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Luo Tribes, Widow Cleansing, and HIV/AIDS: A Proposal for Theological and Philosophical Dimensions to a Kenyan Bioethics of Care for HIV/AIDS Patients

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Abstract

Luo Tribes, Widow Cleansing, and HIV/AIDS: A Proposal for Theological and Philosophical Dimensions to a Kenyan Bioethics of Care for HIV/AIDS Patients

By Shaunesse' A. Jacobs

For the past several decades, the spread of HIV/AIDS has been on the rise throughout the world, with most victims residing in Africa. The disease is the number four killer globally and the number one killer in Kenya, occasionally being trumped by malaria. Although treatments have expanded and testing has become more prominent since 1984, awareness and access to healthcare services is far lower than global statistics due to stigmatization and cultural rituals. Many of these cultural rituals are foundational to ethnic identities, but ministry demands continue to be made that these rituals are altered or eliminated in an effort to reduce transmission and mortality rates. The Luo comprise approximately fifteen percent of the Kenyan population and have been the most adamant in maintaining traditional rituals with a specific focus on widow cleansing. Widow cleansing is a sexual ritual that requires widowed women to engage in unprotected sex with a male relative of her deceased husband to cleanse herself and community of any negative spirits that may be left behind by the deceased. Some widows are then inherited by other men. Because of these practices, young women comprise more cases of HIV/AIDS than men, especially in rural areas. In order to bring about lower transmission and mortality rates, a conception of healthcare must be introduced that seriously takes into consideration the cultural realities of Luo communities. Western approaches to public health and medicine can serve as a positive framework for a Kenyan bioethical approach to HIV/AIDS among the Luo and other ethnic groups, but the western framework must be compatible with Kenyan cultural dynamics and sociopolitical realities. This thesis examines the Luo practice of widow cleansing and its role in the transmission of HIV/AIDS due to the strong interconnectivity between religiosity, tribal politics, and stigma surrounding positive test results. These controversies will then engage theology, public health, and biomedical ethics in conversation to propose a characteristically Kenyan bioethical approach that addresses Luo cultural dynamics beyond the ritual and international responsibility to reduce the transmission and contraction of HIV/AIDS among the Luo.

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Chapter 1: Introduction

For the past several decades, global HIV/AIDS statistics have revealed that approximately seventy percent of people living with HIV/AIDS reside in sub-Saharan Africa. HIV/AIDS is the fourth most fatal disease internationally and the first in Kenya, occasionally being trumped by malaria.[1] After the first case of AIDS was diagnosed in Kenya in 1984, increasing demands have been placed on healthcare institutions to provide the necessary care and cultural awareness to prevent the deaths of approximately 58,000 Kenyans annually.[2] Although treatments have expanded and testing has become more prominent since 1984, awareness and access to healthcare services is far lower than global statistics due to limited healthcare resources and educational opportunities throughout much of the country.[3] This is due to the fact that the majority of Kenya's citizens still live in rural areas, and there are few urban cities that have the infrastructure to support a large number of residents. For the majority of people who live in rural areas, there are significant gaps in awareness and access because of stigmatization and cultural rituals that are resistant to change. Many of these cultural rituals are foundational to ethnic identities, but historical and contemporary western approaches to health that could be beneficial for the communities have not engaged traditional cultures well enough to provide new paradigms of communal identity supporting positive change. The outsider approach of western healthcare also attests to the deficiency of gatekeepers from within the indigenous communities who could guide the entrance of western approaches into the communities and the sharing of important cultural tenets beyond the communities. In the

[1] World Health Organization. 2015. "Kenya: WHO statistical profile." *WHO.* Accessed on 18 November 2015. http://who.int/gho/mortality_burden_disease/en.
[2] AVERT. 2015. "HIV and AIDS in Kenya." *Avert.org.* Accessed on 2 March 2016. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/kenya
[3] National AIDS Control Council. 2014. *Kenya AIDS Response Progress Report: Progress towards Zero.* Nairobi: UNAIDS Strategy, 2.

case of HIV/AIDS, transmission and mortality rates continue to rise because cultural rituals that are considered sources of infection continue to be practiced.

The African continent, specifically Kenya, contains innumerable ethnic groups with shared identities and cultural practices; but each group views their practices in a unique fashion that cannot be easily generalized. The Luo of Kenya are an excellent example of this inability to generalize culture and practice. As one of the five largest ethnic groups in Kenya, alongside the Kikuyu, Luhya, Kamba, and Kalenjin, the Luo comprise approximately fifteen percent of the Kenyan population and mainly reside in rural regions along the banks of Lake Victoria in the western region of the country.[4] This ethnic group has held strong to maintaining numerous traditional rituals with a specific focus on widow cleansing and inheritance. Widow cleansing is a sexual ritual that requires a widowed woman to engage in unprotected sex with a male relative of her deceased husband to cleanse herself and her community of any negative spirits that may be left behind by the deceased.[5] Some widows are then inherited by a brother-in-law or cousin while others remain unmarried for future ceremonies that require unprotected sex with widows. Because of these practices, young Luo women comprise more cases of HIV/AIDS than men.[6] The prevalence of the disease among participants of widow cleansing in Luo communities has not easily been reduced because western healthcare approaches threaten the obliteration of cultural identity through the elimination of the

[4] Kurian, George Thomas. 1992. "Kenya—Ethnic Groups." *Encyclopedia of the Third World, 4 (3).* New York: Facts on File.
[5] Owina, Joseph D. 2002. "Social Development." In *Kenya into the Twenty-First Century*. London: Minerva Press, 191.
[6] Perry, Brian., Lennah Oluoch, Kawango Agot, Jamilah Taylor, Jacob Onyango, Lilian Ouma, Caroline Corneli, et. al. 2014. "Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centred HIV prevention options." *Journal of the International AIDS Society*, *17*(1), 19010. http://doi.org/10.7448/IAS.17.1.19010

ritual. Those individuals who have attempted to create new ritual constructs based on western healthcare and religious teachings have often been ostracized and disregarded by the greater community because they advocate a way of life that differs from the traditional law that all Luo have lived by for centuries.[7] There is also limited access to treatments and care due to the rurality and poverty of the ethnic group, and a patrilineal society that does not support the progressive health of women although they constitute the largest number of HIV/AIDS cases among the Luo. These three obstacles represent a microcosm of issues facing the Luo, but they are proof of the need to study the Luo community and suggest a syncretistic healthcare model, originating from a western bioethical approach, that unites traditional culture and western healthcare initiatives in an effort to reduce and prevent future transmission of HIV/AIDS. The model will also provide better curative care for those currently living with HIV/AIDS in the resource-depleted region.

An etiology of HIV/AIDS provides an essential background to the Luo, widow cleansing, and the HIV/AIDS epidemic in Kenya. The Human Immunodeficiency Virus is a retrovirus—RNA viruses insert copies into the DNA genome for replication—that is often transmitted through sex, infected blood, and birth.[8] The cells that are targeted for replication are the blood cells that normally serve in fighting infections within the body. The general time frame when individuals learn that they are affected by the virus could be several months to years because the first few weeks of the disease's spread throughout

[7] Prince, Ruth. 2007. "Salvation and Tradition: Configurations of Faith in a Time of Death." *Journal of Religion in Africa*, 37(1), 105. doi:10.1163/157006607X166609

[8] AVERT. 2015. "HIV and AIDS in Kenya." *Avert.org.* Accessed on 2 March 2016. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/kenya

the body mimic flu-like symptoms and rashes.[9] Symptoms eventually go away, but the virus continues spreading internally with little to no external signs, resulting in a drop in blood cells that regulate infections and the infected individual becoming highly susceptible to a number of diseases. The decline of the immune system eventually shifts HIV into AIDS, which is distinguished by several infections and symptoms being continually present.[10] As fatal as HIV/AIDS can be, the disease becomes more complex and dangerous depending on which subtype an individual possesses. There are two categories of HIV, HIV-1 and HIV-2, which correspond to the pathogenesis and region of contraction. HIV-1, the most prevalent form globally, can be divided into four subgroups: "group M (main), which is responsible for the current pandemic and causes more than 99% of all HIV-1 infections in the world, group O (outlier), group N (non-M non-O), and group P, which did not spread outside central Africa, for reasons still unclear."[11] Group M, which is most prevalent among the Luo, can be further divided into nine other categories because the virus's attempts at replication often result in many mistakes.[12] Regardless of these mistakes, the virus's approach to replicating is in a unidirectional fashion which makes it easy to group infected populations in certain subgroups and categories of HIV-1 (i.e. the nine subcategories of group M).[13] The grouping method is beneficial to healthcare clinicians and researchers as they work to determine which treatments and medications will best aid certain regions.

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[9] Poku, Nana K. 2005. "Stagnation, Decline, and Vulnerability: A Brief History of Post-colonial Africa." In *AIDS in Africa: How the Poor are Dying.* Cambridge: Polity Press, 52.
[10] Ibid., 53.
[11] Pepin, Jacques. 2011. "Out of Africa." In *The Origins of AIDS*. New York: Cambridge University Press, 11.
[12] Ibid.
[13] Ibid., 13.

When HIV/AIDS was acknowledged as a global threat, the Kenyan president in residence, Daniel arap Moi, completely ignored the research findings and denounced western press for attempting to create new hate campaigns against Africa.[14] Eventually he acknowledged the crisis that stemmed from HIV/AIDS approximately a decade after the first case was discovered in his country. The initial rejection of HIV/AIDS resulted in Kenya being far behind global research and health initiatives because citizens were encouraged to believe that the disease was a false western concoction that had no bearing on Africans.[15] Those individuals who were living with the disease only received treatment for the secondary infections that came along with the virus, and many attributed those infections to witchcraft; therefore, Luo communities often defined HIV/AIDS in such terms during the early stages of the disease because the nation did not have enough information to determine causes and treatments.[16] Once more information became available, Luo communities reduced ascribing the onset of HIV/AIDS to witchcraft, although the "traditional" cause that HIV/AIDS stemmed from witchcraft reduced stigma and provided hope because counter-measures were possible through traditional healing techniques.[17]

The beginning stages of HIV/AIDS awareness in Kenya were located in major urban centers because the disease was connected to sex workers.[18] The first three sites of the disease were Nairobi, the eastern coast in Mombasa, and the eastern shore of Lake Victoria. It was theorized that infected female sex workers in Nairobi and Mombasa

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[14] Iliffe, John. 2006. T*he African AIDS Epidemic: A History.* Athens: Ohio University Press, 67.
[15] Ndati, Ndeti. 2011. "The HIV & AIDS Regime: An Overview." In *HIV & AIDS, communication, and secondary education in Kenya*. Eldoret: Zapf Chancery, 14.
[16] Ibid., *The African AIDS Epidemic*, 91.
[17] Ibid., 92.
[18] Ibid., *Kenya AIDS Response Progress Report,* 16.

transmitted the disease to their male clients, who then took the disease into the countryside when returning home, visiting relatives, or participating in traditional rituals.[19] HIV/AIDS gained momentum and increasingly impacted rural regions, with coastal regions and Lake Victoria's infected populations tripling those within Nairobi. Fishing and subsistence farming lifestyles were initially considered to contribute to transmission in these regions because the casual temporary jobs and nomadic lifestyles generated increased movement of men and women who were encountering other infected populations from Uganda and Tanzania.[20] The patrilineal and traditional structure of Luo communities eventually became sources of concern as HIV/AIDS became more potent among certain ethnic groups as they became permanently established in specific locations in the absence of nomadic and subsistence lifestyles. Surveys concerning sexual practices showed that "men reported unprotected sex with an average of 11.2 partners, women with 2.5."[21] These numbers within and beyond the national boundaries caused researchers to begin to examine which traditional rituals were culpable, and widow cleansing became the number one culprit because it enforced the need for community members to have unprotected sex with multiple partners throughout the different stages of life.

The research that has been conducted over the past two decades has taught the public much about traditional practices and their roles in transmission, but the research has not been effective in influencing the Kenyan healthcare system to provide better care to its largely rural population. Kenya is currently working to model its national healthcare system after western privatized models, but they are not conducive to rural populations because of the limited financial and travel resources that rural communities have to reach

[19] Ibid., "Out of Africa," 27.
[20] Ibid., 29.
[21] Ibid.

urban health centers.[22] The national system, developed by the Ministry of Health, is referred to as a pyramid of five levels: "On the top of the pyramid is the Kenyatta National Hospital, under which come the eight provincial centres, then hospitals in district centres, and lastly health centres and dispensaries in the rural areas."[23] The health dispensaries in rural regions are designed as primary and follow-up care facilities, followed by care at district and provincial centers for specialty care; and these district and provincial centers are often located a minimum of forty kilometers away from rural villages.[24] In the absence of many healthcare facilities in rural regions, especially in the provinces of the Luo, missionaries and their affiliate organizations have historically provided the bulk of the care to rural communities.[25] The pyramid structure for health provision was established in the Kenyan Health Policy Framework Implementation Action Plan of 1994, which resulted in the establishment of numerous leadership positions and divisions to implement the structure throughout the country.[26] Despite the structured layout of the plan, few Kenyans experienced improved health and government resources did not increase the number of healthcare resources available to Kenyans.[27] Based on the language that the Ministry instructed the media to incorporate in their reports, the lack of expansion created distrust in the healthcare system because citizens

[22] Wamai, Richard G. 2009. "The Kenya Health System—Analysis of the situation and enduring challenges." *Japan Medical Association Journal,* 52(2) 137.
[23] Ibid., "Social Development," 198.
[24] Mwabu, Germano M. 1986. "Health care decision at the household level: results of a rural health survey in Kenya." *Social Science and Medicine,* 22(3) 316.
[25] Gitonga, Nahashon. 2008. *Evangelization and Inculturation in an African Context.* Kijabe: Kolbe Press, 64.
[26] Muga, Richard, Paul Kizito, Michael Mbayah, and Terry Gakuruh. 2012. "Overview of Health Systems in Kenya." *The DHS Program*. Accessed 18 November 2015. dhsprogram.com/pubs/pdf/spa8/o2chapter2.pdf
[27] Ibid.

were led to believe that they would receive care if healthcare was under the authority of the government.[28]

The healthcare disparities can also be attributed to unevenly distributed institutions across the country, with forty-one percent of healthcare facilities run by the government, fifteen percent run by non-governmental agencies, and forty-three percent run by private businesses.[29] These facilities, whether owned by the government or private investors, are in need of medical specialists whose qualifications support primary and preventive care.[30] Most clinicians are trained in western institutions and do not return to their countries, let alone their traditional communities to practice medicine, leaving rural regions like Lake Victoria lacking in trained clinicians who understand their lifestyles. There are also few incentives for trained specialists to return home and practice because of weak and shifting healthcare institutions. Although strong efforts were made to bolster healthcare reform and move the country forward according to western standards, Kenya's government officials did not devise a healthcare system that took into account the dilapidated political and financial structure of the country with the majority of its population residing in rural environments.

Another impediment to care for rural communities regarding Kenya's developing healthcare system has been the institution and revocation of user fees for care. Since Kenya's independence in the 1960's, there have been several major phases of healthcare reform. A constant element of the reforms has been to determine whether and to what extent patients would have to pay fees for healthcare services rendered. The Ministry of

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[28] Ibid.
[29] Ibid., "The Kenya Health System," 135.
[30] Good, Charles M., John M. Hunter, Selig H. Katz, and Sydney S. Katz. 1979. "The interface of dual systems of health care in the developing world: toward health policy initiatives in Africa." *Social Science and Medicine,* 13(D) 147.

Health conducted surveys after each change to discover how efficient services would be if patients paid before or after treatments were received; but the only center that implemented fees and accompanying research was Kenyatta National Hospital, the national referral hospital, which was beyond the distance and price range of the Luo community.[31] The final results of the research found that the national hospital "operated like an outpatient department of a primary health care facility because of the structure of service fees. The study also found that the performance of [Kenyatta National Hospital] was below that of similar private hospitals."[32] The institution of fees prior to care also resulted in a decline in citizens pursuing medical treatment because they had no means of collecting funds for sub-par care when they could remain in their villages and take advantage of the proximity and holistic care of traditional healers. Reduced patient intake and misrepresentation on the part of the media led the government to abandon user fees and cover the cost of healthcare for a number of years; but global financial constraints and inconsistent funds from donors (i.e. Japan, the US, the UK, and the European Commission) caused a back-and-forth approach to implementing user fees.[33]

Today Kenya's Ministry of Health has permanently placed user fees in effect, but only after care has been received. Many citizens still struggle with collecting the funds to pay for their care, but there is less of an obstacle to receiving treatment than when fees were due upfront.[34] User fees have been reinstituted because the prevalence of HIV/AIDS places a massive burden on the healthcare system. Basic and specialty treatment of HIV/AIDS consumes approximately seventeen percent of general healthcare spending,

[31] Mwabu, Germano. 1995. "Health care reform in Kenya: a review of the process." *Health Policy,* 32(1) 249.
[32] Ibid., 251.
[33] Ibid., "The Kenya Health System," 137.
[34] Ibid., "Overview of Health Systems in Kenya," 24.

and forty-seven percent of this percentage is designated for prevention in the form of antiretroviral therapies.[35] Although the bulk of Kenya's healthcare budget comes from donors, households contribute twenty-six percent of the total healthcare budget through taxes.[36] Unfortunately, the disparities in care and Kenya's privatized healthcare system result in most households not being able to receive care that a portion of their tax dollars support. The Luo are one of the major groups effected by this reality. When determining whether they will pursue treatment in healthcare facilities, most rural households initially seek treatment at local clinics but soon reduce clinic visits as diseases return or progress is slow. Few households pursue care from district or provincial institutions because an excess of resources are needed as opposed to awaiting the results of clinical treatment, funds and treatment options are limited, or questions exist over which providers to engage.[37] In HIV/AIDS plagued regions, these factors lead to the continued transmission of the disease because individuals do not have the proper resources and structures in place to receive necessary care.

The challenges faced by rural communities have led the Ministry of Health to implement a number of strategies in curbing the rise of HIV/AIDS throughout the country. The number one strategy has been partnering with the World Bank and members of the United Nations to receive loans and condom donations. Germany, China, and Britain have assumed the duty of donating hundreds of millions of condoms that will be freely distributed in government buildings and hospitals.[38] Another strategy has been the promotion of counseling, testing, and antiretroviral therapies. The Ministry of Health has

[35] Ibid., "The Kenya Health System," 136.
[36] Ibid.
[37] Ibid., "Health care decisions at the household level," 316.
[38] Kimani, Dagi. 2002. "Access to Essential Drugs." *Developing World Bioethics,* 2(2) 102.

certain recommendations for when to begin counseling and therapy based on cell counts, which can only be determined if HIV testing is conducted. Counseling seeks to mitigate the fear of living with HIV/AIDS as well as suggests behavior changes since most infected individuals remain sexually active after learning of their HIV status.[39] The sessions also address how to manage secondary health conditions, such as allergies, reproductive infections, and tuberculosis that arise from HIV/AIDS, along with potential approaches to disclosing one's status to family members and future partners. All of this information is provided in a book—*Guidelines for Antiretroviral Therapy in Kenya*—that is available through the Ministry, but most infected populations are minimally literate or completely illiterate.

Their acquisition of HIV/AIDS knowledge has largely come from missionary medics who serve throughout the regions. The infected populations also do not have the space and cultural support structures to take ownership of their HIV/AIDS status and remain firmly rooted in their communities. The informational book is a great start to providing facts and suggestions, but no insight was given to those members of the population who do not have the resources to put such information to use and avoid stigmatization. Antiretroviral therapies on the other hand are more effective than counseling alone among rural communities because they have supported a shift from HIV/AIDS being devastatingly fatal to being a manageable chronic disorder, but only for those individuals willing to alter their lives completely and receive the treatment.[40] To date, the only alternative for the Luo to take advantage of these options has been through requesting religious institutions to establish stand-alone counseling and treatment centers

[39] Kimani, Francis and S.K. Sharif. 2011. *Guidelines for Antiretroviral Therapy in Kenya.* Nairobi: Ministry of Medical Services, Republic of Kenya, 17.
[40] Ibid., 27.

that are not affiliated with any medical institution because the specific needs of the community can be uniquely addressed.[41]

Solving the far-reaching impact of HIV/AIDS is no easy feat, especially in countries working to recover from centuries of oppression and abuse. Just as Kenya began making progress in shaking off the reigns of British imperialism, HIV/AIDS ravaged the country and further divided tribes and cultures based on who could afford access to care and who could not. The Luo and other rural communities have remained in the latter group, facing high mortality rates when better solutions are only kilometers away. Pressures to westernize have created more disparities because the Luo have become an anomaly within their own country, being ostracized internationally and nationally for their efforts to maintain traditional practices and rituals. Unfortunately, healthy means of addressing the numerous facets of Luo culture and their role in creating new cultural dynamics have not always been conducted, causing the Luo to reject many of the suggestions for reducing HIV/AIDS in their region. The failure of the west and greater Kenya in assisting the Luo demands a new approach to care that incorporates both tradition and western medicine. It is the quest for this new approach which prompts the subsequent chapters.

This thesis will examine the Luo practice of widow cleansing and its role in the transmission of HIV/AIDS. The two are negatively connected through culture, tribal politics, and the stigma surrounding rejecting the ritual and having positive HIV test results. The connections to widow cleansing will then be engaged through the lenses of theology, public health, and biomedical ethics. Luo tribal culture will be analyzed

[41] Ministry of Public Health and Sanitation. 2008. *National Guidelines for HIV Testing and Counseling in Kenya.* Nairobi: National AIDS and STD Control Programme, 7.

because it supports the continued practice of widow cleansing based on arguments of tradition and its role in communal identity. Theological analyses are crucial because Luo theology—African traditional and Christian—informs understandings of the disease and communal obligations to those affected. Theology must also be analyzed because there is no way to separate the role that the Divine plays in African views of the self in relation to the world and health.[42]

Current public health and bioethical theories and applications (e.g. beneficence, nonmaleficence, justice, autonomy and feminist ethics) will be analyzed to carve out new approaches that ensure the voices of all stakeholders. Special focus will be given to those from within the Luo community in the effort to reduce the number of Luo victims suffering with HIV/AIDS and better the care of those Luo currently living with the disease. By using these three approaches, outside perspectives that have worked well in other countries can be theoretically introduced into the Kenyan context while also respecting the need for them to be modified to best serve the Luo community. Although non-Kenyan perspectives have largely failed to better the health of the Luo, the limited Kenyan healthcare structures speak to the need for other approaches to be infused with emerging Kenyan healthcare and bioethical perspectives. A final theoretical approach will be used to propose a Kenyan bioethics that is specific enough to serve the Luo community in its fight against HIV/AIDS while also being general enough to be applied to other Kenyan ethnic groups because the emphasis will be placed on a syncretistic union of western and traditional approaches to overcome stigmatization, unhealthy cultural practices, and obstacles to healthcare access.

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[42] Andoh, Cletus. 2011. "Bioethics and the Challenges to Its Growth in Africa." *Open Journal of Philosophy* 1 (2) 72. doi:10.4236/ojpp.2011.12012.

A major limitation in this work stems from the fact that the theoretical framework will depend on secondary qualitative research wherein, there is a lack of traditional and educated Luo voices. Much of the literature used has been highly influenced by western academia, serving as a preliminary drawback to indigenous voices being included in conversations concerning their care. However, the prevalence of HIV/AIDS among the Luo and other rural communities places demands on western societies to support human rights concerning health, healthcare, and public wellness. The need to more actively promote human rights with respect to healthcare and good quality of life in resource-poor areas underlies the significance of this study. Research that neglects offering applicable solutions mimics new forms of imperialism and westernization that can no longer be conducted because it leaves vulnerable populations in desperate conditions with their only option being to abandon cultural identities in an effort to receive care. It is important to note the existing tension of acknowledging the western imperialist history that has contributed to the HIV/AIDS pandemic among the Luo, yet the need to rely upon western healthcare approaches as a foundation for addressing Luo healthcare concerns and disparities. Just as Christianity became malleable to be shaped into a new tradition that united African traditional religions and mainline Christianity into African independent Christianity, so must bioethics and healthcare be malleable to create a new approach to communal health and wellness that respects both traditional culture and western care.

Each chapter will provide a different lens through which the Luo and widow cleansing can be analyzed. This chapter has provided background information about the HIV/AIDS epidemic throughout Kenya, a brief summary of the healthcare sector, and the ways in which these factors negatively influenced the Luo and other rural communities.

Widow cleansing has been minimally introduced as a traditional practice that has been designated as a cause of transmission of HIV/AIDS and high mortality rates, followed by challenging strategies that the Ministry of Health has espoused to combat the spread of HIV/AIDS. The second chapter will provide a historical framework of the Kenyan Luo population to present the humanity of the tribe as a collective community, with general information being given about widow cleansing and its role in the religious and cultural identity of the people. This chapter will include the migration patterns that led to the establishment of the community along Lake Victoria, the tension between Christianity and the traditional religion that has shaped the communal understanding of treatment, various practices that have been identified with HIV/AIDS transmission and intra-tribal tensions concerning which practices to eliminate and how to maintain cultural identity, followed by an analysis of widow cleansing as the primary contested ritual to be preserved.

Chapter three will provide a constructive criticism of the Luo practice of widow cleansing, as well as the complex relationship between religiosity and tribal politics to discover which cultural elements should be altered to counter the contraction and transmission of HIV/AIDS. Several elements will be examined to support a constructive criticism of the practice including: the inseparable relationship between the sanctity of unprotected sex and remaining in the community which challenge attempts to modernize the ritual; the need for widows to balance limiting their risk of HIV infection with meeting cultural expectations and ensuring that their livelihood needs are met; the hiring of professional cleansers as substitutes for educated men who reject the practice and have no concerns about transmission in other communities; and the challenges of some

Christian denominations instituting western practices like condom usage because of the convoluted history of imperialism and the restricted approach to providing holistic healing. The final chapter will propose a framework for a Kenyan bioethics that considers the ethics of western public health and clinical perspectives alongside the social ethics of African societies that inform African bioethics. These considerations will also include the voice of feminist bioethics to provide a platform for female agency with regards to the health of Luo widows. Kenyan ethno-ethics will then engage the country's current limitations of resources and the traditional dependence on global infrastructure to provide care; the need to institute and adopt preventive care strategies and increased primary care centers; and cultural education to train healthcare professionals who provide care in such resource-depleted regions.

Chapter 2: Luo Culture and Widow Cleansing

Two important terms that are often invoked in religious studies and bioethics are personhood and human dignity. Human dignity connotes an inherent quality of human beings that sets us apart from other forms of existence, while personhood is often based on certain qualities that give primacy to rationality and cognition. Popularly invoked in western scholarship when describing western research subjects, these two terms have often been left out of discourses about African research subjects and topics. As such, it is important to explore the cultural framework of the Luo people in an effort to draw more attention to their personhood and human dignity through a rendering and analysis of their historical and social development. Members of the Luo ethnic group have come to be known most popularly for their practices of widow cleansing and inheritance and their connection to the HIV/AIDS pandemic. But there exists a wealth of history detailing who the Luo are and how they came into being as they journeyed farther south into sub-Saharan Africa. Due to the fact that early recordings of Luo history were conducted by European anthropologists and missionaries who created false categories of identification based on biblical and racial theories, this chapter relies heavily on the works of a handful of Kenyan researchers in an effort to develop a more authentic Kenyan account of the historical and cultural framework of the Luo.

For the dozens of sub-groups of Luo across Kenya, Uganda, and Tanzania, each collective has their own oral traditions that exist to historicize the origins of the Luo people writ large. As stated above, the first groups of people to construct a written history of the Luo were European missionaries and anthropologists. While missionaries were involved in recording the oral traditions of the Luo for purposes of translating their native

languages, anthropologists were interested in classifying the different groups of people they encountered by assigning terms for those collective groups who possessed similar traits and characteristics.[43] This process led to a loosely structured system of tribes and languages defined by European scholars, but continued to minimize the African voices across the continent, and Luo-specific voices with regards to the focus of this thesis. Further problematizing the records of the traditions and histories is the reality that European scholars were working with the myth of the "Hamitic hypothesis."

The basic idea of this hypothesis is that "the bearers of culture and civilization to Africa were light skinned Hamitic invaders from Christian Ethiopia…which was linked to the Biblical myth of the dispersal of the [twelve] tribes out from Israel, which provided Europeans with a set of ideas that enabled them to 'explain' the physical and cultural differences they encountered in the region."[44] This hypothesis, developed by Richard Speke in 1863, provided a false racial and religious lens through which research across sub-Saharan Africa was conducted for approximately a century.[45] Despite important information arising from this century of research, the Hamitic hypothesis supported a negative categorizing of darker Africans (e.g. the Luo) as less pure and intellectually endowed than lighter-skinned Africans, who maintained positions at the upper end of the "God given hierarchical chain of organisms that reached from the lowliest creatures to those most perfect in their physical and psychological refinement."[46]

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[43] Campbell, John R. 2006. "Who are the Luo? Oral tradition and disciplinary practices in anthropology and history." *Journal of African Cultural Studies* 18 (1) 74. doi:10.1080/1369685060075032.
[44] Ibid., 74.
[45] Wolf, Eric R. 1994 "Perilous Ideas." *Current Anthropology* 35(1) 4.
[46] Ibid.

Greatly challenging the racial myths of inferiority and European domination that overshadowed the cultures and traditions of the Luo, the rise of Luo scholars and scholarship provided a new lens through which research would be conducted and analyzed. This process began in 1948 by Shadrack Malo. In an effort to find commonalities and the authentic African voices in the Kenyan Luo history, Malo put together a massive collection of oral traditions from 1948 to 1951in the Kenyan Luo province of Nyanza. Malo's methodology consisted of asking the prominent chiefs of each sub-tribe to gather his historians and have the group discuss their origin narratives.[47] Despite important differences across Luo territories, several common themes arose to develop a general framework. The first commonality is that the Luo were originally a part of a large collection of people living along the Nile. European recorders gave these people the designation of "Nilo-Hamitic people," following the Hamitic hypothesis that their fair skin was proof of their descent from the "light-skinned Hamitic invaders from Christian Ethiopia." The gradual development and movement of the people led to the development of sub-groups within the larger body of settlers along the Nile. One of the sub-groups was designated the "Nilotes" by Europeans because the group members moved more southward and shed some of the characteristics that identified them with their Northern African group members.[48] The general time frame of this evolution from "Nilo-Hamites" to "Nilotes" has been dated to approximately 1000 CE.[49]

[47] Malo, Shadrak. 1953. Dhoudi Mag Central Nyanza (A Treasury of East African History). Nairobi: Eagle Press.
[48] Ogot, Bethwell, A. 1967. *History of the Southern Luo.* Michigan: University of Michigan Publishing, 41
[49] Ibid., 40.

The division of the Nilotes as a group distinct from the larger populace witnessed numerous divisions over a period of approximately four centuries.[50] These divisions occurred slowly and were the result of a continental migration of individuals and groups moving more southward along the continent. The gradual migration lasted up to the twentieth century only to be immediately halted by the presence of international politics which altered the ways of life of many rural and urban centers.[51] The freedom to seek new locations for (re)settlement relied heavily on the leaders who assumed the risk of finding regions that provided the proper combination of fisheries and pastures since fishing and cattle farming were the dominant occupations of many groups.[52] As new landscapes and environments were encountered, some groups chose to remain in certain locations to develop as a distinct people while others continued moving south. The group that would come to be known as the Luo was one of the few groups who continued to move south, eventually settling along Lake Victoria. For the Luo, each tribe had specific understandings of how and why migrations occurred; but they could agree that the Luo descended from a massive group of people living along the Nile, who eventually began dividing into many of the contemporary tribes that live throughout sub-Saharan Africa.

The second common theme could be considered the origin narrative of the Luo: all Luo descend from *Podho*, who is seen as the Luo equivalent of Israel's Adam.[53] *Podho* is believed to have "descended from the heavens at Lamogi or Ramogi Hill, a long way north of Uganda; that he died at that place and that one of his sons, *Ramogi*, came to

[50] Ibid., 23.
[51] Ibid., 43.
[52] Ibid.
[53] Ibid., 143.

Nyanza and settled at Ramogi Hill, in Kadimo."[54] The pervasive nature of this narrative has led to the construction of "pure" genealogies which evidence the direct connection that some people have to the divinities of Luo culture and religious tradition. Based on anthropological theories and archaeological evidence, the Luo reached the regions surrounding Lake Victoria in four major groups over the course of centuries. The earlier groups were homogenous and settled in modern-day Uganda. The latter groups were more heterogeneous and settled in modern-day Kenya. A possible theory for the heterogeneity of those Luo settling in Kenya is that they did not enter the new region anticipating a long stay, but would move to the next region if war or poor pasture lands forced them elsewhere.[55] Never encountering war or limited pasture lands, the Kenyan Luo remained in the region with those people who were present before Luo settlements. The confluence of cultures and lifestyles led to intermarriage and a unique view of being Luo. With a set home and an integrated society, a chiefdom became the established leadership style among Kenyan Luo.[56]

As the community continued to grow and dominate the region along Lake Victoria, their cultural values and practices became more routinized and intricate. Religion has been an important factor in this intricacy and routinization as religious thought has evolved from the traditional practices to a more syncretistic manifestation of traditional religion and Christianity, as has been the case throughout Kenya and sub-Saharan Africa. Similar to Jewish and Christian theology, Luo traditional religion believes in a supreme deity who wills all things to happen and human beings are the

[54] Ibid.
[55] Ibid., 144.
[56] Ibid., 154.

focus of the created order possessing the authority to rule over the earth.[57] The name of this supreme deity is *Nyasaye* and he embodies many YHWH-esque characteristics and personae such as mercy, forgiveness, grace, omnipotence, omniscience, creator and universal parent.[58] *Nyasaye* does not exist alone but is surrounded by many spirits, including the individual spirits (*Juok*) that are designated to guide each person throughout his or her life.[59] The presence of the *juok* and *Nyasaye* impress upon the hearts of the Luo that they must live moral lives that are deemed honorable by their deities. Living honorably places one in a position to receive blessings and approval to be granted an ancestral position in the spirit world upon death, which is the ultimate life goal because individuals become immortal.

There is no ancient written code that dictates the proper moral actions for each community member, but there does exist a set of spoken binding rules that originated from the divine moral standards of the traditional religious system. These rules serve as a guide for the entire community, connecting Luo through space and time based on the (dis)honor of their lives. These rules also inform the three major categories of the "living law" of the society—law created in the process of interactions between members of the social order: "laws that prevent, or protect, destruction of one's self, one's family, and one's lineage; laws that protect and prevent destruction of the well-being of all members of the society as a whole land; laws that govern or guide social relationships and actions between members of every social groups as well as between individuals."[60] Not only does

[57] Ayayao-Ocholla, Andrev B. C. 1976. *Traditional Ideology and Ethics among the Southern Luo.* New York: Africa Publishing Company, 167.
[58] Ibid.
[59] Ibid., 189.
[60] Ibid., 218.

the living legal system provide connectedness between the physical and spiritual world, but it also provides connectedness between humans and all other beings in the created order, especially the land. Because of the interrelatedness in Luo communities, each society is highly communal and all possessions belong to the entire community, with specific emphasis on the land. Intangible possessions, such as marriage rites, are also under the domain of the entire community and are open to communal intervention. Ideally these possessions belong to all of the Luo people since community is a common theme across sub-Saharan Luo regions; but practically, the possessions of each person and family are relegated to their local tribes and villages.

It could be argued that many of the underlying principles of Luo traditional religion align well with Christianity, but significant differences exist in the meaning behind many of the practices and religious frameworks. These epistemological differences led to a unique fusion of the two traditions, with major sacrifices and compromises being demanded of the Luo to induct them into Western Christianity. But before these compromises and sacrifices are detailed, the history of Christianity's presence in Kenya must be outlined.

The first attempts to introduce Christianity to Kenya, specifically Catholicism, were in 1498 when Portuguese explorers reached the East African coast; but the faith was not established at this time because of the strong presence of Muslim communities in the region.[61] Several centuries later, following the revivals that were occurring in Europe, Johann Krapf and other German missionaries reached Mombasa in 1844 to begin evangelizing to the indigenous communities via the teachings of the Church Mission

[61] Mutuku, Shammah. 2013. "How Christian Faith started in Kenya and East Africa." *Culture & Religion Review Journal,* 2013(1), 8-15.

Society (CMS).[62] The CMS was created during the latter half of the eighteenth century in Britain as a result of the Evangelical movement, focusing heavily on missionary excursions throughout Africa and India and the abolition of slavery along the western coast of Africa.[63] Christian mission societies like the CMS assisted in translating the Bible and hymn books into the local dialects, as well as establishing schools and medical facilities.[64] For both the schools and medical facilities, the work and participation were inseparable from missionary ideologies. These facilities were attractive because the "missionaries were introducing to them [indigenous Kenyans] the European way of life, which consisted of European dressing, behaviour, literacy and Christianity, all summed up by the term [scholar]. Christianity as such, was not a distinctive way of life, but one of the characteristics of the European way of life, to be acquired for one to qualify for the title [scholar]."[65] Initially overlooking the tensions that existed between European and Kenyan cultures, a significant population of indigenous communities received primary educations and a significant percentage of young adults moved to cities where more opportunities existed for the level of education they had acquired.

Missionary efforts eventually began moving inland and other denominations joined the Kenyan missionary effort to both evangelize and abolish the East African slave trade. The growth of denominational churches led to an increase in Christianity across the country, but the connection between missionaries and colonialism gave way to the rise of

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[62] Park, Sung, Kyu. 2013. *Christian Spirituality in Africa: Biblical, Historical, and Cultural Perspectives from Kenya.* Eugene: Pickwick Publishing, 85.
[63] Hanciles, Jehu J. 2002. "The Sierra Leone Mission: Survey of a Laboratory." In *Euthanasia of a Mission: African Church Autonomy in a Colonial Context.* Westport: Praeger Press, 12.
[64] Prince, Ruth. 2007. "Salvation and Tradition: Configurations of Faith in a Time of Death." *Journal Of Religion In Africa*, 37(1), 92. doi:10.1163/157006607X166609
[65] Gitonga, Nahashon. 2008. *Evangelization and Inculturation in an African Context.* Kijabe: Kolbe Press, 60.

independent churches after approximately a century because Kenyan members sought to unite teachings with traditional religious and cultural practices. Today independent churches dominate the Christian Kenyan landscape, including in Western Kenya where the Luo reside, because of the decades-long struggle to craft a compromising Christianity that was more welcoming to indigenous cultural practices. Religious syncretism was a necessity for the indigenous community as a reaction to former missionary efforts that imposed their religious constructs onto the communities because most, if not all, missionaries in the nineteenth and twentieth centuries entered the African continent having been shaped by the scientific and racial evolution theories being developed in the western world.[66] With such thoughts informing the religious culture that the missionaries took with them, Africans were mainly seen as primitive people to be educated and civilized. Such thoughts created an atmosphere of disdain toward all indigenous practices, causing the Kenyans to choose between those Christian practices to which they would adhere and those which they would reject.

The Luo were no exception to the tensions that existed with two opposing cultures encountering one another, with the most problems occurring between religion and law. Traditional religion and law have been intimately connected in informing Luo public life and morals for centuries, but had to undergo a modification once Christianity expanded into the Lake Victoria territory. Some of the foundational religious and legal tenets that supported their cultural framework were found to be in direct opposition with Christian teachings, such as the importance of being wealthy and generous. To ensure that the community remains united and prosperous, hard work and wealth are considered morally

[66] Ibid., 40.

just traits because one must be wealthy in this lifetime to ensure that he or she is wealthy in the next lifetime.[67] This focus on wealth and prosperity is challenged by Jesus in the gospels of Matthew, Mark, and Luke, with Jesus giving special attention to the poor and encouraging the wealthy to relinquish their riches in order to draw closer to God and reap the eternal benefits of his message. If the Luo choose to sacrifice all attempts at gaining wealth, they stand in jeopardy of the current and eternal downfall of themselves, their families, and the entire community.

Another challenge between Christianity and the traditional religious system regards the spiritual community. As stated above, the supreme deity and lesser spirits are central to the traditional religious system. The growth of Christianity inadvertently led to reduced emphasis upon the lesser divinities (*juok*), which comprise the spiritual world and guide each individual, because *Nyasaye* was the supreme deity most equivalent to a Christian connotation of God. As a monotheistic tradition, Christian practice did not support the worship of other spirits. Unfortunately, this shifted the valence of honoring the divinities in an effort to produce "good" in the world and live a morally upstanding life for self and the community. Although Christianity and the traditional religion have cohered decently, it has happened at the expense of foundational cultural understandings of the Luo community so much so that many continue to assert that "[t]he effect of European settlement in Kenya, including missions, was to gradually obliterate the traditional way of life by forcefully setting Western cultural examples and imposing

[67] Ocholla-Ayayo, *Traditional Ideology,* 224.

living conditions that made the ancient tribal practices and sanctions insignificant and obsolete."[68]

The rejection of the *juok* also meant a rejection of their role in healing and communal wellbeing. Not only did missionary Christianity reject Luo approaches to health, healing, and well-being, but the European medical model was quite lacking in its approach to healing which deviated drastically from that to which the Luo were accustomed. Initially used as a means of evangelism, medical facilities were developed with the intention to "attract people to the Mission Station, to combat polygamy, and to combat traditional healing."[69] For those individuals who sought treatment at clinics, they were taught about Jesus as their great physician in hopes that they would be inclined to convert to Christianity during the vulnerability of their illness and treatment.[70] The importance of Jesus as the great physician was central to the European desire to supplant traditional healers, who were considered a component of an archaic lifestyle that "had been abandoned by the civilized Western world."[71] In order to fully obliterate traditional healers, missionaries discouraged visits to them on any occasion. However, traditional healers were thought by the indigenous communities to be more effective than western "healers" because they inquired into the spiritual reasons underlying the disease/illness of the sufferer: "[u]nlike the Western form of treatment, the medicine-person, in the act of treatment, prayed for the intervention of God, not only to reveal the root cause of the

[68] Park, *Christian Spirituality,* 95.
[69] Gitonga, *Evangelization and Inculturation,* 64.
[70] Ibid.
[71] Ibid., 65.

illness, but also to provide healing. In this regard, Western medicine served only on temporary measure, while the indigenous treatment provided a lasting healing."[72]

Unfortunately, western missionary physicians did not alter their approaches to incorporate spiritual practices such as praying before and after exams and procedures to learn about the origins of illnesses and seek spiritual healing from those illnesses. This lack of action continued to drive many Africans back to those individuals and practices that they felt best informed their understanding of illness and healing. Traditional healing addressed these concerns by the incorporation of four dimensions: accessibility to treatment, detecting the cause of the illness, treatment, and preventive measures.[73] The localization of the Luo communities in village settings also allowed for traditional healers to either live in each village or in an area where multiple villages were close together. Missionary medical centers were far removed from the villages and required ill individuals to travel long distances when seeking physical treatment.[74]

Just as in many American healthcare facilities today, once the Luo reached the nearest medical facility, they were required to wait long periods of time before receiving treatment due to the low doctor-to-patient ratio. The sterile western clinical setting also limited the ability of the physicians to expand their understandings of or participation in determining Luo disease pathologies, such as the onset of disease due to curses or the effects of broken oaths.[75] Among traditional healers, finding the source of the disease, treating it, and developing preventive measures to eliminate its return demanded that the healer serve a dual capacity of physician and pastoral figure. For the western physician,

[72] Ibid., 66.
[73] Ibid., 74.
[74] Ibid.
[75] Ibid., 75.

the pastoral role was either restricted to evangelists or nonexistent because healing was reduced to the physical instead of whole self. John Mbiti poignantly defines the need for holistic treatment of Africans writ large: "Even if it is explained to a patient that he has malaria because a mosquito carrying malaria parasite has stung him he will want to know why that mosquito stung him and not another person…Suffering, misfortune, diseases and accident, are all 'caused' mystically, as far as African people are concerned."[76] While Mbiti frames the need for Africans specifically to understand suffering from a mystical perspective, Christian renderings of suffering also seek spiritual explanations, especially regarding theodicy as a means of understanding how God enacts justice in the world. African pursuits to questions of suffering rest in a general spiritual realm, but Christian pursuits mostly center such questions on God's power and the proper ways to respect this power with minimal comprehension of suffering and illness. Yet, western healthcare approaches did not care to incorporate the mystical dimension of disease, and evangelists desired to remove its presence from the religious and health outlooks of Luo communities.

The reality of different cultural approaches to illness and healing has created a polarized conversation for many years with regards to several traditional Luo practices that are potential links to poor health. In the age of large-scale HIV/AIDS infection along the Lake Victoria coast, Luo health measures and cultural practices have been largely denigrated because death rates remain on the rise.[77] Polygyny, traditional circumcision rites, and widow cleansing and inheritance have all been examined by researchers in and

[76] Mbiti, John S. 1969. *African Religions and Philosophy.* London: Heinemann Publishing, 169.
[77] Nkwi, Paul Nchoji and H. Russell Brand. 2012. "Culture, Behaviour, and AIDS in Africa." In *African Responses to HIV/AIDS: Between Speech and Action,* edited by Segun Ige and Tim Quinlan. Scottsville; University of KwaZulu-Natal Press, 157.

beyond Kenya as major sources of transmission of HIV/AIDS among Kenyan Luo communities. Among those regions of the country that adopt more western approaches to healthcare and wellness, a cultural climate that seeks the elimination of these practices similar to the imperialist tactics of European missionaries in the nineteenth and twentieth centuries has developed and continues to grow.

For those Luo who do not adhere to the differentiation between "good Christian" practices and "bad heathen" practices, they either hold both worldviews unapologetically or have abandoned the Christian enterprise and further inculcated themselves into traditional frameworks of religion and healing. Both of these subsets of Luo are aware of the impact of HIV/AIDS on their communities and the country at large, but they understand the greater jeopardy to health to be *chira*:

> "a sickness that embodies a blockage in 'growth' and that arises from 'confusion' in social relations, when people forget to follow, or explicitly reject, the ritual practices or rules (*chike*) that structure kinship and social life and engender growth. From their perspective, the 'death of today' [HIV/AIDS] expresses a confusion of relations, a lack of continuity with the past, and a loss of moral direction, which necessitates a 'return to Luo ways."[78]

This motivation to return to the Luo ways of the past has elevated Luo customs high above western biomedical approaches to health and wellbeing, with attention to the details of the traditional practices resulting in life or death of the individual and the community. Interestingly, contemporary Luo societies maintain few formally explicit traditional "Luo ways" because emphasis is placed on the implicit daily actions of being

[78] Prince, "Salvation and Tradition," 86-87.

Luo that "shape relations between kin and link generative practices…to broader transformative processes in the land and between the living and dead."[79]

Although most outsiders focus sole attention on widow cleansing and inheritance, polygyny is also highly criticized by many outside of the community and those insiders who follow Christian monogamous relationship principles because it is based on having multiple sexual partners. In an effort to contrast the criticisms, it is important to delineate the social structure of the home. Luo communities are centered on households which branch out to homesteads, clans, nations, and finally conglomerations.[80] Each household is under the direction of a woman and comprised of herself and her children. Homesteads are headed by a man and consist of the households of each of his wives and her children, denoting his wealth and social status based on the number of households in his homestead. Each homestead then comes together under the direction of the Luo Council, which is headed by elders and the chief.

The communal structure is also imprinted onto each marriage with the individuals in the union being "a wife/husband or daughter/son to a household, a homestead, a clan or the nation."[81] The unitive element of marriage as a communal affair easily accepts polygyny because women and children must be cared for and men must be able to prove their ability to care for these vulnerable populations (i.e. women and children) in the Luo society. As long as one chooses to adhere to the customs and rules of the Luo community, it is the duty of the greater community to care for and protect each individual. When the

[79] Ibid., 97.
[80] Oluoch, Elizabeth Asewe and Wesonga Justus Nyongesa. 2013. "Perceptions of the Rural Luo Community on Widow Inheritance and HIV/AIDS in Kenya: Towards Developing Risk Communication Messages." *International Journal of Business and Social Science,* 4(1), 214.
[81] Ibid.

contraction of HIV/AIDS is placed in conversation with polygyny, the mandate to care for vulnerable populations and continue the foundational practices of the community are at the forefront of the Luo defense of the practice. This can be seen in interviews with practitioners that have been conducted by western researchers to address the cultural connection to widow cleansing and inheritance.[8283] Adopting a monogamous marital status and only engaging sexual relations with that one partner may better the health of an individual according to western health constructs, but it leads to the suffering of the community because the traditional customs are sacrificed and women are left to struggle to care for themselves upon the death of their husbands.

Of the three practices that are a part of the HIV/AIDS debate, widow cleansing and inheritance remains at the forefront of the conversation because it is both central to Luo identity and is most critiqued by the many non-Luo communities. Widow inheritance is based on the concept of levirate marriages—obligations of a man's brother to marry the deceased man's wife if he dies without conceiving any children.[84] Similar to the levirate custom, widow inheritance "stipulates that upon the death of a husband, his 'brother' takes up the roles and responsibilities of the deceased's 'home' including towards his wife and children; that is, he assumes the care of the deceased's home."[85] Before the cleansing and inheritance rituals can begin, the widow must complete the proper mourning rituals that signify the death of her husband and inform the community that she

[82] Luginaah, Isaac, David Elkins, Eleanor Maticka-Tyndale, Tamara Landry, and Marcy Mathu. 2004. "Challenges of a pandemic: HIV/AIDS-related problems affecting Kenyan widows." *Journal of Social Science and Medicine,* 60(2005), 1219-1228.
[83] Ambasa-Shisanya, Constance R. 2007. "Widowhood in the era of HIV/AIDS: A case study of Siaya District, Kenya." *Journal of Social Aspects of HIV/AIDS,* 4(2), 606-615.
[84] Schechter, Solomon and Joseph Jacobs. 1st ed., s.v. "Levirate Marriage." New York: Jewish Encyclopedia, 1906. http://www.jewishencyclopedia.com/articles/9859-levirate-marriage
[85] Nyarwath, Oriare. 2012. "The Luo Care of Widows (*Lako*) and Contemporary Challenges." *Thought and Practice: A Journal of the Philosophical Association of Kenya (PAK),* 4(1), 94.

is prepared to be cleansed and inherited. These signs can include wearing the clothes of the deceased husband as a sign of fidelity or shaving the head as a sign of honor and respect.[86] Other women tie banana leaves around their waists as a source of strength, as well as symbolizing their unclean status and continued attachment to their deceased husbands.[87]

Once these signs have been made visible to the community, the physical structure of the houses on the homestead are altered to signal the death of the patriarch (quite similar to a flag being lowered to half-mast), and the widow is stigmatized and isolated by her family and community.[88] During this time, the widow must find a cleanser—if there is no brother-in-law or cousin willing to cleanse and inherit her—pay his fee, and travel to her maternal home to prepare for the union with her inheritor. After these steps have been completed, she can return to her husband's "brother" to be cleansed in order to proceed with repairs on her home and the remainder of her life.[89] The term "brother" has been broadened over time to include cousins or hired men who are willing to perform the sexual rite that initiates the custom and some become inheritors if they are financially able. Of utmost importance is the detail that the cleansing male is obligated to have unprotected sexual relations (widow cleansing) with the widow to cleanse herself, her home, and the community of bad spirits that would be left behind by the deceased husband.[90] While there seems to be an inconsistency regarding care for the vulnerable

[86] Ayikukwei, Rose M., Duncan Ngare, John E. Sidle, David O. Ayuku, Joyce Baliddawa, and James Y. Greene. 2008. "HIV/AIDS and cultural practices in western Kenya: the impact of sexual cleansing rituals on sexual behaviors." *Culture, Health and Sexuality,* 10(6), 589.
[87] Ibid.
[88] Ibid.
[89] Oluoch, "Perceptions of the Rural Luo," 215.
[90] Kimani, Violet Nyambura. 2004. "Human Sexuality: Meaning and Purpose in Selected Communities in Contemporary Kenya." *Ecumenical Review* 56(4), 408.

and the isolation and stigmatization of widows as funerary rituals are carried out, the initial isolation is only temporary to offer the deceased husband the respect and necessary rituals to honor his life and legacy. The completion of the rituals places widows back into right standing with the community and makes them eligible for long term care and protection, according to tradition.

As stated above, the broadening of the role of "brother" has now come to include hired cleansers from outside of the community, especially as HIV/AIDS has spread throughout the community over the years. Such an expansion of ritual participants denotes Luo openness to certain changes and adaptations of their cultural practices, although threats to group survival and slow implementation accompany potential changes in the future. Those non-Luo cleansers are considered by the Luo to be

> "a sexual perverse, or psychopath capable of doing what normal human beings cannot do. He is persuaded to perform a sexual cord cutting ritual to separate the widow from her deceased husband so that the widow may be free to be inherited. Where the widow was still young (in her child bearing age) the process began by breaking the sexual fast by elaborate rites that could last up to a month or more. Where the woman had reached menopause, the enactment of widow inheritance took a symbolic format. The brother/cousin either stayed vigil until cockcrow or gave the widow a roll of tobacco to redeem her from psychic pressure. According to the Luo culture, therefore, the only person who is dead is the one who dies childless. The physically dead (spirits) still have responsibilities towards the physically living members of their families."[91]

Regardless of the "brother" who cleanses, it is the Luo belief that the cleanser takes "with him all the evil spirit(s) that killed the deceased."[92] These evil spirits must be removed lest the widow, inheritor, and/or community be haunted by the apparition of the deceased husband until the necessary rituals are performed. Widow cleansing and inheritance is

[91] Oluoch, "Perceptions of the Rural Luo,"215.

[92] Ayikukwei, Rose M., Duncan Ngare, John E. Sidle, David O. Ayuku, Joyce Baliddawa, and James Y. Greene. 2007. "Social and Cultural Significance of the Sexual Cleansing Ritual and its Impact on HIV Prevention Strategies in Western Kenya." *Sexuality & Culture*, 11(3), 45. doi:10.1007/s12119-007-9010-x

largely practiced the same way it has been for centuries, but the number of Luo men willing to perform the cleansing ritual has dramatically decreased because the men view women as carriers of HIV/AIDS.[93] Cleansing has now become mostly outsourced to professionals from other tribes and ethnic groups; yet, inheritance remains largely a duty of Luo men. Inheritance does not equate to marriage because wives are forever bound to their husbands, but inheritors serve as surrogate husbands who "help the widow comply with sexual rituals and, to a varying degree, provide the widow financial and emotional support."[94] Typically the widow and her inheritor determine the parameters of their relationship because many inheritors are responsible for several households within and beyond the widow's village. Determining the parameters of the relationship is also crucial for other sexual rituals that are to be observed by all community members throughout the year. Inheritors aid widows in the observations of such rituals during the establishment of homes, the beginning of harvest seasons, and funerary ordinances for relatives.[95]

Prior to widow cleansing and inheritance becoming a cultural marker of a select number of ethnic groups across the African continent, the practices were a part of the majority of Africa's tribal and ethnic groups for generations.[96] However, the presence of imperial powers and the demands to eradicate traditional practices in favor of western practices greatly reduced the number of tribes and ethnic groups that maintained widow cleansings and inheritance as a part of their cultural identities. Communities like the Luo

[93] Ibid.
[94] Perry, Brian., Lennah Oluoch, Kawango Agot, Jamilah Taylor, Jacob Onyango, Lilian Ouma, Caroline Corneli, et. al. 2014. "Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centred HIV prevention options." *Journal of the International AIDS Society*, *17*(1), 19010. http://doi.org/10.7448/IAS.17.1.1901
[95] Ibid.
[96] Nyarwath, "The Luo Care for Widows," 92.

who were distanced from major urban centers were able to preserve more traditional customs than other communities; and this distance provided space to be selective about which western Christian practices and to what extent they would be incorporated into daily life. For those individuals and communities that strictly honor the traditional practice, widows are not allowed to make repairs on their homes, farm their land, aid their children in marriage, or a number of other important activities until they have performed the conjugal cleansing act.[97] When the act is delayed or abandoned, those women are considered outcasts of the Luo community and not allowed to participate in any communal practices. Their children are also jeopardized in the process because the community assumes that the children will not be able to lead regular lives due to the negative attachment of their father's spirit to them. Decisions such as who and when they can marry are given a "wait and see" status, which is not usually revoked until the widow consents to being cleansed and inherited.[98]

Because traditionalists view the rejection of widow cleansing and inheritance as a rejection of the unwritten Luo rules of life, the abandonment of tradition is believed culturally to lead to the massive count of Luo deaths from HIV/AIDS over against the individual acts of unprotected sex. The only cure to the HIV/AIDS pandemic is a mass return to the foundational traditions of the people that contributed to their survival for millennia. This thought significantly challenges the western medical model, as well as Christian marriage and family customs, despite the reality that many self-proclaimed traditionalists incorporate Christianity into their identities and reject the idea that they must choose one cultural approach over another. Christian identity becomes secondary

[97] Ayikukwei, "Social and Cultural Significance," 44.
[98] Ibid.

when the improper performance or rejection of widow cleansing and inheritance can affect future offspring, which is unacceptable in a culture that defines life by continued generations.[99] The possibility of contracting HIV/AIDS also becomes secondary when the eternal death of a person is impending in the absence of the ritual and future descendants, leading many to adopt the idea that "it is better to sacrifice one or two people and (ironically) save the community, for this is where the stakes are considered higher."[100] These beliefs support the communal understanding that the individual good is secondary to the collectivist good, which speaks to the tension of implementing modern western healthcare strategies to be later addressed. All in all, western connotations of health have not made it easy for the Luo to abandon practices and identities that they have embodied for generations because some risks are worth taking to ensure continued life according to their traditional worldview.

This chapter has explored a brief history of the Luo people and their slow generations-long movement to arrive at Lake Victoria, followed by the complex history of and relationship with Christianity in the region. Christianity's complex presence has created many obstacles to healthcare, which has negative implications on the HIV/AIDS crisis among the Luo. While Christianity is not the sole source of blame, its complicated history has directly and indirectly impacted Luo communities and their overall health in substantial ways. This information has provided a different background to some of the foundational practices within the community that have been largely negatively critiqued outside of their cultural context. One of these practices is widow cleansing and inheritance, which is practiced by both traditionalists and Christians in an effort maintain

[99] Nyarwath, "The Luo Care for Widows," 95.
[100] Kimani, "Human Sexuality," 410.

cultural ties and avoid communal illness in the form of *chira.* With an analysis of Luo culture and widow cleansing and inheritance having been provided, the next chapter will offer a constructive criticism of the cleansing and inheritance ritual prior to offering a structured framework that unites western healthcare initiatives and traditional practices to combat HIV/AIDS in Kenya's Luo communities.

Chapter 3: Analytical Criticisms of Luo Sexual Practices

Many have called into question the practice of widow cleansing and inheritance and their roles in the transmission of HIV/AIDS, which have become largely associated with Luo tribes in sub-Saharan Africa. The previous chapter provided an overview of the ritual's centrality to Luo identity and culture, while this chapter sets out to provide a balanced criticism and questions that may lead to healthier interventions from western healthcare perspectives. Before such criticisms can be examined, it is necessary that the author acknowledges her limited positionality with the practice. As an American graduate student who came across the topic of HIV/AIDS and its prevalence among Luo communities due to widow cleansing and inheritance through secondary sources, the author possesses no primary experience or on-site observation to enhance the authority of her criticisms. Not only does the author's removed cultural and research positionality generate challenges to the act of criticizing the ritual, but the embedded cultural significance of the ritual and its placement within contemporary Christian and traditional understandings of the community generate challenges to outside criticism. Despite these constraints, the following criticisms and questions will lead to propositions for which cultural practices may be reoriented in the community to create a new framework for individual and communal health as opposed to the continued neglect of individual health in favor of communal health, as has been the custom of traditional widow cleansing and inheritance practices to date. Realizing that the epistemological privilege belongs to the Luo community, the following academic critique will work to incorporate existing critiques into conversation with contemporary health developments.

There are several levels of criticisms that have been developed by researchers through a number of ethnographic and sociological studies conducted among Kenyan Luo communities. Each of these studies has attempted to provide a cultural framework of the Luo before providing statistics on the detrimental effects of widow cleansing and inheritance on the community. While these attempts at offering a grounded context are necessary, complexity arises with regards to the interconnected relationships between sexual relations and the prosperity of the community and land. Prior attempts to contextualize the study of widow cleansing among the Luo have not fully addressed these factors. Such relationships have not yielded easily to the effects of modernization and westernization. There is also complexity in the need for women to participate in their cultural practices and seek ways to protect the health of themselves and their relatives, specifically their children. This issue is exacerbated when outsiders enter the community to cleanse, and sometimes inherit the women, placing outside communities at risk of contracting HIV/AIDS and rendering Luo women semi-isolated from their families. Outside impediments also include the negative influence of some Christian denominations' imposition of condoms, which inhibits the comingling of bodily fluids to seal the sexual act and its benefits for communal prosperity. When brought into conversation with criticisms of widow cleansing and inheritance, these alternate issues depict the need for multiple lenses when examining the negative health effects of widow cleansing and inheritance on Luo communities.

Those who have examined widow cleansing, whether Luo, Kenyan, or Westerner, have all come from academic settings and maintain minimal to no ties to Luo communities. Even those Luo tribespeople who left the communities to receive education

are seen as outsider to rural Luo communities because they shun and denounce many of the traditional practices that serve as identity markers for the Luo. This absence of indigenous voices fully enshrouded in the community has inadvertently added to the authority of internal voices championing the maintenance of widow cleansing and inheritance among other traditional practices. As of late, such gaps have led some academics to also champion the maintenance of certain traditional rituals based on outside criticisms. Philosopher Oriare Nyarath is an academic who draws on some foundational critiques of widow cleansing and inheritance in his analysis of contemporary challenges to providing care for rural Luo widows. These critiques fall into four main categories which have often originated from a pejorative western viewpoint:

> "that the institution violates a wife's right to freedom of choice, that is, the choice to remarry or not to do so after her husband's death…that the institution is one of the main factors in the spread of HIV/Aids, with some critics even expressing the fear of extinction of the Luo community…that the institution encourages the economic exploitation of widows and their families by imposing on them the so-called guardian (*jalako*) who denies the widow and her children the power to inherit the deceased's property…[and] the institution is socially repugnant."[101]

Each category calls into question the efficacy of widow cleansing, either from a social or health perspective; and these criticisms stem from an "enlightened," western social context. While the health concerns are valid in the wake of such a deadly disease in a regional context that bolsters few resources for expansive treatment, the demeaning nature of the critiques is unacceptable. But an analysis of each criticism will now be conducted to discern practical areas of improvement for Luo communities and western healthcare institutions.

[101] Nyarwath, Oriare. 2012. "The Luo Care of Widows (*Lako*) and Contemporary Challenges." *Thought and Practice: A Journal of the Philosophical Association of Kenya (PAK),* 4(1), 103.

"That the institution violates a wife's right to freedom of choice, that is, the choice to remarry or not to do so after her husband's death." As stated in the previous chapter, Luo marriages involve the entire community and do not dissolve upon the death of a spouse. Although condemned from a western perspective, the patrilineal arrangement of Luo society demands that whichever man "is head of the family sees to it that traditions are faithfully transmitted."[102] Unfortunately, this reliance upon the patriarch to ensure that traditions are transmitted removes widows from the decision-making body when it comes to distribution of her husband's assets and reorganization of the family unit. The effects of HIV/AIDS on Luo communities produces much anxiety among widows especially where there are fewer male relatives of the deceased husband alive and willing to inherit the woman and her children, leaving the grieving family in a liminal suspension as they search for cleansers and inheritors. Whereas the inhibition to exert autonomous decision-making capacity is the original aim of western bioethics, the ingrained communal nature of Luo society demands co-dependence on others. This co-dependence has not traditionally fared well with the supremacy of autonomy as seen in the west, but there is room for autonomy to be interpreted through different cultural lenses.

One such area is the cultural tension in seeking an inheritor while being bound to the deceased husband. Widows cannot easily make the choice to remarry. If there was the option to remarry, widows would still be forced to strategically consider those men who were able to support herself and her children. If there were no eligible men with the resources to provide for her and her family's needs, she would be forced to work several

[102] Luginaah, Isaac, David Elkins, Eleanor Maticka-Tyndale, Tamara Landry, and Marcy Mathu. 2004. "Challenges of a pandemic: HIV/AIDS-related problems affecting Kenyan widows." *Journal of Social Science and Medicine,* 60(2005), 1220.

jobs or lose all that she has acquired throughout her lifetime. The rural nature of Luo society does not allow for easy transition from one occupation to another; therefore, the majority of Luo citizens are cemented into their social role within the community.

This analysis demands that the original aim of the critique shift from a focus on a widow's inhibited decision-making capacity to a critique over the lack of resources that limits social mobility throughout the lifespan. Even for those individuals gridlocked into their social positions, their survival is not as complex as widows who are in their child-bearing years because "[w]here a woman's position, status, social network, economic survival and worth are formally tied to being a wife, as they are among the Luo, the negative impact of the loss of a husband is compounded."[103] Women's compounded nature and reduction to becoming a wife, being a wife, and remaining a wife beyond the death of their husbands restricts their ability to remove themselves from the Luo social context and experience life beyond the community. Very few Luo women have the ability to attend universities, keeping them bound to the rural, minimally-educated lifestyle that generations of their ancestors lived before them. As in many other patrilineal societies, men are granted more opportunities to receive formal education; and this restricted opportunity further challenges women's freedoms to resources because the increased population of educated Luo men living outside of the villages reduces the number of Luo men willing to cleanse and inherit widows.[104] The absence of educated men in the communities also reduces the number of authoritative male voices championing the alteration and elimination of a traditional practice that leads to widespread deaths of Luo citizens. On the other end of the continuum are those Luo men who are not formally

[103] Ibid., 1221.
[104] Ambasa-Shisanya, Constance R. 2007. "Widowhood in the era of HIV/AIDS: A case study of Siaya District, Kenya." *Journal of Social Aspects of HIV/AIDS,* 4(2), 606.

educated and insist on the continued practice of cleansing and inheritance despite widespread communal knowledge of the risks and vulnerabilities of transmitting and contracting HIV/AIDS.[105] Such imbalanced power dynamics which do not incorporate the opinions of the central demographic that must participate in the ritual is further evidence of the need for criticisms to shift from freedom of spouses to increased access to resources that allow for social mobility of women. Without such a freedom, women will continue to have their wellbeing and voices undermined in the larger society.

The social fixation of women and widows among the Luo is further problematized when analyses focus on rights and privileges that are not germane to the society. Women do not have the freedom to act independently during most stages of their lives, excluding elder-hood when their age has won them the social status to live according to their own terms. Although the female elders of the community gain the ability to live according to their own terms, they continue to champion traditional practices as a means of avoiding communal detriment and death.[106] Unfortunately, many women are unable to see this stage of independence because they are dying at alarming rates from HIV/AIDS. If women are not serving in the capacity of wives, they are serving in the capacity of mothers; therefore, their choice to abandon participation in traditional rituals affects the spirit of their deceased husbands, the prosperity of the entire community, and the ability of their children to establish their lives independent of the homestead on which they were raised. These multi-faceted responsibilities to individuals and communities beyond each woman reduce the reality of fear around death from HIV/AIDS resulting in few women

[105] Ibid., 612.
[106] Prince, Ruth. 2007. "Salvation and Tradition: Configurations of Faith in a Time of Death." *Journal of Religion in Africa*, 37(1), 103. doi:10.1163/157006607X166609

being active in demanding changes to cultural practices that are placing them at a disadvantage.[107]

Creating structures that support freedom of choice of widows after the death of a husband without changing the communal mindset will have no support because Luo communities do "not readily accept individuals who make decisions that have not been vetted by elders. Those who make such decisions are stigmatized and are deemed to suffer psychological and emotional distress. They easily succumb to pressure and demands to fulfil cultural norms. One can discern this through the experiences of uncleansed widows who are stigmatized and ostracized."[108] The pressure to participate in widow cleansing and inheritance is a major problem for women and women's rights within Luo society, but communal empowerment must be the means by which women receive their voices because the society will not alter its view of marriage as an independent affair between two people. Therefore, it is imperative that western notions of autonomy do not force Luo women outside of their social constructs leading to isolation and humiliation. The women must always be in community with others, but that community must also conform to include women's voices in decisions regarding the support structures they need throughout their grief to aid them in caring for their children and conducting daily tasks in the absence of their husbands. Such a community would call for a change in communal understanding of social roles, which unfortunately have the potential of being considered disrespectful of Luo culture. The community must also

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[107] Oluoch, Elizabeth Asewe and Wesonga Justus Nyongesa. 2013. "Perceptions of the Rural Luo Community on Widow Inheritance and HIV/AIDS in Kenya: Towards Developing Risk Communication Messages." *International Journal of Business and Social Science,* 4(1) 217.

[108] Ayikukwei, Rose M., Duncan Ngare, John E. Sidle, David O. Ayuku, Joyce Baliddawa, and James Y. Greene. 2008. "HIV/AIDS and cultural practices in western Kenya: the impact of sexual cleansing rituals on sexual behaviors." *Culture, Health and Sexuality,* 10(6), 598.

aid women in achieving higher levels of education, especially those women in more rural settings because dependence is greater in rural settings: "[t]here is evidence that most rural Luo widows with secondary school education and economic stability ignore the cultural requirement of guardianship. On the other hand, widows with primary school education and no economic empowerment more readily submit to such cultural demands. Thus intervention through education has helped Luo widows and widowers to refrain from life threatening widowhood rituals."[109]

"That the institution is one of the main factors in the spread of HIV/Aids, with some critics even expressing the fear of extinction of the Luo community." Valid concerns have existed for decades over widow cleansing and inheritance being sources of HIV/AIDS contraction and transmission within Luo communities due to the widespread network of sexual partners engaging in unprotected sex. These networks have occurred across genders and generations via "cross-generational marital, extra-marital, and transactional sex relationships between older men and young women. HIV rates have been particularly high among young women in their late teens and twenties and middle aged men in their thirties and forties."[110] These demographics are so susceptible among cleansing-practicing communities because many deceased husbands have died from HIV/AIDS and have passed the disease on to their younger wives. These wives, in an effort to be cleansed and inherited to remain within the community, unknowingly pass the disease on to their cleansers and inheritors, who are often middle-aged and can afford the added responsibility of another household. These infected inheritors then transmit the

[109] Gunga, Samson O. 2009. "The politics of widowhood and Re-Marriage among the Luo." *Thought and Practice: A journal of the Philosophical Association of Kenya (PAK),* 1(10), 175.
[110] Mojola, Sanyu A. 2014. "Providing Women, Kept Men: Doing Masculinity in the Wake of the African HIV/AIDS Pandemic." *Signs: Journal of Women In Culture & Society*, 39(2), 346.

disease to their wives, within and beyond the boundaries of Luo communities, who are often in their teens and twenties.[111] The cyclical nature of infection and death adds to the poverty dynamics of the communities because the able-bodied workforce continues to die off at an alarming rate.

Daily realities of HIV/AIDS and death invade the lives of all Luo communities, but there exists major skepticism among the Luo that HIV/AIDS cannot be transmitted through widow cleansing because the ritual is mandatory and central to the population's identity. For the minority of Luo who believe that individuals can contract HIV/AIDS from widow cleansing, they believe that hired cleansers from outside of the community are the sources of transmission.[112] Simply proposing the eradication of the ritual is ineffective because sexual relations accompany many rituals, demanding widows who have not reached menopause to bring in their inheritors or find another sexual partner to fulfill their roles in communal rituals.[113] In order for these sexual relations to be complete, they must be performed without the use of condoms; and many widows' in-laws encourage them to seal the rituals with a sex act as a means of honoring the legacies of the deceased husbands and ensuring that future illnesses will not be brought onto families.

The centrality of sex to ritual practices has existed for generations, but the alarming death rates among Luo communities must give way to altered practices;

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[111] Ayikukwei, Rose M., Duncan Ngare, John E. Sidle, David O. Ayuku, Joyce Baliddawa, and James Y. Greene. 2007. "Social and Cultural Significance of the Sexual Cleansing Ritual and its Impact on HIV Prevention Strategies in Western Kenya." *Sexuality & Culture*, 11(3), 43. doi:10.1007/s12119-007-9010-x

[112] Ibid., "HIV/AIDS and cultural practice," 596.

[113] Perry, Brian., Lennah Oluoch, Kawango Agot, Jamilah Taylor, Jacob Onyango, Lilian Ouma, Caroline Corneli, et. al. 2014. "Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centred HIV prevention options." *Journal of the International AIDS Society*, *17*(1), 2. http://doi.org/10.7448/IAS.17.1.19010

however, a vast degree of stigma exists around individuals living with HIV/AIDS, and this stigma jeopardizes efforts at reforming current social and traditional belief systems. Currently fifty-eight percent of the Kenyan population living with HIV/AIDS are women.[114] These percentages alter dramatically in rural settings similar to those of Luo communities, creating heightened isolation from support systems that are being put into place in more urban centers like Nairobi. In the absence of strong support systems, Luo women find themselves associated with the disease and rejected by their communities more and more as the disease progresses. This rejection begins with the implicit need for women to put their health aside and focus on the wellbeing of their children and elderly in the absence of a husband. Oftentimes, signs are apparent that the women have contracted HIV/AIDS, but they do not manage it early on and healthcare institutions are too far removed to take time to get a proper diagnosis.[115] For those women who find the time to visit a doctor, they are terrified of asking for a test to determine their HIV/AIDS status because there are familiar faces who would have access to such private information. The idea of others knowing one's status and potentially sharing it with the community causes women to only seek care for the underlying secondary conditions of HIV/AIDS, which may also raise suspicion.[116] Rights to privacy and confidentiality that are protected in western bioethical settings must be examined within a Luo context to determine the proper balance of disseminated information and privacy in settings of minimal healthcare resources and access. Otherwise, fear emboldens the impact of the

[114] Kamau, Nyokabi. 2006. "Invisibility, silence and absence: A study of the account taken by two Kenyan Universities of the effects of HIV and AIDS on senior women staff." *Women's Studies International Forum*, 29(6), 612-619. doi:10.1016/j.wsif.2006.10.001
[115] Owina, Joseph D. 2002. "Social Development." In *Kenya into the Twenty-First Century*. London: Minerva Press, 192.
[116] Ibid.

disease because there is the fear of contracting the disease, others finding out about one's status, and dying a painful death that has been witnessed by numerous others, all of which stems from widow cleansing and inheritance among Luo communities.

Different health and social support structures need to be put in place to aid those who are currently living with HIV/AIDS, but different practices must also be instituted to curb the contraction and transmission rate of HIV/AIDS altogether. Unfortunately, both changes are shrouded in stigma against the women living with the disease. They are shunned amongst inheritors, who fear that they have received the disease from their deceased husbands, with inheritors often advising others not to accept certain women in Luo communities. Regular gatherings, occasionally accompanied by reporters and researchers, are now being held among potential inheritors with a leader informing the men of the dangers of widow cleansing.[117] At a gathering in the Nyanza Province (Luo territory along Lake Victoria), one man named Ochanga shares his experience with the public: "I knew my brother had died and they told me it was AIDS, but I thought a Luo could not die because of the virus. So I cleansed his widow and I contracted HIV. That is what killed my first wife…The price of a cow. Just one night and you've got a cow,' replies Ochanga shrugging his shoulders. 'My grandfather did it, my father did it, so I was not afraid of doing it. But the sons of the village will cease to do it."[118] Speaking for a campaign that works to reduce the number of men living with AIDS in Kenya, Ochanga's words covertly speak to the continued plight of women living with HIV/AIDS among the Luo. It is beneficial to reduce the number of men living with AIDS, but such campaigns do not provide means of continued care for widows and their children. These

[117] Robson, Angela. 2009. "Male cleansers for hire." *New Internationalist*, (421), 10.
[118] Ibid.

campaigns also reject the opportunity to partner with women and reduce the number of people, regardless of gender, living with AIDS in Kenya. With the bifurcation of society along gender lines, women remain at a disadvantage in receiving communal support for their healthcare and social needs. Widow cleansing and inheritance may be the only means of keeping women in the community, but the practice is forcing them into the fringes of personhood, health, and general wellbeing.

"That the institution encourages the economic exploitation of widows and their families by imposing on them the so-called guardian (jalako) who denies the widow and her children the power to inherit the deceased's property." Ochanga's remarks also draw attention to the poverty dynamics among Kenyan Luo's that drive the continued practice of widow cleansing and inheritance. "Just one night and you've got a cow."[119] Many male cleansers live in poverty, just as widows and children, but the poverty dynamics are much worse in the case of the women. This is seen in the apportioning of a deceased husband's assets and property. Widows are allowed access to their husband's property to cover the fees necessary to secure a hired cleanser. Once the cleanser has performed his duties, the wife no longer has access to her husband's property because the property is then inherited by the surviving male heirs, either sons or brothers of the deceased.[120] If there are no surviving male heirs, the deceased husband's property is distributed among other family members and the inheritor, but the wife retains nothing. Exploitation of widows and children has become increasingly common among hired inheritors because they return to their homes in other provinces while the inherited widows and children remain in their villages. Widow and inheritor meet to maintain a sexual relationship,

[119] Ibid.
[120] Ibid., "Challenges of a pandemic," 1220.

often with the hopes of providing more children to be added to the lineage of the deceased husband, but inheritors have "no financial responsibility for her or her children."[121] Inheritors achieve financial gain and are able to provide those resources to their wives and households, but the inherited widows are never fully included in the inheritor's family and social dynamics. Many inheritors' wives often request that the inheritor not bring the widow and her children into the larger family or move them onto their homestead because that increases the literal proximity of HIV/AIDS to their families.[122]

According to tradition, inheritors have no rights over the deceased husband's property or family because they are only to serve as guardians, but the practice has become so distorted with the prevalence of HIV/AIDS that widows and their children are no longer protected as tradition demanded long ago.[123] Oftentimes inheritors receive the bulk of a deceased husband's property in the form of a widow's payment to perform the cleansing and inheritance rituals. Their high fees leave widows and their children in extreme poverty because they no longer have funds to repair their homes and purchase food; and the pastoral society only provides consistent work during specific times of the year. Therefore, when harvest seasons come to an end, widows "have a hard life because I do not have any source of money for food, especially when weeding period is over, and I have no business. If you get a little money from casual work you have to divide it among all your needs…At times there is not casual work so you have no money in the house at all…and no food."[124] As a means of intervention and assistance, several Catholic

[121] Ibid., "Providing Women Kept Men," 347.
[122] Ibid., 348.
[123] Ibid., "Luo Care for Widows," 98
[124] Ibid., "Challenges of a pandemic," 1224.

organizations have begun offering classes and housing for women effected by this reality, which will be further discussed.

Another dimension to the poverty of widowhood is the need to provide financial status to poor young men who face economic crises. For those widows who are wealthier than most, they assume a traditional male identity by providing financially for vulnerable younger men until those men can acquire enough wealth and assets to have multiple wives and inherit other widows.[125] The overwhelming majority of women do not fit into this category, leading them to work as hard as possible to maintain relationships with their inheritors for ritual and companionship reasons. Regardless of wealth, many women are consumed by poverty because their number of dependents increases based on their relationships with younger men seeking to achieve a higher social status and the children that result from these relationships.[126] Attempting to solve the crisis of limited men willing to cleanse and inherit widows, women also contribute to the continuation of the practice by altering the gender roles centered on care of the vulnerable in ensuring that the ritual would be accomplished. Power dynamics remain in place and women inadvertently perpetuate their unequal social status in Luo communities.

Nyarwath places the crux of widows' exploitation on the guardian's rejection of widows' access to their deceased husbands' property, but the exploitation of cleansing and inheritance also encompasses issues of personhood. Inheritors can make livings by engaging in sex acts several times a year with innumerable widows and collecting the fees that widows must pay to secure inheritors outside of the Luo community. The gains of hired inheritors are often at the expense of widows remaining in poverty with the

[125] Ibid., "Providing Women Kept Men," 358.
[126] Kristjianson, Patti, Nelson Mango, Anirudh Krishna, Maren Radney, and Nancy Johnson. 2010. "Understanding Poverty Dynamics in Kenya." *Journal of International Development,* 22(1), 992.

burden of caring for their children. Widow cleansing and inheritance does not provide defense mechanisms for widowed women and children because the tenets of a patrilineal society must stand; therefore, women and children are denied access to proper healthcare and family dynamics that support individual wellbeing. Widows are also forced to seek the equivalent of an employer (inheritors) outside of their own communities because their husbands' relatives refuse to protect them according to tradition; yet the male relatives demand that such traditions continue being practiced. These double standards result in isolation and rejection when women challenge the status quo or do not fulfill the rituals according to communal standards.

It is crucial to acknowledge again that communal identity should not be taken away from the Luo way of life, but it must be altered when women and children are forced to live in sub-standard conditions because women choose to protect their lives and those of their children by not engaging in unprotected sex with strangers who may carry a fatal disease. There is no easy solution to addressing this tension in the absence of a cultural framework that more readily accepts changes that balance individual and collective identities. The humanity and personhood of women and children should also not be stripped away by their societies because women choose to use their financial resources to survive as opposed to paying the rising fees of professional inheritors. The lack of options, dissipating resources, slow shifting traditions, nonexistent communal support, and high death rates from disease demand that women exploit themselves and be exploited to retain a sense of personhood within their communities, which often ends in early death. Widows must be recognized as equal members of society who retain the capacity to make decisions for themselves and their children without the affirmation of

male relatives or hired companions. Then and only then will women be respected as persons with autonomous decision-making capacity who also respect the traditional concept of communal co-dependence, especially with regards to healthcare decisions and resources.

"The institution is socially repugnant." There is a two-fold approach to widow cleansing and inheritance now being considered socially repugnant, from a western and Kenyan perspective. Both worldviews are rooted in educational attainment and religious affiliation, existing across gender identities. Both Luo men and women have benefited from receiving education and experiencing worldviews beyond those of their Luo identity; but, educated Luo men have rejected widow cleansing and inheritance more than educated Luo women.[127] With education comes higher social status, and many Luo men have begun associating the ritual with backwardness.[128] The pejorative view of widow cleansing and inheritance is a factor in many educated Luo men never returning to their traditional communities because they cannot change their obligations as males and women's expectations and needs as widows. Educated Luo women do not have the option of fully removing themselves from the traditional context because they often have to provide care for their relatives who continue to adhere to traditional rituals and are suffering with and from HIV/AIDS.[129] Although these women gain a different worldview and see the negative effects of widow cleansing and inheritance, they remain bound to the culture in ways that men are not. This binding makes the cleansing and inheritance more

[127] Ibid. "Invisibility, silence, and absence," 612.
[128] Agot, Kawango E., Ann Vander Stoep, Melissa Tracy, Billy A. Obare, and Noel S. Weiss. 2010. "Widow Inheritance and HIV Prevalence in Bondo District, Kenya: Baseline Results from a Prospective Cohort Study." *Plos ONE*, 5(11), 3. doi:10.1371/journal.pone.0014028
[129] Ibid., "Invisibility, silence, and absence," 616.

socially repugnant in academic settings because women continue to bear the burden of living with and caring for individuals with HIV/AIDS.

Gender identity aside, the worldview that educated Luo gain from their universities is firmly rooted in western educational approaches. The strength of British imperial rule pervades Kenya's educational system, which seems to be the only professional setting in which research has been conducted, thereby shaping the research that has been conducted around HIV/AIDS and traditional rituals. Because of this influence, the Luo, who resisted much of colonialism's influence, become the target of much research and disdain concerning the "backward" nature of widow cleansing and inheritance. The semantics surrounding the rituals are rooted in the negative relationship between imperial expansion and traditional societies, but the research that western educational systems has produced provides necessary information about widow cleansing and inheritance as an important source of HIV/AIDS transmission that must be addressed in the isolated and traditional communities of the Luo.

Christianity, another western influence easily generalized because of its usual juxtaposition to traditional religions, has also cultivated an atmosphere of repugnance toward widow cleansing and inheritance. Christianity's spread to Luo communities altered the perception that many possess toward cleansing and inheritance practices. The Christianity of missionaries mandated that those converting from traditional religions to Christianity would be heavily condemned if they continued to participate in polygynous relationships. For widows who converted, they were forced to reject cleansing and inheritance because the relations were not recognized by the Church.[130] The Church felt

[130] Kirwen, Michael C. 1987. *The Missionary and the Diviner: Contending Theologies of Christin and African Religions.* Maryknoll: Orbis Books, 79.

that a widow's eternal marriage to her husband and need to be taken care of in the event of his death are understandable, but should not be dictated by the transfer of bodily fluids from numerous physical relations in order for the widow to gain assistance throughout her life in patrilineal societies.

Unfortunately Christianity's disdain for cleansing and inheritance in favor of monogamy falls short because it attacks the logic of Luo marital and social relationships, which is incompatible with western views of marital and social dynamics. This misrepresented understanding of western Christianity then informs Luo converts because they adopt the same judgments and views of marriage. Christian Luo women who reject cleansing and inheritance do so because the transformation that must accompany one's life post-conversion dictates the elimination of condemned traditional practices from one's life. Living with a double consciousness of religious ideologies versus cultural expectations is an obstacle to attaining true salvation, so converted Luo communities have begun drawing strong distinctions between saved and traditional members.[131] Some of those saved members who were living with HIV/AIDS before conversion now have the benefit of looking to their church communities for assistance with child care and health care as independent churches begin to dominate the landscape more than missionary churches.[132] The ability of some to gain access to resources that all need intensifies the attitude of repugnance toward the majority of Luo women who participate in cleansing and inheritance rituals because western ways of life continue to play an important role in shaping what it means to be a healthy, educated, Christian human being.

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[131] Prince, Ruth. 2007. "Salvation and Tradition: Configurations of Faith in a Time of Death." *Journal of Religion in Africa*, 37(1), 92. doi:10.1163/157006607X166609

[132] Nyambedha, Erick O. and Jens Aagaard-Hansen. 2007. "Practices of Relatedness and the Re-invention of *Duol* as a Network of Car for Orphans and Windows in Western Kenya." *Africa*, 77(4), 529.

Education and religion determine the degree to which individuals repudiate widow cleansing and inheritance, with both providing a different lens to examine the practice. There are many reservations with fully accepting the rejection of traditional practices because of exposure to education and religion, but the information and quasi-assistance that has been generated from the two institutions has provided valuable insights into important changes that can be made in Luo communities to save the lives of hundreds of thousands of people. This is not to say that western approaches to life are better than African approaches to life; however, the information regarding the health of the public must be taken into consideration for a risky ritual like widow cleansing and inheritance. Its value is not diminished because it is socially repugnant to some but because it threatens the lives of women, children, and men within one of Kenya's top five ethnic groups; and the traditional value of community must be receptive to change in order to guard against threats of extinction.

This chapter has addressed four major criticisms of widow cleansing and inheritance. The development of those criticisms has been combined with broader argumentation that takes into account the criticism and the culture to prepare the way for alternative suggestions that have the potential of saving millions of lives as opposed to maintaining a traditional practice that continues to play a major factor in the extinction of a people. Violations of a wife's right to freedom of choice, the role of cleansing and inheritance in the spread of HIV/AIDS, encouragement of economic exploitation of widows, and the social repugnance of the acts have served as threats to the livelihoods of widows and their children for several decades. Widows cannot easily escape the ritual and cultural pressures to participate in the ritual because of limited access to resources

and other worldviews. There are also challenges to outsiders not recognizing the centrality of the rituals to identity, daily wellbeing, and family dynamics; however the pandemic demands that new systems be implemented. The necessity of a new system is the impetus for the following chapter, which will work to provide a framework of a Kenyan ethno-ethics that takes into account traditional culture, religion, and the public's health concerns in the midst of a decades-long HIV/AIDS pandemic among Kenya's Luo populations.

Chapter 4: A Conceptual Turn to a Kenyan Ethno-ethics

Thus far, there has been a specific focus here on widow cleansing and inheritance rituals among the Luo of Kenya. The ritual is both sacred and profane, but the way in which it aids in the wellbeing and cultural identity of the community must be questioned in the presence of high death rates from HIV/AIDS contraction and transmission. The complex histories of tribal conflict, imperial conflict, and the contemporary Kenyan government becoming more westernized challenge the traditional demands to cleanse and inherit widows along Lake Victoria. Simply instituting western clinical and public health measures will not suffice because these measures have been instituted in a mediocre way, causing Luo communities to reject western medicine and health care approaches. Just as Luo identities are fluid and interdisciplinary, a new model of healthcare must possess these same qualities. One approach to addressing the needs of Luo communities and their health is to create a syncretistic healthcare model that incorporates respect for Luo traditions and rituals, provides education that connects tradition to western research about health, and integrates traditional and Christian religions.

Western healthcare systems have turned to biomedical ethics as the discipline to answer the interdisciplinary ethics questions surrounding individuals' health in the clinical setting. Bioethics provides new ways of examining health but does not address all of the health needs of larger populations, which has led to the rise of public health ethics. Both disciplines must come together with Kenyan and Luo cultures to address the desperate healthcare situation of Luo women who are dying at the risk of remaining in their communities through the practice of widow cleansing and inheritance. Although not addressed in this work, there are significant healthcare disparities throughout the whole

of Kenya. Because tribal identities supersede national identities, it is difficult to formulate one form of bioethics and public health ethics for all health issues. This problem also exists in western societies, especially America because the general principles cannot easily be applied to all cultures and healthcare decisions. This notion of principlism does not ultimately aim at being applied universally, but its implementation is often imposed in such a manner; and this misrepresentation demands culturally specific approaches to health. Also, the devastating effects of HIV/AIDS among the fourth largest ethnic group in the country serves as a catalyst for sub-disciplines of Kenyan bioethics to be formulated. The remainder of this chapter will attempt to do just that.

Traditionally, bioethics has been founded upon four principles, which are often called upon in healthcare settings: autonomy (respect for and support of patients' liberty and agency in decision-making)[133], justice ("fair, equitable, and appropriate distribution of benefits and burdens determined by norms that structure the terms of social cooperation")[134], beneficence (the prevention of harm and taking positive steps to help others and ensure patients' wellbeing),[135] and nonmaleficence (stringent norm to abstain from doing harm to others).[136] All four foundational principles can be applied in Kenya and among the Luo, but autonomy must be malleable to the Kenyan context—as it must be in most Christian traditions where community-orientation is key—instead of coming in the form of its western philosophical roots of individual decision-making capacity. "Western individualism…does not seem very attractive to [Kenyans. They feel] it is an

[133] Beauchamp, Tom L. and James Childress. 2012. *Principles of Biomedical Ethics.* New York: Oxford University Press, 102.
[134] Ibid., 250.
[135] Ibid., 262.
[136] Ibid., 150.

irresponsible way to raise children, care for a family, and share life. This viewpoint questions some of the basic [values that westerners] have taken for granted as representing human growth and developing in the area of identity and relationships."[137] Western individualism dominates bioethics, especially in America; and this domination cannot be the driving factor of healthcare and cultural reform in the Luo context because it would be "unjust and amount[s] to cultural imperialism."[138] As seen in chapters two and three, Luo communities have experienced a western religious moral imperialism for centuries and a health-related western moral imperialism for several decades with the rise of HIV/AIDS. The communities no longer need these judgmental systems referencing all the wrongs that they have done via widow cleansing and inheritance, but instead need a constructive judgmental system that takes their communal voice into account with successful western treatments.

To address problems like these, many have begun arguing for culturally-specific bioethical approaches as many developing nations have begun altering the ways in which they promote health and wellness. South Africa and Nigeria are two African countries leading this endeavor with the establishment of ethics review committees to better address clinician education and the best bedside approaches to care and treatment.[139] The limited resources that many countries like Kenya have do not allow them the means of conducting medical ethics like western countries. Therefore, the countries' worldviews must be the primary basis for the continued development of their healthcare systems

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[137] Kirwen, Michael C. 1987. *The Missionary and the Diviner: Contending Theologies of Christin and African Religions.* Maryknoll: Orbis Books, 79.

[138] Mbugua, Karori. 2012. "Respect for cultural diversity and the empirical turn to bioethics: a plea for caution." *Journal of Medical Ethics and History of Medicine,* 5(1) 2.

[139] Ogundiran Temidayo O. 2004. "Enhancing the African bioethics initiative." *BMC Med Education.* 4(21) doi: 10.1186/1472-6920-4-21

while more developed ethical approaches can serve in more of a supportive capacity to specific worldviews. Richard Liebman provided the name of "ethnoethics" for such a bioethical system that is contextually and culturally applied. Ethno-ethics

> "would include moral norms and issues in health care as understood and responded to by members of these societies. Ethnoethics should be informative not only about cross-cultural variation in ethical principles of medicine, but also about variations in issues which in different societies become defined as morally relevant or problematic. Ethnoethical information should be contributed to the discourse of medical ethics, not only by illuminating culturally distinctive moral views and problems, but also by helping provide a more realistic and knowledgeable basis for the exploration of cross-cultural ethical similarities."[140]

Kenyan bioethics as an ethno-ethics provides the space for tradition, ritual, and culture to be a part of the conversation to address the HIV/AIDS crisis because these three components of Luo life create, sustain, and work to solve the crisis. These conversations would begin addressing the morally relevant issues of treatment, rituals, and the various cultural perspectives that have excluded Luo voices from a pandemic that targets them so pervasively. However, very few steps have been made to create a structured Kenyan bioethics. The absence of Kenyan bioethics has unexpectedly jeopardized Luo communities with regards to research and data collection from their rituals.

Most of the research and medical care that has been conducted in Luo societies has focused only on widow cleansing and inheritance to gather data about the practice and its role in HIV/AIDS transmission while providing few alternatives to care or better access beyond urban centers. Ethno-ethics' desire to ensure that gathered data is contributed to the discourse of medical ethics would shift the empirical dimension of bioethics from "ethical analysis to ethically justifiable behavior…and identify new moral

[140] Ibid.

dilemmas."[141] The results of this information can then be shared with studied communities, and researcher and subject can work together to begin overcoming the negative findings. For populations like the Luo, all classes of people would need to be present in the conversations (i.e. educated, poor, widowed, orphaned, inheritor, traditionalist, and Christian individuals) because each is intimately connected to the generational effects of cleansing, inheritance, and HIV/AIDS. The reality exists that such conversations would be saturated with opinions and nuanced cultural interpretations that could impede efforts at reaching implementable solutions. There is also the reality of important voices continuing to be excluded from the conversation. However, the specificity of ethno-ethics can be incorporated into African public health ethics because the basic premises of cultural relevance underlie the communal approach to health that is addressed by public health.

[141] Solomon, Mildred. 2005. "Relating bioethics' goals and practice: ten ways is" can help ought." *Hasting Center Report,* 35(4) 43.

Another obstacle is the limited or nonexistent number of people within Kenyan's Ministry of Health who are working toward cultivating a unique medical ethical approach for the country. As a temporary solution, a continental African bioethics has begun to emerge as a starting point after which individual countries can model their bioethical approaches. Along with the four western tenets of bioethics, African bioethics includes the communitarian approach to life, the sense of good human relations, the sacred nature of all lives, and the roots of African religiosity.[142] The value of community has been discussed in depth within the context of the Luo community, so further explanation will not be provided here; but it is necessary to discuss the other three African values that are deeply connected to African medical ethics and public health ethics. A sense of good human relations is based upon the idea that human beings are required to be the most humble of the created order in an effort to produce social harmony between God, earth, plants, and animals.[143] Social harmony between the four entities presents a much broader sense of community than contemporary western constructs of community and human relations. Quite similar to the

Ethno-ethics principles

1) Communal value
2) A good sense of the human good: is founded upon the *interdependence* of all living creatures instead of just family and village networks
3) *Ubuntu:* human beings should be intrinsically valued, and that intrinsic value demands that all humans are united; moreover, each human must protect the wellbeing of all others.
4) Religiosity: Each person's life is firmly rooted in an understanding of the divine.
5) Feminist bioethicists: to examine the ways in which women are being oppressed by traditional and global policies, especially as primary victims of HIV/AIDS within Luo communities.

[142] Andoh, Cletus. 2011. "Bioethics and the Challenges to Its Growth in Africa." *Open Journal of Philosophy* 1(2) 71. doi:10.4236/ojpp.2011.12012
[143] Ibid.

communitarian value of African ethics, a good sense of the human good is founded upon the interdependence of all living creatures instead of just family and village networks. That the decision of one person affects all of life underlies the methods of healthcare and disease prevention that must be instituted. Calling upon the Luo and the ritual of widow cleansing, one woman's rejection of the ritual is traditionally believed to bring illness and death upon the entire community. Traditional means of healing invoke traditional healers to seek spiritual intervention and perform rituals to offset the individual's rejection of tradition. These human relations are central to communal identity, both human and nonhuman alike.

Human relations also inform the value of the sacredness of human life. Society writ large believes that there is something special about humanity that should be honored and respected. In the west, it is defined as human dignity. In many African societies it is defined as *Ubuntu.* Not only should human beings be intrinsically valued, but that intrinsic value demands that all humans are united; moreover, each human must protect the wellbeing of all others because each human possesses the right to protection of his or her sacred worth.[144] The last core value of African bioethics is religiosity. Africans across the continent possess a belief in the divine, who is held to be central to one's personality. Each person's life is firmly rooted in an understanding of the divine.

> "This stems from the fact that man is understood to be a *humano-divine* being. He is capable of God, [identical to being made in the image of God] not only in terms of origin, but also in terms of dependence and sustenance. He may not have the vision of a blissful union with God in the Christian eschatological sense of a *face-to-face Visio Beatifica* with God at the end of the individual's life. But the African

[144] Ibid., 72.

> knows that God is in charge of everything, his whole life included. All true development to the African takes religion as its basis."[145]

Although each of these ethical principles are firmly rooted in most African societies, it is difficult to build a medical ethics system on them alone because each tribe and clan may have different approaches for enacting them. It is possible that due to these subcultural disconnects are an underlying cause of African bioethics not yet spreading throughout much of the continent. Ethical principles transcend western bioethical principles, sustaining the traditional approaches to life more than uniting with western philosophical approaches to healthcare. As is the case globally, larger cities with more resources like Lagos, Nigeria have progressed in crafting a semi-syncretistic bioethical model; but the number of large cities is not enough to motivate other regions to cultivate bioethical systems.[146] Regardless of the limited mobility that these traditional ethical principles have had in uniting with western principles, they are a great starting point for the inclusion of African voices in African bioethics. More specifically, they are a great place to start when seeking those ethical values that would be central to Kenyan and Luo views on bioethics.

Yet there is an important bioethical voice that is often missing, and that is the voice of women. Chapter three discussed the nonexistent voice that women have when it comes to their health and livelihood, whether in academia or in the rural settings; but feminist bioethics in Kenya is growing faster than bioethics writ large because women are desiring spaces to express their concerns and make autonomous decisions. Following

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[145] Ibid.

[146] Ogundiran Temidayo O. 2004. "Enhancing the African bioethics initiative." *BMC Med Education.* 4(21) doi: 10.1186/1472-6920-4-21

the example of western feminist bioethicists, Kenyan feminist bioethicists are examining the ways in which women are being oppressed by traditional and global policies. Not surprisingly, women are represented by male academics who are taking up the cause of feminist bioethics, but the field has drawn attention to the reality that privatization of Kenyan healthcare has widened the healthcare disparities of women in rural settings, like those widows in Luo communities.[147] Kenyan feminist bioethics has also worked to demand proper support structures in place for women who are pursuing their educations but also caring for relatives because many institutions have written policies in place for women that are never publicized or invoked.[148]

The nascent stages of Kenyan feminist bioethics is crucial to an evolving Kenyan bioethical model because women and children face more challenges to their health than men, especially those living with HIV/AIDS; yet men have more access, albeit still limited, to better healthcare resources. Feminist bioethics is also crucial because the discipline forces all manifestations of bioethics and public health ethics to treat those suffering with HIV/AIDS at micro and macro-levels, "such as global justice and the ethical obligation of resource-rich countries to bridge the global health divide."[149] In Luo communities, similar to other communities across the continent, there are issues of how to obtain informed consent, how to make medications accessible and affordable, and whose standards determine fair benefits for individuals seeking care and support; and

[147] Ouko, John Otieno. 2009. "Feminist Bioethics in the Global Scene: The Case of Kenya as a Developing Nation." *International Journal of Feminist Approaches to Bioethics,* 2(1) 67.
[148] Kamau, Nyokabi. 2006. "Invisibility, silence and absence: A study of the account taken by two Kenyan Universities of the effects of HIV and AIDS on senior women staff." *Women's Studies International Forum*, 29(6), 616. doi:10.1016/j.wsif.2006.10.001
[149] Wasunna, Angela. 2005. "The development of bioethics in Africa." In *Bioética ou bioéticas na evolução das sociedades*. Coimbra: Grafica de Coimbra, 331.

these questions must have feminist representatives to ensure that widows are protected and have a voice because their voices are traditionally oppressed.

Tenets of Kenyan Ethno-ethics

1) Cultural education for western-trained clinicians
2) Broadened analysis to global factors contributing to HIV/AIDS
3) Advocacy for testing and reduction of stigma
4) Establishment of comprehensive health clinics
5) Development and expansion of mental health counseling
6) Adoption of symbolic cleansing rituals
7) Greater access to condoms
8) Stronger legal structures to support female agency and decision-making capacity

Now that a broad analysis of the different approaches to bioethics across Africa and within Kenya has been provided, suggestions for an ethno-ethic model for the Luo community will be constructed to address the healthcare needs of those widows and children suffering with HIV/AIDS socially, physically, financially, and mentally. The starting point for this new model is to educate healthcare clinicians who are trained in the west and by western standards—including those Luo members who were privileged to leave their traditional communities—on the important traditions and rituals that have defined the Luo for generations. Learning this information allows clinicians to have first-hand information about the people with whom they are working to restore and preserve their health. Numerous community members along the continuum of traditional practices should be called upon to work with western practitioners. Not only would such cultural education provide insights into the communities, but it also works to dissolve the hostilities that have traditionally existed between western and traditional healthcare practitioners. There typically exists an overwhelming distrust between the two parties because traditional practitioners desire to guard their healing approaches, which

are often deemed dangerous, less than hygienic, and unscientific by westerners, while western practitioners are deemed by traditional healers to be unqualified to provide holistic care and have ill-motives that lead to widespread death in communities.[150] This distrust must be tabled in order for equivalent efforts to learn about the other, open communication, and sincerity in cultivating relationships to begin the process of replacing the poor relationships that have existed for centuries, which all begin with inclusive cultural education.

As each party continues to learn and build relationships, research focused on a broadened analysis of the many factors that contribute to the prevalence of HIV/AIDS and other fatal diseases among the Luo must be conducted to bring awareness to the culpability of those beyond Luo boundaries. To date, studies on widow cleansing are narrowly focused on why the ritual is a source of HIV/AIDS transmission without providing a broader cultural context of the people and the numerous perspectives surrounding widow cleansing. Those stories that examine other factors mainly focus on limited access to education. The major gaps in analysis must include considerations of the effects global factors have had on disease and mortality rates among the Luo, especially widows within these regions. In the absence of global factors, attention is only placed on the shortcomings of the diseased communities. It then takes ethics decades to catch up to the realities faced by the suffering communities who have been subjected to harm and health risks because powerful communities shape epidemics and have the resources to

[150] Owina, Joseph D. 2002. "Social Development." In *Kenya into the Twenty-First Century*. London: Minerva Press, 206.

institute cost –effective interventions.[151] Including research and research ethics into a general ethno-ethics seeks to also provide protection for Luo culture as it undergoes transitions and new rituals that promote better health. The Luo could shed the victim-offender paradigm that has been attached to them because researchers' communities of origin would have to be directly included in the conversation and assume a measure of responsibility for the poor health and quality of life that dominates the non-western world.

With regards to healthcare and the HIV/AIDS crisis, the affecting global factors began in the 1980's and have persisted in the form of the structural adjustment policies issued by the World Bank and International Monetary Funds. These structural adjustment policies were founded on "cutbacks in state spending, such as withdrawing state subsidies on basic food items and social services such as health and education;" liberalization; devaluation of the currency; control of wages; and abolition of subsidies, all of which increased poverty drastically and reduced health care expenditures.[152] The only solution to begin bettering healthcare systems and services was the privatization of healthcare; yet, millions of people have not benefited from this bettered system. As alluded to at the beginning of this work, Kenya's current healthcare system has an "urban, curative bias, which means that the majority of the population receive unsatisfactory access to health services, and that preventive health care is relatively neglected. Furthermore, coordination is weak between health services and other activities impinging on health

[151] Farmer, Paul and Nicole Gastineau Campos. 2004. "Rethinking Medical Ethics: A View from Below." *Developing World Bioethics,* 4(1) 33.
[152] Ibid., "Feminist Bioethics," 62-63.

levels, such as agriculture, food, water development, education and social services."[153] Rural areas are the last areas to receive medical services, and they rely heavily on missionaries to travel through the regions to provide services. These services often result in basic care and medication, making the ability to receive specialty treatment and medicines, which are a necessity for African communities ravaged by HIV/AIDS, almost nonexistent.

The cultural education and global analysis pieces will not only bring attention to important cultural factors that are foundational and in need of changing, but also to resource-full populations which can no longer neglect their failure at championing human rights. The acknowledgment of these failures in turn necessitates increased championing in regions that will never be able to overcome the suffering that has been brought on them by international political and financial policies. Once Kenyan ethno-ethics has established these two ideals, structured answers can be generated surrounding such practices as cleansing and inheritance to reduce the impact of fatal diseases like HIV/AIDS. Because religiosity plays such an informative role in culture, it should be the first discipline to which ethno-ethics looks to provide answers to questions of health and wellbeing. The religiosity of Luo regions is similar to much of sub-Saharan Africa in that most individuals have some ties to Christianity and are seeking ways to balance their traditional religious and Christian identities. For practices like cleansing and inheritance, Luo members seek justifications for engaging in sexual acts with multiple partners despite being adherent to their churches. The approach of many churches in Luo regions has been to institute programs for widows that serve as alternatives to cleansing and

[153] Ibid., *Kenya Into the Twenty-First Century,* 199.

inheritance rituals, such as the St. Monica program under the direction of the Catholic Church. St. Monica "mobilizes Christians to build homes for women, and to give financial assistance in the form of small loans to help them start self-supporting projects. They act as legal advisors, helping women not to lose their property."[154] These programs also provide training in entrepreneurship and counseling to combat the pressures of traditional culture. But churches must be able to receive funding and increased support and participation from larger medical communities to align with the social support that they provide to the widows.

Although ulterior motives of conversion dominated Christianity's initial involvement in healthcare provisions of poverty-stricken and resource-depleted communities like those of the Luo, churches via missionaries and alternative programs have played a significant role in providing curative practices in these rural areas. Curative practices are imperative and provide the means for affected individuals living better qualities lives than those who do not receive the curative medical and social practices of churches. Yet curative practices will be more effective once communities advocate for HIV testing and end the stigmatization and shaming of those individuals who pursue said testing. Among the Luo, the majority of the community rejects getting tested for HIV/AIDS because they believe they can discern an individual's positive or negative status according to their physical appearance; and for those women who are considered positive, they are forced to be cleansed by professional cleansers. Many women in turn fear getting tested because they do not want to be rejected by male relatives who will perform all traditional duties with respect to inheritance, so they hire professional

[154] Oloo, Pamelah. 2004. "The Church's Mission: Gender and HIV/AIDS among the Luos of East Africa." *Ministry in the Context of HIV/AIDS,* 21(1) 75.

cleansers by default to avoid themselves and the community learning of their status.[155] Unfortunately, not getting tested is a norm and any deviation from this norm could result in expulsion from the community. In an effort to overcome these challenges, the church and educated community members with high social status according to tradition must advocate for new norms that encourage testing. The institution of this new norm may be eased once the clinicians who will perform the tests have garnered respect through the pursuits of a cultural education, which would in turn demand that permanent facilities and long-term practitioners begin to be established in rural communities alongside the few missionary medical services that currently exist.

As churches provide social support and curative medical care, western communities can assume more responsibility by assisting rural Kenyans in establishing comprehensive health clinics, as some educated rural citizens have suggested.[156] These new clinics would have the resources to provide care for patients across gender, age, and disease lines as opposed to only offering one form of care for a select group of people. Well-rounded clinicians would be needed to offer care in these clinics, but it would not be impossible once the physical buildings were constructed, which are currently nonexistent throughout much of rural Kenya. With enough support from the global community, rotating surgical squads could also be implemented in these clinics, with squads being present in each clinic at least twice a month.[157] This would increase the availability of specialty care in close proximity to the villages that many women in rural

[155] Ayikukwei, Rose M., Duncan Ngare, John E. Sidle, David O. Ayuku, Joyce Baliddawa, and James Y. Greene. 2008. "HIV/AIDS and cultural practices in western Kenya: the impact of sexual cleansing rituals on sexual behaviors." *Culture, Health and Sexuality,* 10(6), 596.
[156] Owina, "Social Development," 193.
[157] Ibid., 194.

environments are desperately in need of but currently have no means of taking advantage of because it is too far removed from them. In the case of HIV/AIDS, individuals would have the opportunity to get tested sooner and encourage others to get tested because healthcare options would be more normal and routinized in the society. Widows would also have the medical support to guard their health status, whether they choose to continue participating in traditional rituals or not.

Counseling must also accompany HIV testing. Many women live in constant fear that they are living with HIV/AIDS, but do not want to know their actual diagnosis.[158] Although many widows are aware of their failing health, "the absence of a clear diagnosis kept them and the community from having to unequivocally face the presence of AIDS and its probable consequences."[159] The uncertainty of their health status and the status of their inheritors cements the communal stereotype that women are the reason that HIV/AIDS continues to plague Luo communities. This pressure can only be combatted by religious programs like St. Monica that offer services and care regardless of religious affiliations, closer clinics providing multiple levels of care, and individual and communal counseling. Women must be guided in thinking of themselves and their participation in their own health from different perspectives that do not place them at fault for the death of the community, regardless of their choice to engage in traditional practices and be cleansed and inherited. Western bioethics could provide the foundation for mental healthcare as a component of holistic care that only traditional healers are thought to provide those in Luo communities. There is great potential for extensive rejection of

[158] Luginaah, Isaac, David Elkins, Eleanor Maticka-Tyndale, Tamara Landry, and Marcy Mathu. 2004. "Challenges of a pandemic: HIV/AIDS-related problems affecting Kenyan widows." *Journal of Social Science and Medicine,* 60(2005), 1225.
[159] Ibid, 1228.

mental healthcare therapies, but a focus on partnership rooted in education could ease the cultural tensions existing around mental health. Instituting counseling before, during, and after HIV testing would enhance the support that widows do not currently have when deciding on getting tested and going through with cleansing and inheritance rituals because their current "counselling" approaches are rooted in avoiding the rituals and seeking refuge in mainline churches near urban areas.[160]

Recently, Kenya has increased its counseling services for those individuals living with HIV/AIDS.[161] There are four types of counseling currently offered in resource-abundant centers, that is to say those regions that are far-removed from the rural setting of the Luo: provider initiated, outreach, home based, and antenatal.[162] Usage of these counseling services has grown and increased annually, but disparities continue to exist between the general population and the Luo population. Access to HIV/AIDS counseling is contingent upon Luo stakeholders and ethno-ethics making the resource an important component of communal health and culture in order for individuals to benefit within their communities and learn strategies to accept their condition while preventing it among others. This would be possible and more popular with comprehensive clinics in the communities. Possibility also arises in the form of regular meetings (e.g. biannual or annual) among well respected Luo leaders from each tribe to discuss continued growth of the aforementioned ethno-ethical approach and ensure that the Kenyan Luo community writ large remains central to the procedures addressing the betterment of their health.

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[160] Ambasa-Shisanya, Constance R. 2007. "Widowhood in the era of HIV/AIDS: A case study of Siaya District, Kenya." *Journal of Social Aspects of HIV/AIDS,* 4(2), 612.
[161] AVERT. 2015. "HIV and AIDS in Kenya." *Avert.org.* Accessed on 2 March 2016. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/kenya
[162] Ibid.

The changes that could take place with permanent healthcare facilities and practitioners would also create better opportunities for working with traditional healers to determine best communal approaches to managing and preventing HIV/AIDS. Because many Luo believe that western clinicians do not provide the spiritual healing to complement physical healing, permanent and long-term clinicians can learn a variety of spiritual healing methods from traditional healers. Cultural differences could continue to pit the two against one another, but strong efforts to comprehend cultural context must come before opinions on the legitimacy of care. This occurs often in western institutions when physicians align their conversations with the beliefs of the patient to develop a healthcare approach that will yield positive results. The two can also work toward promoting the implementation of symbolic cleansing for all women that would gradually be accepted, not just elderly widows. Symbolic cleansing entails that the potential inheritor place a cane, coat, and hat in the widow's house then spend the night without having sex. The next morning, he lights a fire, followed by the widow preparing a meal and giving the inheritor some of her deceased husband's clothing.[163]

Symbolic cleansing and inheritance eliminates the need for unprotected sex with multiple partners, especially when most partners have already contracted and transmitted HIV/AIDS. With the right communal and healthcare leaders supporting symbolic cleansing and connecting it with the culture, Luo members will become increasingly aware of the different means of HIV/AIDS transmission beyond the presence and fatality of the disease. As more knowledge is gained and all stakeholders are encouraged to

[163] Ayikukwei, Rose M., Duncan Ngare, John E. Sidle, David O. Ayuku, Joyce Baliddawa, and James Y. Greene. 2007. "Social and Cultural Significance of the Sexual Cleansing Ritual and its Impact on HIV Prevention Strategies in Western Kenya." *Sexuality & Culture*, 11(3), 40. doi:10.1007/s12119-007-9010-x

become a part of the process of preventing HIV/AIDS, Luo members will come to feel that they own their health, they become more receptive to prevention and involved in new strategies, and they become more aware of the means of differentiating between conditions due to HIV/AIDS and those due to traditional curses.[164] They will also look to ethno-ethics' role in providing the platform for traditional and western philosophies to render a new mode of being that addresses health and culture, both of which are intimately connected for the Luo.

For those individuals who do not adopt symbolic cleansing rituals, leading stakeholders could encourage the use of condoms for men and women. Traditionally condoms are looked down upon because they prohibit the intermingling of bodily fluids to complete the cleansing rituals and free widows of potential curses; but integrative and interdisciplinary approaches to health in permanent facilities could shift Luo outlooks on condom usage. The tension that exists in many Christian denominations regarding condoms could also increase usage because many traditions negate their usage for the similar reasons as the Luo, but individual care givers champion condom usage in an effort to save lives.[165] Because Luo women have minimal agency in sexual relationships and are more affected by HIV/AIDS than men, it is vital for widows to determine condom usage in cleansing rituals and the sexual relations that follow. However, before women can have agency in determining condom usage, wider access to condoms must be implemented. International organizations are constantly encouraging the use of condoms but have neglected a critical region suffering with HIV/AIDS. Male condoms are

[164] Ibid., 48.
[165] Kimani, Violet Nyambura. 2004. "Human Sexuality: Meaning and Purpose in Selected Communities in Contemporary Kenya." *Ecumenical Review* 56(4), 413.

dispensed freely in public restrooms and hospitals, but female condoms are not freely available in public institutions and are far outside of widows' price ranges.[166]

Current tradition does not provide much opportunity for women to dictate the presence or absence of condoms during sexual relations, and those women who do have some agency have not implemented it during cleansing rituals because inheritors desire to avoid suspicions of being deemed HIV positive.[167] But the joint support of traditionalists, western-trained clinicians, and the Ministry of Health to provide condoms for both genders and educate the communities on a new way of implementing them into cultural explanations would be a part of a new preventive healthcare strategy that does not demand lots of financial resources or specialty care. Women, especially widows continuing to adhere to cleansing rituals, would begin to view their health as a right to be protected by themselves and their communities because they would have multi-level support in ensuring their voices are heard when deciding how they desire to participate in risky traditions.

Another important dimension to women's agency are legal structures. Ethno-ethics would have the tools to address the poor legal policies currently in place that do not provide widows primary access to their deceased husband's property and assets, while also uniting current policies to the disparate and nonexistent care that widows receive. Having access to inherit their husband's property would reduce the pressure placed on widows to engage in the traditional cleansing ritual because they would have

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[166] Ibid., "Widowhood in the era of HIV/AIDS," 614.

[167] Perry, Brian., Lennah Oluoch, Kawango Agot, Jamilah Taylor, Jacob Onyango, Lilian Ouma, Caroline Corneli, et. al. 2014. "Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centred HIV prevention options." *Journal of the International AIDS Society*, *17*(1), 5. http://doi.org/10.7448/IAS.17.1.19010

financial security and guaranteed shelter that is under their ownership. Shifting property-related policies would also provide widows the opportunity to become legally literate with the assistance of stakeholders who are willing to support widows' access to property rights and security.[168] The changes established in Luo regions would reduce the communal need to advocate for compulsory marriage because widows would have rights and physical resources to live comfortably without the need to risk contracting HIV/AIDS and transmitting it to relatives and hired men outside of the community.[169]

Although the women would have more individual rights and security than women of previous generations, communal understandings of belonging could center on other rituals that are equally important but overlooked because emphasis is mostly placed on widow cleansing and inheritance. A new way of being Luo, both individually and collectively, will begin taking place. Women may then be more inclined to participate in other traditional rituals that promote communal identity without jeopardizing individual health. These communal and health rights would also be respected by the adopted ethno-ethics that is central to providing a wider cultural lens. There would also be a turn toward supporting women in achieving economic independence and increasing the financial resources of their local communities, which could allow more healthcare facilities and resources to be established closer to Luo regions. With the potential for increased healthcare resources, women would have greater access to antiretroviral therapies and supporting medications for the secondary conditions brought on by HIV/AIDS diagnoses.

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[168] Gunga, Samson O. 2009. "The politics of widowhood and Re-Marriage among the Luo." *Thought and Practice: A journal of the Philosophical Association of Kenya (PAK),* 1(10), 172.
[169] Ibid., "Challenges of a pandemic," 1227.

In the absence of a structured approach to a Kenyan bioethics that could be applied to Luo communities, this chapter has provided a brief analysis of western bioethics, general African bioethics, and feminist bioethics in Kenya to craft an ethno-ethics that includes the major components of Luo culture to begin addressing structured solutions to the HIV/AIDS pandemic in Luo communities. Western and African approaches to bioethics and health must be united to learn the necessary cultural information that would give both the authority to propose changes that would save millions of lives presently and in the future. Without unity between the regional approaches to health and community, none of the stakeholders will have the authority to institute necessary cultural changes around traditional practices. There will also be little to no accountability of resource-rich communities throughout the world to support human rights regarding access to healthcare. A challenge exists when combining individually-focused rights with community-focused rights, but a Kenyan ethno-ethics has the power to both provide space for such a combination to occur and the necessary support structures for that combination to be implemented across time and space in Luo and other Kenyan communities.

Conclusion

The isolation of a community, and women in particular, suffering from HIV/AIDS with limited access to national and international resources prompted the preceding research. Specifically targeted for the connection between HIV/AIDS and the continued practice of widow cleansing and inheritance despite the greater Kenyan community having adopted more western approaches to life and communal identity, the Luo are currently at a crossroads to reform their culture or become extinct. To date, the rituals of widow cleansing and inheritance have negatively impacted the culture and tribal politics, and have created stigma surrounding those who choose to reject the rituals and pursue HIV testing. Because of their demand on individuals to participate in multiple unprotected sex acts with multiple partners, widow cleansing and inheritance have affected women far more than men. Widows and their children are not allowed social support as long as they remain uncleansed, and run the risk of remaining socially isolated and in poverty because their needs cannot be met according to tradition.

Tradition, theology, and tribal politics have justified the practices as a means of men caring for vulnerable populations for generations, but the death rates and suffering of women have yet to lead to changed policies. The connections of these three fields to widow cleansing have been analyzed throughout the chapters to provide a space for the traditional culture and western healthcare to converse with one another in an effort to eventually find new solutions and alternative practices. This new approach has been proposed in the form of a Kenyan ethno-ethics which has the potential to serve the Luo community in its fight against HIV/AIDS while also being general enough to be applied to other Kenyan cultures as the emphasis has been placed on a syncretistic union of

western and traditional approaches to overcome stigmatization, unhealthy cultural practices, and obstacles to healthcare access.

The original contribution of this work was to provide a space for the Luo to be seen as persons who might choose to alter some of their ways of life as opposed to merely research subjects that have dominated the HIV/AIDS conversation in rural Kenya. As research progressed, the contribution broadened to include a syncretistic and interdisciplinary approach to health and healthcare among the Luo, as well as holding the global community, specifically resource-wealthy western communities, accountable for the roles that their international policies have played in supporting the poverty and healthcare disparities among Luo widows. Each chapter built upon the other to provide a solid view of Luo personhood, acknowledge the issues of the Luo and the west, and provide potential answers in a constructive manner.

In the absence of a structured approach to a Kenyan bioethics and the nonexistence of ethno-ethics, an analysis of western bioethics, general African bioethics, and feminist bioethics in Kenya was conducted to craft an ethno-ethics that includes the major components of Luo culture to begin addressing structured solutions to the HIV/AIDS pandemic in Luo communities. Ethno-ethics from a Kenyan perspective must begin with education and lead into stronger structures for female agency in order to unite the communal elements of African bioethics with the demands of a new cultural identity. Developing a new identity that balances contemporary attention to individual health with traditional attention to communal health, granted very gradually, would drastically reduce the cases of HIV/AIDS and institute a new cultural dynamic. The avoidance of *chira* can be respected alongside the implementation of united traditional and western healthcare

philosophies in order to directly address the HIV/AIDS pandemic among the Luo and involve the indigenous community in decisions regarding their health.

The theory of ethno-ethics as a means to providing the necessary interdisciplinary structure to combat the HIV/AIDS pandemic in Kenya and among Luo communities could be greatly enhanced by primary field research in an effort to include the desires and concerns of more Luo women in communal healthcare initiatives. This research was founded on much scientific research centered on the negatives of the ritual, with some voices of effected women being included. This produces limitations centered on the differences in cultural understandings between the researcher and subjects, along with this author's varied cultural perspective, all of which limit the authenticity of the primary voices of suffering. The author's varied cultural perspective comes out of the struggle to prevent the superimposition of traditional imperialist values of health and community onto the Luo. Yet there is the need to use a grounded western bioethical framework to seek resolutions that frame a developing Kenyan ethno-ethics which speaks directly to the Luo. Despite these limitations of personal field experience, the preceding analysis of the culture, ritual, and healthcare systems paves the way for increased involvement in eradicating HIV/AIDS and supporting an isolated community achieve better resources and progress based on their understandings of themselves within the world. Widow cleansing and inheritance have had devastating effects on the Luo, and women in particular; but there is much opportunity for the development of new healthcare systems and ethical approaches to health which have the power to sustain and uplift the community, women, and their cultural identities.

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