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**Wasting sperm:
The Maasai context of condom use in Northern Tanzania**

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Abstract

Motivations for condom use are intricate, and the behaviour of individuals and couples take place against complex socio-cultural settings. This study examines in detail the socio-cultural context of condoms among the Maasai, an East African agropastoralist population. A review of ethno- demographic literature demonstrates the socio-cultural significance of sperm in a range of settings. A detailed description of Maasai values relating to sperm is followed by an analysis presenting results from a sample survey (n=35) and focus group discussions (n=4). Whilst reported knowledge of HIV/AIDS was high (100%), unprompted reporting of condoms as a way of preventing HIV infection is low (15%). When asked directly about knowledge of condoms, awareness appears high (86%), but actual levels of detailed condom knowledge are very low. Of those individuals who reported that they knew what a condom was, only 17% said that they knew how they worked. Focus group discussions reveal strongly held opinions and beliefs connected to condoms and their use, including: their contraceptive effect; negative impact on quality of sex; the wasting of sperm; and the 'otherness' of condoms. The implications of these findings for condom provision and uptake are considered in the discussion.

Keywords

Tanzania. Pastoralist. Condom. Culture. Maasai. Sperm

Introduction

Sexual behaviour continues to be the principal objective of global HIV/AIDS prevention efforts. However, sexual behaviour on its own ignores the complexities of the behaviours and experiences of individuals (Dixon-Mueller 1993, Zeidenstein and Moore 1995, Collumbien and Hawkes 2000, MacPhail & Campbell 2001). Whilst the male condom offers a safe, cheap and effective means of both preventing conception and the sexual transmission of infections, including HIV, motivations for condom use (and non-use) are complex and operate at a range of levels (including: individual, couple and community). In low resource settings with low reported condom use we need to understand better why people do not use condoms. The behaviour of individuals and couples must be set against complex socio-cultural settings and understanding these complex environments is essential for the development of effective interventions (Desmond et al 2005, Smith and Watkins 2005). To date, relatively little attention has been paid to the socio-cultural meaning of sperm and condoms, and the implications for HIV/AIDS interventions involving condom use. Comparatively little research has been done on HIV/AIDS and pastoralists in Africa (Coast 2006), even in countries with acute HIV epidemics where pastoralists represent a sizeable proportion of the rural population. The current study concentrates on the Maasai, an East African pastoralist population and examines in detail the socio-cultural context of condom use. Firstly, a review of ethnographic and demographic literature to illustrate the range of socio-cultural meanings of sperm in diverse settings. Secondly, a detailed description of Maasai values relating to sperm, based on a combination of a survey of extant ethnographies combined with a decade of researcher familiarity with the socio-cultural

setting. Finally, the analysis presents results from a sample survey (n=35) and four focus group discussions.

Literature review: the significance of sperm

As a barrier method, either for the prevention of HIV or as a contraceptive, or both, condoms involve the removal of sperm from the sexual act. In order to begin to understand the importance of sperm to the sexual act, it is therefore pertinent to identify major groups of beliefs about sperm and its significance, and the implications for condom use. Six major groups of sperm-related issues with relevance for condom use for HIV prevention are highlighted here.

In settings where fertility is linked to clan or ethnic or family name continuation, sperm symbolise a responsibility of procreation. The dual function of condoms (infection prevention and contraception) places the procreative importance of sperm into stark relief, especially in contexts where contraceptive use is not widespread. For example, in South African Xhosa and Zulu communities, Meyer-Weitz et al (1998) identify notions of masculinity as tightly bound up with responsibility to provide semen, with major implications for condom use (Krumeich et al 2001). Ethnophysiology, in a wide range of settings, identifies the flow meanings of bodily fluids (including semen, breast milk, blood), operating at a variety of scales. Sobo's (1993) research in Jamaica examines the implications of contraception for the blockage or diversion of these flows. Her work concludes that there needs to be a flow of fluids between bodies in order to create and maintain kinship ties, and that if such flows are blocked, for example by contraception, then "cultural ideas of social reproduction" (p.60) are prevented. In

Rwanda, Taylor (1990) highlights the social function of such flows, operating not just at the level of the individual, but also at the societal level, and also highlights the issue of blockages, with respect to condoms. Bond and Dover (1997) examine condom use among migrant workers in Zambia from the perspective of what men and women consider to be the purpose of sex, what it means to have “good” sex, and how these ideas relate to masculinity and femininity. They report a strong emphasis on male potency, including the quality of sperm (assessed in terms of sperm consistency) combined with an emphasis on fertility that militate against condom use. Wardlow (2002) describes the delicate balancing act in terms of the “correct” amount and type of semen necessary for “good” procreation among the Huli of Papua New Guinea, Namely, a large amount of semen from one man will form a foetus whereas many men, each providing small amounts of semen, is described as resulting in disease. A similar patterning is reported by Schoepf, in Zaire (1992). In settings where bodily fluid flows are paramount, condoms might be perceived as aberrant, wasteful and negligent. There are diverse contextual meanings to sexual pleasure, which require that meanings are placed in social context. The theme of successful sex involving ejaculation into the vagina is reported frequently for both heterosexual sex (procreation notwithstanding) and for men who have sex with men. Sperm as being important for women has been noted in a variety of geographic and historic settings. In the early Twentieth Century Marie Stopes ‘espoused such mystical nonsense as that the ‘male secretion’ had a beneficial effect on women’s health’ (Santow 2005). In a historical review of the British Medical Association, ‘Semen was envisaged by some as an elixir for women’s health when absorbed through the vaginal wall’ (Kirk 1996). In Bangladesh, semen is referred to as a tonic for women, and frequent condom use is considered to cause

impotence (Rahman et al 1980). Conklin and Morgan (1996) identify a set of meanings surrounding sperm in Wari society (Amazonian ethnic group), which considers sperm to be key for young female physical development, including the development of her reproductive system. In Tanzania, Plummer et al (2006) report that if sex is to be satisfying and meaningful, vaginal ejaculation is reported as essential, with positive implications for a woman's physical attractiveness. Vaginal ejaculation is reported as essential for male and female sexual pleasure in Zambia by several authors (Bond & Dover 1997, Gausset 2001), although there are differences in gendered descriptions of pleasure. Research among men who have sex with men reveals similar themes, the non-use of condoms for penetrative anal sex reported as representing, for some men, greater intimacy and the symbolic value of giving and/ or receiving semen (Middelthon 2001, Henriksson 1995, Holmes & Warner 2005, Flood 2003).

In many contexts the "wasting" of sperm (oral sex, masturbation, use of a barrier method) is considered harmful to male physical and mental well-being. In Ayurvedic medicine, for example, semen is considered very highly and the physical effects of semen loss in South Asia are known collectively as *dhat* syndrome. In an Indian context, many authors report a widespread conception that excessive sexual activity, including masturbation and night-time ejaculation, leads to a 'weakening' of men (Edwards 1983, Caldwell et al 1983, Bottero 1991, Lakhani et al 2001, Verma et al 2001, Lambert & Wood 2005). Similar constructions have been reported in other populations, including Chinese, Guinean, Zambian and Sri Lankan (Caldwell et al 1987, Goodkind 1991, Gorgen et al 1998). In such settings vaginal ejaculation is considered the most appropriate outlet for semen

Building on the perceived positive aspects of semen for procreation, many societies consider semen to be important for the development of a child *in utero*. Feldman-Savelsberg (Cameroon, 1995), Maynard-Tucker (Peru, 1989) and Gausset (Zambia, 2001) report that regular sex between the mother and father is considered to strengthen the child's development. Conklin and Morgan (1996) report that among the Wari, semen (not necessarily that of the father) aids foetal health.

Finally, sperm is also considered as harmful in some contexts, most notably the classic lactational taboo, reported widely throughout sub-Saharan Africa (Walle and Walle 1988, Lockwood 1995). Studies in Côte d'Ivoire (Ali & Cleland 2001) and Nigeria (Orubuloye 1981, Page and Lesthaeghe 1981, Renne 1993, Lawoyin & Larsen 2002), the Sahel region (Walle & Walle 1991), Zimbabwe and Ghana (Schoenmaeckers et al 1981) report the belief that semen poisons breast milk, with negative health implications for the child. The postpartum lactation-semen taboo is one example, however, of the way in which beliefs about sperm and condom use can operate in an opposite direction. The use (and justification) of condoms by couples where the woman is still breastfeeding, is increasingly reported, relative to non-barrier methods of contraception. This brief review reveals the complex and dynamic cultural values concerning meaningful, decent or natural sex and/or reproduction. The next section outlines the socio-cultural context of the current study.

Study socio-cultural context

The Maasai of Kenya and Tanzania are one of the best-known pastoralist populations in the world, with over 98% of all households owning livestock, and 99% of adults

describing themselves either as pastoralists or agropastoralists (Coast 2002). The notion of the Maasai as a self-contained ethnic unit is misleading (Homewood & Rodgers 1991) and the historical background and linkages of the Maasai with other groups originally viewed as "non-Maasai" have been well documented and supported. The traditional notion of the Maasai as an independently functioning ethnic unit, which practices no agriculture, has now largely been discarded. Spencer observes, "Writers had tended to note that the Maasai do this or that, rather than noting, for instance, that the Purko Maasai do this or the Kisonko Maasai do that" (1988:2). Whilst acknowledgement is made here of subtle differences between clans and sub-clans, such a discussion is beyond the scope of this study. There are, for example, ceremonial, decorative and clothing variations between the different clans. However, in terms of the broader social organisations and major demographic behaviour, the similarities are far greater than the sum of the detailed differences. It is acknowledged that the Maasai are not a homogenous group, and that different authors will produce slightly different accounts of Maasai social structure. This summary attempts to underline those features that are pertinent to a description of Maasai social organisation at the broadest level.

In Tanzania, Maasailand includes much of Arusha Region (Ngorongoro and Monduli Districts), and to date, there are no published data on prevalence levels at the population level in Maasailand. Small-scale studies show recent and rapid rises in the level of seroprevalence, both in the study area and in neighbouring Kenyan Maasailand. Early studies show relatively low levels of seroprevalence in Maasai communities. In 1992 in Arusha Region, northwest Tanzania, Lopez-Corral et al tested for HIV from clinic outpatients (n=80), and no cases of seropositivity were found, although 79% of the sample had a STD at the time of the enquiry¹. Valadez et al's study in Kajiado District used antenatal blood specimens (n=2,082) from pregnant women over the period 1989-1992. The communities from which the women were drawn live very close to a high transmission area - a major trucking route, and reported annual prevalence ranging between 0.95% and 2.23%.

¹ Lopez-Corral *et al* refer to a 1987 study (no provenance given) in which 144 pregnant women were tested for HIV, and 1 case was found to be HIV positive.

More recent, unpublished reports, from local hospitals in the study area, suggest rapid rises in seroprevalence. Of 277 blood samples tested in 1994 at Wasso Hospital (Loliondo, Ngorongoro District), 15 cases tested positive for HIV, representing 5,4% of the sample (Lembikas et al 1996:45)². Most recently, reports from Endulen Hospital show that 19% of blood donors tested HIV+ (Johnson et al 2003).

Levels of HIV/AIDS knowledge tend to be low among Maasai (Kulzer 2001, Coast 2006) Condom provision is extremely low in rural Maasailand. Tanzania has a national social marketing strategy for *Salama* condoms, but few shops sell condoms in the area. Occasionally, condoms are available in the bars for drivers in the tourist hotels, but these bars are closed to local Maasai residents. Provision of condoms by local clinics is very limited and sporadic, with a strong seasonal dimension. During the long rainy season in this semi-arid area, many remote rural clinics are inaccessible by road, and basic essential drug supplies are interrupted and inadequate.

Maasai society is both gerontocratic and patriarchal in its structure, and key to understanding Maasai social roles is the 'age set' system, composed of a group of male contemporaries, united by their communal circumcision. Approximately every 15 years, a new age set is produced and upon circumcision, a boy becomes a *murran* (warrior), and the previous age set *murran* become elders. Circumcised young men are unable to occupy the same house as their fathers, and are expected to be sexually active, despite a normative prohibition on their marrying. There are strict rules forbidding a *murran* having sexual relations with a married woman, and the acceptable sexual partners of the *murran* are young, pre-pubescent, unmarried girls (*entito*). These socially sanctioned sexual partnership, which may for example involve a man aged 20 having sex with an 11 year old girl are illegal in Tanzania where the consent for sexual

² Of the 15 positive cases of HIV, 12 were female and 3 male. This gender-difference probably represents differences in propensity to be tested, with antenatal testing of pregnant women.

activity is 18 years unless the woman is married and aged fifteen years and above³. Most ethnographies summarise the three main phases of a woman's life as *entito* (young girl up to clitoridectomy), *esiankiki* (married women with young children) and *entasat* (older woman with circumcised children) (for example, Talle 1988). Unlike males, where circumcision takes place at a public ceremony and in a large cohort group, girls tend to be circumcised individually. Female circumcision occurs at puberty, the rationale being that this will avoid pre-marital pregnancies. The undertaking of clitoridectomy for females indicates both physical maturity and a change in the girl's social status, and post-clitoridectomy she is considered ready for marriage and childbearing. Female circumcision is almost universal among the Maasai, and is considered essential for correct sexual behaviour and fertility. For example, Kramer (1980) reports that 95.5% of ever married Maasai women in a sample (n=134) were circumcised.

Given the young age at sexual debut for Maasai girls, it is reasonable to hypothesise that the average age at HIV infection for Maasai girls will be substantially lower than in other ethnic groups. Women do not have formal age sets like the men, rather than a woman's life is instead a gradual transition based upon age. Women tend to be classified with certain age sets, according to the age group of *murran* with whom they were the sex partners, but these early sexual partners rarely become marriage partners. Girls become sexually active at a young age, and prior to puberty, a Maasai girl gradually acquires her 'right' to fertility, a culturally constituted process (Talle 1994). The process includes the gradual sexual initiation of a pre-pubescent girl by one or more

³<http://www.interpol.int/Public/Children/SexualAbuse/NationalLaws/CsaTanzania.pdf>.

murran of her choosing. The Maasai have a widely held belief that semen helps a girl to develop physically, literally, to help her breasts grow. *Murran* are considered the epitome of healthiness, therefore their sperm is best for pre-pubescent girls. As *murran*, men are instrumental in constructing a girl's societal approval of her fertility, mainly through sexual initiation and the giving of semen. Whilst *entito* are described as 'choosing' their own partners, it should be noted that coercion, both covert and overt, is condoned. For example, a popular *murran* will be chosen by several *entito*, and it is therefore possible for him to begin to develop his own network of influence and power by asking his partners to have sex with his less *murran* friends. *Murran* often employ the services of old women (*endingi*) to 'persuade' an *entito* to become their partner, and these old women can exert a lot of pressure on the *entito*. The public ceremony associated with "choosing" a *murran* involves the girl giving the *murran* milk to drink. Talle suggests that "the exchange of milk and semen, two body fluids with inherent regenerative capacity, symbolizes a complementary, although not equal, relationship" (1994:281). When married, a woman is obligated to provide her husband and his age-mates with milk, symbolic of the reciprocal milk-semen relationship established when, as a pre-pubescent girl, she participated in the milk-giving ceremony.

Children are highly valued, and are one element of wealth and power for men, together with livestock and the number of wives. In general, there is a desire to have as many children as possible. Fertility (both male and female) is highly prized within Maasai society (TFR 8.6 children per woman) (Coast 2000). High individual fertility means that mother to child transmission (MTCT) will be an important element of the future

transmission of the disease. The presence of an untreated STD is a major co-factor in HIV transmission. STDs are a major cause of morbidity among the Maasai population, with pre-pubescent girls (aged from 8 years) frequently presenting with symptoms. There are no published data on STD prevalence, and hospital-based data on STDs cannot be used to estimate levels of STD among the general population because of very high levels of self-treatment using either over-the-counter generic drugs or traditional medicine. There is little social stigma attached to having a symptomatic STD among the Maasai, although attempts at anonymous partner tracing and treatment have proved futile⁴. The result is high levels of untreated STDs, incomplete treatment, and high levels of re-infection.

Methodology

Data are drawn from a study conducted in September 2002 that investigated the context of HIV/AIDS knowledge and attitudes among rural Tanzanian Maasai men and women. The study site was Ngorongoro District in rural northern Tanzania. Whilst Ngorongoro District is home to the international tourist destination of Ngorongoro Crater, in reality very few Maasai are involved directly in the tourist industry (Coast, 2002). Participants for the study were drawn from outlying rural villages, with little daily involvement with the tourist industry. Local research team members solicited volunteers, who were provided with transport, lunch and soft drinks in return for their time. Participation was voluntary, and the purpose of the research⁵ was explained to each participant prior to

⁴ Pers. Comm. (2002) Dr Zurre, Flying Medical Service, Tanzania

⁵ The research was funded by DANIDA as a baseline survey of HIV knowledge and attitudes in Maasai areas, with a view to planning for HIV information, education and communication programmes.

the individual questionnaire preceding the FGDs. Discussions were sex-segregated, the number of participants in each group ranged between eight and ten, and a total of 35 individuals were involved. Four focus-group discussions were carried out, 2 for women and 2 for men. All FGDs were conducted in Maa, audiotaped and then translated and transcribed into English. Illustrative quotes relevant to the key themes that emerged from the FGDs are presented below. FGDs were preceded by short individual questionnaires, administered in Maa, on HIV/AIDS awareness and knowledge. Views of key informants, including local health personnel and IEC providers, were also elicited.

Results

The socio-demographic profile of the respondents was typical of rural Maasai in northern Tanzania (Coast 2002) (table 1). The majority (72%) of respondents were aged less than 39 years. Half of all married men included in the study were in polygynous marriages, and the majority of respondents were ever-married (85%). Fifty nine percent of participants had no schooling whatsoever, rising to 69% for female respondents.

Table 1 Here

The language used to describe HIV in a Maasai setting requires careful consideration. The Swahili for HIV is *ukimwi*, which is an abbreviation of “*Upungufu wa Kinga Mwilini*”, a literal translation of human immunodeficiency virus. The most widely used word in Maa for HIV is *biitia*, which literally means to shrink. For Maasai who speak

Swahili, the use of the word *ukimwi* to identify HIV and AIDS-related diseases is relatively straightforward. For non-Swahili speaking Maasai, however, the word *biitia* can refer to many illnesses and diseases that involve weight loss, and is not necessarily the sole preserve of HIV and AIDS. Indeed, to attribute weight loss to one named cause would ignore the holistic conception of bodily health for many Maasai. The contested language surrounding the identification of HIV as a distinct disease highlights some of the issues implicit in analyses of data generated by large-scale survey data such as the Demographic and Health Surveys, and HIV awareness-raising campaigns in this linguistic setting (May and McCabe 2004, Coast 2006). In the current study it emerged through discussion, both as part of the individual questionnaires and the FGDs that those individuals with higher levels of education preferred to use the Swahili term *ukimwi* to avoid confusion with the broader group of diseases associated with *biitia*. Given that 100% of respondents answered “Yes”, they had heard of *biitia*, it is likely that some respondents were not referring to HIV *per se*, but to a larger aetiological group of diseases that cause weight loss. Three quarters of respondents stated that they knew of a way to protect themselves from infection, although again some respondents may have been referring to non-HIV illnesses. Of those who stated that they did know of a way to prevent getting HIV/AIDS (n=27) the following routes were mentioned voluntarily: avoiding sex (93%); using a condom (15%); avoid needles (11%); avoid knives (22%); avoid razors (38%); avoid blood transfusions (8%); avoid kissing/saliva (8%); avoid sharing latrines (4%); pray to God (12%); avoid touching clothes (4%); avoid touching sweat (4%); and, avoid sharing toothbrushes(4%). These results are comparable to a study of 170 Maasai men and women in Simanjiro District (Kulzer 2001). Maasai in general have little exposure to the illness, reflected in the low

proportions of men and women who reported knowing someone at first hand who had been infected with HIV, at 10% (n=2) and 6% (n=1), respectively. Whilst reported knowledge of HIV/AIDS was high (100%), unprompted reporting of condoms as a way of preventing HIV infection is low (15%). When asked directly about knowledge of condoms, awareness appears high (86%), but actual levels of detailed condom knowledge are very low. Of those individuals who reported that they knew what a condom was, only 17% said that they knew how they worked.

The discussions about condoms are presented in four groups: rumours; impact on quality of sex; impact on fertility; and, HIV and condoms are 'not Maasai'. A minority of participants expressed the view that Maasai would have to contemplate condom use,

'People will have to use condoms. You cannot take out your heart and lay it on the grass. You cannot take the risk.'

(M, unmarried, 20s, 5 years education)

However, the overwhelming response was that prevention of the disease was useless, and as one participant described, '*It is like an elephant in your path*', there is nothing to do but wait and see what happens.

Rumours

Rumours are not simply incorrect or partial knowledge. In order to have currency rumours need to be communally created and reproduced, and tend to be most potent during times of flux or insecurity (Kapferer 1990, Kaler 2004). Goldstein (2004), mindful of the negative connotations of words such as "myth" and "rumour" prefers to call them "contemporary legends", whilst acknowledging that what really matters is not

nomenclature but the fact that people create and perpetuate them, and they reveal collective insights about health and illness.

Given the low levels of condom knowledge, it is unsurprising that rumours about condoms and their efficacy abound. It should also be noted that several faith-based organisations (FBO) had conducted IEC in the study area. Condom inefficacy was a major element of these IEC campaigns, based upon key informant reports and a review of IEC documentation from the FBOs. Scepticism about the practicalities of condoms abounds, among both men and women, educated and less educated.

'It will not prevent this disease because it is too thin. Besides, what is there to stop a drunken man not wearing it properly, or lying about wearing it when you cannot see in the dark?'

(F, widowed, 44 years, 10 children, 7 years schooling)

'I do not believe that they will work – the liquid will escape. Anyway, is it not possible for the liquid of the woman to pass through to the man?'

(F, married, 31 years, 2 children, no schooling)

Sources of information about condoms were rare in the study area. There were no billboards in the immediate area, although on the main road to Arusha there were one or two (in Swahili), but many of the respondents were unlikely to have travelled along this route. Some government and administrative offices had small (A4) posters about HIV, again in Swahili. The Catholic and Lutheran church had done IEC programmes in the area, but discussions revealed that these presentation had been in Swahili, and for in the audience that could understand, had stated that condoms were ineffective in preventing HIV infection. Contemporary letters from FBOs to newspapers in the area – both English and Swahili – frequently contained similar assertions. Only 3 respondents

stated remembering a specific source of information of HIV, 2 from radio programmes, and 1 from the Roman Catholic Church. One of the issues surrounding radio broadcasts in the area is that they are only in Swahili or English, restricting the number of listeners able to understand the programmes. People had heard of condoms, but probing questions revealed that the majority had not ever seen a condom and had little idea of how they worked. Recent detailed work on this issue reveals similar patterns (Coast 2006). Potential health problems for women, articulated by both men and women, were a frequent concern:

'I don't believe that they work – they're too thin and easy to break. Besides, what happens if they break inside the woman and cause her problems?'

(F, married, 40s, 7 children, no schooling)

'I have heard about them, but never used. I am afraid to use something like that because it can burst or get left inside the woman, and might cause disease'

(M, 42 years, 2 wives, 7 children, completed primary school)

Quality of sex

Good sex, in addition to procreation, involves the 'giving' of sperm from men to women, for the benefit of women. Sperm is considered essential to the social and physiological development of young girls, and all participants agreed that to introduce condoms for *murran* and *entito* would be impossible. Both women and men expressed such concerns:

'It is shameful to see my boyfriend wearing something between me and him'

(F, married, 20s, 2 children, no education)

'What about the enjoyment for the women? They need what we can give them. We cannot waste it'

(M, unmarried, 20s, 3 years education)

Similar themes are found in other ethnographies of the Maasai. For example, Talle summarises the attitude to Maasai men to the use of commercial sex workers, ‘Why should they pay for giving away their ‘blood’ (i.e.: semen) which basically is to a woman's benefit?’ (1999:119).

A further theme linked to the wasting of sperm emerged, relating to the disposal of condoms, an often-overlooked element of IEC campaigns (Sobo 1993).

‘How do you get rid of these things, anyway, it’s embarrassing’
(M, married, 40s, completed primary school)

Such concerns have been noted elsewhere, both in terms of condom use for contraception and for infection prevention (Rahman et al 1980, Ross 1987, Rajaretnam and Deshpande 1994, Jenkins 1999).

Fertility

The key issue of condom use by a husband and his wife or wives related to fertility, and was articulated by both men and women. Husband and wives have sex (although not necessarily with each other), primarily for reasons of procreation. Large families are still an ideal for many Maasai men and women, and mature adulthood is achieved through the production of children.

*‘The husband would make a quarrel with his wife and fight with her and say
“Why do you not want a child from me?”’*
(M, 2 wives, 40s, no education)

*‘Even if a young girl gets this disease, she will still have a baby, so it is Enkai
(God) telling you to have children, but just die sooner’*
(F, married, 30s, no education)

The contraceptive effect of condoms is widely cited in many contexts as a reason for their non-use. In populations where supply methods of contraception are little used, and fertility reduction is not yet seen as advantageous, then the introduction of condoms (albeit for HIV risk reduction) are out of step with fertility needs. Levels of contraception among the Maasai are very low – evidenced in part by the high TFR – and are not widely used (Holloos and Larsen 1997). It should be noted that condom use is consonant with resumption of sexual intercourse during breastfeeding, and was twice referred to by service provider key informants as a clandestine reason for condom use.

Condoms as non-Maasai

The ‘otherness’ of HIV and consequent condom use manifested itself in a variety of ways. For example, the highly ritualised nature of Maasai male circumcision results in a strongly held belief that condoms are unsuitable for penises that have undergone a Maasai circumcision. Attempts by outreach teams from local hospitals to demonstrate the use of condoms using wooden model penises foundered because the models had not been correctly ‘circumcised’. The Primary Health Care team subsequently had the wooden penis model ‘circumcised’ by a local carpenter. In the individual questionnaires those respondents who reported that they had seen a condom were asked where they had seen condoms. The majority of respondents referred to non-traditional Maasai or non-local settings. For example, one respondent had seen condoms as a result of tourists handing them out to Maasai involved in cultural bomas⁶. For many respondents, the only time they had actually seen a condom was inside a packet in shops

⁶ A stylised Maasai settlement, often run and controlled by non-Maasai, where tourists pay to see traditional Maasai lifestyles and living arrangements.

outside of the rural area. The frequent reference to condoms being a ‘Swahili’ (non-Maasai) device underlined the ethnic ‘otherness’ of condoms in a Maasai context.

Discussion

Societies diverge in their explanation of how bodily fluids are constructed and used, with implications for the introduction of “new” technologies such as condoms. The results presented here highlight how, in a Maasai cultural context, an understanding of sperm can impact on the potential uptake of condoms as part of an HIV intervention. The giving and receiving of sperm is valued highly, and since condoms are designed to prevent the transmission of sperm, then the meaning of condoms need to be fully understood by those individuals and agencies involved in promoting condom use as a HIV intervention strategy. The description presented here is not intended to be static, and recognises that these interpretations are changing. For example, rapidly growing temporary rural-urban migration of Maasai men (May & McCabe 2004, Coast 2006) is changing the context of knowledge acquisition and diffusion as more people are exposed to the availability of and messaging about condoms in traditionally non-Maasai settings.

The Maasai have a complex belief system, in which the importance of sperm is embedded in a variety of roles and metaphors including blood and milk. Concerns about sperm are just one factor revealed to be critical for the design and delivery of condom-based HIV/AIDS intervention strategies in a Maasai setting. There have been increasing calls for socio-culturally relevant HIV/AIDS programmes to incorporate locally relevant knowledge. However, the practicalities of designing and implementing

such programmes should not be underestimated, requiring specialist input from linguists and ethnographers alongside public health professionals. Unless local constructions and expressions of sexuality in general, and condom use in particular, are explicitly explored and integrated, then low levels of reported condom use in many populations are unlikely to change, issues of service delivery and logistics notwithstanding. For example, the role of young girls as the socially sanctioned sexual partners of young men in a Maasai context. The integral nature of sperm for this sex is an important dimension of the socio-cultural context of possible HIV transmission, not least because of the physiological vulnerability of young girls to sexually transmitted diseases in general and HIV in particular (Baden and Wach 1998), highlighting the complexity of programme design for prevention of HIV infection. In this, and many other settings, condoms represent more than some simple transfer of technology; they bestow new values to sexual behaviour (Schoepf 1992).

Maasai have a strong identity, both internally and externally. The perception of condoms as non-Maasai is in part due to the sources of condoms – non-Maasai shops, non-Maasai areas, no Maa explanations of how condoms work. However, it is also important to consider that the perceptions of non-Maasai are as powerful as those held by the Maasai themselves. Most HIV-related NGOs in Arusha Region are urban-based and centred, and have neither the capacity (funding, logistics, and personnel) nor an interest in operating outside of the urban area. Service provider perceptions and assumptions about the Maasai are so entrenched that it would be difficult for many such NGOs to operate in a rural context. This is reflected both in the literature produced by such NGOs and in the opinions of the staff. For example, in an interview with one

NGO Director, she described the Maasai as ‘sexually reckless’ and being ‘far too conservative and alone’ for HIV/AIDS intervention programmes to work. Non-Maasai and educated Maasai alike tend to view Maasai as traditional and conservative. Impressions and preconceived notions about the Maasai tend to refer to Maasai men (Hodgson 1999), alternating between the strong and fearless warrior and the intractable herdsman. In explaining the apparent reluctance of Maasai to use condoms (the lack of condom supplies in the area notwithstanding), many NGOs and healthworkers tend to reduce the complexities of Maasai sexuality to some crude description of a society that is sexually deviant.

It is worth reflecting upon the implications of such fine grained socio-cultural knowledge for other aspects of HIV/AIDS interventions in a Maasai setting. If ‘A is for Abstinence’ then acknowledging and confronting the reality that the social construction of maturity for girls involves socially sanctioned sex with older youths, is essential. If ‘B is for Be Faithful’, then this is a construct that needs to address polygynous marriages, because messaging about monogamy and faithfulness are difficult to interpret otherwise.

Finally, technologies and interventions related to HIV infection prevention are developing rapidly, for example, the development of vaginal microbicides. Microbicides can, however, be both spermicidal and non-spermicidal. Work in Zimbabwe (Moon et al 2002) have revealed that there is an urgent need for both spermicidal and non-spermicidal microbicides to be made available, especially in contexts where fertility is still highly valued. In settings such as those described here,

where sperm are highly valued, microbicides might represent a real alternative to condoms (both male and female) for HIV prevention.

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Table 1: Focus group participants, by selected socio-demographic characteristics

	Percent distribution (n=36)
Sex	
- Male	53
- Female	47
Marital status	
- Married	75
- Widowed	10
- Never-married	15
Age distribution	
- 20-29 years	43
- 30-39 years	29
- 40-49 years	20
- >49 years	8
Years of schooling	
- none	59
- less than primary	3
- completed primary	32
- 9-11 years	6
Number of wives (ever-married men only)	
- monogamous	50
- 2 wives	50