Chapter Three

Myths and Rituals – Increasing Women's Susceptibility

New revelations

The initial years of my work gave me a rare insight into another form of women's exploitation through myths and rituals. Each myth and ritual that I came across confirmed my belief that, at times, the more things change the more they remain the same. In the present context they are indicative of the way in which women are susceptible to the HIV virus at every stage of their lives. An in-depth study of sex and sexuality across borders revealed a common strain, basic to the core issue of the entire exercise, that stood out like a stark fact. We worship goddesses – but shorn of the divine aura the flesh and blood woman has no status. Even when the occasional goddess is dragged to a human level, she suffers the fate of the ordinary lesser mortal woman. In Indian mythology even 'Sita', the revered goddess, went through baptism by fire to prove her chastity.

Interviews with various sections of the population, be it with representatives of non-governmental organisations, women in the slums, people living with HIV/AIDS, invariably left me humbled. How little I knew about sex and sexuality. This feeling kept nagging at me at every discussion, every personal interview, every anecdotal piece of evidence relating to the existing myths and rituals around sexuality. Country after country,

whether in Asia, Africa or Latin America, had new revelations to offer.

- In China, I heard the myth that ground rhino horn increases male sexual virility.
- In India and Indo China, it is believed that having sex with a virgin is a cure for sexually transmitted diseases in men.
- Western Kenya abounds with stories from teenage peers that failure to indulge in sex results in back aches.
- The truckers in South Asia have been socialised to believe that it is important to release the heat generated in the body as a result of driving long distances sitting in hot cabins by having sex every 400 miles of driving.
- In Papua New Guinea, a widely prevalent prophylaxis for STDs is to cut the penis and drain off the possibly infected blood after an intercourse which could have been unsafe.
- In Mexico, it is officially acceptable for men to have sex with men, provided they take the active insertive role in anal intercourse as this is regarded as macho or super masculine.
- In many parts of Africa, women insert external agents into their vagina, including scouring powders and stones, to dry their vaginal passages because of the belief that increased friction is sexually more satisfying to the males and this will prevent them from 'wandering out'.

In South Asia, some cultures celebrate the girl's coming of age. Menarche is viewed as a symbol of the girl's fecundity and the family begins to think of arranging the girl's marriage. Among the rituals performed is a ceremonial bath and the distribution of sweets in the neighbourhood. However, linking menstruation to child bearing and de-linking it from sexuality is a mechanism by which the latent sexuality of a woman is curbed. Marriage

soon after menarche is one method by which parents channel the potent sexuality of young women into a socially acceptable state – the state of a nurturing mother rather than a seductress. There is thus an enormous gap between women's lived experience and what women want sexual relations to be. Women in large parts of South Asia have sex, performing it as a duty, to attain a socially secure position or in order to become pregnant.

As soon as the young girl child gets pregnant the ritual of 'Vallaikappu' is performed. The hands of the pregnant woman are decked with bangles, ostensibly to deter any further conjugal relationships during the pregnancy period, and the completion of this ritual signals a temporary separation between the husband and the wife until the delivery and, in fact, until a few months after. It is during these periods of forced separation that men seek sexual gratification outside of marriage. The behaviour is more often than not condoned by society. The girl child, a young mother, returns to her husband's house once again to perform sex as a duty, little aware of her husband's infidelity and her own vulnerability to the epidemic.

In West Africa, a system of societal beliefs has been developed over time to manage the process of procreation. In the scale of social values, childbearing is elevated to a value which confers a high social status. On the other hand, a stigma is attached to a childless woman. In parts of West Africa, the ultimate punishment is reserved for barren women. They are denied formal funeral rights and are buried secretly at night outside the village. Thus, if a woman did have sex with a condom to protect herself from HIV/AIDS, how would she be able to prove that she is fertile? In fact, women in Nigeria practice painful practices to ensure fertility. In Nigeria, 'gishiri', or salt cut, is practiced traditionally. This involves an incision on the interior of the vagina as a cure for infertility.

The loss of life of a woman in childbirth is expressed as the falling of a soldier in the line of duty. Women, in a manner, have internalised this ethic of nobility and duty so that pain and discomfort emanating from

their sexual and reproductive roles are accepted as the very essence of womanhood. The psychological preparation of young girls for childbirth, instead of giving factual information on safe motherhood, aims to increase the threshold of the tolerance to pain. A common example is the advice given to young mothers to endure a level of effort equal to that which would be required to produce water by pressing hard enough on a stone. Because of this stoicism, vital life-threatening signals are not communicated until too late. Severe haemorrhage is viewed by women to be a good sign because the body is seen to be eliminating bad blood. The consequence is a poor state of reproductive health with lesions and cuts in the woman's reproductive tract. This, coupled with a societally induced inability to practice safe sex, has increased women's susceptibility to the epidemic.

In a UN Development Programme study paper entitled 'The socio-economic impact of HIV and AIDS on rural families in Uganda' the author, Daphne Topouzis; brings out the stark realities of such situations through the real story of Miriam. Miriam, a widow from Gulu, lost her husband to AIDS and is herself sick with AIDS. Soon after her husband's death, her brother-in-law tried to inherit her but she categorically refused so as not to infect him and his wife. He harassed her for almost a year and when she still held firm he cut off all financial support to her and her four children. Now he is trying to claim the land that his brother left. A widow's dilemma is whether to be inherited or be abandoned. Wife inheritance thus greatly facilitates the spread of HIV and has the potential of infecting several families very rapidly. When widows are inherited by their late husband's brother, they risk infecting them as well as their co-wives. If any of the wives deliver children, they may also be infected with HIV. In some cases, widows whose husbands have died of causes unrelated to the epidemic may become infected with HIV if the brother-in-law is already infected.

The story of Mariah gives an insight into the lived experience of HIV-positive women.

My name is Mariah and I come from rural Mutoko in Mashonaland East province. I am 35-years-old and have three children of 12, 8 and 5 years of age. I first knew of my HIV status when my husband got ill. We both went for an HIV test and we were counselled and given our results. We were both found to be HIV-positive. We decided not to tell anyone for fear of stigmatisation and ostracisation. We didn't even tell our three children because we felt that it would be very stressful and they might fail to understand what we were going through. My husband got worse and finally died late last year. His relatives insisted that I should be inherited by one of his brothers. This is when I decided to tell them that I was HIV-positive and that my husband had died of AIDS. My in-laws started accusing me of having killed their son and I was told to leave the family. I was also told that the children belonged to the man and so I was not to take the children with me. My in-laws even threatened that they would demand the bride price from my parents. I left my in-laws residence with nothing of my own. I went to stay with my aunt who introduced me to her friend who is also HIV-positive. I soon got to know about a local AIDS support group. I joined the group and have not regretted doing so since then. The group has advised me on how to get back my property and custody of my children.

Mariah had acted with courage, defying existing myths and rituals in a world where reality would otherwise have written on her tombstone, 'She died after passing her HIV to her husband. . . .' The rituals cited above are only indicative and not exhaustive. They are indicative of the way in which women are susceptible to the virus at every stage of their lifecycle – as young girls, as mothers, as wives and as widows.

The list of these myths and practices that have enshrouded human sexuality is long. In many cultures, the genitals are surrounded by mystery because they are the 'instruments' used to put curses on others. Among the Kikuyu, for example, the worst curse is that when a woman, the age of the person who is being cursed's mother, lifts her skirts and turns around.

The initial years of my work on the epidemic were replete with wonder and amazement, which at times often reached a level of shock.

I learnt through the women in Senegal who had been socialised to be submissive in sexual relations to their partners, for 'a woman who says "No" to her husband for sex will not have good children'. The mother's behaviour during the sex act is decisive for the future of the child.

I came across another myth around a sexual ritual related to female circumcision. Folklore had it that an uncircumcised woman is not satisfied by only one man. Thus non-circumcision may drive women to unfaithfulness. In the opinion of Senegalese men, therefore, female circumcision was a good thing since it 'rationalises women's desire and helps women resist men'. The custom was also considered a purifying act, as an uncircumcised woman was considered impure. The respondents in the study in Senegal unanimously agreed that gum tattooing (which was making women vulnerable to the epidemic) was really a good practice as it 'cleared the sight and let out bad blood and also reduced headaches'. Women in Senegal chose to indulge in this practice as it was considered that this increased the contrast between the gums and the teeth, thereby enhancing their beauty.

A culture of silence

The social construction of sexuality, with its inherent myths and values around morality, fertility and sexuality, has been used to project social values and norms that have been different for men and for women. Thus multiple sexual partnerships are accepted and condoned for men in many societies, whereas modesty and virginity as a value is central to the image of womanhood. Cultures in many parts of the world consider female ignorance of sexual matters a sign of purity and, conversely, knowledge of sexual matters and reproductive physiology a sign of easy virtue. Added to this is the absence of a positive language for sexuality. The existing language around sexuality is perhaps the most difficult means of articulating the

same. A conspiracy of silence therefore continues to surround HIV/AIDS.

Women have found it difficult to overcome these barriers and have not been able to open up communication with clinicians and counsellors or even with their peers. Because women have been constrained in talking about sexuality, there is little known about the disease in women. Until now, men have formed the vast majority of subjects in studies that form the foundation for our current treatment of HIV infection with antiretroviral therapy and our best knowledge about prophylaxis and treatment of opportunistic infections. Cotton and co-workers reviewed data regarding accrual of patients to multi-centre trials and found that only 6.7 per cent of the participants were women. As a result, timely diagnosis for women has been compromised by inappropriate case definitions of the symptoms for AIDS.

The existence and persistence of this social construction of sexuality has led to the evolution of a number of rituals that have made women more vulnerable to the epidemic. The rituals have varied forms in various countries. The underlying message that all these rituals portray is that women's sexuality represents the interface between two most potent and insidious forms of oppression that prevail in society – gender and sexuality. The reluctance to address these issues has limited the effectiveness of programmes designed to improve women's health, develop life skills and prevent HIV and other sexually transmitted diseases.

With such an entrenched knowledge base, how then can messages on safer sexual practices to prevent HIV/AIDS make an impact on the human mind – an impact that can foster a process towards positive behaviour change? In Zimbabwe, data obtained through community-based research carried out by women's organisations have strengthened, or rather complicated, these dilemmas even more. Researchers in Zimbabwe are recording how even today, in some parts of Matebeleland, the engagement of fathers-in-law with their daughters-in-law is a culturally sanctioned practice. As it is, women in the developing world marry men who

are much older than them, have had a number of sexual encounters and are therefore epidemiologically more vulnerable to HIV/AIDS. What would be her level of vulnerability if culturally she is required to have sex with her father-in-law as well?

Myths are also rooted in the nature of denial that is associated with HIV/AIDS. Because HIV/AIDS is so frightening, there is a temptation to deny the existence of the disease. After all, wouldn't it be nice if the disease was not there? In large parts of the world, even today, there is a tendency to attribute HIV/AIDS to witchcraft, or to believe that a cure for the virus is available in traditional and alternative medicine. This precondition of the human mind has been keeping people from owning responsibility for their sexual decisions.

As I write, my mind meanders back to the cornerstone in the entire saga – the first myth surrounding women and HIV. AIDS was first detected as a distinct clinical syndrome in the summer of 1981, when physicians in California and New York noted clustering of unusual infections and cancers in their patients. Almost all these patients were young gay men, a group not previously known to have such 'opportunistic' infections. In August, a mere two months after the first cases were reported in men, the same syndrome was identified in a woman. It was soon apparent that women were also vulnerable and within a year or two there were data to suggest that women were as likely to become infected with the virus as men. The initial misunderstanding that AIDS was a disease of men could be attributed perhaps to a historical accident. Yet myths around the virus prevailed. In 1985, a cover story in *Discover*, a popular science magazine, dismissed the idea of a major epidemic in women. The explanation given was that because the rugged vagina was designed for the 'wear and tear of intercourse and birthing', it was unlikely that women would ever be infected in large numbers through heterosexual intercourse. Nevertheless, even as such projections were being written, HIV was affecting millions of women. By 1991, AIDS was a leading killer of young women in most

large US cities. The first myth that women were not vulnerable or susceptible to the epidemic had been broken.

And yet the political will to confront reality was not forthcoming. I was attending a high level meeting of donors and the Government of India, attended by senior Secretaries of State, decision-makers from the donor community, and health experts and professionals. We were honoured to have the opportunity to hear the renowned epidemiologist, the famous Dr. James Chin, speak on the latest projections of the epidemic for India. His prognosis was alarming – a startling figure of 5 million Indians to be infected with HIV by the turn of the century. This figure surpassed the projections made for other diseases like tuberculosis and malaria which till then were considered more serious than HIV/AIDS. Whereas tuberculosis was affecting one in every 7 Indians, HIV was affecting one in every 120 Indians! What Dr. Chin was projecting seemed so unreal to our policy makers.

The meeting concluded with an unfortunate outburst. The Health Secretary admonished the revered epidemiologist – 'Dr. Chin, you are acting rather irresponsibly! This is just going to cause a scare in the Indian population! After all we Indians are not as promiscuous as the people in the other countries where the epidemic is raging. Do you understand our culture? How accurate are your projections? We need to look at the methodology used to arrive at these figures. To me they seem rather inflated.' My jaw dropped. I could visualise and feel the emerging challenge – the challenge of facing and overcoming the syndrome of complete denial caused by a sense of frustration, hopelessness and fear.

This psyche could be felt, seen and heard across the spectrum of our development partners. A year later I visited some highway interventions undertaken by some NGOs in India with the truck drivers. I was intrigued to see that the condoms were being used to repair the radiator leakages in the trucks. Discussions with the truck drivers and the cleaners revealed that the impact of the awareness campaigns on the use of the condoms as

a preventive measure had been minimal. A very logical argument was offered by the truckers. 'Our fathers and forefathers were all truck drivers. They were not infected by HIV/AIDS. In fact they like us did have sex every 400 kilometres of driving as it was believed that this prevented accidents by letting the heat out of the body at regular intervals.'

Learning through unlearning

These discussions were signalling a message for our work. There could be no real success as far as imparting information about HIV/AIDS was concerned unless the old learning which had been entrenched in the human mind was somehow unlearned. It was with this task in mind that we set out to explore the myths and rituals surrounding sexuality.

What was really interesting was that the data were clearly revealing that there was no difference between the literate and the illiterate women in Senegal as far as knowledge about their bodies and their sexuality was concerned. Education with a well thought out component on the gender construction of sexuality was therefore needed to prevent the spread of HIV/AIDS in a country where myths and rituals are more deeply embedded in the human mind than bookish knowledge. The task is huge – where does one begin? The first step remains to be taken, and that is to document the existing myths and practices in each country and encourage a critique on the validity and use of such rituals within the contextual realities of the HIV/AIDS epidemic.

The process will not be an easy one. Questioning deep-rooted myths and rituals will invite anger, denial, frustration, even apathy, but if done with the spirit of inclusion and involvement of those whose power is at stake, at least a new social enquiry will begin. This enquiry will in turn raise questions, some which may not have answers today, but the process will uncover new vistas, new answers, on the path of discoveries, new solutions to fresh challenges and perhaps to the one challenge looming ahead of us – of combating the HIV/ AIDS virus.