, this pattern show one important way of HIV infection spread which is deeply rooted in most African Sub-Saharan countries.

One way to break the cycle is to promote inter-generational sex to stem the spread upon several generations when one came to be careless.

5.3 Others multi-partnership customs

Studies on a group of population shown migrants, traders, teachers, trucks drivers, seafarers, civil administrators and army staff are specifically exposed to HIV infection due to the displacement linked to their job. Those people used moving often.

The link between mobility and HIV/AIDS depends highly to the social and economic conditions of the migrant. 'Such studies indicate that migration and mobility increase vulnerability to HIV/AIDS - both for those who are mobile and their partners back home.'⁸⁵ Indeed, people who are transferred from one place to a temporally or seasonally could hardly move all times with their family.

The reason of separation from sexual regular partner is the most important reason identified to explain the risk behaviour of this population. But usually, those people have to deal also with isolation and loneliness related to many causes (difference of race, culture, language, etc), lack of friendship and inexistence of health service support.

Traditionally, those groups used having new sexual relationship everywhere they move for professional reason. A soldier transferred to a new environment would be tempted to find a new partner or partners and the same cop, teacher or trucks drivers who travel long distances... Many of the trucks drivers have what they call wives in several towns. 'Borbor kamara alias "Rambo" is a truck driver. He describes the job as very interesting and enjoyable. Most times when truck drivers travel with fishmongers, they end up having one new partner. With teachers, a transfer to new place is usually very exciting as it brings about an encounter with many female pupils.'⁸⁶ Within people serving in armed forces, the problem of multi sexual partnership is remarkable. While discussing during a break between soldiers is not uncommon to praise ones who have currently make sex with a highest number of women, just like a contest. Knowing men reluctance to condom use and HIV rate in African's army staff is overwhelming high, such a situation is a threat for public health. According to UNAIDS, many African military forces have infection rates as much as five times that of the civilian population.

Another at risk-group are migrants refugees, seasonally, temporally or permanently migrants workers. Poverty kicks out from their area or prompt people to look for work elsewhere. Migration increases the risky behaviour for partner, the one who leaves and the partner who do not move.

Logically, there is a problem that IOM is about resolving through the world with the partnership of states, UNAIDS and others NGOs. Although the target people enjoy the situation and find it exiting it will be difficult to success changing mindset upon this practice. Failing this, safer sex culture could be upgraded within this population in each country.

5.4 Safer Sex practice

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

In Uganda, HIV prevalence declined from 21% to 9.8% from 1991-1998. Analysing how such data were recorded, researchers found first *reduction* in sexual partners is one behaviour change which leads to prevention success in the country.

It is a behaviour which limits HIV infection exposure if not abstention for sex. Safer sex is *sexual activities reducing or eliminating physical contact with body fluids that contain the HIV virus: e.g., semen, vaginal or cervical fluid, often by means of barriers: e.g, condoms, gloves, dental dams*. Safer sex practice protects, one and his or her partner from HIV infection in 90 per cent.

- Young girls 14 to 24 years are the most vulnerable, education in school, taking also in account out reach young who have dropped school.
- Promoting male condom as well as female condom. Seemly, female condom is perceived as more difficult to use and more uncomfortable than male. Nevertheless if it is well use, female condom constitutes an efficient prevention method against HIV infection, others SDTs and against unwanted pregnancy.
- Microbicides' use is on trial and could be an alternative solution to strengthen women preventing HIV infection though the estimated efficacy expectance is low.
- Attempting to resolve gender issue that erode women's power by making the most with local and global programmes can offer for this fight.
- Involving and arising more men's awareness in the fight against HIV infection.
- Strengthen health education within armed forces and involve them more in the fight against HIV. Make army authorities accountable of war deviant practices that lead to transmit intentionally the virus during conflicts.
- Judge severally civilian and military rapists through tide legislation sooner as the crime committed, even during conflict.

6 DRY SEX

6.1 Practice's description

The term 'Dry Sex' is used to describe two different practices:

1. 'Dry Sex' is used to refer not to **intercourse** but rather to an **outercourse**. In that case dry sex is a 'sexual rubbing and motion of two bodies with clothes on or off, as long as no male fluids can enter the vagina, anus or mouth.'⁸⁷ This sexual practice is encouraged by some

programs as an aspect of an abstinence approach to HIV prevention, as a compromise between no sexual activity and intercourse. This approach does not involve a risk of transmission of HIV as there is no exchange of body fluids, and it is surprising that non-penetrative sexual activity such as this and autoeroticism are not emphasized more in HIV prevention strategies. It is likely that an approach that took a positive approach to sexuality and exploring sexual pleasure could play a role in delaying intercourse, and help young people learn to communicate better with each other and place more emphasis on the emotional rather than mechanical aspects of sex. A more fulfilling sex life could play a role in reducing the number of sex partners.

2. The other use of the term 'Dry Sex' is an old cultural practice, deeply rooted in communities in sub-Saharan Africa, Latina America Caribbean and Southeast Asia. It refers to 'vaginal penetrative sex with non-lubricated genital contact'. This practice requires for women the removing of the vagina's natural lubricant, while men also do not to use synthetic lubricant. In general, women insert a range of drying agents in the vagina before the intercourse: dry cloth, herbs, absorbant stones, chemicals substances such as: bleach, dettol, toothpaste, powder, soap, salt, tablets, antiseptics, etc. Some women ingest before the intercourse a special 'porridge' purposed to dry the vagina. The basic aim is that the vagina should be very tight, dry and hot.

Breaks in skin or mucus membranes increase the risk of HIV transmission, so dry sex is likely to increase the risk of HIV transmission. This second meaning of 'dry sex' is therefore the focus of the rest of this section.

6.2 Main reasons of dry sex practice

The most important reason evoked by people to explain the phenomenon of dry sex practice is that it increases the sexual pleasure of both partners. However a high percentage of women confide that they experience pain rather than pleasure and **resent this**. Most women perform dry sex to satisfy their partner or husband. The men believe that friction enhances their sexual stimulation and pleasure.

A related aspect of this thinking for men is a focus on a tight vagina, which is not natural as women mature and has children. The emphasis on sex with a woman whose vagina is tight, and dry sex, seems to in some ways explain the mythic beliefs surrounding virgins and men's sexual attraction to young girls in these areas. Dry sex has been the trend for centuries and tradition continues to rule, so it is not unusual for women to still comply with men's demand for dry sex. Women who remain wet are assumed to have just had sex with another man, or to have a gynaecologic disease.

'Men love dry sex...Some men tell girls that being wet mean that they have been with too many men.' 'In south Africa, men reported vaginal wetness during sexual intercourse is an indicator of women's infidelity, and have also associated vaginal lubrication with sexually transmitted diseases (STDs) and the use of contraceptives⁸⁸.' Men love dry sex and if women are seeking to maintain a sexual partner she is almost obliged to do dry sex. '*One woman explains*: men do not like loose vaginas. If sex is wet the man thinks that I have sex with someone else and the he won't pay me.'⁸⁹ Sex workers who agreed could also charge more for a dry sex intercourse than for wet intercourse. The problem is that 'men should not swim in female vagina while making sex' said a men. Youth people call girl whose vagina is

wet names and laugh at them. For instance “Chambeshi River”⁹⁰ in Zambia is the name of a river but also the nickname of girls who are aroused and wet during sexual intercourse.

6.3 Other reasons

- Some women affirm that they use dry agents to treat diseases like itching or discharge and vagina's infections. In Nigeria, tobacco leaves are used for this purpose by sex workers. Such approaches will not cure STD's.

- In others countries in addition to the idea of tightness, people practice dry sex for artistic purpose : ‘In Senegal, drying agents may be used where there is a community belief that the vagina is not simply a natural part of the body, but bears the mark of artistic work.’⁹¹

- Some tribes believe it is necessary for hygiene reason, to remove vaginal fluids to create a clean environment for procreation.

- Some practice this tradition as an aphrodisiac, or love potion. Given that men love it, women use it to attract partner or husband and prevent unfaithfulness or to minimise numbers of girl friends outside the primary relationship.

By contrast in some Asian cultures, when a woman's vagina is dry during an intercourse men think that she does not love him anymore. In this situation women who are not arouse during intercourse will think something is wrong with her health and go to the doctor. So, vaginal wetness during intercourse has a positive value in these Asian cultures by association with love and sexual fulfilment whereas in communities where dry sex is a cultural practice, wet vagina is associated with unfaithfulness, abnormality, disease, dirtiness, and lack of sexual pleasure.

6.4 Consequences

The consequences of dry sex are many: physical, psychological. Though studies have not yet established the exact extent of the risk for HIV transmission and STI's it is widely acknowledged. HIV and others STI transmission is facilitate because:

1- The practice prevents condom use. Condoms are ineffective in dry sex conditions as the process excludes any lubricant in vagina or on the condom. If a condom is used it would likely break.

2- Chemicals products which dry the vagina cause inflammation. In addition to frictions during intercourse lesions occur in the vagina's mucous membrane causing vagina epithelium trauma and micro-lacerations during intercourse. Hence dry sex lesions create entry portals for virus. ‘HIV transmission is known to be enhanced in the presence of genital lesions and ulcerations. Since vaginal drying agents have been documented as producing lesions that disrupt membrane integrity, the practice may also increase the risk of HIV acquisition...In addition, intravaginal substances may alter the vaginal pH, which normally serves as a protective factor against HIV acquisition.’⁹²

3. The likelihood of gynaecologic infection increases if vaginal fluids are removed. Drying agents that change the vaginal pH (acidity and alkalinity) undermine natural defence against microbes making infection more likely.

4. The state of mind during the sexual act means that both men and women do not act on, or any longer register, the pain and discomfort involved. Once the intercourse has ended, then

the pain starts. Men and women have reported tearing and bleeding during dry sex in the Caribbean as well as in Africa.

7 RECOMMENDATIONS

Despite the number of resistance causes listed, promote safer sex is the one way to avoid HIV infection. Knowing more than 80% of all HIV infections are acquired in Africa by heterosexual contact⁹³, it almost a must to insist on safer sex culture.

- Health educators should be skilled perfectly in new technical approach to address sexual behaviors change.
 - Through Medias, misinformation should be addressed via aggressive campaign in order to abolish them. Disseminate right information on radio, news papers, theatres, short film, sings, posters, etc. As examples of message 'Condoms do not have a pore that could allow the virus to slid' Condom do not weak genitalia'. Messages should be tailored based on the main misconceptions ongoing at the target place.
 - Both persons involved in a ritual that refers to sexuality should absolutely take HIV tests in respect to the widow period⁹⁴, and then decide to how avoid risk before start intercourse.
 - Make legislation to stop the practice of wife inheritance and wife cleaning.
 - Involve community leaders in the fight and make the most with their social power.
 - Generate political will to support equal rights for men and women in their country.
 - Consider local culture when designing and implementing prevention program.
 - Take small action on the ground is already something that makes sense.
 - Educating repeatedly people on HIV infection prevention through workshop and any gathering opportunity.
 - Promote VCTs is a part of the fight against HIV transmission. VCTs allow earlier ARVs treatment and may-well limit further transmission, reduce mother to child transmission and reduce also stigma.
 - Advocacy for treatment and care for PLWAH, treat them with empathy.
 - In the context multi-partnership or unfaithful within in sexual relationship, men or women could use condom with the regular partner to avoid risk of transmission. Regard to an eventual will of progeny in such a context, it is better to refer to your usual doctor to be advised on how to get a pregnancy with a unfaithful men or woman without risking to be infected.
 - Implement a policy that allows free condom available at all places in the country including the remotest regions as agreed in UNGASS on Aids and utilizing GFATM, WHO's '3 by 5' and all other available funding opportunity.
 - Educating public: men and women on how to put the condom. Like a lot countries are already doing practice putting condom onto wooden models of male genitalia to make people more confident in their self while attempting to make use of it during intercourse.
 - To tackle sexual violence, national government should strengthen legislation against rape to cut through this issue, and enforce legislation. In Uganda, the government passed a bill for 10 years imprisonment in 1990 for anyone who abuses sexually children less than 18 years.
 - Create a sustainable environment that could reduce sexual violence. Multiply advocacy and lobbying groups throughout countries on behalf of sexual violence abolition. For instance let the role of village elders and community in publicly shaming offenders could be explored.
 - Increase army forces' participation to activities which aim to stem HIV infection. About this suggestion a first ever International Conference on HIV and the Military was been in September 2004 in India. The objective of this conference which gathered 14 countries was to involve more and positively Militaries in the global fight against HIV infection.
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- Held army authorities accountable for troops' deviant behaviours such as rape and other violence.
- Including politician and health ministries to statute and make appropriate health policies or to tighter legislation against high-risk behaviour performed. Most powerful African leaders are in position to influence political and social thinking across the continent.
- Starting the fight by involving early at the onset people who are tradition keeper: raising their awareness by education in workshop session. First, the workshop must aim to give to them the capacity to identify themselves the risk relative to each practice which could be harmful. Second, suggest them to propose new way to deal with culture without risk taking. In Malawi counsellors go for workshops on HIV. In turn, they teach teenagers who go for initiation ceremonies.
- Design appropriate safer sex messages regard to this practice in all communities with the community where the practice or myth exists.
- Creating advocacy and lobbying group against harmful aspect of traditional practices to empowering women to resist to undergo harmful practices such as sex cleaning, wife inheritance. Boosting the changes around the women's status and campaign to keep women informed.
- Promote economic self-sufficiency should be the paramount aim of any plan to reverse HIV infection spread.
- Disseminate safer-sex advice, prevention and treatment information on HIV infection in innovative ways that means in the way the target community is able to understand the most efficiently.

CONCLUSION

Certain aspects of cultural practices can facilitate HIV spread. Culture is invented by people; the track in which it moves depends also on the will of the people at a given time. So, culture is a resource which could strengthen the fight against HIV/Aids. It is a question of acting on people knowledge and cognition to make them sensitive on the reality represents by HIV spread. Acting on the attitude and the motivation is not a mere formality; it takes time and continuous endeavours. Awareness rising are not enough. Attempt to make an inner transformation not just in rituals but in values and attitudes. That means to undertake revamping constructions backing up women's weakness and men power within the society. People will not change centuries' practices and beliefs in a few months. This is a long-lasting job which should be done over generations at every level: household, communities, national and inter-regional level. The professionals have now recourse to specific communication methods to ensure sustainable behaviour change which seems successful.

Community-based leaders need to be more involved in development of strategies enable sexual attitudes to be modified. Communities should be encouraged to gather and reflect on solutions. Particular attention needs to be paid to the gender relations, given the pain women experience. The local governments, the public and private institutions international and UN organizations efforts and abilities are valuable.

Certainly, this document misses accurate surveys showing figures on percentage practices contribute to the propagation of the HIV. Other interested people will be able to continue the discussion in this way. In particular it would be interesting to undertake research to have statistical data for instance: percentage of new cases of HIV infection attribute to the traditional surgeries, data on VIH infection due to multi-partnership, etc.

Concerning Africa challenges are numerous. Habits, social conditions and the rules of patriarchal communities are not easy to address. Fortunately it is possible to adapt the

culture to reality, to invent a new sexual standard: the safer sex. Many methods and theories of changes are being developed by specialized agencies. The countries which are used as successful example in prevention has shown communication remain the most effective means to induce a change. The objective of this paper starting point of many constructive publications on the subject of cultural practices and HIV prevention, by this means, stimulate debates on the most taboo in Africa: the sex and sexuality.

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ACRONYMS

ARV	Anti retroviral
IDU	Injection drug user
IEC	Information – Education - Communication
BCC	Behaviour Change Communication
FGM	Female Genital Mutilation
GFTATM	
NGO	Non governmental organization
PEP	
PHR	
PLWAH	People living with Aids and HIV
STDs	Sexual Transmitted Diseases
UN	United Nations
UNAIDS	United Nations???
UNGASS	Declaration
VTC	Voluntary Testing Centre
WHO	World Health Organization