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Identifying AIDS Among the Maasai of Tanzania: Cultural Models and Modern Realities

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Identifying AIDS Among the Maasai of Tanzania: Cultural Models and Modern Realities

INTRODUCTION

This is no longer a new disease; everyone has heard about it, we just do not know its name (Maasai elder, 1992).

This article deals with the pastoral Maasai of Tanzania and how they interpret and relate to the AIDS epidemic. It will demonstrate that Maasai men and women are deeply engaged in learning how to recognise AIDS as an illness by understanding its origin, means of contagion and methods of treatment. The Maasai, inhabiting the savanna borderland between Kenya and Tanzania with their livestock herds, count 350.000 people and constitute just a fraction of the population in the two countries. Compared to many other ethnic groups in East Africa, they have shown a remarkable cultural resilience and continue to distinguish themselves as a separate group within the nation state by their ethnic attire and their traditional way of life.[1]

The Maasai experience of AIDS is a phenomenon of the 1990s when the disease became visible mainly through health information campaigns conducted by various governmental and NGO agencies, and through encounters with anthropologists and other researchers. People heard about AIDS and its consequences through the radio or the church, from neighbours, friends, or from people they met 'along the road'. At the time of this study (early to mid 1990s), the epidemic was verbal practice rather than lived experience. Only a few of our informants knew somebody personally with AIDS or who had seen the disease at close range. AIDS was primarily something one talked or heard about.

The HIV pandemic along with its specific discourse on routes of infection and means of prevention are global phenomena, but take their concrete forms in dynamic and varied encounters with local conditions. Within anthropology it has long been established that globalisation does not automatically lead to homogenisation. 'Local modernities' (or 'vernacular modernities') are concepts applied to capture the dynamics between global trends and local responses (for example, Comaroff & Comaroff, 1993). The way indigenous social structures engage with global systems could fruitfully be seen as processes of locatedness – the substantivising of the verb 'to locate' points to a 'place-making' of sorts of global and modern phenomena. To paraphrase Clifford Geertz writing on a slightly different issue, describing local modernities is not 'a matter of reducing large things to small [...]. It is a matter of *giving shape to things...*' (Geertz, 1996: 262, my emphasis).

This article proposes that the Maasai, when trying to understand and identify the HIV/AIDS epidemic, bring their cultural concepts and historical experience into a dy-

[1] The material presented in this article stems from a three-year (1991-94) employment with the Tanzanian-Norwegian AIDS Project (MUTAN), a research and intervention project in the northern regions of Tanzania (Arusha and Kilimanjaro). The data are chiefly drawn from two Maasai communities – one purely pastoral in Arusha region on the Kenyan border, the other an ethnically mixed community within Kilimanjaro region (Talle, 1995). My acknowledgement to MUTAN staff field work assistance, and to my colleague Inger Altern for constructive views on an earlier draft of the article. Thanks to participants at the colloquium at the Department of Social Anthropology, Freie Universität Berlin for their comments to my paper.

secutive years (1993, 1994) in a remote Maasai district in the Arusha region. Out of a total of 45,162 diseases in 1993, five were diagnosed as AIDS; the year after, 15 out of 42,468 were given an AIDS diagnosis (ibid: 21).

The slow spread of the epidemic into Maasai areas both in Tanzania and Kenya partly follows a general epidemiological trend in Africa of an urban-rural gradient of infection (cf. Klepp et al., 1995; Webb, 1997). According to some verbal sources in Kenya however, the situation may change rapidly. Upon a visit to Nairobi in September 2000, Maasai friends claimed that AIDS is also spreading among them and substantiated their claims with AIDS cases they know of among their acquaintances. It is worth noting that a large part of Kenya Maasailand is geographically close to the capital Nairobi, which is an epicentre of HIV transmission in the region. The antenatal screenings quoted in Woodburn (2000) point to a higher HIV prevalence among the Maasai living close to high transmission areas rather than those in the remoter parts. This suggests that even among the Maasai, the HIV epidemic may take a general course.

The HIV epidemic has been predicted to change over time with a steady, but slow spread from urban to rural areas, and from high 'risk groups' to the general population (cf. Webb, 1997). The lower prevalence of HIV in rural as opposed to urban areas is related to specific social and cultural qualities of life in the two locations, that is a high number of migrant men, single women, temporal residence and high mobility (cf. Webb, 1997). In people's consciousness and in the local discourse of contagious diseases there is a moral and spatial opposition between the town and the countryside (cf. Setel, 1999; Haram, 1999). In the Maasai case, cultural-specific factors (discussed in detail below) may be an additional reason for a low HIV prevalence.

THE TROUBLED SEXUALITY

Health workers in Maasai areas along with many ethnic Maasai (particularly the educated or 'enlightened' ones) voice pessimistic views for the future should the epidemic strike in their midst. According to observations and clinical assessments done by health personnel, venereal diseases are rampant in the Maasai communities causing, among other things, a high rate of infertility in Maasai women. The health workers (often of non-Maasai origin) attribute the prevalence of such diseases to the pastoralists' lack of personal hygiene, their 'promiscuous' sexual practices by age-group members having access to each others' wives, and to poor health facilities in the Maasai localities. During colonial times, government officials were likewise concerned with the spread of venereal diseases among the pastoral Maasai (cf. McKay, 1950; Orr & Gilks, 1931). Statistical figures from pregnant Maasai women in Kenya between 1989-92 indicate an average syphilis prevalence of five percent, but with substantial annual variations, ranging from below two (1990) to almost 13 percent (1992). Gonorrhoea averaged about 11 percent both in women and men for a number of consecutive years (Woodburn, 2000).

Comparing Maasai data with similar data from the Datoga, a closely related pastoral group living in the western districts of the Arusha region, show the same trend. In a sur-

themselves. The inter-generation solidarity is so strong that ideally a *moran* can substitute another in most areas of social life, provided that the collective is venerated. For example, it is not uncommon that two or three young men share the same girlfriend. The sharing of girlfriends does not create jealousy among them; on the contrary, it is interpreted as a sign of male intimacy, friendship and generosity (Talle, 1994). Even the girl interprets this request from her boyfriend as a sign of love; if he wants to share her with his best friend, whom he loves more than anybody else, it increases her prestige.

The legitimate girlfriends of the *morans* are prepubescent girls not yet married, which means that Maasai girls seldom are virgins when they marry. Nor should they be, virgin brides are expressly considered 'immature' (in the meaning of immoral and irresponsible). Traditionally, such brides were sent back to their family to be 'opened', but 'these days we do not care so much and let them stay', some Maasai claim. The penetration of virgin Maasai girls is defined as the 'work' of the unmarried *morans* and not that of elders. The latter marry them only. For the elders to do the work of the *morans*, would not only be unbecoming aesthetically, but more importantly would be a reversal of the age-set order, leading to cultural chaos and thus would be detrimental to the well-being and prosperity of the people.

The practice of sharing girlfriends continues when the *morans* marry and advance to elder status within the age-grade system. Men of the same age-group are free to have sex with each other's wives, given that the women comply and that it is done with due respect to the husband. Although husbands know and accept that wives receive lovers, they would normally not like to be confronted with them directly. Age-set ideology prescribes that age-mates share wives; concrete cases, however, are neither spoken of nor demonstrated. There are individual men who due to 'jealousy' discourage their wives to accept lovers. This, however, goes against age-group morals, causing such men (*olalomoni*, 'jealous person') to be ridiculed and disparaged by age-mates for their meanness. Still others may ask an age-mate, admired for his intelligence, courage or beauty, to impregnate his wife to seal their friendship. Women, in their ceremonial songs, boast about their 'illicit' sexual relations, particularly their relations to young men. Due to a considerable difference in marriage age between men and women, wives are usually much younger than their husbands. Therefore, they 'steal' sex from men of their own age, usually the *morans* they 'played' with as young girls because they say they find them much more attractive than their husbands (cf. Llewellyn-Davis, 1978; Talle, 1994; Talle, 1995). Relations between married women and men of age-sets younger than that of their husband transgress age-set morals and are condemned, especially by the elder men. Conjugal fidelity, which is such an important issue in Western sexual discourse, has no logical foundation within Maasai moral thinking.

The quotation at the beginning of this section is from a female informant explaining the intricacies of Maasai sexual morals by drawing a sharp line between sex in marriage and sex for love. The Maasai practice of arranged marriages and sex within this union is first and foremost to procreate, to create 'life' (*enkishon*). The obligation of performing marital sex is clearly stated both by men and women; a Maasai man who has several wives will take great care in serving his wives equally in terms of sexual and other fa-

from sexual intercourse till they heal. Transgression of these, as well as numerous other rules and precautions, is subject to livestock fines. Severe cases of violations evoke divine wrath and may create infertility in women and livestock, a most dreaded predicament in a community where fertility and prosperity are cultural preferences of highest degree. Missionary activities have so far had little effect on Maasai sexual practices, irrespective of the fact that recently an increasing number of Maasai, at least in some areas, have become Christians.

REFLECTIONS ON PROMISCUITY

When Maasai attend meetings held by HIV/AIDS intervention agencies, one often hears spontaneous utterances from the audience, 'it will finish all of us', 'we will all die', and 'is this true'. Some react with apprehension to the stories they hear, others with disbelief, while others again show indifference and appear more or less unaffected, even resentful, by the news. Some simply do not comprehend the scope of the message. There is no standard Maasai way of responding to the arguments within the HIV/AIDS discourse of sexual abstinence until marriage, conjugal fidelity and condom use in non-marital relations. One of my Maasai field assistants adamantly claimed that the Maasai in general were quite alienated by the message. It was simply too far removed from their conceptualization of reality and lived life. This surely was the case in most instances, but not in all.

Educated Maasai have begun more strongly to voice concern about the sexual practices of their people, above all 'the promiscuous nature of our age-groups', questioning its validity in a 'developing' world (e.g. ole Moono, 1998). Reflecting over one's own moral and sexual practices may be taken as a sign of a modern ambition, which in general has been more pronounced and expressed by younger Maasai than elder and quite often has led to disputes and controversies between generations. The inherent political and moral authority of elders within the age-set system is challenged by the young educated members and their eagerness to organise and bring their people along in the development process (Talle, 1999). From the perspective of younger generations, age-set morals with their collective orientation stand forth as an antithesis to modern values that emphasise individual choice, education and civil rights. (In several Maasai locations in Kenya, age-sets have disappeared).

The fact that quite a large number of ethnic Maasai have begun to question more strongly traditional social and cultural practices (though not without resistance) may signal an incipient modernisation in the Maasai population. Similarly, the growing attraction of outgoing Maasai men towards non-Maasai town women may likewise be seen as an appreciation of a modern lifestyle (Talle, 1995; Talle, 1999). (Maasai women, however, are less likely to seek sexual solace with non-Maasai men). Those who are critical to modern lifeways claim that the youngest age-set (*ilkingonde*) heralds preferences and behavioural practices which are 'ruining the Maasai'. Education is widespread among this age-set and many of them are involved in livestock trade as well

Maasai do not sever the prepuce completely, but leave it hanging in a string of flesh at the back of the penis. The Maasai form of circumcision was previously common among other people as well, for example, among the Kikuyu in Kenya, but they have changed to more modern methods.

For the Maasai, circumcision (*emurata*) is not only a physical operation but as much a cultural practice initiating men into an age-based community. Men who have not been initiated can never grow into adulthood the Maasai say, because they lack the courage and moral integrity fostered in this single-sex fellowship and Maasai males simply cannot relate to such people whom they basically regard as 'children' (*olayoni,* an uncircumcised boy not yet permitted to have sex with females). There are no appropriate terms of address between Maasai and *ilmeek*, no way of sharing meat or any mutual sentiments through common upbringing. Although a word with multiple and variable meanings, *olmeeki* is on the whole negatively charged and to most Maasai signifies 'impurity' (*entorro*) and disorder. In Maasai terms, an *olmeeki* represents the category of the 'other' – the inversion of things and ways positive.

A female healer stated with great conviction that 'they [*ilmeek*] die [from AIDS] because they are not circumcised'. For her that was a straightforward and logical causation. Through *emurata* people can be protected. Acknowledging the linkage between circumcision and the constitution of the moral person in Maasai thought, her comment points to circumcision as an act of protection and inclusion. By being outside the shielded community of a coherent cultural order, people become susceptible to diseases and other bad influences. Even though a disease like AIDS attacks the individual body, a tight and closely connected community may provide a good protection against contagion in general, and in modern Tanzania, against HIV transmission in particular (cf. Douglas, 1992). A parallel term of *olmeeki* is 'Swahili' (*osuaili*). The term derives from the fact that these 'other' people use the Swahili language (Kiswahili) as a means of communication. The fact that they do not stem from a local vernacular signifies a lack of belonging in a coherent moral world.

During a conversation with a young man about AIDS and its consequences, an old man who had been silently listening to our conversation, suddenly asked us whether AIDS is the disease that people get from dogs. He had learnt that women in Nairobi (the capital of Kenya and approximately 200 kms away from the site of our conversation) copulate with dogs for money and then spread the disease to humans. It appears that the 'dog story', which flourished in the Tanzanian press during June 1991when three Germans and a Frenchman were accused of having forced a prostitute in Dar es Salaam to have sex with a dog and videotaped the act, had been given a new twist by the old Maasai man. The question from the old man embodies concepts that Maasai strongly associate with AIDS: 'foreign' women, 'foreign' places, and 'foreign' practices. His understanding of AIDS also exemplifies a general point in this article, namely that 'new' information is deciphered in local terms. This man lived closer to Nairobi than Dar es Salaam, and the Kikuyu with whom the Maasai are close neighbours constitute the majority of the population in Nairobi. Throughout history, the pastoral Maasai have had a close, but constrained relationship to their cultivating neighbours; they have

'Swahili' obviously are a differentiated category and their power of contagion is situated in time and space.

The fact that AIDS is a world-wide epidemic, of which the Maasai are aware, implies that the carrier of the disease may as well come from far away places, like Europe, America or Kenya, as from your neighbourhood if you reside in a 'bad' place that is a non-Maasai location. You may even be injected by the virus in hospitals, said some, bearing witness not only of a Maasai lack of confidence in state authorities but also of a prevailing uncertainty of HIV/AIDS aetiology and causation.

The widespread and well-known association between fatal diseases and 'outside' people does, in the case of the Maasai, resonate with a deeply structured cultural model of an incongruence between 'pure' Maasai (i.e. the 'people of cattle') and other people: be it people living in their midst such as the 'blacksmiths' (*ilkunono*) or 'hunter-gatherers' (*iltorrobo*), other Maasai speaking peoples (Arusha, Parakuyo, Samburu), neighbouring cultivators or far away people (cf. for example Galaty, 1993). The excellence of their own lifeways protects them against contagious and untreatable diseases, in this case HIV infection. The category of 'Swahili', although not fixed, links to concepts of modernity, town life and cash economy, values that are highly contested among the Maasai. In negotiating the modern and global spheres in their own lives, the HIV/AIDS epidemic creates a space for questioning different lifestyles.

PLACES OF DANGER

The government introduces diseases against its own people...when they saw the disease coming why did they not stop it with vaccine or quarantine, like we do with animals. Why allow it to come all the way from Bukoba and to this place.[5] (Man at a public meeting, 1992)

Maasai sometimes refer to AIDS as the 'disease of the Swahili' (*emueyian oolmeek*). Although they are apprehensive about the disease and what they hear about it, conceptually, bodily and semantically, it is still not a concern of theirs. If they just refrain from intimate contact with the 'Swahili' by avoiding their places and their company they will not be infected. To stay free of contagion, however, they need to move in a secured space. Just like livestock were separated and driven in different directions for grazing and drinking when epizootic raged, so must humans do to avoid infection. The HIV/AIDS epidemic has its own geography of dangerous and safe places. Towns, in particular, are zones of danger and insecurity even for HIV transmission.

The town is a place of the 'Swahili' and as such an alien environment to the Maasai. People in towns do not normally speak the Maasai vernacular; they dress differently, have other foodways and adhere to another moral order. Furthermore, townspeople live

[5] Bukoba is the town in northwestern Tanzania where the epidemic first erupted on a large scale in the country. Women from the Haya, the ethnic group in and around Bukoba, have a long tradition of involvement as prostitutes in East Africa (cf. White, 1990).

their bodies, they have experience with the disease and therefore perhaps also have medicine against it, so the Maasai reason.

The Maasai themselves are in the opposite situation: 'We hear a lot about the disease, but we do not know how to treat it...The doctors come back from White people without medicine... Local herbalists do not know what to do. We pray and follow God's instruction...', are worries that people voice. Since there is no cure for AIDS, and because it is associated with genitals (and interferes with fertility), it is regarded as an extremely bad affliction. At the time of this study, Maasai informants had begun to ponder whether AIDS could be the same disease as the 'circumcision disease' (*enamuratuni*). That disease, which affects the genital area, is transmitted through sexual intercourse. Small black spots just like 'worms' (*inkirir*) appear on the genitals, particularly on those of children and women. Circumcised men, however, are not afflicted. The symptoms of the circumcision disease are similar to AIDS: dizziness, back pains, inflammation of joints, and a general weakness of the body. The disease 'drinks the person's blood', say the Maasai, and the body gradually wastes away.

The circumcision disease is relatively new. It appeared for the first time in 1978, and according to informants does not behave as a typical epidemic. Disease cases occur sporadically – one case here, one there, just like AIDS. The first person to get it was a woman and she died from it. Some said the woman was an Arusha-Maasai (also called 'agricultural Maasai') and the one who infected her was an Mbulu cattle trader (ethnic term Iraqw, Cushitic speaking people living in the eastern part of Arusha region). The master narrative of how disastrous diseases are transmitted is recited in this story: the movement and the money of the travelling businessmen – people who transcend spatial and moral control – is bound to bring affliction, and those who consort with them are equally bound to live in danger. The roving male being a symbol of modernity, and the ethnically 'impure' (morally loose) female likewise a symbol of the same, indeed constitute a lethal combination.

In contrast to AIDS, however, the circumcision disease can be treated. A female healer who, according to herself, can successfully treat the circumcision disease by extracting the worms or by actual circumcision if the patient is not yet circumcised, believed that she also would be able to treat AIDS. But she needed a disease case to try her cure on because without practical experience she could not know whether her cure was effective or not. Another healer of the 'circumcision disease' asked us to take him to a hospital and show him an AIDS patient for him to prove the 'strength' of his medicine. Thinking of AIDS as similar to the circumcision disease gives people security and possibility to act. Circumcision has become both a palliative and a preventive cure against obscure and 'new' diseases. Female circumcision, which is a disputed issue in contemporary Tanzania and forbidden by law, appears to be renegotiated within new contexts of morality and political economy.

AIDS is shrouded in mystery and uncertainty about its origin, ways of infection, symptoms, and cure. In a recent book on uncertainty and the 'anthropology of affliction', Susan Whyte (1997) successfully applies a perspective of the American philosopher John Dewey and the 'philosophy of pragmatism'. The pragmatic perspective on

The low HIV prevalence among the Maasai could at this point in history be explained by their restrained contact with 'other' people and their limited involvement with modern living as it evolves in towns and traffic centres of contemporary East Africa. Their 'primitive' lifestyle and resistance to 'development', for which they have been blamed and abused, may ironically prove to be a blessing in disguise. The increasing poverty and the sloughing off of Maasai from the pastoral sector, however, may in time bring large numbers of them into hazardous contact zones of disease transmission.

CONCLUSION

In order to give a global disease such as AIDS a 'name', the Maasai reason through cultural models and concepts, and through practical experience and historical encountering. The local configuration of the epidemic in the shape of discourses, practices and places must make sense for the people. During a discussion with an old Maasai, he asked me, 'What have you been able to do in your country concerning this disease? Have you found a cure?' 'No', I replied. The man continued, 'What then do you expect you can do here – if you have failed there, how can you succeed here?' He began wondering whether it is God's meaning to put this disease on people if it is an incurable disease. If we no longer are able to cure the diseases we have then it certainly is a new situation, he contemplated.

It is in such ongoing processes of sense-making and employing of interpretative skills and creative association that 'modern' phenomena become located. In their struggle to understand AIDS however, Maasai are not searching for 'verities of ideas' but rather, they are looking for security – ways of engaging problems in order to safeguard against afflictions (Whyte, 1997: 216). By avoiding dangerous places and defiling relations, the pastoral Maasai remain assured that they continue to stay free of AIDS. This knowledge, however, is not based on rational calculation as part of a conscious strategy alone, but rather embodied in likes and dislikes, senses and sensibilities, spatial presence and avoidance.

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