January 2010

Deceptive cultural practices that sabotage HIV/AIDS education in Tanzania and Kenya

Mary Oluga
Aga Khan University, mary.oluga@aku.edu

Susan Kiragu
University of Cambridge, United Kingdom

Mussa K. Mohamed
Aga Khan University, mussa.mohamed@aku.edu

Shelina Walli
Aga Khan University, shelina.walli@aku.edu

Journal of Moral Education

ISSN: 0305-7240 (Print) 1465-3877 (Online) Journal homepage: http://www.tandfonline.com/loi/cjme20

'Deceptive' cultural practices that sabotage HIV/AIDS education in Tanzania and Kenya

Mary Oluga , Susan Kiragu , Mussa K. Mohamed & Shelina Walli

To cite this article: Mary Oluga , Susan Kiragu , Mussa K. Mohamed & Shelina Walli (2010) 'Deceptive' cultural practices that sabotage HIV/AIDS education in Tanzania and Kenya, Journal of Moral Education, 39:3, 365-380, DOI: 10.1080/03057240.2010.497617

To link to this article: http://dx.doi.org/10.1080/03057240.2010.497617

Published online: 04 Aug 2010.

Journal of Moral Education
Vol. 39, No. 3, September 2010, pp. 365–380

'Deceptive' cultural practices that sabotage HIV/AIDS education in Tanzania and Kenya

Mary Oluga[a], Susan Kiragu[b*], Mussa K. Mohamed[a] and Shelina Walli[a]
[a]*Aga Khan University, Tanzania;* [b]*University of Cambridge, UK*

In spite of numerous HIV/AIDS-prevention education efforts, the HIV infection rates in sub-Saharan Africa remain high. Exploring and understanding the reasons behind these infection rates is imperative in a bid to offer life skills and moral education that address the root causes of the pandemic. In a recent study concerning effective HIV/AIDS-prevention education, conducted in Tanzania and Kenya among teacher trainees and their tutors, the notion of *mila potofu* (defined by educators as 'deceptive' cultural practices) emerged as a key reason for educators' difficulties in teaching HIV/AIDS prevention education in schools and for high HIV infection rates. Since these cultural practices cause harm, and in many cases lead to death, they are of moral concern. This paper outlines some of these cultural practices identified by educators, including 'wife inheritance', 'sexual cleansing' and the taboo against certain foods, and discusses how these practices contribute towards HIV/AIDS vulnerability. It then offers recommendations for classroom-based life skills and moral education following Jean Piaget's theory of cognitive development in understanding how 'assimilation', 'accommodation' and 'adaptation' can help people discard *mila potofu* in a culturally sensitive manner.

Introduction

Sub-Saharan Africa (SSA) remains the region most heavily affected by HIV/AIDS worldwide. The United Nations Joint Programme on HIV/AIDS (UNAIDS, 2009) reported that of the 33.4 million people worldwide living with HIV/AIDS, two-thirds were from SSA. These latest HIV/AIDS statistics show that in 2008 the prevalence rate for adults aged between 15 and 49 was 7.8% in Kenya, 14.3% in Zambia, 16.9% in South Africa and 25% in Botswana. In Tanzania, prevalence was at 5.7% in 2007 (UNAIDS, 2009, p. 19). The principal mode of HIV/AIDS transmission in SSA is heterosexual contact (Kenya Demographic and Health

*Corresponding author. The Centre for Commonwealth Education, Faculty of Education, University of Cambridge, Cambridge, UK. Email: swk22@cam.ac.uk

ISSN 0305-7240 (print)/ISSN 1465-3877 (online)/10/030365–16

DOI: 10.1080/03057240.2010.497617
http://www.informaworld.com

Survey, 2003) and more women are infected than men (UNAIDS, 2009). The overarching question is why the pandemic remains at such high levels despite numerous education and prevention strategies over the last three decades (Morrell, 2003). The answer to this question is important since it has the potential to reshape the strategies and content of HIV/AIDS interventions, especially for young people in colleges and schools.

Various authors have critically discussed the reasons behind HIV/AIDS prevalence in SSA. Parker *et al*. (2000) cite ecological contexts such as poverty, mobility and internal migration, seasonal work, social disruption due to war and political instability; Kiragu (2009) focuses on how gender inequalities, religion, stigma and discrimination and the historical background of colonialism impact on sexual decisions and behaviour; MacDonald (1996) reflects on multiple concurrent partnerships and intergenerational sex as key drivers; while others (Ahlberg *et al*., 1997) discuss how traditional practices, such as circumcision with shared implements, are complicit in maintaining high rates of infection. Some of these factors, such as widespread poverty and social disruption, have resulted in poor education, a concomitant lack of knowledge of HIV/AIDS transmission and an inability to comply with some of the public health interventions advocated. These interventions include medical circumcision; treating sexually transmitted infections; adhering to a healthy diet for people on antiretroviral (ARV) drug treatments; obtaining and consistently using ARVs for prevention of mother-to-child transmission and for the care of those already infected; and consistently acquiring and using condoms. More recently, commentators such as Mbozi (2000), have added a further, frequently ignored, driver:

> There is no doubt about economic shortcomings as determinants of the high rate at which this deadly disease (HIV/AIDS) spreads. However, there is also evidence that some negative cultural beliefs, traditions and practices, which are deeply rooted in the social and sexual lives of most African ethnic groups, have also contributed to the transmission of the disease. (p. 75)

During a study that explored the challenges that educators (college tutors, teacher trainees and teachers enrolled in continuing education) faced in teaching HIV/AIDS and sexuality in school classrooms, the topic of 'deceptive' cultural practices was frequently raised. Educators called these practices *mila potofu* in Swahili, which they defined as those beliefs and activities practised within a community that present a danger to one's health, especially in the time of AIDS.

This paper focuses on these traditional and cultural beliefs and practices identified by educators in Tanzania and Kenya and interrogates their evidence as to how they impact on the fight against HIV/AIDS. The paper argues that addressing these deceptive cultural practices *sensitively* is both a moral obligation for educators and an important part of the moral education programme of a school, since failing to do so at all results in harm to others, while failing to do so sensitively does injustice to people's right to practise their culture. It suggests that while *mila potofu* poses obstacles for HIV/AIDS-prevention education, circumventing these

practices in a sensitive manner is possible through what Piaget (1970) and others call 'assimilation', 'accommodation' and 'adaptation', which will be discussed in conclusion.

Research design and methods

The research study was conducted in Tanzania and Kenya in order to offer a comparative perspective on the experiences of teacher trainees and college tutors with regard to classroom-based HIV/AIDS education. In Tanzania, there were seven sites from which research participants were drawn. The first site was a primary school in the town of Turiani where the researchers taught a certificate course for teachers. Sites two to seven were teacher training colleges, three of which were urban—Arusha, Dar es Salaam and Iringa, while three were rural—Moshi, the Coastal region and Makete. With the exception of the college in Dar es Salaam (private and Muslim), all colleges were secular and run by the government. Colleges were chosen, in consultation with the Ministry of Education in order to obtain a mix of urban/rural and private/public institutions and to be representative of teacher training colleges in Tanzania. In Kenya, there were two sites, a primary school in the town of Kisumu and a secondary school in Nairobi where the researchers taught the same teacher certificate course as in Tanzania.

Permission to conduct this research was formally sought from the Ministries of Education in both Kenya and Tanzania. Once research permits had been obtained, researchers sought permission from institutional authorities to approach participants and then sought informed consent from individuals to be research participants. The overall research sample consisted of 137 individuals comprising 14 college tutors (including three college principals) and 123 teacher trainees (40 new teacher trainees and 83 teachers who were upgrading their qualifications). These individuals were purposively selected because they were either tutors or teacher trainees in subjects that incorporated HIV/AIDS education. There was an even number of male and female research participants.

Data were collected through individual interviews with college tutors and principals and through focus group discussions with teacher trainees at each of the nine sites. Teachers were divided into discussion groups depending on their regional and ethnic origin, for example, Luo, Luhya, Kikuyu and Kamba in Kenya and Northern, Southern, Central and Coastal regions in Tanzania. Each discussion group had both female and male teachers. Once teachers had identified *mila potofu* as a phenomenon that affected HIV/AIDS and sexuality teaching in the classroom, they were invited to conduct a focus group of their own regarding these 'unhelpful' or 'deceptive' cultural practices in their communities. Having completed this task they, in turn, provided feedback to researchers in focus groups. Interviews and focus group discussions were conducted in English and Swahili and were all digitally recorded and transcribed prior to analysis. Swahili transcriptions were simultaneously translated into English during transcription. Data analysis involved a thorough reading of the transcripts, and teasing out emerging *mila potofu*. These were further coded within similar themes

such as 'taboo of talking about sex', 'nutrition', 'ceremonial rituals and myths' and 'cultural attitudes towards fertility and sexual intercourse'.

The moral implications of 'deceptive' cultural practices

Sithole (2003) aptly defines culture as a complex set of distinctive spiritual, material, intellectual and emotional features that characterise and define a society or social group. In the past 15 years, a growing number of African scholars have called attention to the role of myths and cultural beliefs surrounding nutrition and ceremonial and healing traditions that predispose people to the risk of HIV infection (MacDonald, 1996; Mbozi, 2000; Akinade, 2003; Sithole, 2003). These, and other scholars, report on widow inheritance (Luginaah *et al.*, 2005), sexual cleansing (Ayikukwei *et al.*, 2007), sex with virgins (rape) as a cure for AIDS (Leclerc-Madlala, 2002), mass, unsterile, male and female circumcision (Ahlberg *et al.*, 1997) and traditional styles of body scarification, tattooing and hair shaving using the same knife (Sithole, 2003). So while there is increasing recognition of the adverse effects of various cultural practices on levels of HIV infection, what was most interesting in our study was the clear way in which teacher trainees and college tutors identified particular practices as hindering HIV/AIDS education, called them by a historically understood name, *mila potofu*—'deceptive cultural practices'—and alluded to the moral importance of addressing them within HIV/AIDS education programmes in schools.

As Brandt and Rozin (1997) put it, 'HIV/AIDS has called attention to moral judgements and their impact on disease as few modern diseases could have' (p. 3). They alert us to the powerful role moral systems play in addressing matters of health and disease and argue that:

> All cultures seem to have complex and entangling moral and health beliefs. Moral conventions, at different times and places, have a significant influence on the framing of health and disease-related behaviours. We become more and more aware of the impelling fact that the morality-health link is both very important and little studied. (p. viii)

The empirical evidence provided below, aims not merely to describe these cultural practices, but to offer insight to educators on how they impact on people's 'local moral worlds' (Kleinman, 1999). Kleinman argues that traditions and customs are neither a matter of following pure habits nor of constant self-interrogation about how we make meaning of culture; rather the making of moral beings depends upon the way we place ourselves within local relationships—an area of crucial significance to teachers and teacher educators, as will be illustrated below.

Identifying *mila potofu*

Our research findings can be divided into four main areas. The first concerns the pervasive taboo regarding *talk about sex* between adults and children. This includes the reserved nature of educators in discussing issues related to sex and HIV/AIDS. In general, we found that according to teacher trainees, females and young children of

both sexes were less likely to engage in discussions around sex. Second, there seems to be a plethora of myths and cultural beliefs surrounding *dietary practices* that impact negatively on women and children especially, and distort the educational quest for AIDS prevention and treatment. Third, a number of overt *ceremonial practices and myths* prevail that are directly harmful to those who are subject to them and place them at increased risk of HIV/AIDS infection. Fourth, various *sexual practices*, especially around the common practice of having multiple partners or extra marital partners, exist as cultural idioms of not only male virility but female fertility as well. These place women at heightened risk of HIV/AIDS infection. Each will be considered in turn.

The taboo of talking about sex

The key cultural belief and practice identified by educators as exacerbating the risk of AIDS infection in their communities was the taboo against speaking about sexual matters. In Kenya and Tanzania, not unlike other African countries, the discussion of sex with young people, especially girls, is seen as indecent, unhealthy and unacceptable (Campbell & MacPhail, 2002; Oshi *et al.*, 2005). One female college tutor summed up the taboo in personal terms:

> How does my husband start to talk about sex with my daughter? Where am I at that time? It is embarrassing. Oh no, what would he say, and how would she regard her father? A girl who listens to such talk is considered spoiled [immoral] in our community. There are only specific times like 'a kitchen party' [a pre-wedding occasion for brides] when they are taught, but it is women to women. Not before that. (Female college tutor, Tanzania)

During the course of the study, it was not uncommon for female teacher trainees to walk out of the room when matters of sex were being discussed. College tutors had a laissez-faire attitude to these 'walk outs'. One male college tutor expressed both exasperation and powerlessness:

> Really, these are grown-ups. Some of them are married people and I cannot force them to like what they do not want. If she feels it is against her culture, all I do is to respect that and let her walk out. (Male college tutor, Tanzania)

Furthermore, college tutors reported that parents were not in favour of education about sex and contraception in schools as they claimed it made their children 'immoral'. A male college tutor reported that:

> Talking about sex, especially with girls, is not allowed at all. It is not in our culture to do that, it is not allowed at all.…Parents do not like it; they can even withdraw the child from the school.

At a teacher training college in Coastal region, Tanzania, teacher trainees complained that this taboo against talking about sex meant that both their own college tutors and the children they encountered in their classrooms were reticent (and frequently silent) about discussing issues related to HIV/AIDS. Upon hearing this feedback in an interview, a senior college official responded by saying that:

> HIV/AIDS does not provide teacher trainees with a certificate to discuss *mambo ya ajabu ajabu* [shocking/taboo topics]. We still have to remain decent!

At the same college, a male teacher trainee drew attention to how silence was an obstacle to behaviour change in both young people and adults. He commented that:

> We know that there are some things which our tutors do not want us to discuss in class because it is not allowed in the community. In this way, we miss a lot of truth. (Male teacher trainee, Tanzania)

When asked why children were silent during classroom discussion, a male teacher trainee reported that children 'keep a lot to themselves' because they feared the repercussions of talking about their experiences of sexual abuse. They feared the legal implications and also feared being seen to undermine their culture by speaking about sexual matters to adults:

> One girl told me, 'the way I see it, if I say that my grandfather is the one who did this to me [raped me] I will quarrel with my parents and they will not believe me'. (Male teacher trainee, Tanzania)

Numerous scholars capture the drift from open dialogue in sexuality matters to one of silence due to factors such as colonialism, patriarchy and religion (Foucault, 1976; Fine, 1988; Ahlberg, 1994; Kiragu, 2009). Indeed in pre-colonial Africa, communities such as the Gikuyu of Kenya (Kenyatta, 1938; Kiragu, 2009), Shona of Zimbabwe (Jeater, 1993) and Baganda of Uganda (Bryk, 1933) had a public, collective nature in which sexuality was addressed during initiation and ritual ceremonies. These cultural practices created a public discourse around sexuality, which stands in stark contrast to the silence surrounding the same in contemporary times as exemplified by the teachers in this study. Kiragu (2007, 2009) argues that silence among teachers is caused by the mixture of a lack of training in sexuality and HIV/AIDS education, cultural taboos of talking about sex, a fear of being seen as encouraging children to have sex and fear of being called 'obscene' or 'indecent' by using words such as 'penis' and 'vagina' with children. A Tanzanian college tutor summed up this helplessness. He related how a female teacher trainee had asked for help to know how to respond to children's abusive experiences. When asked by the researcher what advice he would give to this trainee he said, 'I, too, would not know what to do'.

The taboo against talking about sex operated at multiple levels. College tutors failed to speak to teacher trainees, who themselves struggled to speak to children, mainly for fear of offending parents or not knowing how to deal with the situation. In turn, children kept silent because of their fear of transgressing cultural norms and 'quarrelling' with parents, especially in cases where they reported abuse. This conspiracy of silence present in Tanzania and Kenyan cultures (and beyond) conspires to keep young people ignorant about the basic biology of HIV/AIDS and how various cultural beliefs, traditions and practices might be challenged in order to protect them from HIV/AIDS infection.

Nutrition—participation in dietary cultural practices

The second group of cultural practices that affected teachers' educational quest for HIV/AIDS intervention concerned cultural beliefs about food. Teacher trainees

spoke about two main types of dietary beliefs of relevance. The first was the way in which certain cultural practices prevented children and women (including pregnant and lactating women) from accessing a balanced and nutritious diet, which resulted in malnutrition, stunting and sometimes illness and death. For example, certain cultural groups forbade women from eating protein-rich foods such as eggs, milk, fish and chicken. Other groups forbade pregnant and lactating women from eating fruits and vegetables, claiming that they are harmful to infants. More widespread is the practice of preventing women and children from eating until men have had their fill. As a result women and children were frequently inadequately nourished. A female teacher trainee from Tanzania explained:

> Many traditional cultures refuse women to take foods such as eggs, milk, fish and chicken. All these are foods rich in protein. In some cultures, it is only the men who are allowed to eat the chicken gizzard because it is believed to make the men *dume la mbegu* [virile like a bull with sperm] and a woman infertile. (Female teacher trainee, Tanzania)

A female tutor from the coastal region explained the voluntary avoidance of certain foods as a socio-cultural practice or due to unfounded myths. So, for example, some refused to eat vegetables and some fruits because they are seen to be 'lowly foods…food for the poor'. This belief, she explained, is especially common amongst tribes that have traditionally been hunters. She further elaborated how this affected HIV/AIDS intervention. In her experience of volunteering for home visits among people who were HIV-infected and on ARV treatment, she frequently encountered relatives of AIDS patients who actively discouraged them from eating vegetables, fruits and grains in spite of their affordability and high food value in boosting the immune system, due to this belief:

> They completely refused. They said that [eating]…leaves are not important. For them the leaves are for cows not for human consumption. (Female college tutor, Tanzania)

A similar story was related by a female teacher trainee in Kenya, who related that in her tribe, pregnant women are not allowed to eat eggs as it is believed they would give birth to bald babies. Such babies are said to cause poverty in the family. In poor communities, eggs are a main source of protein and are freely available and affordable. This cultural belief results in poorly nourished women and infants. It is made more complex by women themselves perpetuating the practice. During a classroom observation, a married male teacher trainee in Moshi, Tanzania related how his wife refused to eat eggs during pregnancy despite this being the only source of protein he could afford. He was desperate and asked:

> What am I supposed to do? I know eggs are very good for her and I can afford [them] because we keep a lot of chickens. But she refused—she said her mother warned her. (Male teacher trainee, Tanzania)

These beliefs and practices about fruit and vegetables as 'poor foods' and seeing protein-rich food as taboo, despite their ubiquity and importance, due to strong cultural beliefs and gendered positioning as regards food are difficult to address given the strong traditional bases for these beliefs. Due to social pressure to appear

'wealthy' in the community or through a strong belief in such myths or gender-priority, households in many African communities avoid eating, or prevent others from eating, readily available and highly nutritious food. The life chances of those who are subjected to, or partake in, these dietary practices are severely hampered, particularly if these people are HIV-positive. People infected with the virus require a healthy and nutritious diet in order to maximise the effects of treatment programmes. These dietary practices also have an effect on poverty alleviation, since people spend money on market-bought food instead of utilising the abundant supply of naturally growing food or foods that can be easily cultivated in vegetable gardens. One research participant recognised the drawbacks of eliminating good nutrition for the sake of cultural adherence:

> We must put aside our pride and ignorance and take advantage of nature's free gifts. Let us let go of those cultural practices that hold us back. (Female college tutor, Tanzania)

However, many more acknowledged that taking such a step, and helping children, families and communities to do so too, would be a difficult undertaking.

Ceremonial rituals and myths

Educators identified various ceremonial practices in the communities in which they lived that impact on AIDS education and prevention. These include circumcision, traditional healing and cleansing practices and other ceremonial rituals and myths (Ahlberg *et al.*, 1997; Luke, 2002; Ayikukwei *et al.*, 2007). During focus groups, teacher trainees and college tutors spoke at length about the 'dangers' of these practices largely due to the common feature of shared and unsterile instruments:

> When people visit traditional healers in order for their problems to be solved, a common treatment is for the traditional healer to make an incision into the client's skin into which medicine is rubbed. In most cases there is no guarantee that the instrument will be cleaned before the next client is offered the same service. Naturally, such a practice increases the risk of blood-to-blood HIV infection. (Female college tutor, Tanzania)

Another common belief is that HIV/AIDS can be cured through natural or herbal means. A Kenyan female teacher trainee related how the jackfruit is regarded as 'sacred' in her community and is used for healing purposes among sick people, including those suffering from AIDS. 'The belief is that if you eat the fruit for three months and rub the skin of the fruit on your body, you will be cured,' she related. As a result, she explains, people engage in risky behaviours with the belief that there is a cure and once they have undergone this ceremony they no longer take sexual precautions or get tested because they believe themselves healed.

A more commonly occurring belief is that of the virgin cleansing myth. A male Tanzanian teacher trainee summed up this belief:

> Many believe that AIDS is a result of a curse, resulting either from a personal offence to the spirits or mediated by a person who wishes harm. It is a belief among some communities that the remedy to escape such a curse is for the infected or cursed man to have sex with a virgin girl, usually under the age of twelve. Subsequently, the incidence of child

> rape has increased in the communities among which this practice occurs, and this leaves these young girls HIV-infected. (Male teacher trainee, Tanzania)

Teacher trainees had many stories to tell regarding the virgin cleansing myth and spoke of friends and traditional healers being known to advise men to sleep with virgins as prevention and a cure for HIV/AIDS.

Another cleansing ritual involves a woman whose husband has recently died. Commonly known as widow inheritance, the practice is used in a number of ways: to ensure the widow is cared for; as a means to keep the wealth of the deceased within the family; and as a means to appease the spirit of the dead husband and prevent it from visiting and punishing the living (Luginaah *et al*., 2005; Dilger, 2006; Ayikukwei *et al*., 2007). In some communities, where death is considered a bad omen, a widow has to have sex with a stranger or even a 'mad' man so as to transfer 'the bad omen' to him. In this case, sexual cleansing or widow cleansing is seen as a sacred ritual. A 'cleanser' (a man who agrees to have sex with the widow) is identified, some of whom are paid for their services (Mulama, 2010). Widow cleansing perpetuates the HIV/AIDS epidemic since unprotected sex is had with multiple partners. A female Kenyan teacher elaborated further:

> The belief is that a woman who has lost a husband needs to be 'cleansed' before she can remarry. This cleansing ritual requires that a man other than the one who is to eventually marry the widow, to perform sexual intercourse with her. (Female teacher trainee, Kenya)

Furthermore, since this is seen as a temporary relationship meant to serve a ceremonial purpose, condoms are rarely used. Teachers spoke of children being born out of such encounters, evidencing unprotected sexual engagement. The implications for HIV infection are obvious. During focus groups and interviews, participants spoke animatedly of the various villages, regions and countries that participated in these cleansing practices, including Zambia, Mozambique and many parts of Kenya and Tanzania. They also discussed the consequences to women who failed to participate in the practice:

> Women who refuse to participate in this ceremony face the wrath of the extended family as they are blamed for being the cause of misfortunes in the family after refusing to be cleansed. (Female teacher trainee, Kenya)

> In other cases, the deceased husband's family chooses a random stranger, a homeless or sick person, to perform the ritual. (Female teacher trainee, Kenya)

> Some men who act as 'cleansers' have made this a professional practice and charge exorbitantly for the service. In some cases, desperate widows pay agents to get a 'cleanser'. (Male teacher trainee, Kenya)

A particular male teacher trainee told of how when there was competition for widows, cleansers would give items of clothing to an agent who in turn would ask a widow to randomly choose an item of clothing. She would be 'cleansed' by the man whose clothing item she had picked. While most teachers were visibly repulsed by this *mila potofu*, one male Kenyan teacher trainee seemed to be in support of it:

> I don't see why I should not be allowed to look after my sister-in-law in all ways possible. The one inheriting the widow, a brother or cousin to the deceased, has to perform the duties of a husband including providing and receiving conjugal rights. (Male teacher trainee, Kenya)

This teacher highlighted the related practice of widow inheritance rather than widow cleansing. Widow or wife inheritance is the cultural practice whereby relatives of the deceased ensure that the widow remains part of the family. A brother would marry the widow and, if he is already married, become polygamous to protect her and to keep her wealth in the family. In the presence of HIV infection, this practice has the potential for continuous infection from one member of the family to the next, leaving behind related orphans.

Cultural attitudes towards fertility and sexual intercourse

Although many of the cleansing rituals described above are sexual in nature, there are further cultural practices that focus on sexual intercourse and that have important ramifications for the transmission of HIV/AIDS. These include beliefs and practices about multiple partnerships, how to keep a sexual partner and other sexual practices which affect HIV infection. Trainees spoke frequently of the cultural icon of male virility and the common practice of having multiple partners or extra-marital partners. The idiom *ruath tho gi lum e dhoge* (literally translated from Luo as 'a bull dies with grass in the mouth') was commonly articulated amongst Luo teacher trainees in Kenya. They explained that the phrase meant that a man would not forgo multiple sexual partnerships or compromise his male ego to the possibility of contracting HIV/AIDS since such a practice was a sign of his virility and was applauded in the community. Appreciation of multiple sex partners was not only common among men. In Tanzania, it was reported that women from the Coastal region found it prestigious to have multiple sexual partners:

> These women are proud to have different children from different men, and take pride in talking about 'my seven children from six husbands'. (Female college tutor, Tanzania)

Whilst the issue of multiple partnerships as a sign of prestige is not unique to Africa (Kelly *et al.*, 2003), the way in which it is supported by traditional idioms makes it particularly problematic in the context of AIDS education. Another practice supported by a common expression in Tanzania regards the sharing of breast milk between a baby and a sexual partner. A female teacher trainee elaborated:

> *Baba na mwanae lazima wagawane maziwa* [the father and the child must share the milk]. One breast is for the father and the other for the baby. (Female teacher trainee, Tanzania)

Besides denying the infant adequate nutrition, this practice also carries the risk of infection or re-infection between the partners should the woman be HIV-positive.

In many communities, expectant women have been discouraged from having sexual intercourse especially in the last trimester of their pregnancy. Traditional midwives and mothers-in-law from a number of communities reprimand and ridicule women for having engaged in sex until the 'last minute' when a baby comes out

covered in blood and 'a slimy membrane'. To avoid this embarrassment, women deny their husbands sex and in turn, men have extra-marital sex to satisfy their needs. This heightens their risk of HIV infection which later increases their marital partner's risk of infection when they resume sexual intercourse.

Teachers in Kenya mentioned two other cultural practices that increased the risk of HIV infection. Among the Maasai tribe, men are frequently stationed away from the community in search of greener pastures for their cattle. When these men are away, young women ('Maasai virgins') are sent to provide them with 'necessary services', which include food and sex. These young women are allocated to a group of men rather than to specific partners. The implication for HIV infection is obvious:

> When the Morans [Maasai warriors] are out there, they are protecting the community and so their well-being is important. All their needs have to be served. They are sent young virgins to satisfy their sexual needs in addition to carrying foodstuffs and water for them. (Male teacher trainee, Kenya)

Finally, a male teacher trainee in Tanzania related a discussion that he had had with his students (aged 9 to 12). The children told of a custom of grandfathers calling their granddaughters 'my little wife' and grandmothers calling their grandsons 'my little husband'. Traditionally, these pet names are regarded as endearing references with no sexual overtones. However, this teacher trainee related that his students told of how grandfathers sometimes forced their granddaughters to have sex with them. Once again the implications for HIV infection is obvious, while at the same time constituting a heinous crime against children. As reported earlier, children frequently feel uncomfortable reporting sexual abuse at the hands of family members to parents both for cultural reasons and because they will not be believed and will be punished by parents.

Adaptation: the possibilities of critical, culturally-sensitive AIDS education

Mbozi (2000) summarises many of these cultural practices we have discussed according to three categories: (1) social *conduct* resulting from the belief in the powers of an external force, for example ritual cleansing and some dietary taboos; (2) social or sexual *traditions and practices* which are an outgrowth of beliefs related to a perceived role in a social relationship, for example polygamy and circumcision rituals; and (3) social *relations* based on tradition which dictates that something has to be done in a particular way simply because it has been done like that for years, for example wife inheritance and taboos on talking about sex.

This paper contributes to the discussion by providing evidence of the way in which teacher educators and teachers participating in initial or further education identified various cultural practices as 'deceptive' (or *mila potofu*) and made clear how each of these practices sabotaged their efforts at providing effective HIV/AIDS education in their classrooms. Consequently, this final section asks to what extent educators are able to suggest solutions for the existence of *mila potofu* and how these cultural practices might be addressed within educational contexts. Solutions were not immediately apparent. Some reflected on how the most obvious answer, that of directly

refuting these beliefs, was also the most short-sighted. Bayer (1994) has repeatedly warned, and empirically illustrated, that:

> AIDS prevention efforts that are not culturally sensitive will be ineffective. They will fail to promote, support, and sustain the behavioural modifications that are the sine qua non of AIDS prevention. They will fail because they will not reach their intended audience, will not be understood by those who are reached, and will not be accepted by those who understand. They may, indeed, provoke outright opposition. (p. 895)

Many educators recognised multiple dilemmas in minimising the harm of *mila potofu*. Teacher trainees reported that parents were against teaching sex education in schools since they claimed it made their children 'immoral'. They were also scared of breaking ingrained cultural taboos regarding adults speaking to children about sex. As a result, schools had to treat sexual content with caution and in some cases it was dropped altogether. Furthermore, as we have already described, there is silence from children, opposition from parents, reluctance from college tutors and embarrassment from female teachers who walk out of rooms when sexual matters are discussed. If the direct topic of deceptive cultural practices is added to the mix, the expected outcome can hardly be positive. However, educators noted that in the face of increasing levels of HIV infection, we simply 'cannot do nothing' or perpetuate the status quo (Bayer, 1994).

In discussion with educators, it become clear that the challenge in the context of sexuality and moral education must be to raise the critical consciousness of students, while allowing them to maintain the integrity of deeply-held cultural beliefs. Otherwise, impositions from above can cause humiliation and provoke resistance that would be counterproductive to the goals of HIV/AIDS education. Educators recommended that 'safe spaces' be created for discussion of sensitive issues that require a highly trained, open-minded, *insider* approach. An open-minded insider to local culture is possibly best placed to conduct critical thinking discussions that draw on human rights discourses, while at the same time discussing ways in which respectful alternatives might be offered. An insider might help students to discuss the values that underpin various cultural practices and find alternative practices without sacrificing the intention behind the practice or custom.

Piaget (1970) describes this as creating a state of disequilibrium, an uncomfortable state that encourages learning and change. Piaget also describes a continuum of three stages along which change occurs when faced with competing values or clashing worldviews. These are 'assimilation', 'accommodation' and 'adaptation'. Using the open-minded critical insider to guide dialogue and reflection among communities regarding *mila potofu*, assimilation of new practices may occur. For Piaget (1970), 'assimilation is the integration of external elements into evolving or completed structures' (p. 706). In this way, a person tries to understand new knowledge in terms of their existing knowledge. Assimilation can further lead to accommodation over time. Piaget defines accommodation as the 'modification of…[a] scheme or structure by the elements it assimilates' (p. 708). The person changes his or her cognitive structure in an attempt to understand new information, adapting his or her way of thinking to a new experience. He adds:

> Whereas assimilation is necessary in that it assures the continuity of structures and the integration of new elements to these structures; accommodation…permits structural change. Thus, when taken together, assimilation and accommodation make up adaptation, which refers to the person's ability to adapt to his or her environment. (p. 708)

Disequilibrium thus facilitates 'a need to know', where a person is either motivated to change (a learning) or to work harder to find evidence to confirm his/her belief (a rejection) (Hedgepeth & Helmich, 1996). Our data reveal examples of both sides of disequilibrium. Educators were extremely keen for discussions that interrogated these deceptive cultural practices and suggested culturally sensitive ways to change them by assimilating new practices that might begin to neutralise their effects. For example, in the case of wife inheritance it was suggested that discreet and confidential testing form part of the practice, so that each partner may be informed of the other's serostatus and take the necessary precautions. In fact, many of the cleansing rituals could involve HIV-testing prior to the ceremonies and the use of condoms during it. Another example is the 'medicalisation' of circumcision rituals, with educators suggesting that young men be circumcised in sterile surroundings before going to the bush or mountain for traditional teaching in isolation. Male circumcision in hospitals has already been assimilated in many cultures (Brown *et al.*, 2001; Scott *et al.*, 2005; Bailey *et al.*, 2008). Regarding female circumcision, it was suggested that girls undergo the theoretical sex education that normally accompanied female circumcision but no longer undergo the physical cutting. They would then graduate with paper certificates and relevant knowledge and life skills regarding womanhood. These are good examples from this study on assimilation and adaption, where the harmful cultural practice is not 'attacked' but negotiated resulting in a safer practice. However, there were also some examples of rejection of new information, as evidenced by the teacher's wife who refused to eat eggs despite their nutritional value, the male teacher who supported wife inheritance and the college tutor who resigned himself to teacher trainees 'walking out'. Furthermore, research participants had fewer accommodations to offer with regard to dietary customs and practices grounded in the spirit world.

Conclusion

In the Tanzanian and Kenyan contexts, and in the milieu of HIV/AIDS, cultural practices that might previously have been benign now have dangerous and life-threatening consequences. There have been public outcries over these and other *mila potofu*. However, for as long as we believe education to be an effective 'social vaccine' (Bakilana *et al.*, 2005) and the best option to reach young people, cultural practices should be carefully navigated in order not to estrange community gatekeepers. If these gatekeepers close the door to HIV/AIDS-prevention education, the pandemic has the potential to dramatically worsen.

This paper has offered important examples of the *mila potofu* or deceptive cultural practices, identified by educators in Tanzania and Kenya, which exacerbate the

spread of HIV/AIDS and challenge the provision of effective HIV/AIDS education in African classrooms. These educators have identified many of these practices; have begun to reflect on the essence and purposes of these beliefs; and suggest creating safe spaces for insider-led respectful critical thinking and adaptation, while still retaining important cultural values. Human rights education, moral education and HIV/AIDS education delivered by an open-minded critical insider who is both sensitive to cultural practices but who will clearly address those cultural beliefs and practices that impact negatively on the health and well-being of people is critical. To the extent that such an open-minded critical insider helps people to move towards assimilating new values, accommodating new knowledge and adapting (and adopting) new practices, HIV/AIDS prevention may overcome some of the sabotaging cultural practices current in African countries such as Tanzania and Kenya. These are not only moral imperatives but important topics for discussion in moral education classrooms.

Acknowledgements

The authors are grateful to Ingrid van der Heijden and Sharlene Swartz for their detailed comments, which have substantially improved this paper.

References

Ahlberg, B. M. (1994) Is there a distinct African sexuality? A critical response to Caldwell *et al.*, *Africa: Journal of the International African Institute*, 64(2), 220–242.

Ahlberg, B. M., Kimani, V. N., Kirumbi, L. W., Kaara, M. W. & Krantz, I. (1997) Male circumcision: practice and implication for transmission and prevention of STD/HIV in central Kenya, *African Sociological Review*, 1(1), 66–78.

Akinade, A. (2003) Cultural practices that influence the spread of HIV/AIDS in Botswana, in: E. Biakolo, J. Mathangwane & D. Odallo (Eds) *The discourse of HIV/AIDS in Africa* (Pretoria, UNAIDS ICT), 112–116.

Ayikukwei, R., Ngare, D., Sidle, J., Ayuku, D., Baliddawa, J. & Greene, J.Y. (2007) Social and cultural significance of the sexual cleansing ritual and its impact on HIV prevention strategies in western Kenya, *Sexuality and Culture*, 11(3), 32–50.

Bailey, R. C., Egesah, O. & Rosenburg, S. (2008) Male circumcision for HIV prevention: a prospective study of complications in clinical and traditional settings in Bungoma, *Bulletin of the World Health Organization*, 86(9), 669–677.

Bakilana, A., Bundy, D., Brown, J. & Frediksen, B. (2005) *Accelerating the education sector response to HIV/AIDS in Africa: a review of World Bank assistance*. World Bank global HIV/AIDS program discussion paper (Washington DC, World Bank).

Bayer, D. (1994) AIDS prevention and cultural sensitivity, are they compatible? *American Journal of Public Health*, 84(6), 895–898.

Brandt, M. & Rozin, P. (Eds) (1997) *Morality and health* (London, Routledge).

Brown, J. E., Micheni, K. D., Mwenda, J. M., Krchn, D., Muthiri, F. M. & Grant, A. R. (2001) Varieties of male circumcision: a study from Kenya, *Sexually Transmitted Diseases*, 28(10), 608–612.

Bryk, F. (1933) *Voodoo-EROS: ethnological studies in the sex-life of the African Aborigines* (New York, Syd Sculdiner).

Campbell, C. & MacPhail, C. (2002) Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth, *Social Science and Medicine*, 55(2), 331–345.

Dilger, H. (2006) The power of AIDS, kinship, mobility and the valuing of social and ritual relationships in Tanzania, *African Journal of AIDS Research*, 5(2), 109–121.

Fine, M. (1988) Sexuality, schooling and adolescent females: the missing discourse of desire, *Harvard Educational Review*, 58(1), 29–53.

Foucault, M. (1976) *The will to knowledge: the history of sexuality* (London, Penguin Books).

Hedgepeth, E. & Helmich, J. (1996) *Teaching about sexuality and HIV: principles and methods for effective education* (New York, New York University Press).

Jeater, D. (1993) *Marriage, perversion and power: the construction of moral discourse in southern Rhodesia 1894–1930* (Oxford, Clarendon Press).

Kelly, R. J., Gray, R. H., Sewankambo, N. K., Serwadda, D., Wabwire-Mangen, F., Lutalo, T. & Wawer, M. J. (2003) Age differences in sexual partners and risk of HIV-1 infection in rural Uganda, *Journal of Acquired Immune Deficiency Syndromes*, 32(4), 446–451.

Kenya Demographic and Health Survey (2003) *Kenya demographic and health survey* (Nairobi, Kenya, Bureau of Statistics).

Kenyatta, J. (1938) *Facing Mount Kenya* (London, Secker & Warburg).

Kiragu, S. W. (2007) Exploring sexuality education and the burdened teacher: a participatory approach in a rural primary school in Kenya, *Pastoral Care in Education*, 25(3), 5–15.

Kiragu, S. W. (2009) *Exploring young people's sexuality in a poor community in Kenya: a case study*, doctoral thesis, University of Cambridge.

Kleinman, A. (1999) Moral experience and ethical reflection, can ethnography reconcile them? A quandary for the 'The New Bioethics', *Daedalus*, 128(4), 69–99.

Leclerc-Madlala, S. (2002) On the virgin cleansing myth: gendered bodies, AIDS and ethnomedicine, *African Journal of AIDS Research*, 1(2), 87–95.

Luginaah I., Elkins D., Maticka-Tyndale E., Landry, T. & Mathui, M. (2005) Challenges of a pandemic: HIV/AIDS-related problems affecting Kenyan widows, *Social Science & Medicine*, 60(6), 1219–1228.

Luke, N. (2002) Widows and 'professional inheritors', understanding AIDS risk perceptions in Kenya. Paper presented at the *Population Association of America Annual Meeting*, Atlanta, GA, 8–11 May.

MacDonald, D. (1996) Notes on the socio-economic and cultural factors influencing the transmission of HIV in Botswana, *Social Science and Medicine*, 42(9), 1325–1333.

Mbozi, P. (2000) The impact of negative cultural practices on the spread of HIV/AIDS in Zambia, in: S. T. K. Boafo & C. A. Arnaldo (Eds) *Media & HIV/AIDS in East and Southern Africa: a resource book* (Paris, UNESCO), 75–82.

Morrell, R. (2003) Silence, sexuality and HIV/AIDS in South African schools, in: B. Tersbøl (Ed.) *Gender, sexuality and HIV/AIDS: research and intervention in Africa*. Proceedings from a seminar held in April, University of Copenhagen.

Mulama, J. (2010, February 23) Turning over a new leaf, *The Daily Nation*. Available online at: http://www.nation.co.ke/magazines/Living/-/1218/867276/-/qb35f12/-/index.html (accessed 25 February 2010).

Oshi, D., Nakalema, S. & Oshi, L. (2005) Cultural and social aspects of HIV/AIDS sex education in secondary schools in Nigeria, *Journal of Biosocial Science*, 37(2), 175–183.

Parker, R. G., Easton, D. & Klein, C. H. (2000) Structural barriers and facilitators in HIV prevention: a review of international research, *AIDS*, 14(1), S22–S32.

Piaget, J. (1970) Piaget's theory, in: P. H. Mussen (Ed.) *Carmichael's manual of child psychology* (vol. 1, 3rd edn) (New York, Wiley).

Scott, B. E., Weiss, H. A., & Viljoen, J. I. (2005) The acceptability of male circumcision as an HIV intervention among a rural Zulu population, KwaZulu-Natal, South Africa, *AIDS Care*, 17(3), 304–313.

Sithole, J. (2003) Cultural factors in the spread and management of HIV/AIDS in Southern Africa, in: E. Biakolo, J. Mathangwane & D. Odallo (Eds) *The discourse of HIV/AIDS in Africa* (Pretoria, South Africa, UNAIDS ICT), 142–144.

UNAIDS (2009) *Fact sheet: sub-Saharan Africa latest epidemiological trends* (Geneva, Switzerland, UNAIDS).