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**MALE CIRCUMCISION AND THE
SHAPING OF MASCULINITIES IN
MURANGA, KENYA: IMPLICATIONS
FOR PUBLIC HEALTH
A FOCUSED ETHNOGRAPHIC STUDY**

K M NJORGE

PHD

2014

**Male circumcision and the shaping of
masculinities in Muranga, Kenya:
Implications for public health**

A Focused Ethnographic Study

KEZIA MUTHONI NJOROGE

A thesis submitted in partial fulfilment of
the requirement of the University of
Northumbria at Newcastle for the degree
Of Doctor of Philosophy

Research was undertaken in the
School of Health and life sciences
Department of Public Health and
Wellbeing

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Abstract

The recent promotion of male circumcision as a public health strategy in settings with low circumcision rates is based on research evidence suggesting that male circumcision provides heterosexual men with 50 to 60 per cent protective benefit against HIV infection. For the Kikuyu people in Kenya, male circumcision is a cultural ritual and a rite of passage from childhood to adulthood. The study explored the male circumcision ritual and practices in Muranga, Kenya and their implications on public health. A qualitative research design underpinned by an Interpretivist paradigm was employed. Focused ethnographic methodology was used to capture the cultural context of the ritual and its meanings. Participants were recruited through purposive sampling method. Data were collected through in-depth interviews with 13 circumcision mentors, participant observations in three churches and written narratives with 43 male students from six schools. Data were analysed using thematic analysis.

The findings suggest a changing circumcision ritual with women as key agents of change in a ritual considered a male arena. The church, hospital and urbanisation emerged as the drivers of the changes which women effected with the aim of protecting their sons from institutional bullying and the culture of pain in the era of HIV and AIDS. The latest change in the ritual feature boys getting circumcised and recuperating in hospitals.

The changes in male circumcision practices are of significance to public health. The changes in sexual practices are likely to increase the risk of HIV infection counteracting the protective effect expected of circumcision. The study recommends a revision of policies especially the WHO policy on male circumcision for the effective impact on HIV prevention among the circumcising communities. Women can be engaged in mobilising changes in the circumcision ritual that are significant to the health of young men through institutions such as hospitals and churches.

Key words: male circumcision, public health, focused ethnography, Kenya

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My academic rites of passage

This reflection illustrates and describes the stages and phases that I have passed through in my endeavours to earn a doctoral degree.

On reflecting on the experiences of this research, I have come to realise that I really enjoy writing having completed writing this thesis. Even when I did not know what a doctorate was, my father always referred to me as Doctor Njoroge, probably predicting my future. However, my interest in pursuing a PhD degree did not begin until after my Master's studies in public health, when I realized that I was interested in research especially among young people. I have a passion for working with young people and if working with them meant engaging them in research or conducting research related work, then that's where I was going to begin.

Having grown up as a woman in a small village in Kiambu, Central Kenya, I am aware of the challenges that women face. Growing up in one of the rural areas of Kiambu, I watched most women in the village struggle to raise children alone with absent fathers amidst domestic violence and conflicts. In addition, some of the women had simultaneously taken double roles of bread winners and household keepers. Most men spent their time drinking or had moved in with another family. It was also common to see girls drop out of primary school because of pregnancy even when I had no understanding of what pregnancy meant. When I was 11 years old, one of my best friends dropped out of school because of pregnancy which affected me as I did not know how to help her. The school administration started organising girls' talks by sending women elders from the Anglican Church, which sponsored our primary school. Their teachings emphasised prohibitions of keeping away from boys to avoid pregnancy. After joining high school, it was also common to see girls in groups talking in whispers because one of the girls had been "escorted" home after getting pregnant. Getting pregnant in school was shameful and stigmatising. It was also believed that a person's bright future was cut short since education was viewed as the only way to earn the bright future. It was, therefore, about women and girls that I wanted to write about when the opportunity to carry out research came.

My first degree was in Education which required completing one of the compulsory subjects, "Research methodology". The result of the first assignment in this subject was quite discouraging since I scored below fifty per cent and I, therefore, believed that I could not study or work around research methodology. However, by the time I began the research journey, I had forgotten about the experience. It was not until completing the research methodology course for my Master's study later that I wondered if it was the same course that I had failed in my first degree. Prior to taking the Research methodology course, I took a single course in "Humanitarian assistance and International health" at Uppsala University, Sweden which was part of the Master's degree package. At that time, I had no plan of doing a Master's degree in International Health since I already had a Master's in Developing Economics. At the end of the humanitarian course, I knew I wanted to dig deeper into the public health arena. I therefore applied for other single courses in the same institutions such as International Health, Women and Nutrition, Research Methodologies and Epidemiology. However, I was not confident of being accepted since I had no background in health. Nevertheless, I was accepted for the courses which opened my journey to the world of research.

My research interest in women and girls was specifically focused on sexual and reproductive health. However, it was not possible to go for the field research in Kenya since I did not have research funds, thus, my Master's thesis was based on secondary data analysis. The secondary data, I was given by my supervisor were questions written anonymously by young people, which they could not ask anyone else because of shame or fear. My original intention was to select questions that concerned girls in particular. However, most of the literature that I read prior to writing my thesis showed that reproductive health was mostly linked to girls and women and excluded boys. For instance, one of the books "*Rethinking Research and Intervention approaches that aims at preventing HIV infections among youth*" by Pertet *et al.*, (2006), highlighted the "burdened girls" and the "neglected boys" in sexuality. Girls were reported to be burdened with information while boys were assumed to be more knowledgeable and therefore given less information. My Master's thesis was therefore based on questions on sexuality, condoms and HIV and AIDS from both girls and boys.

As I was reading the questions written by the young people, I identified with them in many ways, which motivated me to write about them and hopefully suggest recommendations that could make a change in the lives of the young people. Owing to the word and time limit in writing my Master's thesis, questions on circumcision were excluded.

Reflecting back to when I joined high school, it was my auntie, not my mother who bought my sanitary pads and taught me how to use them just in case my menstrual period started while I was in secondary school which was a boarding school. This became the routine; it was my auntie who took us, I and my two sisters, shopping prior to reopening of the schools. I was thirteen years old then and since I observed this, it was ingrained in me that sexual matters could only be discussed with my auntie. Even when I experienced my first menstrual period, I informed my auntie, not my mum. Perhaps, my auntie informed my mum about it. This was the way I was socialised and probably it was the same way my mum was socialised too. The only warnings I ever received from my mum was to avoid pregnancy as I would spend my life in suffering. Therefore, reading the questions of the young people made me reflect on my years in adolescence, which also motivated me in writing my Master's thesis on young people's sexuality and HIV in Kenya. This was not an easy task as I was just beginning to develop and test my writing skills. However, I made it with the help and guidance of Professor Beth Maina Ahlberg who agreed to supervise me in my Master's thesis; she also mentored me and believed in me through the first years of research.

The two years following my Master's Education were spent writing and collecting data in the field which was enabled by travel grants from a research foundation InDevelops u-landsfond, Sweden. It was at this time that I had my first publication of a research article, "*Voices unheard: youth and sexuality in the wake of HIV prevention in Kenya*", which was based on my Master's thesis. In addition, as I searched for a PhD position, I received field research funds which enabled me to have the experience of interviewing and interacting with participants in the field on male circumcision. Searching for a PhD position entailed putting in applications to various universities. It was my application to Northumbria University that saw me in this position of a postgraduate researcher at Northumbria University. In addition, the willingness by

Professor Mima Cattan, my principal supervisor, Doctor Martha Chinouya, my second supervisor and Professor Beth Maina Ahlberg, to supervise me rubberstamped me as a doctoral student. This was three years ago. The latest discourse on male circumcision as part of an HIV prevention package increased my interest in researching the issue of male circumcision for my doctoral study. I also based my decision on the assumption that working with men can have a spill over effect on the health of women. In addition, working with young people and improving their health behaviour may, in the long run, affect their adulthood positively.

Although passion is important in accomplishing the PhD writing, it is not sufficient. I planned to complete my PhD months earlier to the deadline in order to have extra time to publish an article prior to the submission of the thesis. However, this has not been possible as I realised I needed more time to even have my thesis ready on time. Nevertheless, I was able to co-author an article with Professor Beth Maina Ahlberg on *'Not men enough to rule!' politicization of ethnicities and forcible circumcision of Luo men during the postelection violence in Kenya* from past research on male circumcision in Kenya. Carrying out a PhD study has also provided me with opportunities to work with others and make choices that are particular to my research. My supervisors read my work with much enthusiasm and asked questions that guided me in justifying the choices made in the PhD study.

The PhD journey was not without some challenges such as limited literature especially on male circumcision among the Kikuyu people. Conducting interviews and listening to the mentors' stories was interesting but also challenging as I had to keep opinions to myself and take a neutral position even when I differed with participants' views. Although an outsider in male circumcision which is a male's topic, I was, from another perspective an insider because I am a Kikuyu although not born in Muranga where the study was conducted. I can speak and write the Kikuyu language fluently. Having grown up in Riabai village, Kikuyu was the main language of communication even in the primary school environment. I also had to take Kikuyu as an examinable subject in the lower primary level. That was how I perfected my spoken and writing skills in Kikuyu. Although I am proficient in my mother tongue, there are some words and terms pertaining to circumcision that were unfamiliar to me but the participants explained the

meaning when requested. More on the insider and outsider perspectives is written in the methodology chapter.

I have tried to be objective all through the thesis writing. My imagined audience kept expanding as I wrote my thesis and I was forced to take account of the people who may take different philosophical stances and reasoning from mine. I thus had to strive to make my argument more explicit whilst being aware of my own assumptions and those of others who may be involved in the dialogue. However, learning is not over but is just beginning as there is no end to learning. Therefore, more academic rites of passage are likely in the future.

Acknowledgement

I'm taking this opportunity to appreciate all those who have contributed to the success of my PhD project. My special thanks go to the Almighty God for seeing through the whole journey of my doctorate degree.

I'm grateful to Northumbria University for granting me a studentship to study my doctorate degree.

To my supervisors Professor Mima Cattan, thanks for the selfless time spent reading my drafts and providing invaluable and constructive criticism. I have asked a lot of questions and was amazed that each time you came up with an answer to all my questions. Besides the academics, your care and love kept me smiling. I would not have imagined a better supervisor for my PhD study.

To Professor Beth Maina Ahlberg, you encouraged me to write even when I thought this was not meant for me. You inspired me to pursue a PhD, and introduced me to the world of research. Thank you for all the sacrifice and inviting me to co-author an article with you, which was a privilege and an honour.

To Doctor Martha Chinouya, I'm grateful for your advice and aspiring guidance in my PhD studies. Thank you for the time you spent listening and answering my questions and giving me extra materials to enhance my knowledge and wisdom on this topic.

To Doctor Ann Kamau for guidance and directions during the field work in Kenya. Thank you Professor Alan White and Professor Steve Robertson for introducing me to the world of masculinities.

I would like to thank the participants who shared their stories and experiences in the male circumcision ritual. I really appreciate the precious time you sacrificed to record such an account of the Kikuyu male circumcision. You made it easy for me in the field work, making it fun and enjoyable.

To my mum, Teresia Waithira Njoroge, thanks for your prayers and love, God heard them. My two sisters; Virginia Njuguna and Joyce Mwangi, thank you for your prayers and love during the writing.

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To all my friends especially Ms Phyllis Uchechi and Cousin Ms Jennifer Lobb, for your love, support and care while I was writing my thesis. That was very kind of you. And to my proof reader Ms Alison Bowie, it was nice working with you.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions ideas and contributions from the work of others.

Ethical clearance for this work has been approved. Approval was sought and granted by School of Health Community and Education studies research ethics subcommittee on 12th of May 2012.

I declare that the word count of this thesis is87,023.....

Kezia Muthoni Njoroge

12 DECEMBER 2014

Introduction

1.1. Chapter Introduction

This doctoral thesis used a qualitative research design that employed a focused ethnographic methodology in exploring male circumcision ritual and practices among young Kikuyu men in Muranga, Kenya. This chapter introduces the thesis topic, the rationale and justification of the research. The chapter also outlines the purpose, objectives and the research questions of the study. In addition, the outline of the thesis is included in this chapter.

1.2. History of male circumcision as a rite of passage

Ethnographer Van Gennep (1960), referred to rites of passage as transitions from one social group or phase to another. He asserted that each individual experiences a rite of passage as they pass from one age grade, social relationship and occupation to another. Some are done immediately after birth while some are done later in life. Important transitions in life are birth, commencement of puberty, marriage, life-threatening illness or injury, and death. Nowadays, other transitions include school graduations, divorce and retirement. Some of the rites of passage are gender specific while others are general and applicable to all. Some affect the physical status of a human being (Hinz & Hangula, nd) such as male circumcision. Male circumcision has been a rite of passage and continues to be a rite of passage for many societies. The rites of passage are regulated by ceremonies and rituals and exist in almost all societies. The three main stages in a rite of passage are separation, liminality or seclusion stage and incorporation into the society (Van Gennep, 1960), which are described in more detail in chapter two, section 2.3. These stages are significant to rites of passage that involve transitions from adolescence to adulthood such as male circumcision.

Circumcision originates from two Latin words: “circum” for “around” and coedere for “to cut” (Loosli, 2004). Male circumcision is the removal of a part of or the entire prepuce of the penis foreskin. Different theories have been proposed on the origin of cutting of the foreskin as in male circumcision. According to Cox (1995), the cutting of the foreskin could be attributed to the timing of the onset of sexual intercourse. There was a belief that human beings needed to learn and acquire skills prior to reproduction. Delay in reproduction accorded human beings selective advantage for delaying reproduction until after puberty. Adolescents were thus required to go through puberty in order to use bodily strength to learn adult skills without using their biological strength to reproduce at this time. This allowed for the modification of the male’s penis which provided a solution for phimosis which is considered a hindrance to sexual intercourse. Circumcision is thus said to have been used to regulate this entire process by removal of the foreskin thus doing away with phimosis problems. Circumcision was thus used to define the age at which males begin reproduction (Cox, 1995). Another suggestion has been the prophylactic effect of circumcision especially for societies living in deserts or in very hot weather conditions where sand and dirt can get under the foreskin and cause infections such as urethritis (Remondino, 1891).

Circumcision is one of the oldest and most common operation procedures in the world as described in this section. Circumcision seems to have been universally practiced in Egypt 4000 years ago as depicted by mummies and wall carving records (Alanis & Lucidi, 2004; Short, 2006). There is a suggestion that medical reasoning was responsible for the religious circumcision in Egypt (Spigelman, 1997). For instance, the Egyptians are said to have circumcised in an effort to prevent schistosomal infection (Weiss, 1997). Circumcision was performed by a priest on boys in their late pubertal stage. Hygiene was another reason suggested for circumcision in Egypt. The Egyptians also compared the effect of cutting a foreskin to a snake shedding its skin, making it radiant. It is a universal practice among the Jewish and the Muslim communities, dating back to over 4000 years ago in the Middle East and more than 5000 years in West Africa (Warner & Strashin, 1981; Moses *et al.*, 1998). Circumcision has thus ancient origins and has been practiced diversely all over the world. However, it has lost its original importance of permitting

reproduction and has now acquired more of a cultural and religious identity. In some communities however, it is a route to marriage. Circumcision has recently been promoted due to its benefits to men's health.

1.3. Male circumcision

The WHO/UNAIDS (2007) estimates that 30 per cent of all males from age 15 and above are circumcised. Of these, 70 per cent are Muslims from Asia, the Middle East, West and North Africa, thirteen per cent are non-Muslim and non-Jewish men living in the United States of America (USA), and 0.8 per cent are Jewish (WHO/UNAIDS, 2007; WHO,2006). Male circumcision is practiced in most parts of the world for different reasons such as hygiene, aesthetic, religion, social, cultural and medical reasons (Thomas, 2003).

Circumcision has been practiced for years for non-religious reasons in sub Saharan Africa, aborigines in Australia, Philippines and Eastern Indonesia and Pacific Islands, including Fiji and the Polynesian islands (UNAIDS, 2007). Most African communities practice male circumcision as a rite of passage from childhood to adulthood (Doyle, 2005). Cultural circumcision is a test of courage, and bravery but it is also associated with masculinities, solidarity with other initiates who are circumcised at the same time and self-identity (UNAIDS, 2007). About 40 of the 45 groups in Kenya among, the Bantu such as the Luhya, Kikuyu and Meru people, Nilotes such as the Maasai people and Cushites people such as the Somalia people practice male circumcision culturally. Kenya comprises of 42 ethnic groups which are grouped under three main linguistic families; Bantu, Nilotes and the Cushites (Nangulu, n.d.). Most of these communities do not circumcise infants, but all except the Luhya groups circumcised their girls in the past. Islamic families circumcise boys before they are ten years old (Khamasi & Kibui, 2010). More than 90 per cent of the men in North Eastern, Eastern, Coastal and Central provinces in Kenya are circumcised while the rates in Nairobi, Rift Valley and Western provinces are over 80 per cent.

1.3.1. Male circumcision and HIV

Many studies have shown a significant association between male circumcision and HIV infection (NASCO, 2008; Weiss *et al.*, 2000) leading to the WHO including it in its HIV prevention package (WHO, 2009). Randomized Controlled Trials (RCT) in South Africa, Kenya and Uganda have shown that circumcised men have a 50 to 60 per cent protective benefit from HIV infection (Auvert *et al.*, 2005; Sawires *et al.*, 2007; Gray *et al.*, 2007; Bailey *et al.*, 2007).

Circumcision is argued to remove the foreskin, the tissues of which are vulnerable to HIV infection (UNAIDS, 2007). In addition, lacerations of the foreskin during sexual intercourse can exacerbate the risk of getting sexually transmitted infections (STI), which consequently increases the risk of HIV infection (UNAIDS, 2007). In 2007, the World Health Organisation (WHO) and the Joint United Nations Programmes on HIV/AIDS (UNAIDS) reviewed the evidence from the three RCTs and released a policy with recommendations for Voluntary Medical Mass Circumcision (VMMC) in settings with low levels of male circumcision and high prevalence of HIV and AIDS (WHO/UNAIDS, 2007; CMMB (Catholic Medical Mission Board), 2007). Several of these settings are in East and South Africa (CMMB, 2007). South Africa was reported to have the highest rates of HIV followed by East Africa with Swaziland having the highest HIV prevalence rate of 26.5 per cent (AVERT, 2014). HIV prevalence rates in Kenya were six per cent.

South Africa has low circumcising rates, apart from the Eastern Cape, where 80 to 90 per cent of the Xhosa people practice traditional circumcision (UNAIDS, 2007). The WHO and UNAIDS chose 13 priority countries Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe, to scale up the VMMC programmes (UNAIDS & WHO, 2011). However, the United States President's Emergency Plan For AIDS Relief (PEPFAR) supports VMMC programmes in the 13 countries and also in Ethiopia making a total of 14 priority countries (UNAIDS, 2007).

The response of the WHO and UNAIDS led to the development of a five-year joint strategic action framework to accelerate the scale-up of Voluntary Medical Male Circumcision (VMMC) for HIV prevention in Eastern and Southern Africa from 2012 to 2016 (UNAIDS & WHO, 2011). This was done through the collaboration of different international bodies with national ministries of health. The framework aimed to reach men between 15 to 49 years old and to create long-term services for infants and adolescents. The WHO and UNAIDS policy aims to reduce HIV infections which are similar to one of the eight United Nations Millennium Development Goals (MDG), the MDG 6, the aim of which is to stop and reverse the HIV epidemics by 2015 (UNAIDS & WHO, 2011). The main aim of the eight MDGs that the 189 countries including Kenya agreed to achieve by the year 2015 during the UN Millennium Summit in September 2000 is poverty reduction in its entire dimensions such as disease and illiteracy. Response to HIV is core to critical achievements of the eight MDG (Hecht *et al.*, 2006). This is because HIV and AIDS can impede the achievements of the other MDGs since HIV derails social and economic development by heightening household poverty (UNAIDS, 2008). Effective response to HIV and AIDS epidemic may enhance the achievements of the eight MDGs (UNAIDS, 2008).

Since the WHO recommendation for male circumcision in HIV prevention, most of the 14 priority Sub-Saharan African countries, targeted by WHO and UNAIDS, have started clinical programmes on male circumcision. More than 1.3 million VMMC had been carried out for HIV prevention by 2011 (WHO, 2012). By 2011, Kenya had achieved 61.5 per cent VMMC coverage and was therefore close to its target of circumcising 80 per cent of the men by 2015. Other countries were reported to be lagging far behind their target (Dickson *et al.*, 2011). Nyanza Province of Kenya recorded the lowest level of male circumcision at 46 per cent in 2008 and was therefore the main target of the VMMC in Kenya (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010; NASCOP, 2008).

The WHO policy and recommendation have been contested by many scholars as the evidence on which they are based on, are considered biased, inconclusive and unreliable (Green *et al.*, 2010; Siegfried *et al.*, 2005; Weiss *et al.*, 2000). The policy and the recommendation are also argued not to account for the cultural meanings of male circumcision among the circumcising groups (Ahlberg *et al.*, 1997; Denniston & Hill, 2007; Hill, 2007). The WHO and UNAIDS policy seems to have created the notion among many that with male circumcision, one cannot get infected with HIV. Thirty per cent of circumcised men from South Africa believed they could have sex with many partners without contracting HIV while 18 per cent of uncircumcised men believed the same (Deacon, 2008). This is referred to as risk compensation and is discussed further in chapter 4 section 4.3.1, chapter 9 section 9.3.4 and chapter section 10.4.1 Men from Swaziland were also reported to have interpreted male circumcision as an AIDS vaccine and a replacement for condoms (IRIN, 2008).

The WHO recommendation is based on the assumption that circumcision groups are expected to have lower rates of HIV. However, reports from Central Kenya have indicated that compared to other provinces in Kenya, Central province the home of a universally circumcising Kikuyu people recorded the highest rate of increase in HIV infection rising from 3.7 to 4.7 per cent during a period of five years (Kariuki, 2010). The increase in HIV infection could be contributed to the cultural practices by the young men in Central Kenya during male circumcision, which may counter the protective benefits of male circumcision in HIV prevention. However, the latest HIV estimates from the Kenya AIDS Indicator Survey (KAIS) show that Central province is not among the counties with the highest HIV prevalence. Nevertheless, most of the counties with circumcising groups in Kenya are part of those with high HIV incidence rates (NASCOP, 2014).

The preliminary results from the RCTs on which WHO's policy is based on, showed that having penetrative sex prior to the complete healing of the wound raises the risk of HIV infection (Wawer *et al.*, 2009), a practice observed among initiates in Central Kenya (Ahlberg *et al.*, 1998). A study by Kamau (2007) on male

circumcision among the Kikuyu young men in Kenya indicated that initiates were having sex before the complete healing of the wound and without condoms. This practice by the young men is in contrast to the male circumcision practices that existed with the traditional male circumcision among the Kikuyu people (Ahlberg *et al.*, 1998; Wambugu *et al.*, 2006; Kenyatta, 1998) and shows some of the changes that have taken place in the Kikuyu male circumcision ritual.

1.4. Why men?

This study provides a platform to engage in the world of men as well as to address issues around young men's sexual health. Most gender health intervention programmes tend to be focused on women, whilst men receive little attention (Doyal, 2001; Varanka, 2008; Barker & Ricardo, 2005). Barker *et al.* (2010) assert that most health programmes view men as oppressors, self-centred, disinterested, and violent instead of viewing them as individuals whose behaviours are under the influence of gender and social norms. There is evidence, however, that men also face health disparities (Lipsky *et al.*, 2014). For instance, premature deaths in developing countries are more likely to occur to men than women, and many of these deaths are related to avoidable risk factors (Lipsky *et al.*, 2014). Global evidence shows that men and boys are in worse health than women (Baker *et al.*, 2014). A systematic analysis for The Global Burden of Disease Study 2010 showed that women have a longer higher life expectancy than men (Wang *et al.*, 2013). Similarly, the global life expectancy for men was 68.1 years for men and 72.7 years for women in 2012 (WHO, 2014). Even in low-income countries, the increase in life expectancy from 1990-2012 was higher for women than men by 2.9 years in 2012 (WHO, 2014). In addition, between 1992 and 2012, mortality rates for women in less developed and least developed countries dropped faster for the women than for men (Jamison *et al.*, 2013). Although men have more privileges, opportunities and power than women in society this is not reflected in their health outcomes (Barker *et al.*, 2014).

It has been speculated that men's poorer health outcomes could be explained by men's occupational risks such as exposure to harmful chemicals, risk taking norms associated with men, and health behaviour associated with masculinities (Barker *et al.*, 2014). Some forms of masculinity exacerbate men's likelihood of HIV infection (Skovdal *et al.*, 2011). Subscription to masculinities was suggested to keep men from accessing antiretroviral drug (ARV), disregard doctors' instructions and interrupt the ARVs and the follow-up, unlike the women (Cornell *et al.*, 2011).

Violence is another marker of men's subscription to masculinities, which is an issue of relevance in UNICEF's latest global initiative to end violence to children (see appendix 1). However, women's access to health services may be more associated with their reproductive health in their reproductive health years (Hawkes & Buse, 2013).

According to Hawkes & Buse (2013), health policies and programmes by global health institutions have failed to address gender disparities. They suggest that policy makers assume that gendered approaches are exclusively meant for women rather than for both sexes, which is also reflected in most state governments. Most health professionals have assumptions that men are not interested in their health, which can, in turn, discourage men from using the health services (McKinlay *et al.*, 2010). However, it is possible for men to successfully change from unhealthy to healthy behaviour, which in turn can have an impact on women's health. For instance, a report on engaging men and boys in gender based inequity showed that a third of 58 programmes were successful in encouraging men to end violence on women (Barker *et al.*, 2010). Since male behaviour is one of the major drivers of HIV and AIDS among women (Doyal & Papparini, 2009; Leese *et al.*, 2010) a study on male circumcision will contribute to the health of the women as well.

1.5. Study area and participants

Central province is the ancestral home of the Kikuyu people, the largest group in Kenya. The study area was chosen because it is the only place in Kenya where most cultural practices of the Kikuyu are still maintained, including the male circumcision practices. More details on the study area are given in the next chapter on “Contextualisation of the research”.

The majority of the Kikuyu boys are circumcised between the ages of 10 - 24 years, during November/December school holidays or when the boys complete their primary education (standard 8). This age range matches the WHO’s definition of ‘young people’. Currently, 40 per cent of all new HIV infections are recorded (UNAIDS/AIDs Lawproject, 2008) in this age group. Although the WHO defines young people as those between 10-24 years of age (UNAIDS, 2013), for the Kikuyu people you cannot be referred to a man or a young man until you are circumcised regardless of age. In addition, although under the Kenyan law anyone below the age of 18 is a child, (Kameri-Mbote, 2000) Kikuyu boys are referred to as adults after circumcision. The adulthood status comes with more responsibilities (Herzog, 1973) despite most of the initiates being at their adolescence stage, aged between 10-19 years. This is a period when new health behaviours are formed which impact on individuals’ health throughout their lives (WHO, 2014a). Most adolescents are in the process of discovering and exploring sexuality.

Epidemiological studies have shown that adolescents are the most vulnerable to HIV and AIDS and other sexually transmitted infections (UNAIDS/AIDS Law project, 2008). About 2 million adolescents are living with HIV but it is likely that these figures are rising (WHO, 2014a). Provision of male circumcision for HIV prevention may open opportunities for counselling and provision of information on sexual and reproductive health of the adolescence young men. However, male circumcision for HIV prevention only targets the non-circumcising communities, which may exclude circumcising communities such as the Kikuyu people from accessing HIV counselling services prior to circumcision. It is therefore, critical to explore male circumcision among the circumcising groups such as the Kikuyu people which is the purpose of this thesis.

The aim, objectives and research questions of the study

The aim of the study was to explore the meaning of the male circumcision ritual, the changes taking place in male circumcision in Central Kenya and the implications for public health practices.

Objectives and research questions

The objectives of the research were:

1. To explore and describe young men's actual experiences during and after circumcision;
2. To understand the male circumcision ritual and practices by the Kikuyu young men in Central Kenya;
3. To explore the role of the male circumcision mentors in the male circumcision ritual in Central Kenya.

The research questions were:

1. What are the experiences of the young men during the male circumcision ritual?
2. What is the role of the male circumcision mentors in socialisation of the newly circumcised?
3. What is the impact of male circumcision practices on HIV prevention?

1.6. Thesis Outline

The structure of the whole thesis is outlined below in chapters as illustrated in figure 1.1.

Chapter one introduces the study with the background, rationale and justification of the study. The objectives and research questions are also outlined in this chapter and it ends with an outline of the thesis giving a brief summary of each of each chapter.

Chapter two gives the context of the research and introduces the research area, practices and customs related to initiation and circumcision among the Kikuyu

people in Muranga district where the research took place. The chapter describes past circumcision practices and highlights some of the changes today.

Chapter three discusses theoretical frameworks and models of health behaviour, masculinities, gender and feminism. Social Ecological Model (SEM) is used to highlight the contextual factors that might shape young people's behaviours.

Chapter four discusses public health approaches in HIV prevention while emphasising male circumcision as the latest strategy added to the HIV prevention package. This chapter also highlights the challenges of implementing male circumcision for HIV prevention.

Chapter five provides a justification of the underpinning philosophy of qualitative research design and ethnographic methodology. The chapter describes and discusses methods of data collection, sampling strategy and data analysis. The chapter concludes with a discussion on reliability, representativeness and transferability of the research.

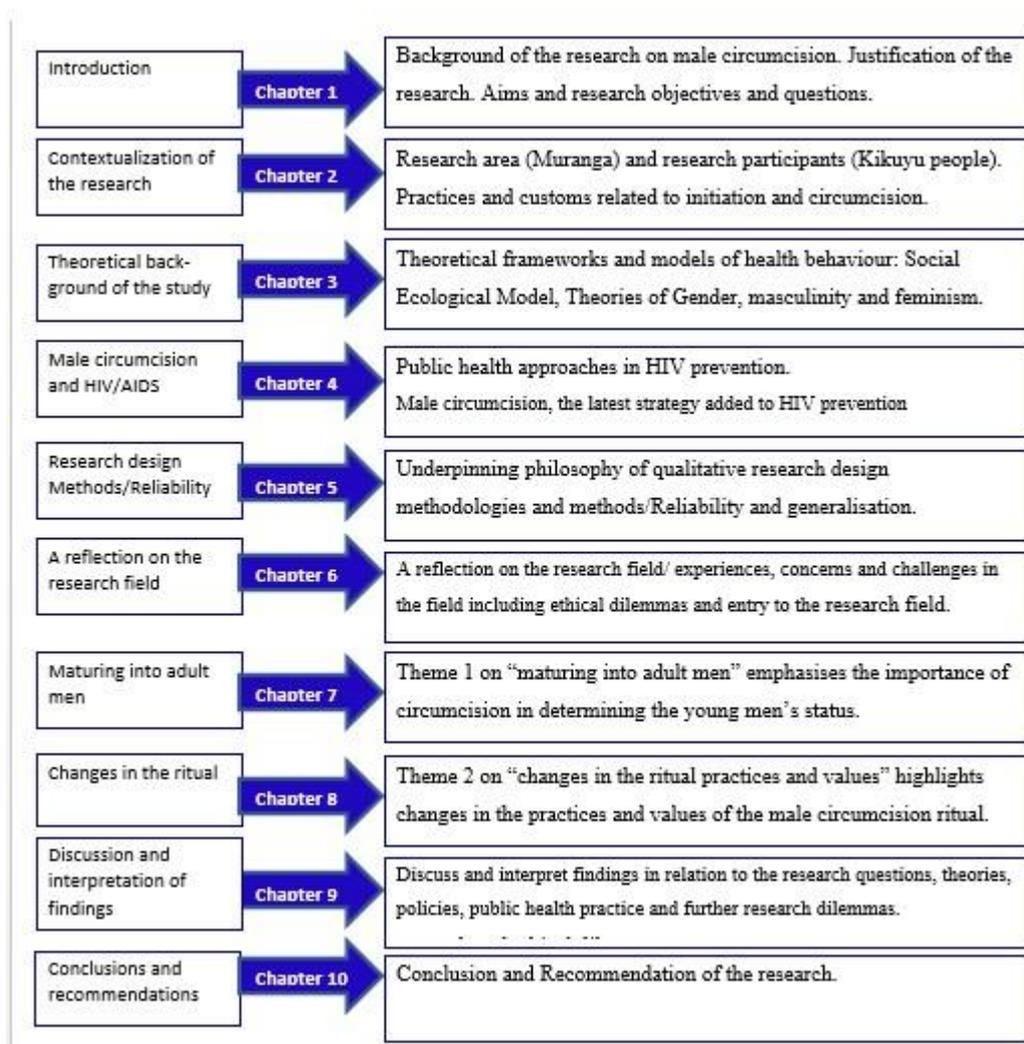
Chapter six describes the challenges experienced in the research field and how they were addressed while taking into account the ethical implications of the research. The chapter describes the reflective and iterative process used in data collection and in the research field.

Chapter seven presents the first theme of the findings, which emphasizes the importance of circumcision in determining the young men's status. The subthemes highlight that becoming a man is not a choice but a compulsory practice, acquiring a new identity, endurance of pain, advice and instructions in the new status, power dynamics at play during circumcision and protection and protective networks. Chapter eight presents the second theme of the findings which highlights changes in the practices and values of the male circumcision ritual. It also portrays the church and hospital as the tools of change and urbanisation as the driver of change.

Chapter nine discusses the main findings in relation to the literature and theories while highlighting implications for public health policy and practice.

Chapter ten provides the conclusions and recommendations of the research. This also includes the implications of the research on health practice, policies and research.

Figure 1.1. Thesis outline



1.7. Conclusions

The chapter has introduced the topic of the thesis which includes the history of male circumcision, and justifications of the study. The chapter included an outline of the objectives and research questions guiding the study. The thesis outline has also been included to give an overall picture of the thesis. The context of the research is presented in the next chapter which describes the research area, practices and customs of the community in which the study took place.

Contextualising the Research

2.1. Chapter Introduction

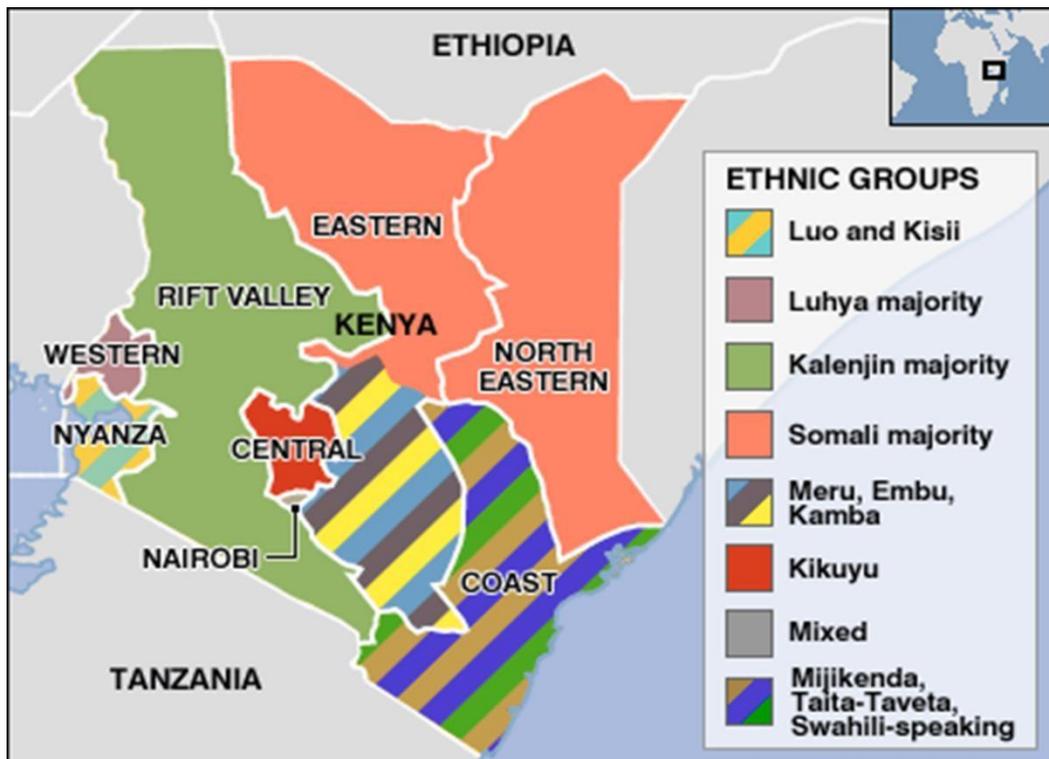
The previous chapter introduced and discussed the background, rationale and the significance of the study. The chapter also outlined the purpose, objective and research questions of the study. This chapter describes the research area, practices and customs of the community in which the research took place especially those related to initiation and circumcision. The chapter describes past practices while at the same time highlighting issues that have changed. The main focus is on the Kikuyu people in Muranga, Kenya. It is written with very few references to literature owing to a dearth of written information on Kenya. A search for information on Kenya and the Kikuyu people and male circumcision among the Kikuyu people suggests that academic literature is limited and most information is found on websites such as Wikipedia or tourist sites. I have drawn on prior knowledge gained in the research field, as an ethnographer and also as a member of the Kikuyu community and the limited literature on Kenya and circumcision as a rite of passage among the Kikuyu people of Kenya.

2.2. Kenya

Kenya is located in East Africa in sub-Saharan Africa. Kenya lies along the equator. It is situated along the Indian Ocean and has a coastline of about 1000km on the ocean. It neighbours Ethiopia to the north, Somalia to the north-east, Sudan to the northwest, Uganda to the west, and Tanzania to the south. Kenya has a wide range of climatic conditions due to the variance in altitude. For instance, the highest mountain in Kenya and the second largest in Africa, Mount Kenya has a permanent snow-cap and the semi-arid region in the West and North, the Highlands and the Great Rift Valley all represent varying climatic conditions in Kenya. Kenya is a multilingual country with approximately 69 different languages, with Kiswahili and English being the main languages. Kenya is reported as the one of the 15 most populous countries in the world (Ringheim & Gribble, 2010). About 20 per cent of

the population of the Kenya live in urban areas (Population Reference Bureau and African Population & Health Research Centre, 2008). Kiswahili, which is also referred to as Swahili, is the national language that links Kenyan communities together while English is the official working language. Various ethnic groups in Kenya typically speak their mother tongue within their communities and with community members. The rural dwellers use the mother tongue more often and Kiswahili and English less frequently. English is commonly used in schools, commerce and government. Most members of different communities are concentrated together in different regions of the country and are linked to the region where they are a majority. The following map Figure 2.1 shows the different regions and the majority of the groups inhabiting the regions. One of the regions is Central province, the home to the Kikuyu people. The Kikuyu people are also referred to as the “*Agikuyu*” people. The expressions can be used interchangeably although the “*Kikuyu*” is more modern and used when speaking English but when speaking in the mother tongue, the word “*Agikuyu*” is more appropriate.

Figure 2.1. Map on the provinces and people of Kenya (28 too many, 2013)



2.2.1. Muranga

The study site was in Muranga district, in the Central province of Kenya. Kenya is divided into eight provinces and Central province is the ancestral home of the Kikuyu people. Recently, there have been changes in the way different regions are subdivided with different districts merged together to form counties. Muranga district is now merged with other districts to form Muranga County. The county is divided into four parts: Muranga North, Muranga South, Muranga East and Muranga West. A county is subdivided into sub counties which are further subdivided into villages or locations, which are also known as *“ituura”* in Kikuyu. *“Ituura”* is the smallest unit of administrative boundaries in Kenya. Muranga district is densely populated and male circumcision is universal among its inhabitants, the Kikuyu people.

2.2.2. The Kikuyu people

The inhabitants of Central province are referred to as the *“Kikuyu”* or *“Gikuyu”* people. According to Kenyatta (1938), the European way of spelling *“Gikuyu”* as *“Kikuyu”* is incorrect, and the correct phonetics would be *“Gekoyo”*, which refers to the Kikuyus’ homeland and not a person. A person from *“Gikuyu”*, the homeland, is *“Mu-Gikuyu”* (singular) and *“Agikuyu”* (plural). In this thesis, the word *“Kikuyu”* will be used throughout as this is the most commonly used expression in the literature. Kikuyu, therefore, refers to the people themselves and also to the language, a Bantu language. Most of the Kikuyu words have no English equivalent making it difficult to translate into English. In addition, some archaic words are still in use that only a few *“Kikuyus”* are able to interpret today. The Kikuyu people were and still are, mainly agriculturalists. Their cultures and traditions have been handed down verbally through generations in the form of vivid stories. Competitions were organised for different age groups among the young people to test their knowledge. This was one of the methods of educating the young people and was done in the form of songs and stories where parents acted as the audience and judges, correcting the groups competing and announcing the winner (Kenyatta, 1938).

However, today teaching is carried out through formal schooling. The church has recently become a platform for teaching cultural practices of the Kikuyu people during male circumcision.

2.3. Rites of passage in Kenya

Sobania's (2003) description of the rites of passage among the Kikuyu people of Kenya informs the greatest part of this section. However, he describes rites of passage for both men and women because at that particular time, female circumcision was still widely practiced openly. Male rites of passage tended to be more public, unlike rituals that marked the transition of girls to women which were colourful but less dramatic. The rites of passage were referred by the same name, took place at the same time in the village although the girls and boys were physically separated (Keck & Sikkink, 1998). The changes in names of the practices reflect the debates on the meaning of the rites of passage. For instance, female circumcision was called cliteridectomy and later Female Genital Mutilation (FGM) in reference to violence against women. Although Sobania (2003) acknowledged the importance of representing the culture as dynamic and changed, he wrote using the present continuous tense to represent the rites of practice in the Kenyan communities without necessarily specifying details of practices in each community. According to Murchison (2010), this can imply constancy and ongoing behaviours and practices. In this section, past tense will be used in order to take into consideration the historical nature of practices and their potential to change whilst pointing out notable changes.

Use of rituals, symbolic acts and ceremonies as important markers of particular critical life events are common features among most communities in Kenya. Birth, initiation, marriage and death are corporately referred to as rites of passage. Initiation rites mark the transition of a person from childhood to adulthood. Social age was more important than biological age since passing the necessary rituals accorded the individual a social status. For instance, the Kikuyu people counted their age after circumcision, while uninitiated members of the Kikuyu society were

socially regarded as children. A Kikuyu¹ was highly esteemed following the change in status from childhood to adulthood, or from being a girl to being eligible for marriage or from being a warrior to becoming an elder.

Initiations were strategically used for learning and transfer of knowledge and skills. Stories were used as shared learning experience among the initiates, for entertainment and at the end of the story, a commentary was provided to demonstrate the desirable and undesirable human behaviours such as greed and kindness. During the initiation period, initiates were secluded and stayed away from the community. Initiates were reintegrated into the society after the seclusion period, and this was surrounded by elaborate celebrations. This was also a time when they could demonstrate publicly what they had learnt. Apart from learning, the seclusion period served as time to allow for any physical changes, body decoration and healing. A Kikuyu's new and different social status after going through the rite of passage was described in terms of symbolic death and rebirth.

Every rite of passage has a three-stage structure as mentioned in chapter one. The first stage is the symbolic death as the person separates from the previous status and the final parts connotes a rebirth and reintegration into the community while assuming a new status. The period between the old or previous status and the new status is called 'liminality (van Gennep, 1960). The liminal stage is marked by a period of seclusion (Turner, 1967). The seclusion period, also called the preliminary period, separates the person symbolically from the old life. The separation stage, also known as preliminal, involves a complete detachment from the past social status while the liminal stage or transition stage is the stage inbetween the old and new status and symbolically leaves an individual without a clearly defined status and, therefore, an outsider. However, at this stage, the person is in preparation to take up the new role. The final stage, also known as post liminal, involves reintegration to the society and allows the person to take on a new role. These stages are significant to rites of passage that involve transitions from adolescence to adulthood such as male circumcision.

¹ The term Kikuyu mostly refers to a person, either male or female. For instance a "*British*" refers to either a man or a woman. Where the term refers to the whole community then the term Kikuyu people is used.

In the past, after initiation, young girls got married while the young men entered into a warriorhood phase, which prepared them for elderhood. Warriors were subject to elders and mostly stayed in camps away from the community. The warriorhood phase enabled the development of comradeship and group cohesion (Sobania, 2003). The warriors took care of the animals. The elderhood stage came with new responsibilities such as running family affairs since marriage was part of the ritual that marked the change of status. The elders ran the affairs of the community and were known for being cautious, private and exercising judgement wisely.

The passage from childhood to warriorhood and adulthood, in most societies, is/was constructed through an age-set system. "An age-set is a social institution that groups together males who, after being initiated together, take a unique name to identify themselves" (Sobania, 2003 p.162). Sobania (2003) compares an ageset to an alumni who carry a similar name after they graduate. The men carry these names forever and refer to each other as 'age mates' (*wakini*) if they share the same age-set regardless of their age. Historical events, history and legends of the people were remembered and recorded this way. For instance, if there was a severe famine at the time of the initiation, that age-set was known as "*ngaragu*", that is, famine (Kenyatta, 1938).

According to Kenyatta (1938), the Kikuyu people recorded the time when a certain disease such as syphilis was introduced by the Europeans by naming the initiation group after the disease. Age mates passed through various stages of life throughout warriorhood and adulthood together. Each of these stages is referred to as an age grade, with the age system comparing to climbing a ladder from lower grade to higher grade with each grade conferring the men a new status with expected rules of behaviour, privileges, and responsibilities (Sobania, 2003).

Different communities in Kenya have different rituals and practices in the rite of passage. Circumcision is a common feature of initiation associated with puberty and transforms a boy or girl to an active participant in adult life. The most common month of circumcision is currently in December, a timing which is symbolic as it marks the end of the primary school year and the beginning of the high school year. From personal communications that I had during the field work, circumcision used to take

place in April and in August. Although it was not made clear when circumcision in April and August ended, some of the mentors interviewed were circumcised in August, the oldest being 43 years old. However, the school holidays in April and August are three weeks long and, therefore, considered too short compared to the December holiday which allows ample time (five to six weeks) for seclusion, the healing of the wound and instructions. This period also marks the end of primary school and the commencement of tertiary education, mostly in secondary school at the beginning of the New Year. The secondary school also referred to as high school compares to high school in the United Kingdom. Teachers were also against boys circumcising before completion of school because once the boys become men they became difficult to discipline (Ahlberg *et al.*, 1997). Circumcision confers adulthood on an individual, but it is through marriage and giving birth that the individual proves manhood and womanhood and establishes a kinship network (Sobania, 2003).

Some Kenyan communities such as the Kisii, Maasai, Somalia, Meru and Pokot practiced the rite of passage of girls to women and some still practice today which includes the FGM ceremony (Sobania, 2003; 28 Too Many, 2013). This was also widely practiced among the Kikuyu in Kenya. An uncircumcised girl could not marry, bear children and was looked down upon in disgust (Keck & Sikkink, 1998; Kenyatta, 1938). Female circumcision has been used to refer to different operations such as cliteridectomy, incision and infibulations which are defined below. Keck & Sikkink (1998) allege that to refer to these operations as female circumcision is to equate this to male circumcision yet the two bear few similarities to each other. However, for the Kikuyu people, the male and female circumcision was similar and both conferred adulthood status on boys and girls. FGM involves partial or complete removal of external genitalia or any alteration or injury of the genital for non-medical reasons (WHO, 2011). There are different types of FGM as defined by the WHO (WHO, 2011):

- Type 1, FGM involves partial or complete removal of the clitoris or prepuce. This is also known as cliteridectomy.
- Type 2, FGM which refers to partial or total removal of clitoris and labia minora. This could include or exclude excision on the labia minora. However, there are variations in the form and degree of cutting.

- Type 3, FGM involves the cutting and drawing together of the labia minora and/or labia majora with an aim of covering the vaginal opening which includes or excludes excision of the clitoris. In most cases the cut labia are stitched together for an almost complete cover of the urethra and the vaginal opening. This is known as infibulation. The stitches are later removed for sex or child birth. In some cases reinfibulation takes place.
- Type 4, FGM entails other forms of FGM that include pricking, cauterization, piercing, incising and scraping. Pricking and nicking entail drawing out blood without alterations of tissues or alterations of the genitalia. This is also known as symbolic circumcision.

FGM is regarded as a violation of human rights (UNICEF, 2005). In Kenya, it was first criminalized under the Children Act 2001, if conducted on females below the age of 18 year old (IRINNews, 2011). However, this only drove the practice underground and explained why the FGM rates dropped. A country report on FGM in Kenya shows a decrease in FGM practice among 15-49 year olds; 37.6 per cent in 1998, 32.2 per cent in 2003 and 27.1 per cent between 2008 and 2009 (28 Too Many, (2013). 28 Too Many is a charity organisation working to end FGM in 28 African countries.

According to the report, FGM in Kenya was later banned in 2011 owing to its condemnation by many for its health risks among women. This involved criminalisation of all forms of FGM including the stigmatisation of uncircumcised women. The ban also allowed the police freedom to visit places suspected of FGM practices without a warrant of arrest (IRINNews, 2011). Legislation is not sufficient in stopping the FGM practice but is more successful when combined with an increase in awareness and community dialogue (28 Too many, 2013). Other strategies involved using leaders and respectable figures in the community to run community dialogues. Among the Maasais of Kenya, engaging the church/church leaders in communicating with the parents has prevented some of the girls from going through circumcision (28 Too Many, 2013).

The post-independence conversion of many women to Christianity, especially in the Highlands also influenced the practice of female circumcision, a practice condemned by Christians. The European missionaries called circumcision barbaric, and medically risky, while for the Kikuyu people, it was a form of cultural identity (Young, 1967). Although female circumcision was said to be common among other cultural groups of Africa, it is said that the missionaries concentrated more efforts on banning the practice among the Kikuyu people. This was probably because Kikuyus were more receptive to missionaries' teachings and had more converts than other cultural groups in Africa. In addition, the missionaries and the administrators had more influence and some supporters among the Kikuyu people than among the Maasai people. The missionaries also refused to admit circumcised girls to school and some of the church members were excommunicated for circumcising their girls (Keck & Sikkink, 1998).

Education has also played a role against FGM and acts as what Sobania (2003) refers to as a modernising agent. In addition, many people acknowledge the adverse effect of the practice on physiological and physical health, in particular, women's reproductive health (28 Too Many, 2013). Some communities still practice FGM since they believe that girls cannot get married uncircumcised while others subscribe to it as a form of religious obligation (Sobania, 2003). For some, FGM is an ethnic identity and it is viewed as the entrance to marriage and a way of getting a high bride price (GoK, 2010). For those who practice it, FGM is used to curtail women's sexual pleasure which may be culturally unacceptable before and after marriage (GoK, 2010). During circumcision, girls are taught about domestic issues, becoming a good wife and the use of sound judgement to make decisions. These days, girls are taken for FGM at a young age because when older, many of them may resist the practice because they will have been educated about the harmful effects of the practice. Among the Kikuyu, the Mungiki group has been known to enforce FGM on women as a cultural norm, disregarding the law against the practice (UNFPA/UNICEF, 2010). However, with intervention from the Government, this seems to have stopped. Some of the communities in Kenya such as Kisii, Maasai, Somali, Samburu and Kuria still practice female circumcision secretly (Howden,

2014). It is not clear whether the Kikuyu people still practice female circumcision although it is out of the scope of this study.

2.3.1. Male circumcision among the Kikuyus

Male circumcision is an important rite of passage for all societies in Kenya apart from the Luo and Turkana people (Wambugu *et al.*, 2006). Neckerbrouk, (1998) in his anthropological work on the Kikuyu's male circumcision between 1971 and 1973, defined male circumcision in two different ways. Male circumcision is referred to as "*irua*" in Kikuyu and is most probably derived from the word "*iruo*" which means pain. Firstly, circumcision refers to the preparations, ceremonies and rites including the physical operation of the genitals, in this case, the penis. Secondly, the word "*irua*" in a narrow sense refers just to the physical operation whether performed on girls or boys. In this study, the physical operation is referred to as the "cutting" as described by the participants. Different past practices are described in this session, however, there are no records available as to when these past practices started or ended.

According to Kenyatta (1938), male circumcision is a rite of passage through which manhood, adulthood and expectations of masculinity are conferred. To most societies in Kenya, male circumcision was more of a social achievement rather than a biological one, despite the physical cutting of the male penis. Theories proposed on rites of passage suggest that although initiation rites took place at puberty, the focus was not on the physical and biological changes during puberty itself but rather was directed on the social meanings (van Gennep, 1960). In contrast, Whitman (1967) asserts that rites of passage are planned around biological changes. Furthermore, most of these rites are planned around age ten, which may point to the cultural acknowledgement of adrenarche and initial sexual desires (Herdt & McClintock, 2000). Neckerbrouk (1998) describes circumcision as the most important physiological practice which determines sociological events in a man's life. The ceremony was anticipated by many but was also an ordeal to dread. The cutting was a test of courage and endurance of pain where the boy was not supposed to flinch or scream in pain (Kenyatta, 1938; Leakey, 1977) as it was a sign of weakness and proof of lack of manliness among his age mates.

The uncircumcised adult was seen as a non-being that had no social value, was looked down upon, was a laughing stock, a foreigner, and could not marry. There was a belief that he could not have children (Wambugu *et al.*, 2006). Such a person was seen as a mere child and treated as one, or abnormal and was insulted as “*kihii*” (boy). The uncircumcised approached the circumcised cautiously, silently and respectfully, otherwise, this would have been considered impolite and he could have faced punishment. Male circumcision was a precondition to access women, which could lead to a line of descendants, ownership of livestock and land, and which according to Neckerbrouk (1998) constituted the very source of life. Even the most Westernised and most educated Kikuyus did not neglect this ritual and ensured that their sons participated in the ritual. For instance, a study by Mbiti & Malia (2009), indicates that the Kikuyu men living in the United States of America (USA) still circumcise their sons to ensure continuity of their culture. Nevertheless, apart from the cutting, some of the rituals and practices associated with male circumcision are not possible in the USA.

Preparations for the male circumcision ritual in the past were essential as any neglect of it would attract the evil influence of the spirits. As the circumcision period approached, the fathers presented the sons as candidates. A boy was required to go through the re-birth stage, prior to circumcision (Wambugu *et al.*, 2006). This was the responsibility of the parents, which entailed killing a goat, sprinkling the blood and eating the meat. According to Wambugu *et al.* (2006), the boys and girls had to qualify for circumcision. Age-wise, the boys had to be between 15 to 18 years of age and girls had to be between 12 to 14 years of age. It was important that they had not passed their puberty. Menstruation for an uncircumcised girl was looked upon as impurity and had to be cleansed by going through circumcision. Rites of passage among most Kenyan communities today, take place during adolescence. However, adolescence as traditionally defined differs from present definitions. Currently, puberty marks the beginning of adolescence but in the past when a girl started menstruating she was considered ready for marriage (Omungala, 1989). Rites of passage marked the end rather than the entry of adolescence as is the practice today (Ginsberg *et al.*, 2014).

In the past, boys could get circumcised earlier if their fathers were rich. However, they had to get permission from their uncles (from the mother's side) and give them a goat, "*mburi ya manyarume*" (goat for the uncles). Prior to circumcision, the boys went on a rampage engaging in haphazard behaviour especially in the homes of women who were known to be mean. At this stage, boys were referred to as "*nguru*" (Wambugu *et al.*, 2006, pg 87). The "*Nguru*" refers to circumcision candidates. Different kinds of songs and dances were used during different stages of the circumcision ritual. The onset of the ceremony was marked by celebrations consisting of songs and dances such as "*Matuumo*" and "*Mumburo*". The "*Matuumo*" was sung some days preceding the eve of the circumcision. The "*Mararanja*" was sung throughout the night before the circumcision day while "*Mumburo*" was sung a day before dawn prior to the ceremony. The songs and dances allowed the use of, what may be considered indecent language by many, but was meant to educate the initiates about sexuality (Middleton & Kershaw, 1965). Such language was forbidden except during such rituals. According to Cavicchi (1977), the songs accustomed the initiates to the rules and regulations of the boys' and girls' relationship. "*Ngurus*" went in groups and wore decorated crowns. They would go to women who were mean when they were cooking and would hit the trellis for soot to fall on the food if she denied them food, as a form of punishment. Most women were not willing to go through this kind of embarrassment and therefore willingly gave the "*nguru*" food (Wambugu *et al.*, 2006). Some crowns were more expensive than others depending on the parents' wealth (Wambugu *et al.*, 2006). Girls also went to parties adorned with ornaments and blew whistles as they danced on the road and outside houses.

In the last few days before circumcision, boys and girls were instructed by a wise man assisted by his wife. Kikuyus' internal affairs were governed by a generation of elders who decided on the time for circumcision and planned and organised the male circumcision ritual (Wambugu *et al.*, 2006). They were to teach boys and girls good conduct and behaviour as circumcised people and about maintaining respectability of their sex in sexual matters. A circumcision fee consisting of hydromel, local beer, millet porridge and a fat goat was paid by the father of the boy (Wambugu *et al.*, 2006). After circumcision, the initiates were taught during an eight-

day seclusion period by persons who had knowledge of community values and norms about sexuality, marriage, social and family life (Worthman & Whiting, 1987). The circumcision ritual not only graduated Kikuyu boys into manhood and warriorhood in the community's junior age-grade but also gave them the potential for respected elderhood (Worthman & Whiting, 1987; Kenyatta, 1938; Leakey, 1977). After circumcision, the boy was referred to as a 'man' and could hold cordial conversations with his father while his mother would not scold or order him about as she did with the boys (Mbiti & Malia, 2009). Respect was emphasised and initiates accorded respect to each other and the older people in the community.

Despite the freedom to have relationships with girls after circumcision, the initiates were careful since sex before marriage was not allowed. A collective exercise called "*ngwiko*" (a type of controlled sexual play which allowed new initiates both boys and girls to sleep together, to explore and enjoy each other without penetration) was used to instil sexual discipline among boys and girls (Ahlberg *et al.*, 1997). The Kikuyu people would not kiss on the lips and therefore "*ngwiko*" took the place of lip kissing (Kenyatta, 1938). Kenyatta adds that the public display of affection, where kissing is done in public is seen as vulgar in the Kikuyu community. The initiated girls would visit their boyfriends in a special hut, "*thingira*", which is known today as "*Kiumbu*". They brought their favourite foods and drinks as a token of affection which was shared among the age group who ate it collectively in the "*thingira*". No boy would eat what had been brought by the girlfriend by himself. In this way, boys who had no girlfriends were included.

During eating one of the boys would bring up the issue of "*ngwiko*". If there were more boys than girls the girls were asked to choose partners; this was referred to in Kikuyu as "*kuoha nyeki*", "*to tie the grass.*" The girls did not have to choose their intimate friends as this would be viewed as selfish or unsociable although sometimes they would have "*ngwiko*" with their closest friend but they followed the rules of exchanging partners. Both girls and boy would go to bed together and the boys removed all their clothes while the girls removed only the upper clothes and remained with their leather skirt and soft leather apron "*mwengo*". The two V shaped parts of her leather skirts "*mothuru*" were pulled forward and attached to the waist

tightly as a form of protection for her private parts. They would lie together facing each other with their legs interwoven but not moving their hips. They would then fondle and rub their breasts against each other, as they had love conversation until they fell asleep. It was the warmth of the breast that they were supposed to enjoy and not the full sexual intercourse. The tribal laws prohibited a man from pulling a woman's "*mothuru*." The man had to put his sexual organ between his thighs to avoid touching the girl with it.

The girls were forbidden from touching a man's sexual organ. However, in a longstanding relationship, the girl could allow him to put his penis on her thighs without penetration. Full sexual intercourse was prohibited and punished (Kenyatta, 1938). If a man tried to open the "*mwengo*" in the night, the girl would report it to her friends and he was taken to the age group meeting "*gitongano kia rika*" who ostracised him and would bar him from having "*ngwiko*" with others since they had lost trust in him. "Ngwiko" was a check and a test of moral values put in place by the Kikuyu people. Moreover, peer pressure, taboos and the fear that violation of these rules would lead to the disintegration of harmony and social balance, culminating in diseases and catastrophes regulated the young people's behaviour. Fuller sexual intercourse resulted in social stigma of the couple. The girls were ostracised or got a heavy punishment and would be forced to prepare a feast for all girls and boys of her age groups if they became pregnant outside marriage.

The man was also punished by the tribal council and sent on "*kuhingwo*" referred to as "Coventry" by all the girls and young men in his age group. She was also ridiculed and sent on "*kuhingwo*." It is not clear why he was sent to Coventry which is a place of celibacy which could imply that when one was sent to "*kuhingwo*" [restricted]. They were not allowed to participate in *ngwiko* which was a form of sexual play that is forbidden to celibates. Such socially regulated moral and sexual discipline no longer exists and new practices have emerged. The traditional male circumcision ritual changed when "*ngwiko*" was abandoned at the onset of Christianity as the missionaries considered it to be against Christian values. Subsequently, many boys started getting circumcised individually and in hospitals (Worthman & Whiting, 1987). More changes have taken place in recent years, partly because of education,

urbanisation (Mbito & Malia, 2009) and commercialisation of the ritual where male circumcision is conducted in special schools of circumcision for a fee (Kepe, 2010). At the time Neckerbrouk (1998), wrote about circumcision, the Kikuyus no longer had long ceremonies and rites over several days as had previously been the case. Most of the traditional forms of the circumcision rite had practically disappeared and circumcision had become medicalised and took place in hospitals. He noted that circumcision was reduced to the removal of a foreskin. The songs that accompanied different ceremonies had lost meaning and function, although they had survived in some form, such that family members, friends and neighbours danced to some of the music they had preserved on tapes.

Neckerbrouk (1998) also noted that the cultural practices in the male circumcision ritual were non-homogenous from one region to another. He suggested that this could have been as a result of the influence of the Maasai male circumcision practices. Kikuyus are said to have Maasai blood in them which led to two types of male circumcision rituals among the Kikuyu people, one representing the Maasai and another one the Agikuyu people. Culturally the Kikuyu ethnic group is divided into two moieties, the Kikuyus and Kikuyu "*Ukabi*"². The two groups have been subjected to the cultural influence of the Maasai but this has been to a greater magnitude over the "*Kikuyu Ukabi*" (Neckerbrouk, 1998) mostly through trade and intermarriages (Lawren, 1968). Kikuyus, for instance, emulated the Maasai people by drinking some milk before going to war (Lawren, 1968).

2.3.2. Current Male Circumcision practice among the Kikuyu

The Kikuyu male circumcision rite has undergone great and rapid changes as a result of modernisation (Worthman & Whiting, 1987). Social and cultural changes produced by Western religious education and media have influenced the Kikuyu male circumcision practices. The public face of the ritual, such as dances, no longer exists. Currently, circumcision represents a ritual that is a mixture of old and new texts, symbols and performances. Male circumcision is no longer a community's

² *Ukabi* is the term used by the Kikuyu people to refer to the Maasai people.

function but rather a private one. Currently, male circumcision takes place in two main places; the home and the church. This depends on where the “cutting” or recuperation or both take place. Most of this information was derived from personal conversations in the research field prior to the PhD programme³.

Circumcision at home

A boy is referred to as having been circumcised at home if he goes to the hospital for the “cutting” and returns to recuperate at home. In discussions with participants in previous field research, it is clear that no “cutting” takes place at home today, but that every boy is taken to hospital for the operation. A mentor accompanies the boy to the hospital for the cutting and takes care of him at home until he is healed. A mentor is compared to the wise man mentioned in section 2.3.1. However, previously the wise man was married since the wife also accompanied him in giving advice. Marriage is not a prerequisite for mentorship today, which reflects some changes that have taken place in the male circumcision ritual.

Circumcision in the church

When the church is involved, it is the church which independently organises the whole circumcision process including taking the boys to the hospital. Usually, a committee nominated by the church members and church leaders, plan and organise the circumcision in the church. Circumcision in church entails “cutting” of the boys in a make-shift hospital, in the church premises or in hospital and recuperation takes place in the church. Some of the churches take the boys to a hospital for the “cutting” but the recuperation takes place in the church. In cases where the cutting takes place in the church, the church hires a doctor. Although not explicitly explained, the doctor may be from a private hospital since they may have the freedom to work outside the hospital. In one of the churches I visited in my previous field research, one of the organisers of circumcision was a doctor

³ I conducted field research on male circumcision in different locations in Muranga in 2009 and 2010 during the circumcision season in December.

experienced in male circumcision operations and, therefore, carried out the procedure in the church.

The initiates circumcised in the church have no mentors but they have caretakers (young men) who clean up after them, take care of their practical needs and report their concerns to the church official in charge. However, initiates can have individual mentors at home to guide and support them prior to and after circumcision in the church. Most churches conduct follow-up meetings during the school holiday where they discuss and address challenges met by the initiates. Initiates circumcised at the same time in the church are given a group name (ageset) which denotes a special event taking place in the country or community in that particular year or season of circumcision just as it was practiced in the past. For instance, in 2009, one of the churches gave the initiates an age-set name “*Katiba*”, a Kiswahili word which means constitution. “*Katiba*” denoted the constitutional reforms and debates that dominated the country that year and throughout the season of circumcision. A new constitution was ratified in Kenya in 2010.

There are no set standards for the churches to follow during the male circumcision ritual. For instance, all churches charge a circumcision fee to every initiate but the amount charged differs from church to church. This is dependent on activities and training (counselling classes) organised in this programme. While some churches pay the teachers and counsellors, others get teachers who can speak without a payment. The subjects taught in each church vary; however, sexuality and HIV and AIDS subjects are covered in all the churches. Some churches have detailed organised programmes that demand a higher budget than other churches. Each church organises a graduation ceremony at the end of the programme which is symbolic of a ‘road license ceremony’ explained in chapter seven, section 7.2.5. Not all churches take young women for the initiation programme. Although the young women do not get circumcised, they are taught together with the initiates and receive a certificate at the end of the programme.

2.3.3. Faith Based Organisations and churches

Faith Based Organisations (FBOs) and churches have played a significant role in running male circumcision programmes in Kenya (CMMB, 2007). The churches and FBOs in Kenya run male circumcision programmes which are similar in nature. A Faith Based Organisation (FBO) is “any organisation guided and inspired in its activities by faith principles or from a particular school of thought within the faith” (Clarke & Jennings, 2008). Some FBOs are comparable with Non Governmental Organisations (NGOs), grass root organisations or movements.

FBOs have at least one of the following: a mission statement clearly reflecting religious values, a structure that allows a board of directors to be selected based on Christian values and financial support from religious sources (Ferris, 2005). A church, on the other hand, is synonymous with a denomination and gathers people together as a congregation to accomplish their purpose (Louthian & Miller, 1994). The FBOs are trusted and respected by most people in the community and have the infrastructure, capacity and network that can be utilised to provide circumcision services (CMMB, 2007). Most of the FBOs have hospitals, churches, schools and leadership. Only churches were part of this study since I did not identify any FBOs that were running male circumcision programmes in Muranga. On realising that the circumcision at home lacks complementary teachings, the churches and FBOs started running male circumcision programmes where they organise teaching prior and after circumcision (Ginsberg *et al.*, 2014). Most of the churches in Muranga, run the teaching a week after the cutting. The boys enrol in a three to five-week programme depending on the churches’ arrangements. The boys range between 12-18 years of age.

The financial charges by the churches are deemed to be significant by most community members. The money is used to buy food, for hospital fees, to pay the teachers and counsellors and accommodation. In some instances, bursaries are given to boys who cannot afford the circumcision fee. The teachers and counsellors are paid to run teaching and counselling sessions with the initiates during the recuperation period in the church. The teaching sessions cover topics such as morality, life skills, HIV and AIDS and culture and development by different

speakers. On the last day, which is the graduation day, initiates are assigned a name of their age group, and they are also presented with a certificate outlining skills and subjects taught during that period. This is a day of celebration where they return home with their parents. In some of the churches, girls attend the teaching sessions with the boys although they do not undergo the operation. On the last day, both boys and girls pledge to abstain until marriage. Involvement of the girls in the churches' circumcision programmes in Kenya is part of the community initiative. In the parental circumcision meetings I attended in 2009, many parents requested to have their daughter admitted to the churches' circumcision programmes because of the teaching and training provided for the initiates. At that time, some of the churches had admitted girls to the programme to attend a week of teachings, a week after the boys, are circumcised. Teachings begin the second week after the cutting as the initiates are halfway into the healing.

2.3.4. Common words used in the male circumcision ritual

Below are the words commonly used in the male circumcision ritual and will be used in this study.

Table 2.2. Common words used during the male circumcision ritual

<u>Kikuyu</u>	<u>English</u>
Irua	The circumcision ritual
Itiirini	The site where the cutting of the penis (foreskin) took place (by the river) in the traditional circumcision
Ituura	Location/ village
Kahii	A small boy
Kihii	A big boy
Kirui	Initiate
Kiumiri	A “ <i>kiumiri</i> ” is one who has “come out” after the seclusion period. The plural of “ <i>kiumiri</i> ” is “ <i>ciumiri</i> ”
Kugimara	To mature physically and also used to refer to circumcision
Kurua	To be circumcised
Kumira	This refers to “coming out” after the seclusion period of an initiate. Once they come out they are referred to as “ <i>ciumiri</i> ” “those who have come out”
Mugima	Mature physically or a person who is circumcised
Muruithia	Circumciser
Muthuri/ Mundurume	Man
Mutiiri	A mentor
Mwanake	Young man

2.4. Conclusions

This chapter provided an overview of the context in which the research took place. The chapter is, however, limited by lack of literature on the research area. Circumcision practices described in this chapter shows that the culture is not static and is continually evolving and changing under the subjection of various factors such as Christianity, education and urbanisation. The next chapter will describe theoretical backgrounds and theories of the study. Theories and models are used to explain how behaviours and actions are shaped.

Theoretical Background

3.1. Chapter Introduction

The previous chapter described the context in which the study was conducted. This chapter discusses theoretical frameworks for masculinities, gender and feminism and the social ecological model of health behaviour. Although there are many theories and models that can be used to explain masculinities, gender, behaviour and feminism, the ones deemed relevant for this study have been discussed in more detail. The Social Ecological Model is used to highlight the contextual factors that may shape young people's behaviours during the male circumcision ritual which takes place around adolescence stage among the Kikuyu boys. Feminism is described with emphasis on African feminism. The section on violence and masculinities addresses types of violence and the reasons why violence is attributed to men.

3.2. Theoretical frameworks and models

Theories of masculinity, feminism and gender are used in this chapter to provide an understanding of factors that shape behaviour and will also act as reference points for the research (Noar & Zimmerman, 2005). The social ecological model (SEM) will provide a visual representation of a theoretical explanation of biological, social and structural influences on health. The SEM can also act as a guide for practice research, intervention and policy development (Farmer *et al.*, 2006). Understanding socialisation of boys and men is fundamental especially because circumcision socialises the Kikuyu boys. Theories used to explain socialisation, deal with how we learn roles, gender identity and gender roles expectations (Chafetz, 1999) as explained in the next section.

3.2.1. Gender Identity and Socialisation

Socialisation assumes that children with different sexes are socialised into gender roles (Giddens, 1993) and shown how to be male and female leading to the acquisition of a gender identity (Crespi, nd). According to Kessler & Mackenna (1978), gender refers to the psychological nature of cultural behaviours and social practices associated with being male or female. Gender identity is how a person internalises being feminine or masculine or how gender becomes part of us (Ryle, 2014).

Socialisation thus can construct gender norms that are problematic in that gendered behaviour assumes women's subordination. This view asserts that women are socialised into subordinate roles and learn to be docile, passive, ignorant and emotional (Millet, 1971; Mikkola, 2012). Patriarchy is a core cultural norm in the Kikuyu culture which allows domination by men and subordination of women (Soetan, 2001). It is fuelled by socialisation through the family structure by parents and community members (Izugbara, 2004). Most gender differences are displayed in the division of labour and are seen in the socio-structural practices that are guided by distinct gender status and power (Eagly, 1987). Traditional gender conventions in most societies ascribe distinct types of positions for men as providers and women as carers (Hojgaard, 2002). Rites of passage such as male circumcision are institutions through which gender hierarchies are enhanced (Barker & Ricardo, 2005).

Sociologists emphasise the central role of socialisation in the segregation of labour in society (Hitlin, 2006). Not only do most women in many societies take different jobs than men do, and with lower status and rewards, but they also manage domestic work (Inglehart & Norris, 2003). Khan (2011) argues that in almost all societies, women have greater responsibilities in domestic work while men take greater responsibilities in external activities. However, Mikkola (2012) argues that since gender roles and norms are learned they can be unlearned, but according to social theorists, this is very difficult because there are many different influences that socialise men and women.

Circumcision is said to play an important role in the socialisation of initiates in many African societies (Barker & Ricardo, 2005) and studies show that these may shape their attitudes and behaviours related to sexual health (WHO, 2007). Male circumcision as a rite of passage reinforces the masculine stereotypes and encourages subordination of women (Njogu, 2008). Njogu suggests that male circumcision can be a hindrance to gender equality and the promotion of women's rights because of the socialisation of boys during male circumcision. However, this may not be different in Western cultures. According to Stets & Burke (2000), men in some Western cultures are aggressive, competitive and instrumentally oriented while women are passive, cooperative and expressive. Even if gender socialisation has slightly changed, stereotypical behaviours are still reinforced (Kimmel, 2000).

Different theories of gender socialisation outline different ways in which daily interactions with individuals in the society takes place. However, one of the similarities between them is that society is the core source of interaction between individuals. Since most gender roles and gender identity views are first noted at an early age, most socialisation theories describe childhood experiences (Chafetz, 1999). Socialisation theories are limited in that most of them seem to focus on parents' and children's characteristics rather than on the application of the theory (Reskin, 2003). Gender socialisation can be explained using three approaches: individual, interactional and institutional (Ryle, 2014; Wharton, 2004). Gender socialisation can be explained at the individual level as it explains how gender is posited inside us either genetically or biologically. However, looking at the acquisition of gender from an individual perspective leaves out a lot of other processes through which gender is learned. Individualistic approaches of gender concentrate on the gendered person and assume that action by a person is dictated by their personal characteristics, traits and emotions (Wharton, 2004). Integrative theories of gender, on the other hand, take into account interactional and institutional approaches to gender.

Biological theories of gender, for instance, capitalizes on observable differences between men and women. The interactional and institutional frameworks of gender take a contextual approach and address other forces that shape gender outside an individual. The interactional and institutional approaches, allow for a relational aspect of gender than the individualist approach which addresses the individual context. Interactional frameworks emphasize that conditions and environmental factors interact with and sometimes offset internalised personalities and behaviours to create distinct genders. Institution frameworks are also known as gendered institutions frameworks which view gender as ingrained in organisations and institutions structures and practices (Wharton, 2004). Social practices in organisations are assumed to play a vital role in the production and reproduction of gender. Institutional theories are critiqued for being too deterministic and their failure to recognize the human power of choice and decision-making (Raffel, 1999). Research on inequalities requires that not only individual aspects of gender are taken into account but also agencies that create and support these inequalities (Archer *et al.*, 2003).

In this study, on circumcision of young men, I assume that gender is not just a product of individual traits learned through socialisation from an early age but, rather, that it is a sum total of broad forces that incorporate cultural influences. One of the theoretical perspectives of gender socialisation is social learning theory (Liao & Cai, 1995), which will be used to explain the socialisation process in the next section. Most of the studies and research on social learning theory were conducted some years ago which demonstrates that its application is scarce.

Social learning theory

Social learning theory suggests that behaviour is learned as gender becomes internalised through interactions with the surrounding (Ryle, 2014). The theory posits that learning does not happen unconsciously as the psychoanalytical theories postulate, rather learning takes place consciously. Social learning theorists argue that there are many ways in which people are socialised into men and women through observation and imitation of behaviour and attitudes (Bandura, 1963). This

is referred to as observational learning where behaviours are first observed then imitated. Imitation is also known as modelling (Daugherty, 2012). Those observed are referred to as models. Live observational learning takes place when behaviour is demonstrated, verbal observational learning takes place when behaviours are explained and symbolic observational learning takes place through mass media, books, and movies (Daugherty, 2012). However, learning does not imply that behaviour change will take place (Berman & Kozier, 2008). For instance, not every child who watches violent movies goes on to become violent.

Social learning takes place through imitation and modelling when a child imitates those around them irrespective of getting a reward (Bandura, 1963; Ryle, 2014). For successful imitation by an observer, attention, retention, replication and motivation must be in place. Retention of what is learnt can be enhanced by rehearsing the learned behaviour. It is difficult for a very young child whose cognitive skills are still developing to imitate complex physical actions. Children are more likely to model after the people similar to him or her such as same sex parent or peer (Bandura *et al.*, 1961; Siann, 1994). This is referred to as identification (Siann, 1994). Social learning theorists have shown that it is mainly the parents who socialise the children (Grusec & Hasting, 2007). However in the male circumcision ritual described in this study socialisation of young men is taken over by other men. Although social learning posits that imitation takes place throughout a person's life, research shows that this is not always the case, but that imitation can also take place immediately during the experience of a new behaviour (Aker & Jennings, 2009).

People respond to behaviour imitated by the children either by reinforcing it through rewards or inhibiting it through punishments (Bandura *et al.*, 1961). This is one of the ways in which gender identity and roles are reinforced or inhibited in children. The Kikuyu boys may be motivated to get circumcised in anticipation of the reward that the ritual brings. For instance, a circumcised man was promoted to a higher class of "*anake*" [young men] and was also appreciated by the members of the community since "*anake*" provided defence for the community (Wambugu *et al.*, 2006). The original social learning theory described a conspiratory role of parents

who planned what behaviours should be rewarded and punished (Ryle, 2014). However, in reality, this is not the case and this was later amended since conscious efforts by agents of socialisation in the socialisation process is not necessary (Bandura, 1963). Social learning theorists have identified gender stereotyped roles which are expected behaviours viewed appropriate for a certain sex but not for the other (Mischel, 1970). Gender identity formation during initiations rites may also enhance gender stereotypical roles (Burbank, 1996). Gender socialisation takes place when gender appropriate behaviours are rewarded and a punishment is given for drifting away from the prescribed roles and identity (Thorne, 2004). Rewards and punishments can be verbal or by use of gestures and expressions. For instance, when a girl cries she is soothed and held, but a boy may be told that “boys do not cry”. Another way of reinforcing gendered behaviour is through descriptions of male and female children with males and females described as strong and delicate respectively (Mikkola, 2012). Thus, through such interactions gender socialisation takes place, often resulting in reinforcement of male and female stereotypes (Wharton, 2004). According to Geis (1993), gender stereotypical constructs shape perception and treatment of males and females.

Imitation does not just take place through personal live models but also through those presented through mass media (O’Rorke, 2006). The amount of television viewing, movie watching, and radio listening, for instance, motivates and influences behaviour and matches the level of gender stereotyping especially in children (Daly & Perez, 2009). Children can thus learn vicariously from mass media and can also imitate their parents watching television and movies or listening to a particular kind of music (Bandura, 1963). Media not only creates personal characteristics in a person but can also change existing ones based on the level of exposure (O’Rorke, 2006). Of concern in social theories is the use of aggression and alcohol in the media (Gentile & Bushman, 2012). As described in Xhosa’s initiation, violence is part of the initiation rites and initiates are exposed to violence during the initiation rites. Since most of the initiates are adolescents at the time of the rites, they are likely to perpetrate violence on others in the future.

Media representation of violence is portrayed in a positive way as the models used are more attractive in these actions (Griffin, 1994). However, violence on television is said to have a short term effect and does not result in permanent violence. People who do not engage with mass media may still be influenced by it if their network revolves around other mass media consumers (O'Rorke, 2006). Gender stereotypes are enhanced through the media where women are portrayed in the media as feminine, caring, gentle, and cooperative and men are viewed as assertive, competitive and providers and dominant over women (Wood & Reich, 2006; Morris, 2006). Most of the female models in the mass media are portrayed as sexual objects, concerned about appearance, and more attractive than men (Morris, 2006). Learning takes place symbolically by modelling after the models on television.

Observational learning also takes place symbolically through school books and texts, which can be used to perpetuate gender bias and stereotypes in schools and at home. Gender stereotyped characters, traits and attribute have been used in children books labelled as non-sexist (Diekman & Murnen, 2004; Thorne, 2004). Initiations rites are compared to schools where gender appropriate behaviour are taught to the initiates (Hergoz, 1973). It is after circumcision, for example, that men are likely to be assigned physically challenging work such as warriorhood (Gilmore, 1990). Although many females are shown to take masculine characters, few males are given feminine characters (Evans & Davies, 2000). Gender stereotypes have been enhanced using language (Lenton *et al.*, 2009) which may enhance verbal observational learning. Similarly, during male circumcision, the instructions that were given were meant to impress in the initiates the end of childhood and expectations of adult-like behaviour (Wambugu *et al.*, 2006).

Although there has been a cultural shift from the generic use of masculine and the pronoun "him and man", they are still common in most books. Use of masculine generics is not gender neutral and has a significant influence on adults' and children's thinking. For instance, children are more likely to imagine male characters and attributes when masculine pronouns are used (Henley, 1989). A study in New York with secondary school students aged 14-18 showed that those who read a

Harry Potter book in a gendered language such as French and Spanish displayed more sexist attitudes than those who read in a gender neutral language such as English (Wasserman & Weseley, 2009). Children below 8 years of old are likely to learn new behaviour with less effort from adults (Bushman & Huesmann, 2006). This is because children are able to observe not only from the media but also the environment around them (Bushman & Huesmann, 2006). In male circumcision initiates are likely to observe what other initiates and mentors do and follow after them (Bandura, 1977). The more similar the initiate think he is with the mentors or other young men the more likely he is in imitating their behaviours.

Cultural accounts of gender constructions

Anthropological studies on initiation rites describe different ways each society shapes gender through the initiate's rites and rituals. This being an ethnographic study on male circumcision, it reflects on initiation rituals and rites practiced in the past that could influence gendered behaviour in societies that still maintain traditional practices. Although some of the practices may have stopped or changed, their influence may be significant for some of the initiation rites and practices today.

A man would thus be incomplete unless he is in a relationship with another person. According to Gilmore (1990), men are seen to be in need of greater cultural intervention, owing to the strong bonds created between a male child and the mother. However, Roscove (1995) disagrees with this theory because of the diverse ways in which different parents socialise their children into gender roles. These accounts on the socialisation of initiates into gender roles might be reflected in this study where the Kikuyu young men are socialised into gender specific roles during the ritual. It is possible that Kikuyu men reflect gendered behaviour learnt during the circumcision ritual.

Van Gennep (1960) was the first to recognise the ritual's role in gender identification when he realised that female circumcision involved removal of the genitalia part that most resembled the male's genitalia. Later Gluckman (1962) noted that male circumcision completed the female circumcision by removing the genitalia part that resembled the labia. Male circumcision was thus arguably seen to align a person with their biological gender (Boddy, 1989). Freud (1966) argues that initiation rites are a form of castration by a jealous father on his son. However, critiques of Freud's theory instead postulate that the rite of passage is aimed at resolving the conflict of sex identity experienced by boys and sometimes girls due to the close ties with the mother during childhood. Thus, rites of passage are meant to break maternal ties and reinforce male identity and solidarity (Bettelheim, 1955; Burton & Whiting; 1979; Gilmore, 1990). Herdt's (1981; 2006) work with Sambian men from Papua of Guinea illustrates a ritual that promotes male gender by the creation and enhancement of masculinities through solidarity with other men. Cohen (1964), however, disagrees with some of the theories since they fail to show the universal conflict between sexes. Cohen, therefore, argues that rites of passage and exclusions where the boys sleep away from home were meant for solidarity among men, avoidance of brother-sister incest in adolescence and promotion of kinship.

Other scholars have highlighted the gendering nature of initiation rites during adolescence. According to Bettelheim (1955), an initiation ritual marked boys as men with power over women. The bleeding of males during circumcision was linked to menstruation and childbirth in women (Bettelheim, 1955). He argued that circumcision was a way of turning boys into men and claiming symbolic power over the women. His theory is reflected in some cultures where bleeding is symbolically referred to as seizing women's reproductive power (Mead, 1949; Hogbin, 1970). For other cultures such as in Papua of Guinea, nose bleeding and oral insemination of the young men by the older men is meant to develop the initiate's male gender (Herdt, 1982).

However for the Melanesian, the gendering process has no singular identity but is a combination of both male and female (Strathern, 1988). Among the Melanesian, gendering is androgynous but a new identity is produced during initiation, which defines a man's gendering role not as a "male" but as a "potential father" with the responsibility of reproduction (Strathern, 1988). Thus during initiation, a person is gendered from cross sex to same sex and is referred to by their reproductive roles. This means that a sexually active but incomplete person is produced but should be completed in relation to another person (Strathern, 1988). Gilmore (1990) argues the cross gender relations pose a challenge to the achievement of the full male gender by boys. Gilmore's conclusion is that greater cultural interventions such as male circumcision are needed to socialise males than females. Many rites, however, reinforce traditional and patriarchal gender norms (Barker & Ricardo, 2005). Gender norms affect norms of masculinities and feminism that are socially acceptable in a given context (Creighton & Oliffe, 2010). Some of the cultural norms on masculinities have been attributed to men's health and practices (Creighton & Oliffe, 2010) as discussed in the next section.

3.2.2. Masculinities and health

Masculinity and femininity are traditionally referred to as the extent to which individuals view themselves as masculine or feminine given what it means to be a man or a woman in society (Burke *et al.*, 1988). Although used in everyday conversations, defining or measuring the two terms is a challenge (Golombok & Fivush, 1994). Most societal expectation is that masculine and feminine traits are displayed by males and females respectively (Chafetz, 1974). Despite the social definitions of masculine and feminine traits, there are some females who view themselves as masculine and some males who view themselves as feminine. Another societal expectation is that all men and, similarly, all women portray and possess similar personalities and traits. Connell (1995), however, suggests that there are more differences among men and among women than there are between men and women. He disputes the existence of any true masculinity and cautions that the focus should be on the processes of masculinities rather than definitions of

masculinity as an object (Connell, 1995). He argues that there are multiple masculinities or plural masculinities. According to Greig *et al.* (2000) pluralising of masculinity implies that there are different ways of being a man leading to masculinities.

Masculinities mean different things at different times to different groups of men (Kimmel, 2000). However, Connell (1995, p.71), alleges that the extent to which the term masculinity can be defined at all “is simultaneously a place in gender relations, the practices through which men and women engage that place in gender and the effects of these practices in bodily experience, personality and culture.” Thus according to Connell, masculinities are not singular, but rather multiple, dynamic, contested and socially placed in both place and time. Masculinities can be explained through biological theory, male role theory that includes role strain, relational models and postmodern theories of masculinities. Theories have, in the past, represented differences between men in terms of biological characteristics which disregard social influences on males’ attributes (Cronje, 2012). Thus, associating people with their innate biological female and characteristics was viewed simplistic. Sex role theory was rejected by Pleck (1981) who instead introduced role strain theory arguing that males did not suffer from sex role identity creation but rather from the strain associated with sex role expectations (Segal, 1990). The rejection of sex role/role strain theory has led to an increasing emphasis on social factors in the shaping of masculinities. This agrees with Connell’s (2001) argument, of seeing gender in terms of social relations as the best approach.

Relational models

In contrast to the sex role theory, a gender relational model does not view men and women as bipolar but gender is seen as a set of relations between men and women and a set of relations between women and between men (Robertson, 2007 p.4; Connell, 2000). Thus, masculinities are not obvious in relational models, but are rather viewed as an element constituted in gender order (Connell, 1995). They are also seen as constructions of specific patterns and hierarchical social relations to females (Robertson, 2008). The models suggest gender relations where men and

women's interactions with each other in certain environments and situations significantly affect their health (Sabo, 2000). For example, Swedin (1996) showed that expectant fathers who participated in "father training" groups, were more likely to cultivate closer bonds with their partners and healthier relationships or what Sabo (2000, p.137), referred to as "positive-gendered health synergy". However, these may not be applicable in developing countries where parental leave is only given to working women. In contrast, the magnitude to which some cultures support men's sexual violence toward women can result in a "negative-gendered health synergy" which may enhance women's risk of HIV and AIDs and STI infections, unwanted pregnancies, psychological trauma, and stigma (Sabo, 2000).

In relational models, masculinities have hierarchical relations between each other. Some forms of masculinities referred to as "hegemonic masculinity", are highly esteemed at a particular time in a given place (Connell, 1995). Hegemonic ideals uphold the cultural beliefs that men are more powerful than women as their bodies' physical features are more robust. The term hegemonic points to the existence of multiple masculinities which are not all equal (Kimmel, 1997). Apart from a focus on a hierarchical order of men in relation to women, this provides a different kind of gender order on hierarchy between men. In this case, all other masculinities are subordinate to the highly esteemed masculinities. Connell's model is, however, contested by others as lacking as it is viewed as naturally deterministic, lacking human agency and thus detached from day to day life (Jefferson, 2002; Whitehead, 2002; Wetherell & Eddley, 1999), which has led to a rethinking and clarifications of the model (Connell & Messerschmidt, 2005). Lusher & Robins (2009) pointed out that Connell's model lacked interrelationship between the individual and cultural and structural factors and needed to clarify the specific contexts within which masculinities are enacted (Moller, 2007).

Individuals 'doing' gender in everyday life need to be explored through specific local contexts (Lusher & Robins, 2009). Wetherell & Edley (1999) alleged that Connell's concept of hegemonic masculinity fails to explain how men negotiate their masculinities in everyday life which make it difficult to predict men's behaviour (Whitehead, 2002). Wetherell & Edley (1999) further questioned the singularity of hegemonic masculinity and doubted if a single system of hegemony existed or rather if it should be hegemonic masculinities. They argued that men take different positions at different times in life both contesting and conforming to different rules of masculinities. This implies that men subscribe to traditional masculinities in some respects, but also distance themselves from them at different times. Men's lives are therefore more complex than described by hegemonic masculinity (Whitehead, 2002). Thus to some men one of the ways of being hegemonic means distancing themselves from hegemonic masculinity as a form of gender equality. This critique points to the need to focus on the specific contexts of masculinities in any given setting. Nevertheless, Connell notes, that many men with significant social power do not subscribe to hegemonic masculinity (Connell & Messerschmidt, 2005).

Hegemonic masculinity is positioned in relation to complicit masculinities. Complicit masculinities are those masculinities that benefit from hegemonic masculinity without subscribing to them. Gender hegemony is postulated to operate not just through the subordination of femininity but also through subordination and marginalisation of other masculinities (Connell, 2000). Hegemonic masculinity leads but other forms of masculinities are either marginalised or subordinated to them (Robertson, 2007). Gay men are an example of subordinated masculinities as they can face violence, exclusion, abuse and economic discrimination (Howson, 2006). Unlike subordinated masculinity, marginalised masculinities are not directly excluded but become marginalised from full participation in the society perhaps due to disabilities (Howson, 2006; Robertson, 2008; Connell, 2000). Connell (2000) concentrates on some forms of masculinity such as domination, oppression, suppression, and subordination. According to Moller (2007), the use of hegemonic masculinity ignores other practices of masculinities and as Jefferson (2002) suggests, it becomes easy to lose sight of the specific male practices that happen

every day. The orderly pattern of masculinity by Connell rejects the idea that individual men are also authors of masculinities. A rigid pattern of masculinities would thus make it easier to create a symbolic expression of masculinities. Thus, Hearn (2004) prefers the term hegemony of men rather than hegemonic masculinity.

Culture provides possibilities and constraints for social action. Individuals draw out beliefs of what is valuable in a social system by perceiving what is generally held by others in negotiating norms and behaviours. This is because hegemonic, subordinate and marginalised masculinities are different in different cultures (Lusher & Robins, 2010; Howson, 2006). There are, for instance, differences between masculinities among black men in rural and in urban working classes in South Africa (Morrell, 1998). Connells identify and interpret any violent behaviour as a way of increasing masculinities (Moller, 2007). For instance, the interpretation of boys' violence as exploitative disregards what these actions mean to them and how they feel about such actions (Moller, 2007). Bordo (1994) suggests taking a different stance of looking at men's bodies through the window of invulnerabilities and disempowerment. She adds that there is a need to address plurality, complexity and contradictions of masculine experiences and feelings rather than just focusing on locations and position in relation to a singular pattern of masculinity. Lusher & Robins (2010) similarly argue that the relational model fails to take into account individual beliefs that underpin the hierarchical and dominative relational order. This would imply that those who endorse masculinity powers that are above femininity will be at the top and those who dislike them take the lower position. Moller (2007) agrees with Bordo (1994) and argues that hegemonic masculinity cannot be applied to studies of areas of diversely lived experiences such as sports culture, performance in schools and masculinities in media. Nevertheless, concepts of hegemonic masculinities can be applied in a discrete and small peer group of men (Moller, 2007) similar to this study.

Men and Violence

Violence is one of the main causes of death among people aged 15-44 years in the world and is now recognised as a public health concern (Krug *et al.*, 2009). Many debates around violence contribute to the difficulty of defining the term violence that works in all situations and at all times (Hearn, 1998). Violence can sometimes include or exclude abuse, physical violence or only include some forms of physical violence (Hearn, 1998). Violence is sometimes visible through the media but most of it take place out of sight at home, in workplaces and in medical and social institutions. Some of the victims of violence are too weak, young or sick to protect themselves whilst others are pressurised to keep quiet about their experiences of violence (Krug *et al.*, 2002). It is sometimes embedded in cultural and economic contexts and includes acts of a physical, psychological and sexual nature and includes neglect. What may be referred to as violent in one situation or period may not be termed as violent in another. In this thesis, the World Health Organisation's (WHO) definition of violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug *et al.*, 2002, p.5) has been used.

The framework used in the WHO's world report on "*Violence and Health*" divides violence into three types: self-directed, interpersonal and collective violence depending on the perpetrator (WHO, 2010). Self-directed violence sees the person as the perpetrator *and* the victim who self-harms or even commits suicide. Interpersonal violence refers to violence between individuals, which is subdivided into family and community violence. Family violence includes violence against children, intimate partner, and elders while community violence includes violence against strangers, acquaintances and it encompasses sexual violence, sexual assaults, youth violence, violence at work and other institutions. Collective violence entails violence committed by a group of people and covers social, economic and political violence. In 2004, interpersonal violence was the 12th leading cause of

morbidity in the world while Africa was reported to record the highest rate of interpersonal violence with most of it occurring at the community level: roads, shopping centres, and bars, public transport spaces (WHO, 2010). The United States of America was reported the second highest with interpersonal violence, followed by Europe. Most of the African countries have concentrated their efforts on achieving Millennium Development Goals (MDG), of which none of the goals address the prevention of violence. This is a significant challenge since violence undermines the achievement of the MDG (WHO, 2010). There is, however, a lack of recent statistics on violence, although the WHO plans to publish the latest report on global violence in 2014.

Research has shown that violence and health-risk behaviours are frequently the consequence of socialisation to norms of masculinity (Phillips, 2006). It has been proposed that boys could learn violence by being exposed to or through imitation of what is aggression and violent actions (Jasinki, 2001). Jasinki (2001) suggested that for such learning to take place, there has to be some reinforcement. The longer the exposures to violent conditions, the more aggressive the images are that are formed in a person, who would subsequently refer to them when confronted with a potentially threatening situation (Ferguson *et al.*, 2008). This implies that no one is immune to the effects of violent stimuli, emphasising the need to avoid exposure to violent conditions (Carnagey & Anderson, 2005). The family is referred to as the main socialisation agent where the boys learn violence through socialisation. The assumption is that if a boy grows up witnessing violence in his family, he may learn to use violence to appropriate his demands (Jasinki, 2001). Delsol & Margolin (2004) however, suggest that men who grow up in violent families can be nonviolent in the future, as a result of possessing strong interpersonal connections and the creation of a psychological distance from their family of origin. Socialisation of violent behaviour through peers and media has also been reported (Miedzian, 1991; L'Engle *et al.*, 2006).

Violence is used in masculinity dominating over femininity and other masculinity (Connell, 2000). Hanmer (1990) similarly states that all forms of violence are meant to control, dominate and express power and authority. Violence is a form of domination but also a measure of imperfection as it demonstrates the illegitimacy of power (Connell, 1995). However, Connell's model of relational gender order fails to theorise the place of violence in dominative power. Nonetheless, violence is an indication of contestation, the illegitimacy of power or legitimacy of power (Lusher & Robin, 2010). Some hegemonic masculinities, for instance, support the killing of women as a form of violence, as a display of male domination against the women. In some countries in the Middle East, women are killed mostly by men at the slightest suspicion of adultery or even as a result of becoming a victim of rape (Kordvani, 2002). Violence has been used to dominate and express power and authority through colonialism. In Africa, colonialism has been linked to violence, which was used sometimes to control the colonised (Bennet, 2012).

Masculinity is one of the constructs for understanding violence (Kimmel & Messner, 2001). However, based on social constructions of gender roles, masculine traits differ from male to male (Krienert, 2003), which may imply that violence levels are different depending on the masculine traits. Parson (1964) implied that masculinity was internalised during the adolescence period and led boys to behave more carelessly and irresponsibly than girls. To men, excelling in violent situations enhances their masculinities if they are able to defend themselves (Messerschmidt, 1993; Cavender, 1999). Most men, who have used violence to assert masculinities, may see this as the only way to display masculinities or manhood (Beirne & Messerschmidt, 2000). Certain ideals of masculinities encourage risky sexual behaviours and violence against women (Garcia-Moreno & Watts, 2000). Research has shown that the link between HIV and AIDS and violence is located in the ideals of masculinities that uphold men's strength and toughness (Coovadia *et al.*, 2009).

A discussion on violence is important in this study where rituals such as male circumcision are agents of socialisation in society (Gwata, 2009; Barker & Ricardo, 2008). Almost all cultures have distinctive rituals and practices to initiate men into a position of power and supremacy (Sev'er, 2012). Male circumcision and initiation rites have been used as a tool of violence by men against men and women in wars and as a symbol of domination. During the 2007 post-election violence in Kenya, male circumcision was used as a tool of violence against Luo men, a non-circumcising group (Ahlberg & Njoroge, 2013). During the 2007 presidential election in Kenya, when the losing party refused to concede defeat and alleged rigged election, ethnic violence resulted. It was alleged that Mungiki, a Kikuyu militia group revenged against the Luo people whose presidential candidate had lost the election to a Kikuyu president by forcibly circumcising them (Kamau-Rutenberg, 2009). Male circumcision is said to act as a tool for the creation of a hyper masculinities ritual (Sev'er, 2012), an excessive form of stereotypical male behaviour (Courtenay, 2000). Hyper masculinities are displayed during endurance of pain through rites of passage (Connell, 2000) such as male circumcision. Going through pain and other forms of violence is part of the social construction of manhood during the male circumcision ritual (Vincent, 2008). Those who are able to overcome victimisation at a given point become the perpetrators of the same acts at another point in life (Sev'er, 2012). Hyper masculinities, therefore, occur in cycles; before, during and after male circumcision (Connell, 2000; Toch, 1998).

Xhosa male circumcision practices display the highest form of hyper masculinisation. Although most Xhosa circumcision rituals teach against violence, some of the practices allow violence against uninitiated men and women (Sev'er, 2012). Xhosa initiates express a need for cleansing off dirt at the end of the ritual, which should be deposited in the girls and women and this is a form of gender violence (Tshemese, 2010). Myths are used to enforce such behaviour. For example, having sex with a girlfriend after circumcision is claimed to affect that relationship negatively such that it cannot last for long (Feni, 2006; Tshemese, 2010; Vincent, 2008). The young man is therefore expected to have sex with another girl who has multiple partners, which can promote rape and sexual violence. Since

activities encouraged during circumcision involve girls and women, male circumcision is not exclusive to young men. In addition, research indicates that women play a central role in the construction of masculinities (Lusher & Robin, 2010). Therefore, exploring feminism in this study is significant in understanding the place of girls and women during the 'wiping of the soot' which is explained in detail in chapter 7, section 7.2.5 and which is discussed in the construction of masculinities during the male circumcision ritual. The next section discusses feminism with a major focus on African feminism.

3.2.3. Feminism

Although feminism began in Europe and North America in the 19th Century (Lagro-Jansen, 2007), it has spread all over the globe but has acquired different labels, making it difficult to have a universal definition (Ebunoluwa, 2009). Although feminists do not agree on the definition of the term 'feminism', some of the definitions refer to the experiences of women. Cuddon's (1991) definition of feminism attempts to describe and interpret or reinterpret the female's experiences. Hooks (1984) on the other hand, defines feminism as a movement that was meant to end oppression against women. The word 'feminism' comes from the Latin word "femina" (Ebunoluwa, 2009) and is formed with the word "femina" or woman, which refers to one who fights for women (William & Wittig, 1997). The first feminist movement struggled for better health care of women while the second wave of feminism has fought against inequalities and power roles differences between men and women (Lagro-Janssen, 2007).

Ebunoluwa (2009) suggests that the main goal of feminism is to free women from sexist oppression. Other authors have proposed different motives and goals of feminism. According to Mikkola (2012), the main motive of feminists is to make a distinction between gender and sex in order to counter biology as the main determinant of a male and female. Although most feminists have disagreed on the term 'sex' and 'gender', most of them endorse the distinction between sex and gender where sex stands for females and males depending on biological features

while gender denotes women and men respectively as influenced by social factors (Mikkola, 2012). In the process of explaining male dominance, feminists have developed different ideologies that highlight three common traditions of feminism: radical, social and liberal feminism.

The principles of radical feminism focus on women's subordination, sexuality, and reproduction as men's area of control (Edley & Wetherell, 1995). They call for fundamental changes by rejecting male dominance (Walter, 1996), radically questioning men and women (Humm, 1992), and analysing concepts such as men, patriarchy and masculine characteristics as a source of power, and women and gender (Petersen, 2003). Social feminists demand fundamental changes in the economic and class structures of the society. They see the poor structure as the root of all oppression and exploitation of women through low pay and unpaid labour (Campbell & Wasco, 2000). Liberal feminists believe in the classical liberal philosophy and emphasise freedom of choice and more opportunities to reduce under-representation but without radical changes in institutions such as motherhood and monogamy (Edley & Wetherell, 1995). While feminism represented the needs of white women, it failed to represent the needs of the women globally (Ebunoluwa, 2009). This led to other concepts of feminism such as womanism by Alice Walker (Arndt, 2002) and others with an African concept.

African feminism

Feminism is the movement to end the oppression women as a group (Mikkola, 2012). African feminism takes into account the African philosophy of life which stresses marriage as a social institution (Maduka, nd). Although it condemns all forms of patriarchy intended to dominate women, it complements man and woman by maintaining the male/female principle in the creative order. Both men and women suffer from the patriarchal social structure. This means that African feminism does not do away with men but rather accommodates them (Maduka, nd). This is referred to as positive feminism due to its complementarity and accommodation of human relationships, unlike negative feminism which requires a radical and militant transformation of patriarchal institutions (Maduka, nd). Arndt (2002) describes

African feminism as women's concerns; to transform existing gender relations on equality of women and other cultural practices that have harmful effects such as female circumcision and marriage conventions of young women.

Some of the terms used in African feminism are womanism, motherism and stiwanism. Although the term 'womanism' is used in African feminism, it differs from 'womanism' described by Walker (1983). Womanism, a type of feminism (Walker, 1983), examined the intersection of race, gender and class oppression (Campbell & Wasco, 2000). It was concerned with black women's needs, which are said to differ from those of white women. Womanism identified triple-fold oppressions of the black woman: racist, classist and sexist oppression unlike feminism, which was only against sexist oppression against women (Ebunoluwa, 2009) and only catered for white women (Hooks, 1984). However, Walker's womanism did not fit the African women whose love for children, central to motherhood was not accounted for in Walker's womanism (Arndt, 2002). African women also felt that they were not fully represented in Walker's womanism, which accommodated lesbianism which is not acceptable in Africa (Ebunoluwa, 2009) and, therefore, wanted to redefine feminism for their own purposes (Arndt, 2002). Although there are lesbians in Africa, they are stigmatised and, therefore, most operate underground. This is because to most Africans, lesbianism is strange and likely to bring self-oppression (Kolawole, 1997). In South Africa, for example, Muholi (2007) has discussed the marginalisation of lesbians and the need to end the silence in the lesbian community.

Another alternative to feminism is motherism (Acholonu, 1995). Motherism focuses on the core of motherhood of an African woman's experience. Motherism does away with matriarchy and patriarchy as Achonolu views these terms as Eurocentric and instead uses patrifocality and matrifocality as a representation of women's and men's complementary positions such that no gender totally dominates the social life of the people. For instance, men are dominant in the socio-political spheres while women dominate in the spiritual and metaphysical segments. Some men, on the other hand, lack awareness of being privileged and are not as powerful as alleged by the feminists. Edley & Wetherell (1995) suggested that men only lack power when

compared with other men and some women with better jobs, more education, higher class and race who are aggressive and physically strong. However, Achonolu (1995) asserts that when it comes to economic power, any gender can dominate.

Ogundipe (1994) proposed another term known as 'Stiwanism', which focused on the African women's needs such as social transformation, harmony, and peaceful societies. Stiwanism was meant to bring transformation to society, which was seen as a responsibility of both men and women. It describes African women's experiences such as extreme poverty, issues with in-laws, older women oppressing the younger ones, oppression of co-wives by the other women and oppression of women by men. Another oppression addressed by African womanism is racism. Although this is applicable in South Africa, Ebunoluwa (2009) was of the opinion that African women are likely to have economic and sexist oppression as their major concern. Stiwanism and motherism have, however, not gained wide acceptance in Africa (Ebunoluwa, 2009). Although there is no documented reason for this, it could be attributed to the recent and different forms of feminism in Africa while most Africans are not willing to be identified by or identify with feminism.

Although most African women accept that oppression and unfairness exist, most refuse to accept the feminist identity (Nfah-Abbenyi, 1997) and those concerned with alleviating women's hardships and promoting women's livelihood in Africa are embarrassed to be referred to as feminists. This is suggested to arise from misconceptions surrounding the concept of feminism often termed as anti-male, anti-religion, anti-culture which may not be the stance of every author who comes across as being a feminist. A person, therefore, may be forced to reject feminism or redefine the terms to correct the misconceptions. Most African feminists, especially Nigerian scholars, have argued that Western feminism imposes Eurocentric terms on Africa such as gender and too many campaigns against men (Ouzgane & Morell, 2005). Oyěwùmí (2003) similarly, argues that feminism in Africa is an import from the West and accuses African feminists of importing western concepts. Although there have been attempts to have different forms of Africa feminism such as

womanism, stiwanism and motherism, there is yet to be an African form of feminist theory that is unique to African women (Ebunoluwa, 2009).

3.2.4. Socio Ecological Model

The Socio ecological model (SEM) is an ecological model that can be used to explain social and structural influences on young people's behaviour. Interpersonal behaviour theory such as SEM takes into account wider forces such as family, friends, and peers that influence behaviour (Hargreaves, 2005) but with less focus on decision making (Rimer *et al.*, 2002). Intrapersonal behaviour theories, on the other hand, are important in explaining determinants of an individual's health behaviour but fail to take into account social, physical, environmental and structural factors (Parker & Aggleton, 2003). Addressing individual factors of behaviour provides a limited perspective, missing the complex picture and deeper understanding of multiple factors that affect young men's health behaviour while in interaction with other familiar factors (Voisin *et al.*, 2006). Adolescents' behaviour may be understood in relation to the social context and the adolescent reference group (WHO, 2000), which can be addressed by interpersonal theories such as the SEM.

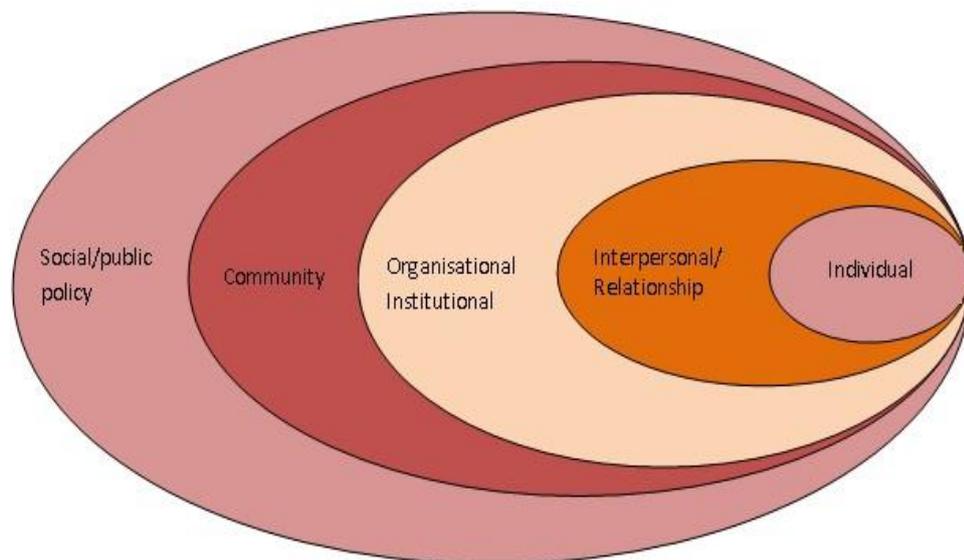
The Socio Ecological Model (SEM) is useful in providing a framework for enhancing understanding of a distinct problem in a given context. It helps to identify the cause of a problem (DiClemente *et al.*, 2007) which in this study proposes likely forces to influence decision making by the Kikuyu young men. It provides a framework for understanding multiple factors and barriers of health at each single level of the five levels (Raingruber, 2014) outlined in figure 3.1.below. The five levels relate to the factors and actors who might shape the behaviours and actions of a person and, in particular, the initiates among the Kikuyu people.

These levels are:

1. Individual level also known as the interpersonal level where factors, such as knowledge, beliefs, attitudes, skills or intention to comply with certain behavioural norms are explored.

2. Interpersonal or relationships level which refers to individual interactions with actors within the family, friends, neighbours, co-workers and acquaintances who may play an important role in an individual's decision to perform behaviour.
3. Organisational or institutional level connotes contexts of school, health organisations, work, church, professional or neighbourhood groups. Institutions are core channels for instilling social norms and values and can thus provide and maintain social support for behaviour change.
4. Community level where the family, church, informal social networks, and neighbourhood provide social support and resources.
5. Social and Public policy is the fifth level which represents factors and actors in government, laws and policies and media.

Figure 3.1. The Socio Ecological Model (adapted from McLeroy et al., 1988)



Interrelationships between different levels and within each level are equally important. Thus, one single factor is not considered more important than the other and interaction between these factors over time affects behaviour (Raingruber, 2014). The model allows consideration of biological, social and environmental determinants of health (Sallis *et al.*, 2002) since our health is shaped by multiple interacting factors. It also shifts the focus on individual factors in shaping behaviour such as skills or genetics but considers both the proximal and distal factors in shaping behaviour (Raingruber, 2014; Sallis *et al.*, 2002). Ecological models are, however, limited in that they are largely descriptive in nature (Santariano, 2006; Scannapieco *et al.*, 2005). In addition, there is a paucity of literature that explains SEM in detail and its application. Although not explicitly explained as to how SEM was developed, it has been alleged that SEM resulted from work by a number of researchers such as Bronfenbrenner's (1979) development of ecological systems theory, which focused on the relationship between an individual and the environment; McLeroy's (1998) work on the ecological model of health behaviours, which had the levels of influence on health behaviour classified into five main areas; and Daniel Stokol's (1992) Social Ecology Model of health promotion, which identified the core concepts of socio ecological model. The work of the three researchers has been modified and evolved to what is referred to as socio ecological model. There are thus different versions of the socio ecological model using slightly different levels of environment influences. The Social Ecological model which is based on four principles (Glanz *et al.*, 2002):

- Multiple influences should be behaviour specific.
- Environments are multidimensional and complex with varying characteristics in terms of size, temperature, facilities, and safety.
- People's interaction with the environment can be described at different levels of organisation at individual, family, small group, organisational, community or population levels.
- Interrelationships between people and their environment are dynamic and reciprocal. Relationships between an individual and the environment are reciprocal which is referred to as reciprocal causation (McLaren & Hawe, 2005).

The social ecological model may enhance understanding of individuals' behaviour in a setting of the study group, such as the Kikuyu young men in Muranga. Although SEM allows the identification of factors related to the behaviour of a given population group, which enables the development of intervention strategies and designs, this is not the purpose of this study. However, it can be used to recommend future intervention strategies around male circumcision and young men.

3.3. Conclusions

This chapter has reviewed the literature on existing knowledge and concepts of theoretical frameworks of behaviour, gender, masculinities and feminism. The discussion on the SEM points to different levels of influence on healthy behaviour in reference to the male circumcision and initiation ritual. The role of culture emerged central in definitions and discussion of gender, feminism, masculinity and violence. Socialisation of individuals and shaping individuals' behaviours, enhanced by the male circumcision ritual was highlighted. African feminism deviates from Western concepts of feminism in order to address the needs of African women. The next chapter will address the link between culture, HIV and AIDs and male circumcision.

Male circumcision, HIV and AIDS

4.1. Chapter Introduction

The previous chapter discussed the literature related to the theories relevant to this study. This chapter discusses public health approaches in HIV prevention, with more emphasis on male circumcision, the latest strategy added to the HIV prevention package. The chapter defines terms and discusses different aspects of HIV and AIDS and the public health discourse on male circumcision in HIV prevention. The last part of the chapter discusses traditional male circumcision and its implication for health.

4.2. Public health approaches to the prevention of HIV and AIDS

Public health can be defined as the collective efforts of a society in ensuring that the health of the population is improved. It addresses the collective health needs of a population, rather than merely those of individuals (Novick & Morrow, 2008). The main challenge of a public health approach is the prevention of disease (De Cock *et al.*, 2002) and is based on a step by step process of defining and measuring a health problem, finding the causes of the problem, determining solutions to the problem and implementing and evaluating strategies that are effective (Satcher & Higginbotham, 2008). To be effective, the public health approach must take into account health promotion, early detection of diseases and prevention and aim for universal access to health care (Satcher & Higginbotham, 2008). However, a lot of investments from local, national, and international resources are needed in public health for sustainable change in behaviour, lifestyle and social environment (Rychetnik *et al.*, 2004). One of the crises that public health is addressing the epidemic of HIV and AIDS.

HIV is an acronym for Human Immunodeficiency Virus, which causes a condition known as AIDS once it comes into contact with the blood (Irwin *et al.*, 2003; Pinsky & Douglas, 2009). The virus affects certain cells of the immune system called the “Helper T cells.” It infects the immune system, damaging cells, impairing their function and gradually reduces the body's ability to resist infections (Scherrer & Klepacki, 2004; Parliamentary Office of Science and Technology, 2003). AIDS refers to Acquired Immuno Deficiency Syndrome and occurs at the final stage of HIV infection. It is the most severe stage of HIV (Davies, 2009; Scherrer & Klepacki, 2004). HIV is transmitted sexually, through the anus, vagina (Brewer, 2012) and to a lesser degree by oral contact (Campo, 2006). Other routes of transmission involve sharing of needles, mostly through intravenous injection and other injections and perinatal transmission (Brewer, 2012). HIV is transmitted through four body fluids; blood, semen, breast milk and vaginal secretion (Stolley & Glass, 2009; Kamaara, 2005).

Globally, 25 million deaths have been reported resulting from the HIV pandemic since it was first discovered in 1981 (Merson *et al.*, 2008). An update report on the Global AIDS Epidemics by UNAIDS and WHO states that approximately 35.3 million people were living with HIV in 2012, which reflects an increase from 32.2 million HIV infected people in the previous year (UNAIDS/WHO, 2013). However, the global rates of the AIDS epidemic do not reflect the HIV rates discrepancies in different regions. In East Asia, the HIV infection was reduced by 25 per cent while in South and South East Asia, it was reduced by 10 per cent in the 2009 (WHO, 2009). In the Global Report on HIV epidemics, new infections were reported to have increased in Eastern Europe, Central Asia, Middle East and North Africa (UNAIDS/WHO, 2013). However, the African continent is the most affected by HIV and AIDS (William *et al.*, 2006) with Sub Saharan Africa being the hardest hit by the epidemic (Mukandavire *et al.*, 2007). In 2012, 70 per cent of all new infections were accounted for in Sub-Saharan Africa (UNAIDS/WHO, 2013). Sub-Saharan Africa is said to be the global epicentre of the HIV pandemic and in 2005 was reported to have 25.8 million people living with HIV in 2003 (Kartikeyan, 2007). Kenya in East Africa had an estimated HIV prevalence rate of 5.1 per cent in 2008 (NASCOP, 2008).

In many regions of the world, new HIV infections are heavily concentrated among young people aged 15-24 years of age who are the most vulnerable to HIV infection. In 2012, about 2.1 million adolescents aged 10-19 years in low and middle income countries were living with HIV (UNAIDS/WHO, 2013). It is possible that some may have contracted HIV through perinatal transmission. However, research has shown that this is not necessarily the case as some young people experience sexual debut before 13 years of age (Njoroge *et al.*, 2010) and can, therefore, get infected with HIV through sexual contacts. Data on young adolescents aged 10-14 years are however scarce, limiting information and updates on the HIV situation in this group. Many young people take risks and experiment with sex which exacerbates their risk of HIV infection during rapid physical and psychosocial changes taking place in their lives (WHO, 2006). Other factors that increase the risk of HIV infection among young people include; lack of knowledge about HIV and AIDS, lack of education and life skills, lack of access to health services, early sexual debut, early marriage, sexual coercion and violence, child trafficking and orphan-hood, exploitation and abuse of street children (WHO, 2006).

Since the efforts to find a vaccine against HIV and AIDs have been futile, other strategies to reduce HIV infections have also been put forth in the public health arena (Peter *et al.*, 2010). The main strategies employed in HIV prevention efforts include sex education and change of behaviour, condom use, and treatment (Bonell & Imrie, 2001; Jamison *et al.*, 2013). Sex education is directed at individuals who are under 14 years of age since they are assumed unlikely to have been infected with HIV (Parliamentary Office of Science & Technology, 2003). Although different studies show mixed results of the impact of sexual education on young people. Some of the studies have shown that providing sex education on a regular basis to the 15-24 age group who are at high risk of HIV infection reduces infection rates (Parliamentary Office of Science & Technology, 2003). There have been

controversies on abstinence only programmes. The US government has used a lot of resources to support abstinence only programmes. However, the 2005 national data on sex education laws and policies in the USA show that abstinence only programmes are correlated with teenage pregnancies and birth rates (Stanger-Hall & Hall, 2011). Although there is a paucity of literature on abstinence only programmes in middle and low income countries (Fonner *et al.*, 2014), a review of 35 school-based sex education programmes found that abstinence based programmes were not effective in delaying sexual debut but some of the comprehensive sex education programmes reduced some risky sexual behaviour (Kirby & Coyle, 1997). Chin *et al.*, (2012), on the other hand, conducted a systematic review and meta-analysis of comprehensive programmes and abstinence only programmes and found that comprehensive programmes reduced HIV and STI infections and pregnancies but abstinence only programmes had inconclusive results. However, for any sex education programme to succeed, factors such as culture, sensitivity to the community beliefs, organising sex education programmes together with the stakeholders, training on communication, refusal and negotiation skills and use of participatory teaching methods should be taken into account (Mckeon, 2006).

In Kenya, the introduction of sex education was resisted by religious leaders, schools authorities and parents in the 1980s which led to the withdrawal of books used to teach the subject from bookshops. Although the FBOs and religious groups have resisted sex education in Kenya, students who are to benefit from the programmes have never been consulted on the content of sex education. However, HIV and AIDS education was introduced in schools in 1999 (Duflo *et al.*, 2006). Sex education is currently taught through Christian Religious Education (CRE) curriculum to Form Four students only (Wanyonyi, 2014). Sex education is not explicit although it entails teaching:

- Human sexuality which shows the biological and physiological and reproductive roles between males and females. A distinction is made between sex and sexuality since sex is just a component of sexuality.

- Christian ethics which equip students with skills to make moral decisions and choices when faced with challenges including sex based on Christian values.
- Forms of responsible sexual behaviour which involves definitions, causes and effects. This also includes a topic on leisure which is linked to sexual behaviour.

Since sex education is directed at Form Four students and CRE is not a compulsory subject, some Form Four students and those from the lower classes are excluded from the subject (Wanyonyi, 2014).

Unlike CRE which is not compulsory, HIV and AIDS education is meant for every student. It involves teaching medical and scientific facts about the disease as the curriculum is based on HIV infection, transmission, and protection. The curriculum also assumes a homogeneous audience that is not sexually active and emphasises abstinence as the only way to prevent HIV and pregnancy. Although teachers are trained, the teaching system in Kenya is said to be more didactic, non-participatory, inflexible and assessment driven (Boler & Aggleton, 2005). Yet, HIV and AIDS education is expected to be interactive using role play and group work. In addition, active learning is suggested for social and health skills since it enhances the building of skills, for instance, on how “to say no to sex” (UNICEF, 2009). Teachers are frequently uncomfortable about discussing HIV and sex education with students and engaging them in discussions (Njue *et al.*, 2009) because they do not feel adequately prepared to discuss such a sensitive subject (Farah *et al.*, 2009). Sex educators may also be shy and embarrassed to discuss sexual matters with young people due to religious and cultural beliefs. Nevertheless, comprehensive school based sex education that incorporates community and school based elements have been suggested to be most effective in changing behaviour in middle income countries (Fonner *et al.*, 2014). This points to a gap in research and in programmes in Sub-Saharan Africa that address social cultural norms and beliefs, which might guide discussion of sexual matters between young people and adults (Marston & King, 2006).

4.3. HIV and AIDS and public health policies

A policy is a framework or statement of intended actions which guides decision making in order to achieve a given goal in an organisation or government (Geurts, 2011). Policies on public health provide a framework for improvement of the health of the population (Hunter, 2007). However, policies can either provide opportunities to progress or hinder health. The main challenge is not in the policies but in the implementation of the policies. In addition, most of the resources are directed at health care services and are, thus, neglecting the development and implementation of public health policies (Hunter, 2007). Public health efforts to reduce HIV infections and treat infected people are complicated due to politicisation of the epidemic in developing countries and internationally (Murphy *et al.*, 2006; Court, 2006). This may result in policies that are politically based rather than evidence based (Court, 2006). For instance, decentralisation of the Ethiopian government at the time of the HIV and AIDS policy development caused disruption and led to slow progress in the development and implementation of the policy in Ethiopia (Stover & Johnston, 1999). In order to succeed in policy development and implementation, all stake holders must be involved and allowed to participate. In Ghana, there was less participation in the development of HIV and AIDS policy by other organisations and government departments outside the Ministry of Health and it was not until after discussions with other countries that other participants were included. In addition, in the early phases of the HIV and AIDS epidemics, most countries saw no need for developing comprehensive guidelines (Stover & Johnston, 1999).

Some recent and prominent public health policies have focused on the criminalisation of HIV, although the literature on the issue is limited (Mykhalovskiy, 2011). This is a global initiative which is recorded in Europe, North America, Latin America, Caribbean, Asia and Africa (GNP+, 2010). Criminalisation of HIV involves the conviction and prosecution of people for non-disclosure and exposure of others to HIV infection (Newman, 2013). Charges are brought under a variety of laws such as murder, manslaughter, HIV transmission or exposure to HIV, assault, attempted murder and grievous bodily harm (UNFPA *et al.*, 2008). The criminalisation of HIV has been criticised and the use of public health legislation as a complement has

been suggested (Interagency Coalition on AIDS and Development, 2010). The criminalisation law has not been shown to change people's sexual behaviour (Interagency Coalition on AIDS and Development, 2010).

Criminalisation of HIV and AIDS can result in incarcerations even of people who may pose an insignificant risk. In addition, people who are HIV infected may even pose more risk in prison due to the lack of regulations of risk behaviours and preventive measures (Interagency Coalition on AIDS and Development, 2010). The penalty may also be burdensome especially with inconsistencies in judgment. For instance, a person may be jailed for life for non-disclosure which may not have led to HIV transmission, while another person gets one year for attempted murder (UNAIDS, 2012). This could act as a barrier for people accessing the voluntary counselling and testing services (VCT) to avoid knowing their status, which would then be more detrimental to public health. The human rights bodies view this as a violation of HIV infected people's human rights, which may aggravate their stigmatisation and marginalisation. This may be seen as a way of burdening HIV positive people with the responsibility of prevention rather than encouraging individual responsibilities for safe sex, irrespective of their HIV status. The laws also fail to take into account lack of an environment that encourages disclosure (UNAIDS, 2012). Although the implementation of HIV criminal laws is intended to deter 'offenders' and 'potential offenders' from engaging in risky behaviour, it may actually drive risky groups such as illegal drug users and sex workers further underground for fear of being prosecuted. Others argue that this is meant to protect vulnerable groups such as women, girls, migrants and prisoners (UNFPA *et al.*, 2008). Thus, criminalisation of HIV may enhance further harm to both HIV positive and negative people which may fuel HIV transmission rather than provide the protection intended.

One of the main HIV prevention policies is the "ABC" model of prevention which means 'Abstain, Be faithful and Condom use' (Cohen, 2003). It has been suggested that the ABC approach focuses on individuals and fails to acknowledge factors that make people vulnerable to HIV/AIDS (Murphy *et al.*, 2006). In addition, it is argued that the ABC approach fails to take into account social, political and economic

causes of the epidemic, which results in victim blaming (Murphy *et al.*, 2006). The largest international source of funding for HIV and AIDS, the US President's Emergency Plan for AIDS Relief (PEPFAR), has promoted abstinence programmes both in the USA and in low and middle income countries. However, as discussed earlier, there is an indication that abstinence programmes have not been effective in changing behaviour (Santelli *et al.*, 2013). In addition, human rights groups and medical professionals suggest that abstinence only programmes have scientific and human rights problems because they promote medically inaccurate information that withholds risk reduction information, censors text books and teachers and fails to consider non-heterosexual relationships (Santelli *et al.*, 2013). Abstinence only programmes are also said to put women at risk in cultures where women cannot insist on abstinence, are subordinate to men and are unable to negotiate for safe sex (Rogowska-Szadkowska, 2009).

In Uganda, 'loving faithfully and zero grazing' were promoted more than condoms (New Vision, 2003). 'Zero grazing' was a slogan used by the Ugandan government to warn the Ugandans to stay away from indiscriminate sex and stay with one sexual partner (Okware *et al.*, 2005). While Uganda was declared successful in reducing HIV rates, today HIV infection rates have gone up, which suggests that abstinence only programmes have driven some groups such as sex workers and homosexuals underground (Kron, 2012). The policy may have failed to take into account the socio cultural issues in African countries such as Uganda. In addition, this could be attributed to Ugandans having not tested in the past or unreported HIV incidences in earlier years which have been reported lately. In Botswana, HIV and AIDS was referred to as a "radio disease", and people were offended by the ABC slogan in English as it was seen as disrespectful to the culture, which does not allow open discussion of sex (Allen & Heald, 2004). This highlights the critical requirement for policies to address the cultural context for effective public health impact.

Condoms have been referred as the most effective method of HIV prevention especially for those at high risk of infection (Hughes, 2004; Winskell *et al.*, 2012). They have been said to reduce the risk of HIV infection by 85 to 90 per cent if used

correctly (Parliamentary Office of Science and Technology, 2003). In Asia, Thailand was successful in promoting condoms in brothels but also in addressing infidelity and faithfulness in the general population, especially among young men, using community mobilisation (UNAIDS, 2004). However, although condom efficacy in generalised epidemics is likely, evidence of its primary role in HIV prevention is lacking (Turin, 2009). Developing countries face the challenge of availability and accessibility of condoms. In addition, condom promotion programmes fail to take into account women and girls, including those trafficked into prostitution. Moreover, women who are victims of violence are likely to lack negotiating power on condom use (UNAIDS, 2004). In Sub Saharan African countries, it has been reported that women's suggestion for condoms use is frequently met with violence (Winskell *et al.*, 2012). Although this study is about men, the study location is patriarchal in nature, thus likely to have heterosexual relationships which impact on women. Female condoms are also said to be in limited supply and underutilised owing to high costs, unavailability or inability to negotiate condom use (Holden, 2008; Mantell *et al.*, 2011). In addition, the promotion of male condoms alone may leave women vulnerable to HIV infection. However, the promotion of female condoms would also require the involvement of men, especially in a culture where women cannot negotiate for condoms.

Young people are reported to have a low use of condoms in Sub-Saharan Africa despite accounting for half of the HIV infections (Winskell *et al.*, 2011). Challenges facing condom campaigns include beliefs that condoms promote extra marital sexual affairs, impede abstinence, reduce sexual pressure and encourage multiple partners (Hearst & Chen, 2004; Winskell *et al.*, 2011). In addition, some young people are only interested in avoiding pregnancies but not HIV, thus viewing condoms as contraceptives tools (Wakabi, 2006). Research has shown that pregnancy is viewed as having an immediate effect on the lives of young people, unlike HIV which takes some time to affect an individual (Oduro, 2009). These concerns may be mirrored in the content of HIV information given to young people. This is also highlighted in the changes in the rite of passage among the Kikuyu people discussed in chapter two. The ritual used to be a means of teaching sexual

education but has today been done away with, especially for the girls. In cultures, where women cannot negotiate condoms, other contraceptive methods such as the pill and safe days may be used to prevent pregnancies. Although other contraceptive techniques will prevent pregnancies, young men and women are left vulnerable to HIV infections. In long-term relationships, couples tend to stop using condoms because not using condoms is a sign of trust. In addition, the notion that HIV only affects certain categories of people such as prostitutes cause young people to ignore protective measures since they view themselves as invulnerable (Oduro, 2009; Njoroge *et al.*, 2010).

The promotion of “be faithful” as an HIV prevention strategy disregards monogamous married women who are one of the groups at highest risk in Africa (Ntozi *et al.*, 2003). This is due to the high incidence of extramarital sexual activity and sexually transmitted infections among married men (Ntozi *et al.*, 2003). The assumption that marriage is protective is misleading especially due to existing socio cultural beliefs governing sex in marriage. In Uganda, for instance, women have no right to deny their husbands sex (Gaje & Ali, 2005). In addition, most women in Asia and Africa do not have the choice to abstain when they want to (Murphy *et al.*, 2006). The public debates on HIV prevention policies give the impression that a single strategy such as education or condom use, or biomedical innovations, holds the key to reducing HIV infections (Collins *et al.*, 2008). However, a combination of strategies involving bio-medical, behavioural and structural strategies in HIV prevention is proposed to be more efficacious than using a single strategy. This creates a synergy for the reduction of HIV incidences compared with employing isolated HIV prevention packages (Jones *et al.*, 2014; Kurth *et al.*, 2011). However, the prevention package must take into account risks at the intrapersonal, interpersonal, sexual level, needle sharing networks, and the community level while accounting for the epidemiologic context (Kurth *et al.*, 2011). Apart from the ABC HIV prevention strategies, the WHO has suggested the inclusion of male circumcision as the fourth strategy into the prevention package (WHO/UNAIDS, 2007). The recent promotion of male circumcision is one of the preventive strategies of HIV.

4.3.1. Male Circumcision and Prevention of HIV and AIDS

Male circumcision has recently been proposed as a strategy for HIV prevention by the WHO. Prior to the 20th century, it was undertaken for cultural and religious reasons (Szabo & Short, 2000). Alanis & Lucidi (2004) assert that male circumcision provides a protective benefit from HIV as evidenced from ecological and biomedical studies in African countries. Many studies have shown a significant association between male circumcision and HIV infection (NASCOP, 2008; Weiss *et al.*, 2000). Apart from protection from HIV infection, other studies have shown that circumcised men have a low prevalence of sexually transmitted infections (STIs) including HIV, penile carcinoma, urinary tract infections, and ulcerative sexually transmitted infections (Weiss *et al.*, 2006). Urinary tract infections are shown to be associated with uncircumcised males, with infants below one year being at greater risk than adults (Tobian *et al.*, 2010).

In 2007, the WHO and UNAIDS passed a policy and a recommendation for Voluntary Medical Mass Circumcision (VMCC) as part of the HIV prevention strategy (WHO, 2009). As described in the introduction chapter, VMCC was recommended in settings with low levels of male circumcision and a high prevalence of HIV and AIDS, based on the evidence from three randomised controlled trials (RCTs) carried out in Kenya, Uganda and South Africa (WHO/UNAIDS, 2007). The RCTs were prompted by previous observations that groups that practiced routine circumcision had lower levels of HIV and AIDS than those who did not circumcise, although it was acknowledged that other factors could have led to such differences (Siegfried *et al.*, 2005). Most of the settings recommended for VMCC were in East and South Africa (CMMB, 2007), with Nyanza province being the main target of the VMCC in Kenya (Government of Kenya, Ministry of Public Health and Sanitation & NASCOP, 2010). Nyanza province had the highest level of HIV prevalence of 15.1 per cent in the 2012 Kenya AIDS Indicator Survey (KAIS) (NASCOP, 2014).

Following the KAIS report, scientific findings have been criticised for claiming that male circumcision reduces HIV infection because, despite the increase in the number of males circumcised in Nyanza province, it continued to have the highest

level of HIV prevalence (NASCO, 2014). Other factors that could be responsible for the increase in HIV prevalence, for instance, could be the failure to test for HIV in the past by the population in Nyanza. It could also be an indication of a reduction in mortality rates among the HIV infected persons in Nyanza province. However, the KAIS study showed that the rate of HIV infection among the 17 per cent circumcised men was lower than that of the three per cent of the uncircumcised men (NASCO, 2014).

The evidence from the three RCTs on the effectiveness of male circumcision in providing significant protection against HIV infection focuses attention on ways in which the absence of the foreskin reduces the risk of HIV infection. Laboratory tests show that the foreskin layer of a penis has a greater susceptibility to HIV infection than the cervical or external layer of the foreskin tissue (Patterson *et al.*, 2002). It has been suggested that male circumcision is likely to reduce the risk of HIV-infection by decreasing HIV target cells. This is attributed to the thick Langerhans and T memory cells in the inner surface of the penis, which are targeted for HIV infection (Dini, 2010). Langerhans cells are close to the surface skin, inverted and exposed during sexual intercourse (Donoval *et al.*, 2006) and, therefore, likely to be the main entry point of the HIV virus (Dini, 2010). De Witte *et al.*, (2007) however, claim that the Langerhans cells are the main defence mechanism in the immune system without which the body is more susceptible to STIs and HIV infection. They argue that Langerhans cells are needed to block HIV cells and it is only when the viral load is high that the HIV is transmitted into the body. Thus, the foreskin of the penis seems to play a dual role of enhancing the prevention and the transmission of HIV. Hill (2007), however, asserts that the foreskin has more benefits than its removal, especially in infants, due to its mechanical, sexual, sensory and protective functions. The foreskin acts as protection from ammoniacal nappies and prevents meatitis, meatal ulceration, and meatal stenosis and infections.

For adults, the foreskin is said to be beneficial during sexual intercourse as it is free to glide and slide over the penis during sexual intercourse reducing friction, vaginal dryness and abrasion (Cold & Taylor, 1999). The penetrative force is argued to

increase ten times when the foreskin is absent (Taves, 2002). Although a circumcised penis dries more often, the uncircumcised penis stays moist which can enhance trapping of pathogens and secretions requiring regular cleaning (Hankin, 2007). Penile hygiene is critical for the protection from microorganisms for both men and women. In Malawi, penile wipe with microbicides was used for penile hygiene and was said to remove the microorganisms responsible for STIs infections (Taha *et al.*, 2005). However, there were speculations about whether the wipes caused abrasions and inflammations which could enhance HIV transmission. This may require further research. Zwang (1997) argued that the foreskin protects the nerves responsible for direct stimulation during sexual intercourse. When the foreskin is present, stimulation is enhanced by the stretching and movement of the foreskin, which can be controlled by an individual motion and stretch (Taylor, 2007). Therefore, most circumcised men are said to suffer from premature ejaculation. Different studies seem to have contrasting results with some men reporting dysfunctional orgasm and others reporting sexual satisfaction after circumcision (Wolff *et al.*, 2014), whilst others were inconclusive (Hoschke *et al.*, 2013). However, some studies indicate that male circumcision promotes sexual pleasure (Riess *et al.*, 2014; Tarimo *et al.*, 2012). In one study from Malawi, women stated that circumcision was irrelevant to sexual pleasure but that it was dependent on how a person was socialised (Ngalande *et al.*, 2006). However, another study in New Zealand found that women with circumcised partners experienced vaginal dryness, a condition known as “arousal disorder” (Bensley & Boyle, 2003). Nonetheless, findings that indicate sexual difficulties after circumcision of the man may hinder the promotion of VMMC as public health strategy for the prevention of HIV.

After circumcision some men may engage in risk compensation (see introduction chapter section 1.3.1.) by increasing risky sexual behaviour because of the view that male circumcision renders them free from HIV infection (Westercamp *et al.*, 2014). Men may also avoid using condoms or even resume sexual activities prior to complete healing of the wound. This could, in turn, leave women more vulnerable to HIV and STIs, reducing their negotiating power for condoms especially in situations

where men have economic and physical dominance over women. In circumstances where men believe that circumcision makes them invincible to HIV infection, women may be labelled as HIV carriers [blamed for being HIV carriers], leading to feminisation of HIV (Hankin, 2007). The effort to circumcise men has faced other challenges. For instance, most religious groups have claimed that there is not enough evidence to support circumcision while fear of pain may prevent men from taking part in VMMC since circumcision is considered a traumatic experience (Taddio *et al.*, 1997). Sexual pains and pleasure, fear of pain and safety are some of the predictors of acceptability of male circumcision (Scott *et al.*, 2005; Westercamp & Bailey, 2007; Westercamp *et al.*, 2012). In spite of these concerns and fears, most African nations are running VMMC programmes (CMMB, 2007).

In addition to the debate on the removal of the penis foreskin, the WHO and UNAIDS's recommendation was criticised for failing to take account of the cultural meanings related to male circumcision in contexts where it is a ritual practice (Ahlberg *et al.*, 1997), with some researchers questioning the claims of the three RCTs. Hills (2007) argued that all lead researchers in the RCTs had publications in favour of male circumcision prior to conducting the RCTs which may have led to a research bias. In addition, all the three RCTs were terminated early. Denniston & Hill (2007) suggest that studies terminated early often tend to overstate the effects of intervention. Preliminary results of the three RCTs showed a probability of risk of HIV infection during penetrative sex before the complete healing of the wound (Wawer *et al.*, 2009), a practice observed among young men in Central Kenya (Kamau, 2007). Despite all the criticism, most countries have scaled up male circumcision as an HIV prevention strategy. However, promotion of male circumcision as HIV prevention strategy gives less attention to traditional circumcision and traditional circumcision providers. According to Brewer *et al.* (2007), traditional male circumcision may be increasing HIV and AIDS infections especially among young men who have not had sex prior to circumcision.

4.3.2. Traditional male circumcision

Although medical circumcision is being promoted, traditional circumcision is still practiced by many societies of Sub Saharan Africa. However, circumcision rituals and practices vary from society to society. Traditional male circumcision has been practiced among the Muslims and in Sub Saharan Africa since precolonial times (Deacon & Thomson, 2012). Very little data exist on traditional male circumcision although some data can be found on male rites among the Xhosa people of South Africa. Different countries and ethnic groups carry out traditional male circumcisions at different ages, ranging from age six in Indonesia (Niang & Boiro, 2007) and Senegal, to 35 in Zambia while in East and South Africa circumcision takes place between 12 and 22 years of age and West Africans circumcise earlier (WHO, 2009). In Xhosa custom, the ritual is performed most commonly on males ranging between the ages of 15 and 25. Traditional male rites mostly occur before marriage and involve: 'physical violence, seclusion, testing, imparting of selective knowledge, death and rebirth symbolism, change of names, dances and songs, costumes, and dietary and sexual taboos' (Silverman, 2004:421). For most initiates, the healing period involves isolation, bullying and humiliation (WHO, 2009). It is a means of separating the boys from the mother and integrating the man into the society (WHO, 2008).

Traditional male circumcision has been described as a health hazard (Meissner & Buso 2007; Schmid & Dick, 2008). This is because it was carried in a non-clinical setting, without anaesthesia by a traditional provider (WHO &UNAIDs, 2008; Wilken *et al.*, 2010). Among the Xhosa of South Africa, senior men are responsible for the cutting. Complications in traditional male circumcision range from haemorrhage, sepsis and even deaths. Research has shown that in South Africa about 70 per cent of the initiates expected complications (Peltzer *et al.*, 2008). Between 2001 and 2005, the Eastern Cape province of South Africa recorded 1748 hospital admissions, 177 deaths and 107 genital mutilations or amputations following circumcision (Meissner & Buso, 2007). In comparison, a recent study carried out in Kenya reported complication rates of 35 per cent with wound infection and delayed wound-healing, the most common among the initiates after traditional male

circumcision (WHO, 2009). Hunger, cold, dehydration and use of unsterilised objects in the cutting without any stitches are other challenges initiates in South Africa experience (Schmid & Dick, 2008).

During circumcision, boys in South Africa are expected to endure pain as a test of their masculinity while endurance of the cold weather is tested through denial of blankets (Schmid & Dick, 2008). However, there are some aspects of the male circumcision that are valuable. Some of the rituals involve instructions to the adolescent boys on maturity and expectations of being respectable members of the community (Schmid & Dick, 2008). During the healing period, most of the initiates go through a training period, featuring sexual education although for some there is a high level of secrecy over what is taught to the initiates (WHO, 2009). Among the Xhosa of South Africa, circumcision is a highly sacred, secretive ritual and cannot be discussed with outsiders (WHO, 2008). Those who filter the secret to the outsiders suffer sanctions. It is a taboo for the women or uncircumcised boys to try and gain information about circumcision. However, a few have violated the rules to expose the harmful effects of the ritual (WHO, 2008).

Certain cultural practices featured in traditional male circumcision are likely to increase the risk of HIV transmission and may reverse the potential benefits of male circumcision in HIV prevention. In some communities, boys are encouraged to have sex shortly after circumcision before the wound is completely healed and one knife maybe used to circumcise several boys. Prolonged wound healing is attributed to traditional ways of cutting the foreskin or complications after traditional male circumcision. This has implications for HIV prevention since the risk of contracting HIV is potentially higher when the wound is not fully healed (WHO, 2009). Some of the practices and aspects of male circumcisions discussed here are similar to those of the Kikuyu people of Kenya as described in chapter two.

Apart from the VMMC programmes, most African governments have not been involved in the male rites. However, the Southern African government has set the

Eastern Cape's circumcision legislation which dictates the legal age for circumcision at 18 while boys of 16 years old may be circumcised with the permission of their parents or guardians. Although the Xhosa traditional circumcisers are nowadays inspected and asked to show the instruments they use in circumcision and the sterilising chemical, there is no eye witness proof that they are compliant. This is because as a cultural practice, some people are not allowed to be present during the actual cutting (WHO, 2008). Regulation of traditional male circumcision is still a challenge and may continue being a hindrance to the public health efforts especially in VMMC programmes. Kenya is one of the countries that have implemented male circumcision in HIV prevention strategies.

4.3.3. Kenya's response to the WHO male circumcision policy

All the WHO 14 priority countries mentioned in chapter one in Eastern and Southern Africa have scaled up male circumcision with 5.8 million men circumcised in 2014 (Dickson *et al.*, 2011). Kenya was one of the 14 countries that responded to the call to scale up male circumcision despite cultural, political and logistic challenges (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010). In 2007, a male circumcision task force was formed in the country (Mwandi *et al.*, 2011). Consequently, in 2008, the Kenyan government passed a new policy on free and Voluntary Medical Male Circumcision (VMMC) directed to the "non circumcising communities", such as the Luo community in Nyanza province (amfAR, 2008). As mentioned in chapters one and two, some communities in Kenya have not practiced circumcision traditionally (the 'non-circumcision communities') while others have (the 'circumcising communities'). However, the policy in Kenya has future plans to include the "circumcising communities" as well as infant circumcision. The male circumcision exercise was to be carried out in health settings and sterile environments. This involves taking what the WHO refers to as a "human right based approach" which requires male circumcision to be carried safely, with informed consent, without discrimination and coercion (WHO, 2007). Although not explicitly stated on the procedure of acquiring informed consent during the VMMC in Kenya, the WHO guideline states that circumcision should not be carried without the informed consent of the individual or by the parent or guardian when a child is not

able to give consent (WHO, 2007). In addition, ethical considerations are said to be taken into account during the VMMC (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010).

International ethics and human rights stipulate that male circumcision should not be carried out if it is going to have adverse health effects or has no health benefit for the individual (WHO, 2007). Older children have to consent to male circumcision especially because surgery on the genitalia is irreversible. However, obtaining consent may be culturally alien to some cultures (Rennie *et al.*, 2007). In addition, some parents may be uncomfortable giving consent on behalf of their sons as this may involve revealing their sexuality and HIV and AIDS status. This is also a challenge if a parent consents to the circumcision but the adolescent refuses or vice versa. Other challenges on ethical considerations in the WHO public health policy regarding HIV prevention in male circumcision in developing countries centres on language, coercion or monetary enticement and illiteracy (Mystakidou *et al.*, 2009). Such barriers may hinder the outcome of the policy despite having many of the men circumcised. Moreover, some men may be interested in male circumcision but they may not be prepared to have an HIV test which is a requirement for the operations. Moreover, there is important to think of solutions to give them if they are HIV positive.

The WHO policy indicated that circumcision would not replace other prevention methods, but would be a component of the government's new Abstinence, Be faithful, Condoms and Circumcision (ABCC) approach. One of the Kenyan Government's goals was to increase the percentage of circumcised men aged 15 to 49 from 84 to 94 per cent by 2013 (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010), as this was the age group most affected by HIV. Apart from Nyanza province, the Western, Rift Valley, and Nairobi provinces are known for low circumcision rates, and thus the target for VMMC programmes. Although there were subsequent plans to reach the traditionally circumcising communities, the Government's intention was to offer a medical, not a cultural intervention (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010). In 2007, Nyanza province recorded about 14.9 per cent HIV prevalence rates (KAIS, 2012). The

Kenyan Government proposed a three to five year phase to realise its goal (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010). The Kenyan Government estimated that if 80 per cent of males between 15- 49 years of age were circumcised in Nyanza province by 2013, then approximately 900,000 HIV infections would be avoided. The Ministry of Health (MoH) organised the VMMC in three phases. Phase one was aimed at 15-49 years old while later phases target less than 15 years old and infants for future VMMC programmes (Mwandi *et al.*, 2011).

Acceptability of male circumcision in Nyanza province, among the Luo people who do not practice male circumcision traditionally was enhanced by factors such as a fear of the HIV epidemics as a motivator and political support, with the prime Minister of Kenya then Raila Odinga and other politicians from the Luo community endorsing male circumcision which had been resisted by the Luo elders. This brokered a meeting with the Luo council of elders which began a series of intense public consultations with the stakeholders, such as young people, religious and women's groups and professionals in 2008 (Mwandi *et al.*, 2011). The leadership was thus attributed to the success of the scale up of male circumcision as part of the HIV prevention strategy. The Luo council of elders, the custodians of the Luo culture, accepted and acknowledged male circumcision as an additional strategy for HIV prevention. They did it on condition that the word 'policy' in the male circumcision guidance document would be removed, leading to the national task team changing the title of the document from *National Policy for male circumcision in Kenya* to "*National Guidance on Voluntary Male Circumcision in Kenya*" (Agot, 2009). They viewed the term policy to equate to a law, thus not voluntary. They also wanted the term 'voluntary' to speak louder so that all would know it was a voluntary exercise (Agot, 2009). These negotiations between the Luo people and the Government illustrated the need to adopt and use terms that are culturally acceptable and understood in the implementation of public health policies. In addition, the Luo council of elders wanted the VMMC to be directed to all communities so that it was not just the Luo people who were targeted. This could have been seen as a way of

stigmatising a particular group by the whole country who may view them as HIV vectors.

The popularity of the VMMC was reported high among Luo boys and teenagers. Forty five per cent of the voluntary male clients during the annual Rapid Results Initiative were below 15 years of age. Circumcising such young clients most of whom were not sexually active was argued not to have an immediate impact on the HIV epidemic. Provision of VMMC services to males 25 years old and over was a key challenge to attaining Kenya's national target of 80 per cent VMMC coverage among uncircumcised males aged 15-49 years by the end of 2013. Thus, communication strategies to attract older sexually active people to the male circumcision programme are vital (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010). Despite a successful response to circumcision, follow up has not been effective. Statistics showed that only 23 per cent of the males circumcised returned for follow up and only 39 per cent had opted to be tested for HIV. These rates were much lower than those achieved during routine service delivery (GoK, Ministry of Public Health and Sanitation & NASCOP, 2010). Although male circumcision is a male's arena, studies show that women play a key role in men's decision on VMMC. Therefore, the Kenya VMMC programme has been running a communication campaign encouraging women's involvement in men's decision to get circumcised (Lanham *et al.*, 2012). Some of the women have thus played a key role in convincing their male partners to enrol for VMMC services.

4.4. Conclusions

HIV and AIDS prevention efforts in developing countries seem to be experiencing challenges despite the introduction of the fourth prevention strategy of male circumcision. Cultural factors have been discussed as part of the challenge in the implementation of HIV and AIDs policies emphasising the need to pass or adopt policies that are culturally sensitive. In addition, taking into account the voices of people to whom policies are made was shown to play a role in the promotion of VMMC. Although male circumcision is promoted to the non-circumcising groups, the cultural practices of the circumcision groups may give the opposite results expected of the male circumcision prevention efforts. In addition, the acceptance of VMMC programmes by the non-circumcision communities is still a challenge in the recommended settings. Kenya has, however, had a successful implementation of the VMMC programmes, although the follow up has of the newly circumcised men has not very successful.

Research Design

5.1. Chapter Introduction

The previous chapter discussed male circumcision and public health, in particular, in relation to HIV and AIDS. In this chapter, the underpinning philosophy of qualitative research design, methodologies, and methods employed in this research are discussed and justified while terms and principles are defined. The data collection process and analysis are also described. Credibility, reliability and generalisation of qualitative research are discussed.

5.2. The aim and objectives of the research

The aim of this study was to explore the meaning of the male circumcision ritual, the changes taking place in male circumcision in Central Kenya and the implications for public health practices. The objectives of the research were:

1. To explore and describe Kikuyu young men's actual experiences during and after circumcision.
2. To understand the male circumcision ritual and practices by the Kikuyu young men in Central Kenya.
3. To explore the role of male circumcision mentors in the Kikuyu male circumcision ritual in Central Kenya.

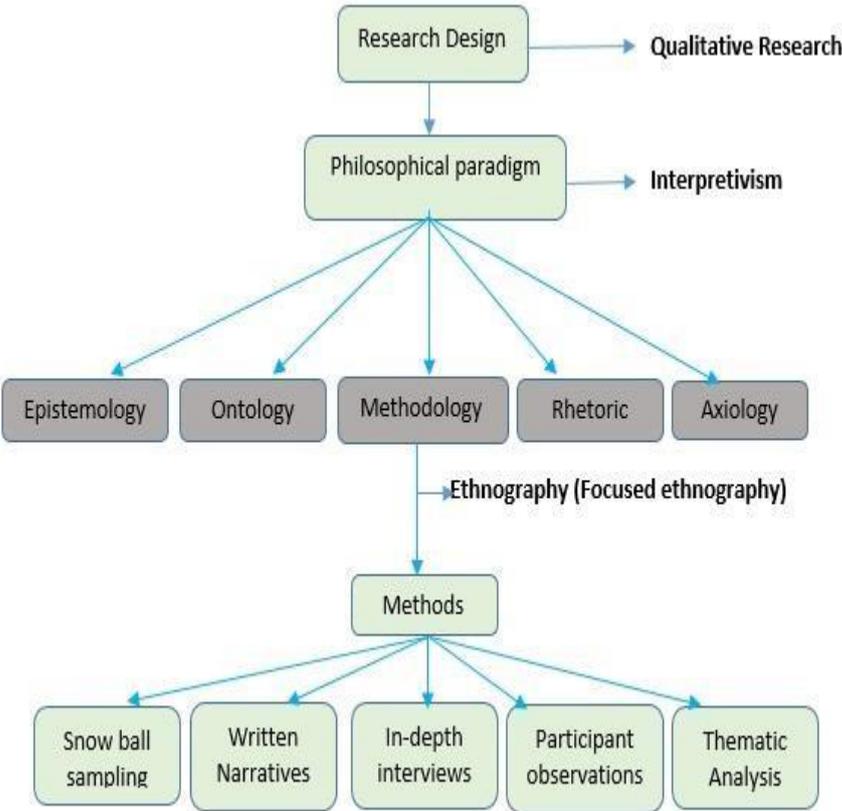
The research questions were:

1. What are the experiences of the Kikuyu young men during the male circumcision ritual?
2. What is the role of Kikuyu male circumcision mentors⁴ in the socialisation of the newly circumcised?
3. What is the impact of Kikuyu male circumcision practices on HIV prevention?

⁴ Male circumcision mentors take the boy for circumcision, "the cutting"; in the hospital and take care of them on return home as they recuperate until they are ready to go out on the road.

The research design framework adopted in this study is illustrated in figure 5.1. The research theoretical perspective of interpretivism informed the ethnographic methodology which informed the methods used in sampling, data collection and data analysis.

Figure 5.1. Research design framework



5.3. Research Approach

The decision to employ a qualitative research design in this study was based on the research aims and objectives, which required in-depth exploration of the participants' experiences. A qualitative research approach was appropriate in this study as it also aimed to explore the meanings of the male circumcision ritual and sought answers to questions on how the social context and experiences of the participants were constructed. A qualitative research approach thus enabled exploration of constructed meanings and how young men made sense of their world and their experiences (Bryman, 2012; Creswell, 2003) in the male circumcision ritual. In addition, qualitative research allowed for the employment of methods such as participant observation and in-depth interviews resulting in a narrative and descriptive account of the male circumcision ritual and practices (Bryman, 2012).

Qualitative research enabled a holistic approach where the male circumcision ritual as a social phenomenon was understood and described rather than predicted. The qualitative research process and not just the end product were described in detail. The qualitative research design in this study was informed by the interpretivist philosophical worldview assumptions and ethnographic research methodologies. The methodological approach informed specific methods of data collection and analysis such as narrative writing, in-depth interviews, observations and thematic analysis.

5.4. Philosophical approach

A paradigm is a philosophical world view on the complexities of the real world that guides actions. Paradigms are classified in ways in which they respond to basic philosophical questions or assumptions (Creswell, 2009; Lincoln & Guba, 2000). Philosophical questions are based on ontology, epistemology, axiology, methodology and rhetoric questions. Ontology addresses the nature of reality, epistemology focuses on the relationship between the researcher and what is being studied, axiology addresses the role of values in the research while methodology addresses the question of how a researcher acquires knowledge and rhetoric

describe the language to adopt research. Although more than two paradigms exist, McGregor & Murnane (2010), report two main paradigms; positivism and interpretivism. The objective to explore young men's circumcision experiences influenced the use of interpretivism in this study.

5.4.1. Interpretivism

In this section, I will describe the epistemological, ontological, axiological, rhetorical and methodological underpinnings of interpretivism. Rhetorically, qualitative research is often written in the first person. This is also emphasised in ethnographic methodologies. However, this research aimed to have a balance between the first and third person in research as suggested by Jones (2010). This is described later in this chapter. Methodological assumptions allow participants to be discovered through close interaction with a researcher. This is to enable a construction of meanings consistent with the experiences of the participants.

Ontologically, interpretivism takes a relativist stance that multiple realities exist, which is subjective, socially constructed and interpreted to the context (Crotty, 1998; Guba & Lincoln, 1994). Multiple realities of the male circumcision ritual resulted from different perspectives from the mentors, young male students and church leaders in interaction with parents (Hudson & Ozanne, 1988). Multiple realities thus exist owing to individual and group differences. Mentors and young male students reflected on different perspectives as they were positioned in different groups and played different roles in the ritual. Each participant constructed meanings and perspectives, some of which were unique compared to those of other participants. Although different individuals contributed varying perspectives and meanings in this research, the nature of realities (ontologies) created were viewed holistically (Hudson & Ozanne, 1988). Instead of taking them as parts, the sum of the parts was taken into account resulting in multiple realities. This is because reality must be seen as a whole whereas trying to fragment it leads to the disintegration of reality (Rist, 1977).

Epistemological assumptions accept that the researcher interacts with the object of research and can affect that object. Findings are created through the interactions of a researcher and the researched. The epistemological stance in interpretivism requires dynamic interactions between the participants and the researcher in order to understand experiences of the participants (Ponterotto, 2005). Participants made partnership possible in this research (Geertz, 1973) in the creation of meanings. The study relied on my personal insight as a researcher to co-create meanings by being actively involved in data generation through interaction with participants in the in-depth interviews and the writing of narratives. Participants wrote their own stories while I constructed meanings from their stories. Participants thus became collaborators and co-creators of knowledge and meanings through member checking and follow-up (Janesick, 2000).

In axiological assumptions, there are assumptions that there is a value-laden purpose to the research. Axiological assumptions allow a researcher to state their values and the value laden nature of information gathered (Ponterotto, 2005). In qualitative research, unlike in quantitative research, values occupy an important position. The researcher's attachment and passion for the research must be acknowledged and explained. The close interpersonal contact between myself and the participants could not be fully eliminated. However, Spradley (1979) proposes that rapport does not imply a close relationship but enhances negotiations and sharing of meanings and ideas. Patton (1990) on the other hand, suggests that researchers keep a distance from the participants while Wilde (1992) suggests that to get information one has to self-disclose to the participants. He added that a researcher should be viewed as a human being with experiences who is able to empathise with participants.

My background, insight and subjective experience of interaction may have added to the unique construction of knowledge. My worldview became part of the interpretation and constructions of meanings and played a role in shaping the findings (Seale, 1999; Patton, 2002; Ladkin, 2005). Having had no experience of

male circumcision, I had nothing to disclose but the participants had to feel comfortable to share their experiences. By listening without judging, laughing or ridiculing their experiences, I enabled them to give details of practices, incidences and experiences in the male circumcision ritual. Nodding was used to assure the participants that I was listening and engaged in their narrations. I empathised and sometimes felt angry at some of the harassment the participants had to go through during circumcision. However, I controlled myself not to show or voice it but it is probable that the participants were able to sense it. Researchers can and do react to participants' stories (Hubbard *et al.*, 2001). In this instance, the researcher's private emotional world connects with the public world (Gould & Nelson, 2005).

5.4.2. Ethnographic research methodology

Methodology is the strategy or plan of action behind the choice and use of particular methods (Crotty, 1998). It addresses the why, what, from where, when and how data are collected and analysed. A qualitative methodology such as ethnography, grounded theory and phenomenology under the interpretive paradigm has views of multiple truths and realities and are used to find how the research question is answered (Hudson & Ozanne, 1988). An ethnographic methodology was adopted in this study as it entailed studying the shared and learned pattern of behaviour, values, and language of a group that shares a culture and social meanings (Creswell, 1998; Roper & Shapira, 2000; Silverman, 2006). In an ethnographic study, the researcher participates directly in the setting if not in the activities (Brewer, 2000). I was not directly involved in the activities of the participants in the field, but I was in the research setting. However, I endeavoured to be part of the male circumcision meetings to avoid the position of being a complete stranger. For instance, when parents and guardians stood for prayers and singing, I joined them and sang the songs that were known to me.

According to Pool & Geissler, (2005) people are unconsciously influenced by the culture in what they do and how they do it (Pool & Geissler, 2005, p.11). The cultural context was of particular interest in this study and underpinned the research questions and objective. The aim of the study was to look beyond what people say

and to discover the shared meaning which refers to “culture” (Roper & Shapira, 2000). Culture acted as a device that enabled a better understanding of what the Kikuyu young men do and why they do it during and through the male circumcision ritual. Geertz (1973) suggests that culture consists of shared meanings and that meanings are public and go beyond the human mind. Although individual and subgroups differ from each other, they share a common culture which enables them to communicate, live and work in groups and interpret each other’s behaviour. Interactions with the participants revealed some differences in some of the common experiences and practices between individuals and groups depending on their setting, religion, values and relationships around them, but there was also common knowledge shared between them. Ethnography as a process and product of research was used to describe the cultural behaviour of the Kikuyu people (Bernard, 2013) and relate the young men’s stories in their own words (Roper & Shapira, 2000; Brewer, 2000).

There are different ethnographic approaches that have evolved over the years. These approaches include critical ethnography, visual ethnography, focused ethnography, performative ethnography, auto ethnography and multi-sited ethnography (Falzon, 2009). Critical ethnography is said to have a political link and strives to address processes of injustice and unfairness in a culture with an aim of empowering the participants by challenging the status quo (Gordon *et al.*, 2007; Merten, 2005). The aim of this study contradicts that of critical ethnography as it was to explore the meanings and the changes in the male circumcision ritual and the implications for public health. This study did not aim to empower the study participants although it allows for proposals of recommendation that could be used by policy makers for enhancement of young men’s health. Performative ethnography requires an ethnographer to present findings in the form of dramatic performances in order to satisfy a given group (Bryman, 2012) whilst auto ethnography is characterised with an autobiographic nature which does not fit with the present study (Mertens, 2005). Multisite ethnography involves the study of a given phenomenon in multiple researches. Focused ethnography focuses on small units of culture in a relatively short time (Roper & Shapira, 2000). Focused

ethnography was used in this study as it dealt with a small social group of the Kikuyu people and parts of their culture on male circumcision (Boyle, 1994; Knoblauch, 2005). Focused ethnography fitted with this study as it allowed for a study of a distinct issue and a small sample of participants with specific knowledge about male circumcision by a single researcher (Higginbottom *et al.*, 2013).

Focused ethnography

Focused ethnography is referred to as mini ethnography (Leininger, 1985), micro ethnography (Wolcott, 1999; Roper & Shapira, 2000; Polit & Beck, 2008) and ethnographic approach (Savage, 1995). Focused ethnography will be described alongside other common concepts of what is referred to as conventional ethnography (Knoblauch, 2005). Although not explicitly defined in materials used in this study, conventional ethnography is characterised by a long duration of time in the research field. Focused ethnography is different from conventional ethnography in that it focuses on a smaller culture or group within an institution (Holloway & Todres, 2006). Although different from conventional ethnography, focused ethnography is not seen as being in opposition to ethnography but rather complementary to it (Knoblauch, 2005).

Focused ethnography assumes that the researcher has some knowledge of the topic to be studied. Although male circumcision is a male subject, I had some knowledge about the subject from the literature review of the subject prior to the field work. The focus is on specific topics and interview topics that are structured around the research subject (Morse, 2007; Spiers & Wood, 2010; Higginbottom, 2011). Whereas a researcher delineates their interests in the topic and enters the field with specific research questions in focused ethnography, a conventional ethnographer enters the field open without a particular focus of topic (Knoblauch, 2005). Thus, a focused ethnography researcher carries out the research in a shorter time than in conventional ethnography (Roper & Shapira, 2000; Savage, 2006) since focused ethnography is also to be carried in one's own culture (Knoblauch, 2005). This involved immersion in the field work without necessarily "going native" but getting "close and personal" (Jones, 2010). This contrasts with

Emerson's (1987) concept of immersion, which is characterised by a lengthy period of stay in the research field as in conventional ethnography.

The aim of the data collection was, therefore, not to reconstruct the whole field work but rather to gain an understanding of male circumcision practice from an insider's perspective which Cruz & Higginbottom (2013, p.39) refers to as "background knowledge". The background knowledge informed the research question prior to the field research. Reflecting on this, because I am a Kikuyu and thus "an insider", I understand most of the cultural symbols and expressions. However, I realised that the knowledge of most of the ritual practices in male circumcision is only shared among the men. I had not heard of some of these practices prior to the field work. In addition, even having a good comprehension of the Kikuyu language, many of the expressions used by men relating to the ritual are only known to men.

Focused ethnography does not prioritise participant observations (Spiers & Wood, 2010; Higginbottom, 2011) as in the conventional ethnography. In focused ethnography, participant observations can be carried within a given time frame, limited or eliminated (Morse, 2007). However, the observer role is advocated for in focused ethnography than the participant role in conventional ethnography because it is less time consuming (Higginbottom *et al.*, 2013). It is also advocated for in field where active participation is not required. Observations were made in the male circumcision meetings with parents in churches running male circumcision programmes as discussed later in this chapter. In conventional ethnography, participant observation is one of the main methods in data collection. Although focused ethnography differs from conventional ethnography, the researcher must adhere to ethnographical scholarly rules and norms to reduce personal bias. In carrying out the research, I acknowledged my previous experiences and values in the research I had conducted in the past. Having investigated issues associated with male circumcision previously, this made me aware of what to expect. However, despite the hunches I had of what to expect, I had to be flexible, open and revise the previously learnt knowledge to avoid them limiting me in any way. Nevertheless,

the methods used in the previous research were different as I had used focus group discussions, which were not used during this research.

Although Knoblauch (2005), suggests using audio-visual data collection methods in focused ethnography but only digital recording was used in the interview. While video-recording and photography are other methods of data collection, not all people in this culture are willing to be photographed. Such methods may become intrusive, create resistance and consequently be ethically inappropriate (Fetterman, 2003). In my previous research, I found that even the use of tape recorders was met with hesitation by some participants and they had to be reassured of confidentiality and the limitations of capturing every statement in writing. Visual data collection methods are not appropriate in all contexts because of the way they are interpreted by people in different cultures and how well they fit with the aim of the research. In this culture, as in several other African cultures (Pink, 2001), even if some people may accept that photographs are taken of them, they often want to dress up for them, dictate how they want their image represented (choose the site and the pose for the picture) and ask for a copy of the photograph. Digital recording reduced distractions that accompany note taking, allowing me to attend fully to the participants amidst listening, thinking and preparing for probes (Busfield & Lyon, 1996; Matthews & Ross, 2010). The recording also enabled recordings to be saved as files, with a numerical index linked to them, which could be transferred to the computer allowing easy access and retrieval of the recordings.

Length of Study

The fieldwork took three and half months. Knoblauch (2005) suggests that short term field visits is one of the features of focused ethnography, while others like Newell & Burnard (2011), state that ethnography is usually a “one off process” with researchers rarely returning to the participants and sites to clarify issues that emerge in the original data collection because of time and financial constraints. The duration of focused ethnography in the field varies from weeks (Weinstein & Ventres, 2000; Munhall, 2007), to a month (Hopkins, 2002) or months and years and is influenced by the researchers’ time and finances, research question and setting (Roper &

Shapira, 2000). When the research questions were answered and no new information was emerging (law of diminishing returns), I left the research field as this was a sign of data saturation (Fetterman, 2003). In addition, the financial and time constraints as guided by my PhD timetable required that I left the field after three and a half months of data collection.

Style of reporting

Ethnography allowed the use of conversational tales and realist tales to describe findings in this study. Conversational tales highlight descriptions of the research process, challenges and reflections in the field research among the Kikuyu people (Van Maanen, 1988). Conversational tales consist of accounts of my personal experiences of how the research was undertaken, detailing the problems and the challenges encountered in the field in this study. Realist tales, on the other hand, were used to describe participants' experiences while accounting for their voices in quotes used in the findings chapter. Van Maanen (2011) suggests incorporating conversational tales within a standard ethnography rather than having them as separate chapters or as appendices. A separate section on the challenges encountered in the field is provided in chapter six and my personal experiences are also incorporated in this chapter.

Thick description was employed and entailed use of direct quotations in the findings chapter and emphasis on the use of the first person when writing. This is in contrast to thin description where everything is recorded descriptively but describes the field setting and events in as much detail as possible in relation to the context (Jones, 2010). Thick description led to a lot of detail while also having to consider the word count limit. Emerson *et al.* (1995) describe ethnographic writing with a shift between third and first person, especially when writing field notes. Similarly, Light (2010) advises that a student has to balance the use of third and first person. A combination of the first and third person and use of extensive quotes from the research field have been used in this research, which Light (2010) affirms as a central part of ethnographic writing. This accorded a voice to the participants, who should be

allowed to speak their own way without correcting or improving on what they said (Coffey, 1999). In this study, narratives written in English by the students have been used in their original format without correcting the grammar and expressions (see sample in appendix 11). This was also a way of acknowledging that participants are human beings and not objects (Wolcott, 2009). A brief coded description after the quote has been used in the findings to present the gender and age of the students. The male students' written narratives were anonymous.

The three main methods of data collection used in ethnography are observations, interviews and documents. In this research, triangulation of methods was employed; observations, in-depth interviews and written narratives were used to collect data. The use of different methods of research is known as triangulation (Denzin, 1978). Triangulation enhances comparison of issues and levels in ethnography (Fetterman, 2003).

Limitations of focused ethnography

In this study, the field research enabled explorations of male circumcision through in-depth description of the practice which is one of the elements of ethnography useful for describing specific cases in detail. Being an ethnographic study, it is not possible to replicate or generalise the findings in this research. A researcher using ethnography on similar techniques may not arrive at the same conclusion. Sutton & Matthew (2004) argue, however, that the sacrifice of generalisation for depth is a fair trade off as long as the loss of generalisation is acknowledged. Ethnography is a time consuming methodology and emphasis on building rapport with the participants can result in over familiarisation which could impact negatively on the researcher's interpretation of data. Owing to the descriptive nature of ethnographic data, maintaining confidentiality can be difficult.

Role of an ethnographer and reflexivity

Reflexive data were produced by thinking about what I was doing, experiencing and feeling, and about reactions to participants. This involved deeper reflection of both past and present while involving the five senses and asking questions such as: 'which part did I play, how would I have influenced some behaviour?' (Watts, 2010 p. 187-188). Reflexivity was also of importance when leaving the field such that when the field starts becoming familiar and more like home then it is time to leave (Seale, 2004). As a Kenyan woman researching a male dominated issue, the question as to whether there was some information that was withheld from me by the participants does arise. This question still remains unanswered. Creation of rapport with the participants was important in this research to help clarify emerging issues. The two elderly men I interviewed acknowledged in some instances that they were not aware of some of the practices shared by the young men probably owing to the age gap.

As an ethnographer, I was a human instrument (Fetterman, 2010) aiming to eliminate any biases and preconceptions prior to the entry into the field. However, it is a challenge to evaluate the extent to which an ethnographer achieves this, due to the internalised beliefs and values and preconceptions that may be difficult to eliminate. This may also have included having respect for the participants. My status was that of insider and an outsider, an insider by having grown up, been brought up and learnt the culture and the language of the Kikuyu people. However, I grew up in a different Kikuyu setting, of Kiambu as opposed to Muranga where the study took place. I was also an outsider being a woman researching a topic relating to the Kikuyu men. In addition, I was a relative outsider owing to my education level compared to that of the participants, with Europe as my place of study. Only one of the mentors interviewed was studying at university level at the time I did the interviews. Only two mentors spoke in English during the interview, the rest preferred and were comfortable in Kikuyu. They all knew this was an academic study by a student researcher. However, I only divulged my educational status when asked. This was aimed at reducing any feeling of inadequacy by the participants when talking to me.

5.4.3. Research methods

The ethnographic methodology chosen in this study dictated the research methods used in data collection, data analysis, interpretation and write up. Data collection and analysis methods are discussed under this section. Data were collected using participant observation and in-depth interviews. These two methods are recommended in ethnography (Brewer, 2000). Written narratives were also used to collect data from young male students. Field notes and reflections were noted using a note book which also acted as a diary, to enhance immersion (Knoblauch, 2005). Data were analysed using thematic analysis.

Data collection

Data collection lasted three and half months. Prior to the commencement of the male circumcision programmes in the churches, meetings referred to here as 'parents' male circumcision meetings' were held in the church. Observations of the parents' male circumcision meetings took place in three churches. In the male circumcision programme, the church enrolls boys for circumcision, who are able to recuperate and get advice and teachings in the church premises for a fee. The fee included the hospital fee, caretakers' and counsellors' honorarium and the food for the initiates. Data were collected in Kikuyu, English, Kiswahili and Sheng language.

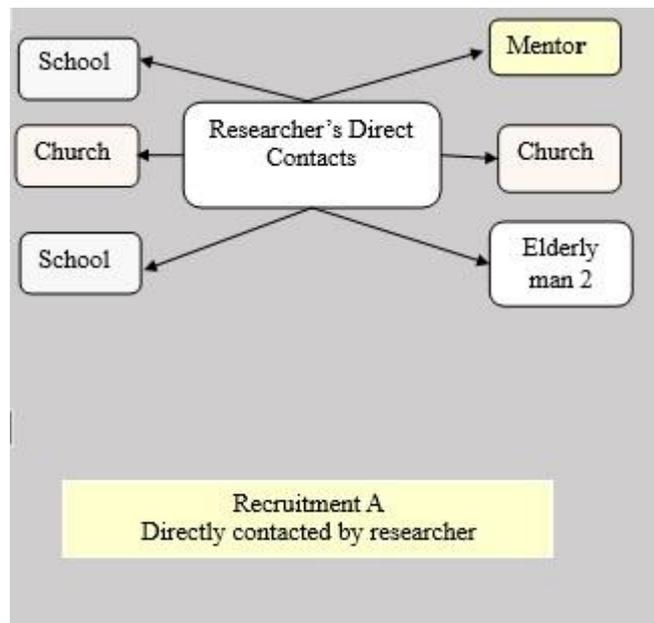
Sampling strategy

Purposive sampling is a form of non-probability sampling where inclusion criteria for participation are decided by the researcher depending on the research subject (Oliver, 2006). The participants are supposed to be specialist in the knowledge sought and capacity and voluntariness to participate. Purposive sampling was appropriate for recruiting a sample relevant to the research questions (Bryman, 2008) and ethnographic research (Bryman, 2012). It is linked to small in-depth qualitative research designs and is useful for a sample that is not statistically representative (Teddlie & Tashakkori, 2009) as in qualitative research. Purposive sampling was employed to recruit participants, in particular, snow ball sampling,

which is based on social networking and provides an informal method of reaching a population of interest (Atkinson & Flint, 2001). Snow ball sampling, also known as a chain referral sampling, is considered suitable for hard to find groups (Bernard, 2013) such as the male circumcision mentors. Male circumcision is mostly conducted privately, as a family event, which explains why the male circumcision mentors were hard to identify. Participants were included in the study because they had knowledge and experiences of male circumcision. However, members of a group with specific features are likely to know each other and be in contact with each other.

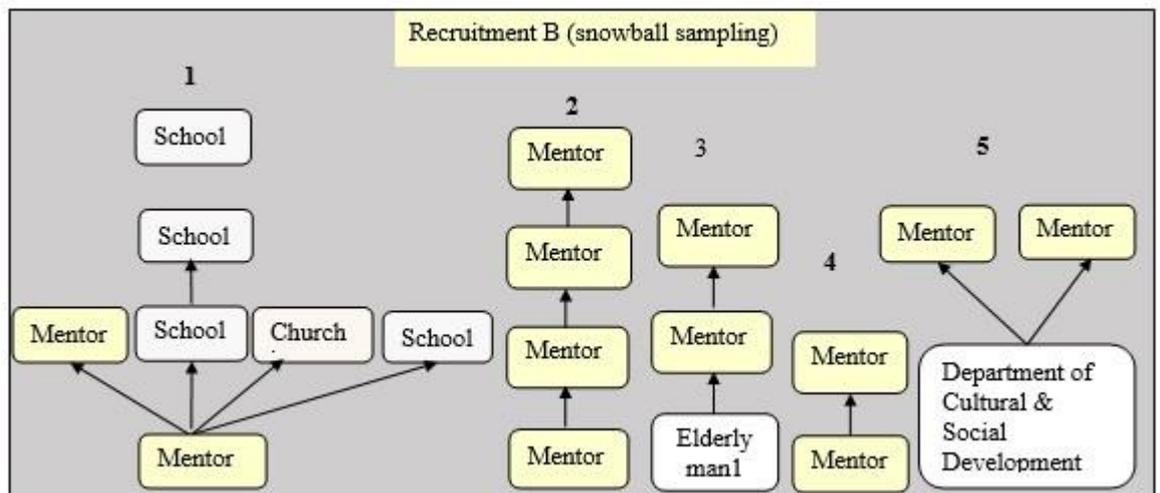
The sampling was conducted in two ways: I recruited some of the participants directly (Recruitment A, figure 5.2) while others were identified by other participants and community members as in snow ball sampling (Recruitment B, figure 5.3). Each box in figure 5.2 and 5.3 represent a single participant. Recruitment A, in figure 5.2 below represents all participants who were directly contacted by the researcher. I contacted two schools, two churches, one mentor and one elderly man directly without being referred by other people. The two schools and two churches were located during the field work and I approached the gatekeepers who allowed me entry.

Figure 5.2 Sampling recruitment Framework A



Recruitment B in figure 5.3 represents all the participants who were identified and suggested by others as in snowball sampling. There are five chains showing how each participant was referred by a previously recruited person. Two of the male circumcision mentors were recruited and contacted through the government authority in charge of the local youth groups' official registration. All the youth groups are enrolled with this department, where I got a list of the youth groups with contacts. A 103 year old elderly man (Kirika) was referred to me by a member of the community. The elderly man (Njuki) later referred two mentors to me who agreed to be interviewed. The other three chains under recruitment B began with mentors who were referred to me by the members of the community and the chain grew from there as each person referred me to the next contact. I talked to community members at the canteen where I stopped to drink juice as I waited for the bus and engaged them in discussion on male circumcision topic. It was in asking community members for directions that I got information about two of the churches that were conducting male circumcision.

Figure 5.3. Sampling recruitment framework B



Snow ball sampling poses some challenges as it does not represent the larger population. I was able to know some of the characteristics of the population in

question, but did not know the representativeness of the sample. The participants only reflect the willing participants while excluding those who were not approached for the study (Griffith *et al.*, 1993). However, in qualitative research, it is not the representativeness that is important but rather being able to describe the context well enough for others to recognise or to transfer to other contexts of their interest.

Study Sample

Participants who took part in this study included 14 mentors, aged between 21 and 42 years old, 43 young male students aged 13-21 years of age years as illustrated in table 5.1 below 2 elderly men aged 54 and 103 years old and observations in three churches. Students circumcised at the same time in one region shared an age set and were thus age mates regardless of their age differences (see chapter 2). The students were recruited from six secondary schools. Two secondary schools were located in Muranga North, two in Muranga South and two in Muranga East. Two of the secondary schools identified in Muranga East were prompted by mentors' descriptions of the region where the schools are located as a place where male circumcision practices are enforced among the young boys. Parents were observed in three churches running supervised male circumcision programmes. The use of gatekeepers (church leaders and schools heads) was essential in accessing the churches for participant observation and schools for the narrative writing sessions with male students.

Table 5.1. Distribution of male students' participants

Category	Age (years)	Number
Form fours	17	3
	18	8
	19	7
	20	3
	21	1
Total forms fours	22	
Form ones	13	1
	14	2
	15	4
	16	6
	17	5
	19	2
	No age written	1
	Total form ones	21

The mentors had experiences of mentoring circumcised boys. Their work was to care, support and mentor the young men during and after circumcision. The boys and/or the parents choose the mentors prior to the ritual, depending on each region. All the male circumcision mentors interviewed took care of initiates circumcised at home. Most mentors preferred to use the Kikuyu language apart from two mentors who spoke in English but also used Kikuyu intermittently. One of the mentors who responded in English seemed to have several roles as he had been a mentor but was now mobilising other mentors as advisers for initiates who already had mentors. He also organised training sessions for the mentors through the Department of Health on mentorship roles such as wound care after circumcision. This was not the case in the past since mentorship roles in male circumcision have always been transferred from one mentor to another through apprenticeship, not through training

from the health department. However, churches do not have circumcision mentors but instead hire young men and teachers who they refer to as caretakers and counsellors respectively during the male circumcision programme. The initiates circumcised in churches have the freedom to get a personal mentor after leaving the church premises. I did not interview the caretakers/counsellors since the study only proposed to interview the male circumcision mentors. Not all churches in Muranga organised male circumcision programmes in 2013.

Field notes

Field notes were taken in a notebook which also served as a diary during observations of parents' male circumcision meetings in the church premises. The field notebook was used to revisit past experiences and the effects these could have on my interpretation of the research (Tricia Le Gallais, 2008). I used my own judgement on what and when to write notes. What may be considered important to note down depends on the researcher's background (Munhall, 2003). Initial observations and reflections were noted immediately and written out comprehensively after leaving the field. Field notes were taken in short form (short hand) during observations and typed out in full at the end of day. This involved writing key words, codes and noting clues understandable to me. This was to avoid a lot of attention directed at me during the observations. According to Munhall (2003) spending too much time writing notes during the interviews inhibits immersion in the culture and can cause distractions for the participants. I therefore, had to balance between the writing and observing to avoid missing out much of the happenings during the meetings. During in-depth interviews and narrative sessions, no notes were taken until the session was over. This enabled a concentrated focus (listening and probing) on the mentors' responses as the interview was being recorded. This also provided freedom to write in privacy. Notes were written up immediately on the same day after collecting data.

Written Narratives

Narrative is a common method of data collection in ethnography, although few researchers have used written narratives. Written narratives and self-generated questions by young people have been used in some of the research carried out in Africa on sexuality (Kiragu *et al.*, 2006). This method has also been used in schools in Kenya (Ahlberg *et al.*, 1997; Ahlberg, *et al.*, 2001; Khamasi *et al.*, 2011) and in Zimbabwe (Chikovore *et al.*, 2009). Narrative writing was chosen based on past experiences in the field where I found that, newly circumcised young men aged 11-14 years tended to shy away during focus groups and in-depth interviews making it difficult to get rich data. This could be explained by male circumcision being a sensitive topic and the young men maybe grappling with new experiences of transition from boys to men. Narratives are vital in qualitative research as it is believed that “telling one’s stories helps create a sense of oneself” (Marshall & Rossman, 2011, p.151). In addition, as Keats (2009) suggests, narratives give a rich and deep understanding of people’s experiences and lead to new knowledge and perspectives.

Prior to the narratives writing, I met the students, informed them of the research and gave them a copy of the information sheet. Those below 18 years of age (minors) were given a parent/guardian’s consent form to take to their parents/guardians, for a signature if they wanted their sons to take part. These students had to sign an assent form after their parents/guardians signed the consent form. In most cases, I returned to the schools for the narrative writing a week after meeting the students, but this depended on an appointment date approved by each school. Male students in Form One and Four classes were asked to narrate their actual experiences in male circumcision in writing. The students were given a narrative writing guide (see appendix 10), but were also free to explain questions beyond the guideline. To reduce any form of intimidation on the students, teachers were requested to leave the classroom during the narrative writing. The students were asked to their names but had to write their class and age. They were also free to use a language of their choice from English, Kikuyu and Kiswahili. Most students used the English language but occasionally wrote some of the words in Kikuyu or Kiswahili and Sheng. Sheng

is a slang language coined from two languages Swahili and English. The "h" was taken from the middle of "Swahili because "Seng" would have sounded odd. Like most slangs, Sheng is commonly used by the youths and although it started with the Nairobi urban youth, it has spread to almost all the other parts of the country. Although some students may be more articulate than others, it is their experiences rather than how they described those experiences which were of interest to this study.

Most students had learnt about research and field work in their geography lesson and were therefore able to relate to what I was doing. This was practical for them and most of them were willing to participate in the research. Narrative writing sessions were conducted during the students' free time to avoid disruptions of classes. The written narratives allowed the young men freedom to reflect, express their experiences, and meanings attached to these experiences anonymously and share what they would not have shared publicly. Some of the final salutations used by the participants and words showed that students felt free to ask and say anything they wanted in writing anonymously. Some of them were even bold to write and suggest where I could get some more information. The students had the opportunity to ask questions prior to the narratives but it seems they were more comfortable doing so anonymously. Being anonymous probably gave them the confidence to participate and it is possible they may not have participated otherwise. Two Form Four students wrote that they were under oath not to disclose the information they had received during circumcision at the end of the narrative:

For your notice, the information I have given to you was not to be told, since there was a vow or "kwihitithio" never to give the information out especially to a woman so keep it secret. Just for your study, good luck in your research and all the best. (Form 4, 20 years).

Similarly another one wrote:

The information I have given you is supposed to be secret to grave. It was just because of your study, good luck (Form 4, 22 years).

In this culture, it is very common to appreciate someone's time with a gift and for the students, this was rewarding. The students received bookmarks and hand bands with the Northumbria University logo after participating. However, they were not aware that they would receive gifts until after they had completed the narrative. The narratives from the Form One and Form Four students were later compared to identify trends in the practices in the ritual. Narratives were conducted first as they were used to develop the in-depth interview protocols with the male circumcision mentors.

In-depth Interviews

In-depth interviews with the male circumcision mentors were conducted using an in-depth interview protocol with open ended questions (see appendix 8). The Indepth interviews was used as a guideline for conducting the interview and a way of ensuring that topics of interest to the study were covered. In-depth interviews allow ample time with the participants and a rapport is developed which is said to be necessary for collection of rich data (Marshall & Rossman, 2011). Nevertheless, a, I was not limited to the in-depth interview protocol, but asked extra questions beyond it, depending on new emerging information as this may add new ideas and dimensions to the study. I used probes to follow up on new emerging issues.

None of the mentors were willing to meet with me more than once. Therefore, after explaining the information sheet, during the first meeting, mentors who were interested in participating in the study signed the consent forms and asked for an interview immediately. However, before meeting the mentors, I made at least two telephone calls to introduce myself and to explain the research. The mentors would usually propose a date and venue for the meeting during the first telephone call. A second telephone call was made to remind the mentors of the scheduled meeting. Of the 14 male circumcision mentors, only two agreed to schedule a second meeting. All the same, almost all the male circumcision mentors I approached were willing to participate and give additional information after the interview when requested on the telephone.

All the in-depth interviews were digitally recorded apart from two (one with a mentor and one with an elderly man (Kirika) where the recorder's battery ran out. For those interviews where I could not use a recorder, I took notes as the mentor and the elderly man talked. I transcribed them the same day since the conversations would be fresher in my mind than if transcribed later. Although it seemed very easy to remember details the same day when referring to the notes taken in short form while in the field, it was impossible to capture details such as pauses, use of "mhhh" and laughter. Writing notes cannot match the speed of speaking and is more difficult to capture every detail as a recorder would do (Munhall, 2003). Both the recorded and transcribed data were kept secure and confidential, without identifying participants.

Participant observation

Participant observation is a key characteristic in ethnography and is linked to interpretivism (Taylor & Bogdan, 1984). Observation is divided into unstructured and structured observation (Pretzlik, 1994). Participant observation is unstructured whereas in a structured observation, the researcher is disconnected to what is being observed. A participant observer can take on several different roles from being a full observer to a full participant as suggested by Munhall (2003).

- Complete participant: A complete participant takes the position of a complete participant as he/she becomes a member of the group being researched but in a covert role (Bernard, 2013). The researcher becomes a complete member of the group researched and sometimes the researched are aware that they are being observed but they do not know the reason for it. It is assumed that this gives the most accurate data. However, it is risky and difficult to infiltrate all groups and there is a possibility of compromising with the group values and practices (Mathew & Ross, 2013).
- Complete observer: A complete observer takes a covert role but aims for complete objectivity as he/she does not participate in the group's activities

(Mathew & Ross, 2013). The observer's unbiased and neutral position has little influence on the observed.

- Participant as in observer: A participant observer takes an overt role as in most ethnographic studies as member of the group being observed (Kawulich, 2005). The observer can be an insider doing the observation or can be an outsider who participates in some aspects of life around them (Mathew & Ross, 2013). The disadvantage of a participant observer role is that people may change their behaviour once they realise that they are being observed (Mathew & Ross, 2013).
- Observer as in participant: I took an "observer as in participant stance" which allowed participation as desired in a group which I had no membership (Kawulich, 2005). Data collection is likely to be more formal and requires significantly less time and increases the objective of the researchers as they distance themselves from the people. This also implied that the participants were aware that they are being observed. Adler & Adler (1994) asserts that this "*peripheral membership role*" still allows enables a researcher to "observe and interact closely enough with members to the level of an insider's identity despite lack of participation in activities that are core to the group membership."

Participants were observed in parents' meeting organised in the church and with an aim of achieving intimate knowledge on male circumcision (Roper & Shapira, 2000; Watt & Jones, 2010; Angrosino, 2007). The main aim of the observations in these meetings was to understand the discourse around the male circumcision ritual and practices among parents and church leaders. It was also a way of checking terms used while at the same time confirming some of information given by mentors and young men on the ritual. Participant observations may extend over a long period of time and are good for studies of participants that are not easily accessed (Bernard, 2013). In this study, observations were not carried out over a long period of time. The observations lasted the time of the meetings, which were only held once in each church. This still enabled immersion (Knoblauch, 2005) in the culture and later standing away from it so as to intellectualise and reflect on what had been seen and

heard (Fetterman, 2010; Bernard, 2013). However, Watts & Jones (2010), argue that in order to immerse in a culture, a researcher must be accepted and to be accepted, he or she must build rapport with the participants. Although there was no time to build rapport with the parents in the meeting, I was able to do so with the gatekeepers (church leaders) with whom I talked to personally a couple of times prior to the observations and after observation to clarify my observations.

Munhall (2003) argues that it is impossible to separate the researcher from the researched in an unstructured observation. Marshall & Rossman (1999) suggested that the challenges of observations arising from a researcher's presence are overstressed. They argued that it is impossible for an observer to change and influence customs and practices of a community or a group of people built over a long time. Observations in this study took place in a closed research field, the church and classrooms. Observers can be overt where their identity is hidden or covert where their identity is revealed (Bryman, 2004). In this research I took an overt participant observer role as it raised fewer ethical issues and avoided any form of deceit as in a complete observer participant role. I wanted to be close to the participants in an open way but also with their permission. It was not possible for me to be a full participant as the parental meetings were meant for parents and the programme organiser, for parents and or boys.

Observations in the three churches during the parents' male circumcision meetings took place in the Baptist, Catholic and Presbyterian churches. The Catholic and the Presbyterian meetings were held in classrooms while the Baptist meeting was held inside the church auditorium. The Deliverance and Anglican churches organised male circumcision programmes but did not hold a parents' meeting. In all the churches, parents attended the meetings as they came to drop off the boys apart from the Catholic Church. Parents' male circumcision meetings were, therefore, attended by both the parents and the boys in all the other churches. In the Catholic Church, parents came for the meeting while the boys were to come to the church a week after the parents' meeting. In all the meetings, parents were given time to ask questions, but only a few parents asked questions or made suggestions. Although

male circumcision is a man's arena, most of the parents who escorted the boys to the four churches were mothers. It was expected that men would bring the boys for circumcision. In the Catholic Church, the chairman of the meeting asked the mothers where the fathers were. When one of the mothers said that the husband was at work, the chairman responded "*I believe the male child is more important than work, please, women let's talk to our husbands*". He insinuated that the male child was being neglected, yet this was the time (during circumcision) the boy needed the father most. In this meeting, there were only two men, a father and a young man who came on behalf of his cousin.

Data transcription

Data were transcribed verbatim into English in the word document format and later uploaded on Nvivo version 9 software programmes⁵. Transcriptions were transferred into Nvivo software for easy management of the transcripts. Recordings were listened to directly from a personal laptop and typed into the word document. One hour of recording took about four hours of transcribing. However, time spent in transcription is useful for informing the analysis in the early stages and aids the researcher in familiarising, understanding (Braun & Clarke, 2006) and interpreting the data (Bird, 2005). The written narratives were also typed into word format and words that were not in English were translated while maintaining the meanings of the words in the local text.

Transcription can be a challenge when it involves interpretation and translations between languages, especially if a researcher does not speak the language of the participants (Davidson, 2009). Since I am conversant in both Kikuyu and Kiswahili, an external transcriber was not required, which can sometimes expose participants' identities and compromise their confidentiality (Oliver *et al.*, 2006). Use of slang and diction was common among the male students. For instance, some of the students used the word "msupa" and "dame" to refer to a girl. I know the meanings of most slang words used in Kenya, but new slang words develop continuously. Consultation

⁵ I attended the Nvivo class as part of the Post Graduate Training during the PHD programme

with other young people in Kenya helped to establish the meaning of these words. Nevertheless, there are terms that have no English equivalent and once translated the entire meaning is lost or they are misinterpreted. In such instances, I used the closest English words but also retained the original words. Smith (2008) argue that conducting interviews in the local dialect, while maintaining original phrases and words to the context minimises the loss of meanings. In addition, my third supervisor is Kenyan and also speaks and understands Kikuyu and Kiswahili and guided me in establishing meanings of some terms and words in the local language.

Data analysis

The process of data analysis commenced in the pre-field stage while writing the research questions, during and after the fieldwork. This involved reflecting on observations and notes taken daily while noting issues of interest. Analysis in the field enhanced immersion into the raw data (Knoblauch, 2005; Jones, 2010) which enabled me to identify gaps and challenges that were addressed as the fieldwork progressed. Data were analysed using thematic analysis (Aronson, 1994; Braun & Clarke, 2006) with the aid of Nvivo version 9 software (Bazeley, 2007). The Nvivo software package allowed for better organisation of the data and provided a good overview of all the categories in the process of refining and redefining the themes.

Thematic analysis

Thematic analysis was used in this study to identify, interpret and report themes whilst enabling a deep engagement with the data and understanding of the content (Bryman, 2012; Matthews & Ross, 2010). Thematic analysis is the main method of data analysis used in ethnography (Jones & Watts, 2010). Data familiarisation in thematic analysis is recommended which was enhanced by having to collect data in person. It is also a method of analysis that can be used with many forms of qualitative data. This was compatible with this research as different forms of data, written narratives, in-depth interviews and observations notes, had been collected. Due to the lack of literature on thematic analysis, Braun & Clarke (2006) will be quoted more often from their detailed description on thematic analysis. Rather than

using different analytical methods for different types of data collected, thematic analysis was chosen because it can be used with many types of qualitative data. It is also often directly and indirectly associated with other types of data analysis such as discourse analysis (Boyatzis, 1998; Ryan & Bernard, 2000). The method is flexible but results in a rich and detailed account of the data (Braun & Clarke, 2006). It is, however, reputed as lacking clear and specific guidelines (Antaki *et al.*, 2002), poorly branded (Braun & Clarke, 2006) and thus underdeveloped (Bryman, 2012). Although it is claimed that there is no general agreement on the thematic data analysis process (Tuckett, 2005; Attride-Stirling, 2001), data were analysed using the steps described by Braun & Clarke (2006).

Thematic analysis enabled the production of themes based on a range of factors. A theme can represent the entire data set as a main theme but this may compromise the depth of analysis. It can also represent important issues about the data in relation to the research question and it can emerge from little or large amounts of data depending on the researcher's judgement (Braun & Clarke, 2006). It has been suggested that one can approach the data with a particular aim or be open minded without having any preconceived ideas on what themes will emerge. Both approaches were used in this study and accorded me a reflexive and open mind during analysis, resulting in many codes (Braun & Clarke, 2006). I immersed myself in the data to further familiarise myself with the depth and breadth of the content. This was done by reading and rereading the material many times, while taking into consideration the pre-knowledge of the data especially since I collected the data personally. After rereading, patterns of data were noted down. The next step involved coding the entire data set by sorting data that were linked to each other. Coding, also known as indexing, is the process of assigning labels to chunks of data so that codes are interlinked to highlight similarities and differences within and between texts (Bryman, 2012).

Codes can be keywords, themes or phrases that may or may not be actual terms and phrases in the text being analysed (David & Sutton, 2004). Nvivo codes are codes labelled from the participants' words and are also referred to as manifest codes while latent codes are drawn from the researcher's interpretations. A balance of the two types of coding has been recommended (David & Sutton, 2004). Manifest coding can result in the fragmentation of data, while latent coding is likely to lose the context of what is said (Bryman, 2012). These two types of coding were used accordingly, where some of the codes were direct phrases by the participants while others were the result of the interpretations of the texts.

Codes were later sorted into potential themes, while assembling all data linked to this theme. Some of the codes could be linked to a major theme, others to subthemes while others that did not fit under any theme were put aside as 'other'. Jones & Watt (2010) suggest having as many key themes as possible to ensure that nothing is missed out. The last step ensured that the coded parts matched the entire data set in order to come up with a thematic map. The themes were refined by going through the coded data again and the codes regrouped where necessary.

When there were no new codes emerging, the coding process ended. Participants' stories were described in detail using contextualisation to recreate the field setting (Wolf, 2007; Jones, 2010).

Interpretation in Interpretivism

Hermeneutics is one of the approaches in interpretivism related to interpretation (Schwandt, 2000). Just as there are multiple ontologies, there are multiple interpretations. Although at a given time I had to interpret and state an understanding of the participants' perceptions and meanings, interpretation is a never ending hermeneutic circle. A constructivist embraces a hermeneutic approach whereby the hidden meaning is explored and drawn out through deep reflection (Schwandt, 2000). Hermeneutics seeks understanding rather than explanation and is positioned in a particular social context (Kinsella, 2006). In this case, there was repeated interpretation commencing from the research field and continuing after the

data collection. Gummesson (2003) asserts that interpretation takes place all the way through from the beginning of the research to the end.

Once interpretation takes place, it enters current interpretation and later enters into future interpretation (Hudson & Ozanne, 1988). Interpretation is never completed. Once a researcher is content with the interpretation he/she remains with the understanding they have attained (Kinsella, 2006). Once I was satisfied with the interpretations of the data, the interpretation process ended. However, interpretation can be carried out all over again from that point. According to Denzin (1984), one does not get *the* understanding rather one gets *an* understanding. In this study, interpretivism aimed for a particularistic rather than a generalised approach, as it was on a specific phenomenon, that of, male circumcision in a given time and place. The study took place among the Kikuyu people in Muranga, which only represents a small part of the Kikuyu habitants. There is a possibility that the cultural practices understood at that particular time when the research took place may be different in the same place at a different time. Geertz (1993) refers to the context bound phenomena as thick descriptions, which delimit generalisation of statement (Berger *et al.*, 1982). William (2000), however, claims that generalisations are possible in interpretivism.

The main goal of this study was to seek “Verhesten” in the male circumcision ritual of the young Kikuyu men (Wax, 1967). Verhesten in the interpretivist approach is referred to as deep understanding by Wax (1967), thick understanding by Geertz (1993) and understanding based on the context of study (Holloway, 1997). Aiming for Verhesten required being active in the research process to grasp the shared meanings since language, customs, meanings and culture are continuously being created by people’s joint activities. Verhesten is, however, not sufficient for understanding although it is necessary. I aimed for the shared meanings among individual mentors and young male students but also the interactions between the individual participants’ meanings, and the interactions between shared meanings and individual meanings in male circumcision.

5.4.4. Ethical considerations

Ethical considerations were taken into account in this study. The study was approved by the Northumbria University ethical committee. A research clearance was granted through the National Council for Science and Technology (NCST) in Kenya. I also applied for affiliation which was granted through the Department of Sociology in Nairobi University Kenya, which is one of the requirements for a research clearance by NCST. A researcher has a duty to uphold beneficence by avoiding harm and maximizing benefits (Polit & Beck, 2012). The study aimed at doing no harm to the participants. Participation in a research can lead to anxiety and exploitation, while publishing of articles may sometime destroy the integrity of participants (Hammersley & Atkinson, 1993). One of the commonest data collection techniques in qualitative research are interviews which are usually designed for sensitive topics and are likely to trigger anxiety and distress (Corbin & Morse, 2003; Richards & Schwartz, 2002). However, Corbin & Morse (2003) assert that the risk in most qualitative research is not as much as biomedical research. This does not require the researcher to avoid probing and asking for clarifications but to be aware of the ethical issues involved. Thus as a researcher I endeavored to be sensitive and vigilant in anticipating such problems as suggested by Polit & Beck, (2012). Based on Corbin & Morse, 2003 arguments, unstructured interviews allow much control from the participants and reduces associated risks. In addition, I planned to discontinue the interviews and narrative writing if any issue of distress and anxiety arose. There were no issue of anxiety and distress experienced in this study.

Exploitation may also arise as a result of power imbalances between the participants and the researcher (Hammersley & Atkinson, 1993). It is for this reason that I did not divulge my academic status unless when asked to avoid any feeling of inadequacies by participants when talking to me. The participants however knew this was an academic study by a student researcher. It was also important to manage the relationship in the field research by being close to the participants and carrying research professionally. A researcher should provide an environment that is trustworthy and be sensitive to the power they hold over participants including situation leads to participants assumptions by participants that they are friends with

the researcher (Polit & Beck, 2012). I strived for a neutral position, avoiding intrusiveness by scheduling my interviews around school break times and choosing neutral meeting places with the mentors. In addition, I took into account the participant's inconvenience and opportunity cost into participating in the study. For instance, most in-depth interviews took at least one hour. A place of meeting was agreed based on length of travel and convenience of the participants.

Privacy and anonymity of participants were ensured by keeping their identity private. Divulging a participant's identity may result into a lot of harm such as prejudice, reprisal as well as their social exclusion. To protect the male students they were asked to write anonymously by excluding their names in the written narratives. Confidentiality is an ethical principle which ensures that no private information of the participant's is passed on to another person (Houghton *et al.*, 2010). A researcher is allowed to breach confidentiality, in case of vulnerable individuals who share accounts of abuse or concern (Cowburn, 2005). Use of pseudonyms, initials and exclusion of identifying details from the transcripts enhanced confidentiality.

Informed consent is a prerequisite in all research where the participants are identifiable (Richards & Schwartz, 2002). However in few cases ethical committees can rule this out to exclude any potential harm. A minimum requirement for an interview study should be that written consent be obtained from the participant after they have been informed, verbally and in writing, about the study in details. The information sheet was given and explained in details verbally to the participants to read just in case of any lack of understanding of some of the written English. Participants should also be given time to both consider their participation and to ask questions of the study which was done in this study. While others argue that consent should be a one off process, the British Sociological Association's Statement of Ethical Principles state that obtaining consent should be "an ongoing process" allowing for renegotiations of the consent throughout the research (British Sociological Association, 1991). However, this may be financially constraining and sometimes impractical due to participants and researchers 'geographical differences in location as was the case in this research. In addition contacting participants repeatedly may be considered as harassments. However despite of

these shortcomings, Richards & Schwartz (2002) still recommend informed consent as an ongoing process. For instance, a qualitative researcher must reiterate of the voluntary action of the participant and the freedom to withdraw from participation at any time during the study.

A researcher aims at achieving a rigorous interpreting of data to such an extent the findings are trustworthy. Misinterpretation of data should be minimized which is likely when a researcher works in isolations (Richards & Schwartz, 2002). The researcher was supervised all through the PhD process. This was enhanced by describing theoretical approach and challenges experienced in the field research as suggested by Richards & Schwartz (2002) and Richards & Emslie (2002). In addition, the researcher employed reflexivity and acknowledged biases in research.

5.4.5. Trustworthiness in qualitative research

The notion of validity and reliability applicable in quantitative research does not apply in qualitative research. Validity refers to the accuracy of the research findings while reliability refers to replicability of findings. Although these concepts are linked to quantitative research, even qualitative researchers must address the accuracy and valid representations of reality as a way of defining the strength of qualitative data (Ritchie & Lewis, 2003). However, validity and reliability are not viewed differently in qualitative research (Golafshani, 2003). Some of the measures of validity in qualitative research are descriptive validity, interpretive, internal validity, external validity, research bias, evaluative validity, emic validity and theoretical validity (Thomson, 2011; Johnson & Christensen, 2004).

Descriptive validity (Maxwell, 1992), also known as credibility (Walsh, 2003), was enhanced through accurate descriptions of participants' views through interpreted data, yet reflecting the original data. This involved description of the research setting and behaviour of the study group in chapter two. Tape recording of the in-depth interviews with mentors enabled capturing of stresses and different pitches in the participants' voices. Although it was not possible to tape record the male students' voices, the written narratives were typed out as written by the male students without

correcting their grammar and expressions. This was to avoid altering the intended meaning. Although their articulation of expressions may have been different in their mother tongues, they chose to write in English, their second language even when they had the option of using other languages.

Interpretive validity entails using reports from the participants' perspectives rather than the researcher's perspectives. This was done by taking the participants at their words as the ultimate interpretation of their world. Their voices were used in the quotes to represent their world view. As Winter (2000), asserts, participants will have a valid interpretation of their actions which may be different from that of other people. Triangulation of methods was used to enhance interpretive validity. This was done by using different approaches in addressing the research questions (Guion *et al.*, 2011) to elicit different perspectives from different participants. For instance, in chapter eight table 8.1 presents different participants' views showing the trends and changes in male circumcision through the time of elderly men and young men. In addition, there was methodological triangulation (Guion *et al.*, 2011) where different data collection techniques such as in-depth interviews, narrative writing and participant observation were used to enhance validity since they all had similar conclusions on the key findings. However, triangulation can be time consuming which was not a challenge in this study as each group was interviewed at a given time before going to the next group. I started with the schools with narrative writing and then moved to in-depth interviews with mentors and moved on to the observations. The first two observations were carried while conducting the in-depth interviews.

Crang & Cook (2007), suggest that validity can be enhanced by theoretical adequacy, which in this study related to a particular group of people, Kikuyu men, and their circumcision practices. Theoretical validity which enhances accuracy beyond description and interpretation was achieved through reflections of the theories proposed in the literature review. Research bias was addressed through constant reflection and reporting the whole research process and interpretation to allow the readers to gain an understanding of the research findings and conclusion.

I endeavoured to acknowledge biases and challenges encountered in the field in the reflection process. This is addressed in chapter six.

Creswell (2007) suggests different ways of measuring validity and reliability such as thick description. Thick description was used during the write-up of this thesis especially in describing the findings. This entailed use of direct quotes from the participants to demonstrate the interpretation process leading to the theme and subtheme development. Other concepts that measure validity and reliability in qualitative research include rigour, credibility, transferability, dependability, confirmability, adequacy and trustworthiness (Davies & Dodd, 2002; Lincoln & Guba, 1985; Hall & Stevens; 1991).

Transferability by Walsh, (2003) and replicability are challenges in qualitative research (Bryman, 2012). Macnee & McCabe (2008) argue that transferability does not predict results but rather confirms what is meaningful in a given setting or a specific group of people is meaningful in another setting or with a specific group of people. While Marshall & Rossman (2011) view replication of data findings in qualitative research as impossible. Holstein & Gubrium (1997) argue that studies cannot and should never be repeated. Bryman (2012) asserts that replicability is not impossible but is difficult to achieve especially in an ethnographic study like this one, and instead to aim for originality. He further argues that if repeatability is aimed for, which is rare, a researcher should include sufficient details of the process of the research (Thomson, 2011). Transparency was thus aimed for by describing the research process, sampling techniques and recruitments, research design and epistemological perspectives of the research (Auerbach & Silverstein's, 2003). This research process has been explained in detail in order to enhance the reader's understanding. This is what Walsh (2003) terms as dependability or the extent to which findings can be replicated. Good practice, with a good record of the research process such as the selection of participants, was adopted to enhance credibility and dependability. Findings are particular to a given setting and culture but can be replicated in as similar setting (Thomson, 2011). This may not imply replication of

exact findings but helping the audience to achieve a similar level of understanding as the researcher's original idea. Even if the audience may not agree with the findings of the researcher, they will understand how the researcher arrived at those findings (Auerbach & Silverstein, 2003).

As a researcher and the main instrument in the field, what was significant for me in the field may not stand out for another researcher. In addition, a researcher with a different personality, age and gender may elicit different responses from the participants. Bryman (2012) argues that interpretation of data is subjective to a researcher's knowledge and, therefore, a different researcher in this study may not replicate same findings. It is also not possible to ensure that participants' perceptions emotions and feelings will be static if the study is replicated. William (2000) argues that moderatum generalisation is possible where findings can represent a broader set of known features. This may be possible when compared with similar studies on male circumcision practices in other ethnic groups in Kenya. Although the findings are particular to a certain environment, replication of findings comparable to the themes discussed in this research in a similar environment, using similar strategies is, however, possible. This is because male circumcision practices may vary from one location to another in Muranga region as well as between other parts of Kenya.

5.5. Conclusions

This chapter discussed the qualitative approach methodology and methods used in the research. The field work shows dynamic interactions between the researcher and participants. Although the researcher is the main instrument in the research field, the creation of data requires collaborating with the participants. Reflexivity and interpretations of data are highlighted as an ongoing process. In addition, being a qualitative study, the sample was small and, therefore limited in representativeness rather than generalisation amidst rigorous description of the research process for the credibility of the study. The next chapter is a reflection of the role of the researcher and challenges experienced in the field.

Reflections on challenges in the research field

6.1. Chapter Introduction

The previous chapter discussed the research design, philosophical world view, methodology and methods adopted in this study. This section is a reflection on what occurred in the field. It highlights concerns and challenges including ethical dilemmas involving consent forms, information sheets and recruitment encountered in the field. There were concerns about the acceptance by the participants and the challenges included access to information, administering of the consent forms and the information sheets.

6.2. Arrival in the field

When I arrived in Kenya in September 2012, the school teachers were on strike, which delayed the research by three weeks. Because of the strike, the narratives in the schools could not go ahead immediately as planned. Consequently, the indepth interviews with the circumcision mentors were also delayed as the development of the interview schedule was dependent on the findings from the narratives. In addition, the male circumcision parents' meetings only begin in December when the schools are on holiday. However, I used the last week at the end of the strike to speak with some of the community members I met in the town to get contacts for potential participants, circumcision mentors and churches and schools.

Prior to meeting the participants, I was concerned about their acceptance and whether they would volunteer information to me. According to Dewalt *et al.* (1998), appearance, age, ethnicity and gender are some of the factors that determine acceptance by participants in the field. In the construction of identity in the field, self-appearance is essential (Amanda, 1999). The dress code was, for example, important. I chose a balance between formal and casual wear as I thought it would help in ensuring that the participants accepted me. I used dark coloured clothes and minimal make up compared to what I would normally use to avoid being conspicuous

or standing out. Parity with the participants was aimed for, to enhance trust, comfort in my presence and acceptance by the participants. I was, however, forced to wear trousers sometimes in accessing places that required the use of a motorbike. Most of the women in this area, especially the rural places, wear dresses and skirts while trousers are associated with a foreigner or a city dweller. However, this was done for comfort on a motorbike as accidents happened frequently and thus wearing trousers would be more decent in case of an accident. This did not, however, seem to be a problem and from my own perspective, the participants seemed to accept me just as I was.

I approached the participants in a soft spoken manner while displaying a gentle and mild demeanor. This is what would be expected of a young Kikuyu woman especially when talking to older people. In addition, as an insider, I understand the greetings and pleasantries in the Kikuyu culture that enhance rapport with strangers. Due to my role as a woman researching a topic associated with the male gender, the practices of which are kept secret from outsiders made me nervous and I thought that the mentors may not be willing to discuss the male circumcision practices with me. Although Hammersley & Atkinson (1995) assert that it is difficult to avoid the implication of gender in the research field, I did not feel that this was a constraint in interviewing men. A study by Padfield & Proctor (1996) indicated that gender differences between the interviewer and the interviewee may not be as important as the skills of the interviewer. In addition, sharing the same gender may not guarantee that the participant is at ease; rather the shared culture may reduce some barriers between the researcher and the participant (Lee, 1997). Most mentors were happy to talk about the male circumcision practices and some mentors wanted reassurance that they were not telling me too much about the practice. Some participants seemed to think that I was looking for particular answers and they wanted to know if they were “on track” or “off track” from my expectations. Perhaps they expected interruptions, the usual way of engaging in a conversation. This was a challenge because I needed the participants to tell their story but I constantly used nods and “mmhh” to reassure them that I was listening.

I have previously carried out field research on male circumcision with a group of mentors, which yielded rich data. However, in this study, in-depth interviews, which meant meeting one mentor at a time, were conducted. Most of the mentors were willing to narrate the male circumcision practice especially once they realised that it for educational purposes as will be illustrated further in this chapter.

6.3. Challenges in the research field

The following were challenges encountered in the research field:

- Access to information
- Entry to the field and accessing participants
- Information sheets
- Consent forms
- Gatekeepers
- Meeting venues
- Ice breakers
- Participation

6.3.1. Access to information

A search for information about the study setting on different websites suggests that very little is written about Muranga County/district in Kenya. Searching in the city archives, library and the government offices in Muranga was tedious and time consuming and revealed nothing on Muranga. Even after consulting with different researchers and government officials in Muranga County, no one seemed to know where such information could be accessed.

A second challenge was to gain information from the male students' narratives. Most of the students answered the questions in short numbered sentences without giving details, rather than the intended narrative format. After the first narrative exercise, the narrative guide questions were changed after consulting with my supervisors. Since the questions in the narrative guide were numbered (see appendix 9), they were retyped and printed in the form of a paragraph which excluded the numbering (see appendix 10). More questions were included because the students did not

volunteer information that was not asked for in the paragraph. Questions added were: Are you aware of “*kwihura mbiro*”, wiping of the soot? Were you forced into the male circumcision practices (wiping of the soot and road license)? Did you go through with it? After how long did you wipe of the soot? Did you use condoms and why?

6.3.2. Entry to the field and accessing participants

Although I already had a research permit in Kenya, I was expected to report to all the district offices and education offices in Muranga. A government officer known as a District Commissioner (DC) governs a district and an Education Officer (EO) is a government officer in charge of education in the whole district. The diagram below (Figure 6.1) demonstrates the subdivisions of governance starting from the highest at the provincial level to the lowest at the sub location level in Kenya which has now been changed in the new constitution. At the time I was collecting data, the new subdivisions had not come into effect.

Figure 6.1. Subdivisions and Public administrations in Kenya



The public administration services were not always effective in facilitating a smooth entry into the field. For instance, when I first reported to Muranga North, early in the morning, the District clerk asked me to wait outside since the DC was not in the office. The DC and the district clerk's offices were opposite each other. At three in the afternoon, I realised that the man who kept passing by me in the corridor was the acting DC who had been in all morning. The District clerk had forgotten our presence (I was waiting with other researchers from Kenya). This proved to be a more time consuming process than I had anticipated especially because of the bureaucratic procedures involved. Some of the officers were not keen on following the research procedures. It also seemed that some of the officers were not aware of their responsibilities in the research taking place in the region. In Muranga South, the Education officer told me *"I'm very busy right now; I just came from leave, why you don't come another day....anyway you can just start the research and if anyone asks you for a letter then you come back."* I did not have to go back to the Education officer because the research permit turned out to be sufficient for the school heads teachers and deputy head teachers.

6.3.3. Information sheets

Most of the mentors complained about the length of the information sheet and most opted for a verbal explanation of the research rather than reading it. The tool that was meant to aid participants in understanding the research was deemed too long and most of the participants did not read it. After explaining the research, most participants especially the mentors returned the information sheet although they were supposed to keep a copy of it. Most of the participants, including the gatekeepers and parents, were not keen on reading the information sheet or the research. In one of the male circumcision meetings in a church, the gatekeeper (pastor) told me to wait around for him to sign the consent form. He said, *"You never know, one extra signature.....could mean that you pass or fail your exam"*. This gatekeeper was not a parent but a church elder who was not supposed to sign the consent form. It was, therefore, clear that either he had not read or had not understood the research even after the information sheet had been explained to

him. It could also have been that the research was not of interest to him. Hamersley and Atkinson (1989) suggest that the type of reception granted to a researcher may depend on what kind of a person she/he is rather than the research she/he is carrying out. It was not clear if some of the participants who did not read the information sheet were illiterate. The lowest level of education attained by the mentors was grade seven in primary school, which I thought was sufficient for comprehension of the simple English used in the information sheet. However, the two mentors who responded mainly in English were the only ones who read the research information sheet. It was not possible for parents who were illiterate to read the information but even those who were, were not willing to go through the lengthy information sheet.

6.3.4. Consent forms

Consent forms were received with much suspicion because of the signature required. Most of the participants preferred to just write their names rather than a signature. More challenges on informed consent were experienced during observations of parents' male circumcision meetings in the churches. Informed consent forms were signed at the end of the meetings in all churches. Once the gatekeepers ensured that the parents had unanimously allowed observations in their meeting, they thought that implied that they had agreed to sign the consent forms. The organisers of the parents' male circumcision meetings did not want their schedules interrupted with the signing of consent forms prior to the meetings especially in the venues where boys were to be circumcised that evening.

Parents could not understand why they had to sign consent forms or the significance of the signature. It was almost rude to ask for the signatures in the consent forms when they had already given consent by the word of mouth at the beginning of the meeting. A report on ethics of research related to health care in developing countries shows that some people may refuse to sign a consent form in the belief that they may be signing away their rights (Nuffield Council on Bioethics, 2002). In addition, unfamiliarity with research documents and terms such as 'consent form' may deter them from signing (Nuffield Council on Bioethics, 2002). In my case, it was even

difficult to explain what a consent form was as there is no Kikuyu equivalent term for it. Illiteracy posed another challenge where those who could not write asked their friends or sons to sign on their behalf. This can be embarrassing for most illiterate participants. All the mentors were literate and signed their consent forms.

Although the parents allowed me to observe, more parents kept streaming into two of the parents' male circumcision meetings that I attended in the churches. At the end of the meeting, I still had to go through another session of explaining the research to the parents who came late for the meeting. It is thus a problem to be able to get consent from everyone who might enter into the field of observation (Munhall, 2003) as they may enter the field at different times. I endeavored to talk to the entire group of parents who had come late but some were in a hurry to go home. All the same, some parents who were present from the beginning of the meeting seemed to have advocated for me as they explained my role to the parents who arrived late. Moore & Savage (2002) note that ethical committees' requirements on acquiring informed consents, overlook relationships between the researcher and the researched. They suggest that the researcher should have the freedom to respond to different situations in the field without being inhibited by the prescribed rules from the ethical committees.

6.3.5. Gatekeepers

Entry to the field such as schools and churches is controlled by the gatekeepers (head teachers, pastors, priests and reverends). This may require negotiations with gatekeepers who may determine the participants and the site of research (Munhall, 2003). Gatekeepers can sometimes cause ethical dilemmas. Access to the field may require lengthy negotiations between different gatekeepers. Ease of gaining access to the field may determine the researched and the site. Even after gaining entry to the field in Muranga, there was a need for negotiations to access the participants. Although I had proposed to recruit students in boarding schools, this was not possible since school teachers were on strike prior to my arrival in Kenya. This left Form Four students with very few weeks prior to their Kenya Certificate Secondary Education (KCSE) exam, which is the final exam for admission to the University.

Therefore, no school heads were willing to set aside extra time to organise a parents' meeting with me as I had proposed. The students had to take the research information sheets and consent forms to their parents/guardians after our first meeting. Access to students in boarding schools proved more difficult than those in day schools (non-boarding schools) since they were not in contact with their parents daily. The narrative writing was, therefore, limited to day schools only. The second appointment in schools was dictated by the school timetable and exams that had been cancelled during the teachers' strike. When gatekeepers give access to a researcher, this may override the will of those further down the hierarchy (Tett & Maclachlan, 2006; Wiles *et al.*, 2005).

Efforts to speak to all the male students in Form One and Form Four in every school were sometimes frustrated by the gatekeepers, as in the case where a deputy head teacher brought ten students (five Form Ones and five Form Fours) into the room. The other male students were not given a chance to decide if they wanted to participate and negotiations to return another day were dismissed because of the busy exam schedules in the school. To ensure that the ten students were not coerced into participating, I explained the information sheets in detail and informed them of the freedom to stop their participation or present a blank sheet of paper at the end of the narrative session.

Some of the school heads were also concerned about the English comprehension level of their students and were reluctant to allow me access to their students. This happened twice, at two different schools where a deputy headmistress and a headmistress said that the students could not participate because they were 'not bright'. The headmistress suggested a visit to the neighbouring boarding school (directly opposite their school) which had bright students. I explained that the students were free to write in their mother tongue if they could not write in English and was later allowed to carry out the research.

It was difficult for me to balance between respect in this culture and asking the teachers to leave the classroom as proposed in the research. Some of the teachers followed me to the class where the narrative exercise was going to take place although I had explained the voluntary nature of the exercise was and the need for the researcher to be alone with the students. All the same, in cases where the teachers came into the room at the beginning of the narrative writing, they later left on their own accord.

In the first school where I conducted the narrative exercise, the deputy head teacher assembled 56 Form One and Form Four students. The teachers had not started teaching because most of the students had been sent home for school fees. Just before the parental consent forms were given to the students, the headmaster came into the classroom and asked: *"Who is under 18 (18 years of age)"..... Form Ones!!*"and everyone laughed. He was insinuating that it was only the Forms One students who could be under 18 years of age and not the Form Four students. All the Form Four student said they were 18 years and above while most Form One students took the parental assent form. It could have been embarrassing for some of the Form Four students to acknowledge they were under 18 years of age.

Again, there was no way of proving everyone's age but I had to go by what the students had reported. On the day of the narrative writing, only nine Form One students had the parental/guardian consent Forms signed out of the 22 who had taken the forms. The deputy head teacher asked the students whose consent forms were not signed to leave the class and told them he was going to punish them. I reassured him that this was a voluntary exercise and only those who were willing needed to participate regardless of the number. The male students may have been uncomfortable to approach their parents for a signature possibly because it was a sensitive topic to discuss with their parents. In addition, if the parents were illiterate only the sons could have signed on their behalf. In another school, the deputy head teacher alleged that the boys were likely to sign the parental/guardian consent forms themselves. I had no way of proving this and I had to accept all the signed parental/guardian forms from the students as proof of permission from the parents

to participate in the research. In addition, two school heads (a woman and a man) informed me that all the students were above 18 years old before I was taken to the class and there was no need of involving the parents. When I went to meet the students, I found that some of the Form One students were in fact below 18 years of age. However, they all received consent and parental/guardian assent forms to take home prior to the next session on narrative writing.

When gatekeepers grant the researcher access to the field, this may override the will of everyone under his authority (Munhall, 2003). In some cases, individuals are not able to refuse participation to research that their elders or leaders assent to (Nuffield Council on Bioethics, 2002). Although I did not dictate how to be introduced to the parents in the circumcision parental meetings in the churches, most of the gatekeepers introduced me at the beginning of the meeting and appealed to the parents to help 'the student' (me) by signing the consent forms at the end of the meeting. At the beginning of the meeting, the parents were asked if they allowed me to stay in the meeting by the chairman of the organising committee "*Will you allow her to stay in the meeting?*" they responded unanimously "yes". I did not have the opportunity to meet and explain the research to the parents in the absence of the gatekeepers. Munhall (2003) notes that challenges in the field include ease of access, the researcher's presence influencing the participants' behaviours and the participants understanding the role of the researcher.

It was easy to access the church and the parents' meetings but it was not possible to ensure that my role as a researcher was understood. I introduced myself and the research to the gatekeepers who in turn explained my research to the parents at the start of the meeting, but there was no time to answer questions about the research until after the meeting. It was only in the Catholic Church where I was given the opportunity to inform the parents about my research directly. However, this was solved by obtaining informed consent from the parents, which I got immediately after the parents meeting but not without some challenges as discussed above. Because I had to rely on gatekeepers in most field sites, I lacked full control as a researcher.

This research may not just have been subjected to the researcher's influence but also the gatekeeper's (Munhall, 2003).

6.3.6. Meeting venues

Meeting places with the mentors were scheduled in places convenient for them and safe for me. It was not possible to meet with the mentors in schools as proposed in the research. One of the meetings with the mentors was held in a restaurant that was very noisy while another meeting was held by the cattle dip, very close to the road. The meeting was now and then interrupted by passers-by greeting the two mentors interviewed that day. The recorder was switched on and off several times while at the same time keeping track of the interview questions prior to these interruptions. In one school, the person who had the key to the hall where the narrative exercise was to take place was not around. An old abandoned library room without chairs and tables was used, and the Form Four students wrote standing up or squatting which was quite uncomfortable. Although I asked their teacher if we could meet in a classroom instead, she simply said that "*they were going to use their laps instead.*" Apart from two Form Fours students, who left the room, the rest stayed to write the narrative, although I had anticipated that more would leave the hall due to the uncomfortable conditions.

In another narrative exercise, there was no big hall to contain all the Form One and Form Four students in the school. In addition, the Form One and four classes were on opposite sides of a main public road. I was asked to conduct the narrative writing with Form One and Four students simultaneously as this was during the last evening break before the students went home. By the time, I returned from the Form One class, the teacher on duty had already started collecting the Form Four student's narratives before most of them had finished writing as it was time to go home.

6.3.7. Ice breakers

Questions that were meant to break the ice in the beginning of the interviews elicited different reactions. Most of the mentors would laugh, stammer or hesitate before responding. Some of these questions asked for age, level of education, religion and marital status of the mentors. In addition, there is no Kikuyu equivalent word for “religion” which made it more difficult to ask the mentors about their religion. Reactions by the participants to these questions made me uneasy and uncomfortable. The last two mentors with whom I used the icebreakers were uncomfortable as reflected by their reaction. One of the mentors asked, “why” after he was asked for his religion while the second one gave a vague answer when I asked for his religion “*Nii ndi mugikuyu nii*” (I’m a Kikuyu). I took it that he did not want to answer this question and, therefore, did not probe further. This was also an indication that he had no religion and was just a Kikuyu. Again, in asking for his age, he repeated the questions after me, “my age?” Sometimes the participants had their own way of breaking the ice. One of the elderly men Njuki (our first meeting) told me “There was a programme on male circumcision on the radio yesterday, I wanted to call you but I thought it was too late”. The statement opened up our discussion and acted as an ice breaker in this interview.

To address the challenge on ice breakers, the interview questions were amended to start with questions on the organisation of male circumcision “How is male circumcision organised in this community?” This elicited a better response and provided a good starting point for discussion. Since the participants had already been briefed about the research on the telephone prior to the interviews they probably were expecting questions related to circumcision rather than the “ice breakers”.

6.3.8. Participation

Participation was not much of a challenge. Nevertheless, in one of the schools, all Form One students declined to participate. A week prior to the narrative writing, most of the Form One students in this school had returned the parent/guardian consent forms and declined participation in the first meeting. This was the only school where the parents' consent forms were returned on the first day. The location in which this school was situated had been described as dangerous by the other mentors and students. The teacher assigned by the head teacher to assemble the students doubted if the students were going to participate in the narrative as they were known to be uncooperative. This made me slightly nervous and worried, but I clarified that it was voluntary and the only those who were willing would participate. However, the Form Four male students who the teacher least expected to participate, participated apart from two who left the classroom after reading the narrative guide.

6.4. Conclusions

This chapter has highlighted the unforeseen challenges encountered in the research field and how they were addressed. Ethics to be considered may vary from study to study, owing to the cultural context in which the research takes place. The role of the gatekeepers demonstrates the power imbalance that may be present during data collection. Gatekeepers can act as a hindrance to the access of participants or force unwilling participants to participate. In addition, the research emphasises the role of the researcher's the appearance, position, language and expressions as importance for acceptance by the participants in the field.

Research Findings

7.1. Chapter Introduction

The previous chapter discussed the reflections and challenges experienced in the research field. This chapter will present the findings of the data collected in Kenya. The analysis of the data from students, mentors (young men) and the elderly older men yielded two main themes “*maturing into adult me*” and “*changes in the ritual practices and values*”. The theme “*changes in the ritual practices and values*” is discussed in part two of the findings chapter. The theme “*maturing into adult men*” emphasises the importance of circumcision in determining the young men’s status, the processes, practices, ceremonies and experiences of the initiates becoming adults through the different voices of the young men and their mentors. Quotes have been used to illustrate the findings.

The table 7.1 below explains the codes used to represent the participants.

Table 7.1. Codes representing participants in the data Analysis

F	The class in secondary school. F1/f1, F4/ f4, representing a Form One student and a Form Four student respectively
M	Mentor. e. g M7 is mentor number 7
f1 15	Form One student aged 15 years
f4 19	Form Four students aged 19 years.
R	Researcher

7.2. Maturing into adult men

The word “*kugimara*”, which translates as “to mature” in English, was commonly used by the participants to describe the transition of an uncircumcised boy to a circumcised man. The word “*kugimara*” is a common word used in daily conversations referring to being “grown up” used for both boys and girls when they are grown up in age and their physical features develop into that of adults. The Kikuyu people, however, specify if they are talking about physical maturity or maturity in behaviours or both. Although the term “*kurua*” should be used to describe a circumcised boy, the term “*Kugimara*” is viewed as being more respectful.

The subthemes discussed under this theme are

- Circumcision is not a choice
- End of childhood into a new identity
- Enduring pain
- Advice and instructions
- Circumcision ceremonies
- Violence through ceremonies
- Protection and protective networks

7.2.1. Circumcision is not a choice

It is circumcision which accords a boy the status of an adult man among the Kikuyu people regardless of his age, behaviour, character, and bodily growth and development. Mentor 4 referred to circumcision as compulsory for every man as it marks the separation between the two stages of childhood and adulthood. Without going through circumcision, you are not regarded as a man in the society. Transition from a boy or child to a man is only possible through circumcision as emphasised in the conversation below:

R: Do you have to be circumcised to be considered a man?

M4: This is a must, without going through circumcision you cannot be considered a mature man.

Men seem to have a responsibility of enforcing the circumcision ritual on every man. Although circumcision is no longer described as a community function today, remaining uncircumcised not only affects the uncircumcised individual but brings disgrace on every other man in the community regardless of whether he is related to them or not. To end the disgrace brought upon them by the uncircumcised man, the men take charge by ensuring that any man found uncircumcised is circumcised. A man's decision to get circumcised or not is, therefore, not his decision alone. Even with marriage and children, acceptance into the men's world is not possible without circumcision. It is only after circumcision that one is recognised as a man by those who have been circumcised and recognised as 'men'.

Mentor 5 described how the uncircumcised man is tied to a cart naked and driven round the town for all to see that he is a "kihii" (uncircumcised). One of the men accompanies the cart collecting money for the circumcision fee. This usually attracts a crowd, with some people making fun of him as they contribute money while saying that "*perhaps it was lack of money that delayed his circumcision.*" Circumcision then becomes a public issue mostly for the men as they are the ones who contribute the money. The uncircumcised men may try to keep their status secret, probably to avoid such humiliation. This is demonstrated by M5's description of an uncircumcised man who was forcibly circumcised in one of the towns of Muranga County:

I think that my friend here can tell you that there was a man who was selling cock [chickens] in this place (town) but he was not circumcised. The only person who knew was the wife. The son completed class eight and it was his turn to get circumcised. Now this boy cannot go for circumcision before the father because if he does before the father there are some beliefs that...The man was seen in the city and all the men gathered and asked him to show them and he ran away and hid in one

of the shops here behind (he points at the backyard). The men were going to get him out by force; it is my friend here who “wamuhonokirie” (saved him). He went inside and the man agreed to get circumcised. My friend went and addressed the men and told them he was going to ensure that he (the uncircumcised man) got circumcised. My friend and two other men went to the hospital up there and he got circumcised the same day. The next day his son got circumcised. The mother had to cook for two men...laughs. (M5)

I was surprised to hear this narration that highlighted a public humiliation of a man. However, M5 narrated this laughingly which suggests that forced circumcision is taken lightly. In addition, the ways in which the uncircumcised man acquired the status of maturity may have made him feel less of a man, contrary to what circumcision was supposed to achieve because he was forced into circumcision and was publicly humiliated.

The story suggests that a married man would, therefore, remain a kihii and a child despite taking on adulthood responsibilities such as marriage. It appears that men are firm in enforcing circumcision on the uncircumcised men such that in the case above it was a friend who “saved” the man from being displayed from a cart as a kihii. This scenario demonstrates a non-voluntary circumcision, as the man was left without a choice of remaining uncircumcised. The only choice he had was circumcision. Such events seemed to occur from time to time because he told of a similar occasion where a man, his father’s age-mate was circumcised at the time when he got circumcised. I had the notion that probably some men would have wanted to stay uncircumcised but only agreed to it, to avoid such public humiliations.

Apart from being called a “kihii”, an uncircumcised man is referred to as a dog. A dog is the least valued in most homes in this community and stays outside the house usually in a kennel and where there is no kennel, the dog sleeps on the verandah (Field notes, Njuki). I got the impression that calling the uncircumcised ‘dogs’ or an animal may be a way of robbing them of their humanity, was disrespectful and stigmatising. To be accepted and honoured in the society, most boys may choose to get circumcised. The Form One student quoted below chose circumcision just because he did not want to be looked down upon and devalued as a dog:

I choose this because in our society, uncircumcised boy is carried as a dog...
(f1 16e)

An uncircumcised man is rarely respected among other Kikuyu men. An uncircumcised boy in Form One would, for example, be excluded by the others in his class, because the expectation is that boys get circumcised before entering Form One. M5, who was also a parent, told me that uncircumcised students would not be able to concentrate on their studies because of being bullied and labelled a “kihii” and being isolated from the company of young men. Therefore, despite knowing that it would be a painful process, boys cannot stay uncircumcised. It may be that if they had a choice they would avoid the painful ritual. It appears that the parents also faced pressure to ensure that their son is circumcised in order to save him from harassment and isolation as demonstrated in the quote below:

Because if he goes to Form One before he is circumcised, he will suffer and he will not have a good environment. The parent thus has a role that once he is through with class eight, his age shows that he is grown up. So when he is going to Form One (first class in high school) he must be mature. Therefore, whether he has money or not the parent has to provide. Therefore, he will not go to Form One as a kihii and suffer a lot with the others calling him kihii. And he cannot concentrate on his study

being called a kihii. Now see, the others will even isolate him because the “anake” (young men) will be staying together and he is a boy and he is the only one. (M5)

Circumcision is depicted as compulsory in the Kikuyu society since the “uncircumcised” is not regarded as a man. The pressure to be accepted and respected in the society forces boys to get circumcised because otherwise they may be forcibly circumcised. Apart from the pressure in the society, the parents may also be experiencing the pressure. Although not discussed here it seems that the young and elderly men have their ways of finding out about those who are not circumcised in order to enforce the practice.

7.2.2. End of childhood into a new identity

There is a lot of emphasis on the change of status for the initiates, with them becoming men or moving to a new stage of life, after circumcision. Phrases such as “He has now become a man” are commonly used. Under this subtheme, the process of maturity to adulthood is described. It is not just what the boys have become but also the stage of boyhood (uhii) they just ended. This may act as a reminder and emphasis for the initiate to completely turn away from boyhood. This requires a change of behaviour and leaving the company of boys and all aspects of boyhood as emphasised in this quote:

It is the move from one stage to the next, from “uhii” (boyhood) to the next stage. (M4)

One of the persons to let the initiates know that they have moved from childhood to adulthood is the mentor. In addition, he ensures that the boy moves to the new stage of manhood. The suggestion is that by the time he comes out, he must be manifesting manhood as expected by the society. It seems that the initiate’s transition to manhood is emphasised during the healing period by the mentor before the “coming out” as written by the Form Four student below:

Yes I had mentor and his work was to check on me through my healing period of the ritual is to enable you move from childhood to manhood. (f4 18)

Similarly, mentor 8 in the quote below implies that it is his responsibility to ensure that the initiate is not a boy anymore. This may put pressure on the initiates to prove the change of status for the mentors' sake since the mentors want to show the people in the community that the initiates they were taking care of are now men. In addition, there may be pressure on the mentor to prove that he is capable and worth investing in as insinuated by M8 in the quote below:

I have to ... show people that he is out and that he has crossed over to another stage in his life. That he is no longer a kihii (boy), he has become a man (M8).

Although the mentors emphasised that the initiates should stop “wana” (childishness), there were no specific instructions on how to do that. Rather they are to use common sense to know the difference between acting like a child and acting as an adult. This was echoed by one of the mentors:

As one is growing they are able to watch how adults behave and are able to copy adult-like behaviours (M1).

The initiates are left to find out for themselves what this means. There is a suggestion that the initiates observe how other young and older men behave and imitate them. In addition, having grown and up watching adults, there is a tendency to imitate what are unwritten codes and regulations of the expected behaviour in the society. The initiates may look for cues of approval and disapproval of behaviours acceptable in the society.

Some of the advice to the initiate was that they should display that he is a 'real man' implying that he should not just be a man but a 'real man'. Other mentors described it as being "man enough" and "one who can take anything". To be a real man meant being tough and fearless. According to the students' narratives, this also meant not having fun with a "kihii", not playing with nor playing the games that the boys play such as "mubara"⁶ and "ngurutuki"⁷. There is a suggestion that those who were not real men were compared to kids and, therefore, behaved like kids. It is possible that some initiates did not become real men according to the cultural standards set among the Kikuyu people. This is demonstrated in the quote below by a male student:

They told me is that I should start being a real man and not kid. (f116d)

The students suggested that an initiate had to transform successfully into a man according to the Kikuyu people. Some of the childish characteristics that an initiate is not supposed to exhibit are that of being naive. This gave me the impression that a young man is supposed to display knowledge, wisdom and critical reasoning. There is a suggestion that the healing period is also the time to end naive attitudes in the initiates. Childhood is thus compared to being naive which should not be the characteristic of a man:

The meaning is that you have successfully become a man in the society and left all the childish behaviour and naivety (being naive). (f4 18)

Circumcision appears to confer automatically a cultural male identity on a male. The way an initiate behaves and the way other people treat him is different after circumcision. The new identity seems to come with greater responsibilities. One of the mentors reported taking up more adult

⁶ Mubara is an old car tyre or bicycle rim and when pushed with the hands moves in a circular motion ⁷ A wooden cart made of wood usually used to carry loads such as water and usually operate on by boys

responsibilities as a sign of maturity such as being in charge of the whole home in the absence of the parents as in this quote:

..In fact when your parent left home, they said, know that you are the one I have left in that house. This meant that any cow and children in that house is your responsibility (M6).

In addition, the mentor also takes time to explain to the parents how to treat the young man after initiation. There are some chores meant for the uncircumcised that he cannot engage in. For example, one of the mentors said that he had told a mother not to give the initiate some of the house chores that she had given him in the past such as washing utensils. In addition, he is expected to socialise more with initiates which requires more time on the road⁷ as explained below by mentor 14 (M14):

A mutiiri must be in constant conversation with his parents (initiates' parents) after he "kumira" comes out, he (mentor) should let them know that he (initiate) should not be given chores such as washing utensils and he should not be refused to "kumira" (come out) or visit another initiate like him (M14).

The impression I got was that initiates are supposed to start linking themselves to a new social network of the newly circumcised, which may culminate in an age group. In the past, an age group adopted a name which was important for identification and age was calculated from the time of circumcision which is not the case today. This is probably done to maintain and preserve some of the cultural practices of the past. In addition, age group enhances solidarity which is may be the reason why this is emphasised by the young men today. This also keeps the initiate away from the home as it is mostly the women who stay

⁷ Once an initiate recuperates, he is now free to "go to the road" which is referred to as "coming out" because after the operation in hospital, he is only allowed outside of the house when he is going to the toilet.

at home the whole day while the men go out in the morning and return in the evening as the providers of the house.

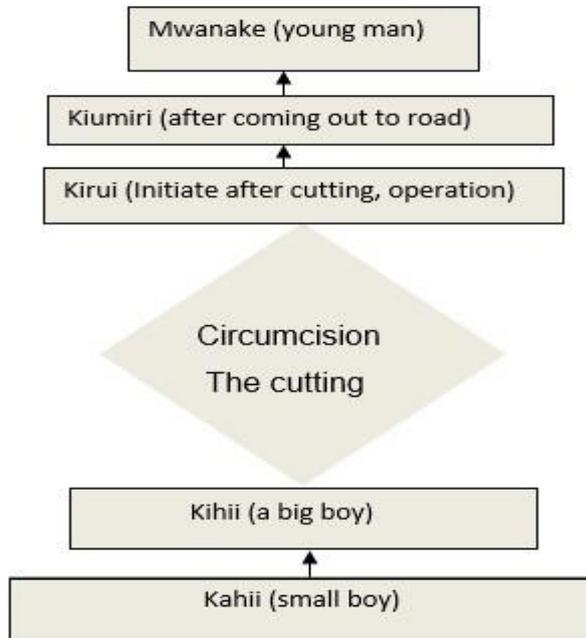
Process of maturity

Male circumcision was described as a process of transition from childhood to adulthood rather than just an operation or cutting. None of the participants referred to male circumcision as the cutting (surgical cutting of the foreskin) in describing the meaning of circumcision. Different phases described by the participants suggested that every man is expected to pass through circumcision stages in this order: “*kahii*” is a small boy, “*kihii*” (*big boy*), “*kirui*” (*initiate*), “*kiumiri*” (*one who has come out*) and “*mwanake*” (*young man*) as in figure 7.1 These terms were commonly used and understood by most participants. It is only the stage of and the term *kihii* that was portrayed to be undervalued by the community which could explain the eagerness by the boys to move to the next stage of honour, of “*mwanake*”, a young man. However, as explained in chapter two one becomes a young man once another group of boys get circumcised after him. The motive of circumcision might be the desire to get a better name and status. From the time of the cutting to becoming a man there are many activities, practices, rituals and ceremonies to mark the new status. The following excerpt from a mentor’s transcript indicates some of the levels and terms used until a young man is referred to as an adult man:

As I had told you earlier when you are born you are called “kahii” (small boy) and once you grow a bit bigger you become kihii (big boy) and that is almost abuse (derogatory)....and since you are now kihii (big boy) you want to move to the next stage to become a “mwanake” (young man) (M5).

The figure below attempts to illustrate the different stages in the circumcision process based on what M5 explained. Although the other participants kept mentioning these terms “*kihii*” – “*kirui*”- “*kiumiri*”- “*mwanake*”, it was mentor 5 who narrated the connection and hierarchical process of circumcision to me.

Figure 7.1. Levels of passage from childhood to adulthood



Although the cutting takes place in the hospital, the circumcision process continues at home in the initiate's room/house. The cutting is, therefore, a part of the circumcision event ceremony among the Kikuyu people.

Symbols of New Identity

After circumcision, the initiates assume a new identity as expressed in the new life and by the changes in almost all aspects of their lives. There are symbols that mark the new life. The initiates get a new bed, new sheets, thereby marking the start of a new life and a new identity as illustrated by a Form Four student in the quote below:

*I stayed in an isolated house.....According to our customs one had to change everything that he used to use i.e. bed sheets –new ones, new bed.
(f4 18h)*

Not only does a boy move to another stage and hierarchical level of an initiate, but in some instances the new house, new clothes attest to the new life of the newly initiated man. The new things are possibly symbolic and represent the new life. An initiate stays “*thingira*” or “*kiumbu*” in a room or house. This appears very important as one mentor insinuated that a boy cannot get circumcised before making an arrangement for a room or a house. For those who cannot afford to build a new house, they can stay in a room that is attached to the main house but has a separate entrance from the main house as explained in this quote:

He cannot go (for circumcision) without a house, unless they have a stone house which has a room attached to it at the corridor, then he can get circumcised there (M11).

The separate room or house is a sign of independence for the initiate of a real man. Isolation is meant to separate the initiates from the parents and also from siblings. Moving from the mother’s house to a new room is viewed as a form of promotion by the initiates. The single room where the initiates /young men live is called “*kiumbu*”. However, the young men referred to it as a “cube”. One of the

Form Four students compared living alone in a “cube” as promotion and others delighted in the sense of privacy that comes with the new life as shown in the quote below:

I used to live in a room next to my mum’s room. In this isolated house is where one was to be mentored by the mutiiri on matters concerning new stage of life. (f4 18)

I moved from my mother’s house and [was] promoted to stay in a cube (kiumbu). (f4 17)

Most students described the new room as unique as it is prepared and decorated with pictures. Most initiates are circumcised after class eight, Kenya Certificate of Primary School Exams. A few months prior to the exams, they receive exam good luck cards (success cards) which they hang on the wall. According to M8, a class

eight boy does not have much property to cherish except for the cards which why they are very precious to him. It is, however, interesting to note that the students still keep the “success cards”, perhaps to remind them of the past education level as they move to the new one. A Form Four boy explains how the decorations made it different from the former room he used in the quote below:

It was decorated very much with pictures and even the success⁸card I was given in primary school. The house was very different because it had so many decorations. (f4 17)

The mother does not enter into the cube and is, therefore, oblivious to what is taking place inside it. Although there is more emphasis on the mother not being allowed in the room because circumcision is a male issue, the father is also not allowed in the room. Just like in the past, the father had to leave the son to the elders and mentors after circumcision until after healing (Wambugu *et al.*, 2006).

There is also a suggestion that the mothers may have been more involved in the boys' lives such as monitoring and checking the boy's rooms and activities prior to circumcision. The elderly man (Njuki) who told me this, also explained that the other siblings were made aware of these differences and changes and would therefore not enter their brother's room as they used to in the past. A Form Four student narrated of living alone in a space where the mother was not allowed:

I lived alone and where mother could not enter. (f4 18)

The Form Four students did not go on to elaborate further what he meant. However in the past male circumcision research I carried out in 2009-2010, I was told by the of the church elders that I could not meet the initiates the first week of their recuperation. They explained that they avoided having any girls/women near the boys to avoid anything that would arouse their emotions causing their penis to erect

⁸ Cards sent to wish students good luck are referred to as “success cards” in Kenya. They are also labelled as success cards. This is the word that the students wrote in the narratives.

before prior healing. I was given an appointment at the end of the second week of their recuperation.

7.2.3. Enduring pain

Pain appears to be very important for the cutting and proving to be a man. To prove that they are men, the initiates are expected to endure pain from the “cut”, during the healing, instruction and follow up period. Enduring pain also means not crying even when the situation might warrant a cry. The mentors would be present during the cutting and might threaten to beat the initiate when they got home if he cried. This is likely to make him endure the pain and not cry to avoid beatings at home. There seem to be tests of endurance such scolding and threatening but with expectations that the boy will not cry, as described by the mentor below:

A young man is not supposed to cry, you will be scolded and scared but you are not supposed to cry. (M13)

It appears that crying is prohibited among the initiates because they have changed their status to men. This implies that it is all right to cry, prior to becoming a man. Crying is thus despised as it devalues the individual's status as it is associated with a boy or a child who cry because of a little pain even from a pinch. *There is a perception that the initiates can cope with any kind of pain.* The following quote shows that after becoming a man (after circumcision) the men should not cry:

He should not cry.... now he has become a man so why should he cry. (M10)

The initiates go through a lot of pain especially when the wound is being cleaned. It is a paradox that the mentors confirm that the cleaning of the wound is painful and that an initiate is justified to cry yet they (mentors) do not want them to cry. However, it is in the painful aspects of the ritual that the initiates are supposed to portray endurance by not crying. The mentors' expectations from the initiates contradict the reality. The young men are not to cry for the benefit of the mentors

and the boys who are yet to be circumcised. Crying reflects badly not only on the initiate but also brings embarrassment on mentors and puts fear in the boys. Crying thus signifies shame, and disgrace, contrary to the respect the ritual is expected to bring on the initiates and their mentors. One of the mentors admitted that cleaning the wound is very painful such that the initiates cry but they (mentors) do not want them to cry as illustrated below:

M12: This part gets pus and is squeezed to remove the pus. This one is very painful because before the pus is removed it will be very painful and the young men cry and we don't want them to cry.

R: You said you don't want the young man to cry, why?

M12. He will embarrass us by crying and if another boy hears this, they will fear to get circumcised.

There was a suggestion that boys run away when they reach the hospital for fear of pain. This is despite being prepared for the pain psychologically. Perhaps this may be as a result of other initiates, who are the first to be circumcised, crying. The mentors, however, had ways of ensuring that the boys eventually got circumcised, illustrated by the following conversation:

R. do you advise them about pain before they (boys) go (for the cutting) M11: Yes you do. You know there are some who even run away before you reach the hospital.....Laugh

R: What do you do when they run away?

M10: You run after them and take them.

It also appears that pain is intentionally inflicted by the mentor. Crying sparked anger and irritation in the mentors who reported a tendency to increase pain to the initiates who cried as illustrated in the quote below:

In the bandaging of the wound your mutiiri (mentor) would not have a good heart to work for you. He tended even to add some more salt and iodine so that you can feel more pain. (M7)

According to Njuki salt is used on wounds as a natural antiseptic and steriliser. He said, however, that it was advisable to use salt in the form of a solution to avoid its abrasive effect on the wound. Mentor 7 reported that some mentors would use more salt as a means of punishment of the initiates because of the stinging effect on the wound. Despite being aware of circumcision as a painful process and not wanting the boys to cry, the mentors acknowledged doing nothing to reduce the pain. Since the initiate agreed to go through with circumcision, this is taken as circumscribing to the pain inflicting culture that goes with the ritual. Mentors suggested that if the boy was not ready for the pain, he should not go for circumcision as in the quote below:

R: How do you help him in reducing the pain?

M10: No, he accepted this and so he has to endure the pain

The mentor suggested that the boy has a choice to either be circumcised or not to be circumcised. This contradicts with that mentors force the boys to get circumcised, even if the boys ran away on the day of cutting. Although forcing the boys to get circumcised in this section is discussed from the perception of pain, cultural expectation as discussed above in section 7.2.1, circumcision is not a choice but is portrayed as the way of life for the Kikuyu boys.

Stitches also play a part in the endurance of pain among the initiates. After the operation, the stitching of the wound is done using either absorbable (absorbed by the flesh) or non-absorbable stitches. The non-absorbable stitches are removable and cheaper than the absorbable ones. Absorbable stitches are more expensive and less painful since the painful process of stitch removal is excluded. Stitch removal is done at home by the mentor or the mentor's age mate. The mentors confirmed that one cannot claim to be circumcised without going through the session of stitch removal, which denotes the climax of the ritual. It is the most painful part and bleeding is inevitable. M8 compared the stitch removal pain to the "hell of a thing". Mentors also reported that some mentors choose the non absorbable stitches because they want the initiates to experience pain, even if they have been given enough money for absorbable stitches. The mentors frequently see this as an

opportunity to take money by paying a lower circumcision fee at the expense of the boys. This is described by mentor 10 below:

There are two types of stitches: The absorbable and non-absorbable stitches. The non-absorbable ones are cheap but you as mutiiri (mentor) may feel that the boys will feel too much pain when removing it. If the mutiiri is mean and is only interested in money because yes he can make money with circumcision. He might ask the doctor to use non- absorbable stitches and use the extra five hundred shillings that was to be used to pay for the absorbable stitches. (M10)

The non-absorbable stitch may not just be chosen for the mentor to make money but also to ensure that the initiates suffer. Mentors volunteer to take the boys for circumcision as an opportunity for revenge against what the initiate did as a boy. The mentor below claims that men and young boys are not friends giving a probable reason why the young men punish the initiates who have just graduated from being boys to men. It also appears that the young men disregard the initiates and still look upon them in a similar manner to the boys as the quote indicates. It is likely that the boy may be unaware that he had disrespected a mentor:

R: Based on what you said that a mutiiri will choose the non-absorbable stitches, what's the meaning attached to it?

M10: The young men and boys are not friends at all. If this boy had disrespected the mentor and comes to ask him to take him for circumcision he will make sure he suffers for it if he is not merciful.

In addition, a boy may not know in advance of what to expect during circumcision including revenge from a mentor. This may also highlight the boys' and parents' lack of understanding of the type of stitches used during circumcision and the trust in the mentor to make a sound judgment for their sons during circumcision. However, since the parents do not accompany the boys for cutting, it may be a challenge for them to ensure absorbable stitches are used during the stitching of the wound. Although

the endurance of pain is implied necessary by most mentors to prove manhood, M10 described the intentional use of non-absorbable stitches on the initiate as a means of making the initiate suffer.

Although there could be means of reducing the pain, the use of pain killers is limited and is not done in the open since the initiates should endure rather than reduce the pain. It is the mentor who controls how many pain killers an initiate should use rather than the doctor as is usually the case. One of the mentors explained that if the peers found out that an initiate was using a lot of pain killers, they would bully, isolate, beat him and refer to him as uncircumcised which translates to a “kihii”. Having become a man, the initiate is expected to persevere by passing through painful tests. This highlights the importance of pain in the ritual. The quote below shows that men can beat a young man if they found out that they had used painkillers:

Men say you are not circumcised and they can beat you because they say you have been given painkillers. (f1 14)

Painkillers are discouraged since, as the mentors argue, pain is not caused by the wound, but rather by the erection of the penis, and, therefore, other strategies are used to calm the penis. The mentors advised the initiates to use a cold metal torch or a padlock once the penis erects. A metal torch is kept on top of the roof in the night for a cold effect and is used anytime an initiate has erections. The quote below explains the use of padlock to reduce the pain of an erected penis:

You had to persevere the pain and that's why we used a padlock since most of the pain did not come because of the anesthesia... the numbing medicine. (M7)

Similarly, another mentor reported the use of a torch or a bottle to prevent expansion of the penis in the quote below:

We give a torch or a bottle with cold water to see...eehh ... for cooling the penis and stopping the erection. (M12)

The mentors were more concerned with the erection of penis and not necessarily the pain. According to the mentor, if the penis erected, stitches would be stretched and they would have to go back to the hospital for new stitches. It seemed that pain is acceptable but should not lead to the incurrance of more costs by having to return to the hospital or a delayed healing if the stitches are stretched. This is illustrated in the quote below:

If he (initiate) erects and the stitches expand we might have to go back to ... hospital. (M11)

Preparing the young men for pain prior to the cutting by the mentor is likely to induce fear in the young men who find ways for overcoming the fear. The boys feel better to know that other boys in the neighborhood are getting circumcised which can be a form of group support. Mentor 8 described the strong bond between him and “ngabu”⁹ now his best friend with whom he got circumcised at the same time. Group support was one of the ways that young boys reduce fear and tension of circumcision as in the quote below:

R: Who prepares you and tell you are not supposed to cry?

M7: A day before your mentor will come and talk to you and prepare you psychologically and tell you the part on pain. If you are lucky and boys from the neighbourhood are also getting circumcised, then you can encourage each other and go together. Once you access the hospital, in the minor theatre, if the one ahead of you does not cry then the others will not be tense.

The importance of being strong while rejecting fear is ingrained in the uncircumcised boys. The Form Four students used similes comparing the sadness of other boys to being an orphan, one who has no a parent and bravery to a soldier. The students felt that a man may be allowed to have fear, but must not show it to emphasise his manliness. They said they were prepared in advance by former initiates of the need

⁹ Ngabu: Those who get circumcised at the same time refer to each other as “ngabu”

not to display fear. In addition, there was also need to make light of their experiences or what they were about to go through. This is demonstrated in the quote below:

By the time I reached there I met many boys, some were very sad like have lost their parents but I was as strong as a soldier and was not fearing because my comrades who were back home were telling stories about how I cannot show my heart challenge [Not to show fear in his heart]. (f4 21c)

It appears that it is not just the young men but also the doctors who reinforce the culture of pain. One of the mentors suggested that doctors can sometimes use the wrong dose of anaesthesia which would not have a numbing effect on the boy if he was afraid. Some of the action was also a way of torturing the initiates by inflicting unbearable pain. Cowardice was punished and boys were forewarned of this prior to circumcision and informed of the consequences once they returned home from the hospital. The mentors said that a mentor and one of his age mates are present when the boy gets circumcised to witness the cutting. The boy is not supposed to flinch in pain during the cutting because other young men would isolate him for any sign of cowardice as in the quote below:

Even the doctor could not treat you in the best way. He could even inject you not the full amount of anaesthesia. For one, you are a coward and then the other young men would sideline you. You are not even supposed to close your eyes (M7).

When I asked why the initiates were inflicted with pain, I noticed that most mentors hesitated before responding and struggled to provide me with a straight answer. From the interviews, it would seem that pain appears to be intentionally induced to test the level of endurance in the young men as a proof of manliness. Fear, and especially showing fear is also seen as a proof that you cannot endure the pain. The options for reducing pain are not always employed and it appears that mentors often opt for pain increasing methods and tactics instead.

7.2.4. Advice and Instructions

Through the narratives, I got an impression that the initiates received a lot of information, which was overwhelming and seemed to create an “advice shock” after circumcision. Students referred to this information as “uncommon” suggesting that this was information they had not heard before. There was advice on sexual matters and relationships, and general advice, teaching and respect.

General teaching advice and respect

Some of the advice was general, while some other advice was considered boring, bad and/or good as in this quote:

They give advice on things which is good and bad. (f4 17)

This may reflect on the erosion of the teaching function of the male circumcision ritual as it seems there is no objective of the advice given.

Some of the terms, words and proverbs in Kikuyu are exclusively reserved for men and the initiates would not have heard them prior to circumcision. Coupled with a lack of objective for this teaching, this could make the initiate indifferent to such teaching. However, it appears that only a few terms were reported to be taught by the young men. The young men visiting the initiates appeared to be teaching haphazardly, whatever came to their mind, with each visitor picking different issues. Mentor 8 referred to it as “a bit of advice”, perhaps because of the haphazard nature in which they advised or talked. According to the student narratives, the teaching on the Kikuyu culture was focusing on a few terms and names of different parts of the house that are likely meant to acquaint the initiates with the Kikuyu language. They should only speak in Kikuyu. The initiates are expected to remember all that they have been taught by the end of the healing period. Mentor 8 relates this below:

Now the advice part is done by those guys I'm telling you and I will not call it advice. There is a bit of advice. The old things like they will teach you about traditions, they will teach you about the kikuyu culture like you don't talk in

English or Kiswahili.....this is a Kikuyu thing. You are taught the deep Kikuyu, proverbs; you are taught what the name below your belt is. You don't know because you have never thought of such a thing. You are asked the name of under the bed and then you are given "kiberi"...the old names (M8)

Mentor 1 mentioned that in the past, there was extensive teaching on Kikuyu language, terms and proverbs. He felt that today, young men were only taught a few words and proverbs hoping to use this as a way of harassment of the initiate, in case the initiate could not remember what he had been taught by the end of the healing period. One of the Form Four students seemed to suggest that most of the advice given by other young men was not convincing enough. There was a suggestion that some initiates did not follow the advice given by the initiates.

There was a sense of exasperation expressed by the initiate who compared this to having a headache from the advice given. A "headache" may be caused by too much information than they can bear or advice that is forced on the initiates. This is illustrated by the quote below:

Young men gave me a headache of giving me advice that looks like true though I never agree with it. (f4 19f)

Respect for the elders especially the parents and the mentor, for example, by greeting the older people on the road, moving out and making way for them on the road appears to be given more emphasis by the mentors. The mentors tell the initiates to obey their parents despite having become an adult. The quote below emphasizes the mentor's advice on respect:

However they are very cautious about respect. They will tell you to respect your mother, parents and mutiiri, very much yah. (M8)

Respect is viewed as mandatory for the initiates. They are not only asked to respect parents but also their age mates who they went through circumcision together with as in the quote below:

Respect is a must and the ones you got circumcised with the same time are “akiini aku” (your age mates) and you must respect them. (M4)

Advice on Sexual Matters and Relationships

Information on sexual matters was commonly given and discussed by young men, and one Form Four student affirmed this by writing: “Yes, too much sexual matters”. According to one of the male circumcision mentors, it was important for the initiates to know how to approach a girl since that is what prepared the initiate for marriage. The narratives gave an impression that once they get circumcised, marriage was the next important stage, thus they needed to prepare for it. The young men and mentors taught the initiates how to approach, interact and relate with girls. However, the young men used other names instead of the right names of the organs in the female reproductive system. However, these names were not listed down by the Form Four students as is illustrated in the following quote:

Advice on sexual matters was more than any other thing but I myself I refused to debate on it because it is like kind of placing bad names about female reproductive system and other more.(f4 18)

Some of the advice was concerned on how to ask a girl for a date, which included instructions on how to go about it. This was probably because the initiate may not have done this prior to the ritual and was, therefore, unsure of how to do it as in the quote below:

Then you are given advice on how you can ask a girl for a date and you are given instructions on how to do. (f1 14)

Mentor 8 seemed to suggest changes that may have taken place in rules and instructions about dating and has to treat a girl at the time he was circumcised, unlike today. At the time of the interview, he was 23 years old and had been circumcised about ten years earlier. It appears that the sanctions in place about where and with whom to carry out some of the activities acted as barrier to engaging in behavior such as drinking alcohol as reported below:

Good discipline came about because there were people who watched over you. You could not for example use “mbija” (whistle) on the girls. You could not take beer when the older ones were there so it took long before you drank beer. As for cigarettes you could smoke hiding. If you had to have a girl you had to have one, and not one who is older than you. Today I see that our young men are dating women who are older than them, you had to go for one who is younger than you. (M7)

Mentors admitted that it was difficult to approach a girl, but said that their role was to help the “ciumiri” (initiates who have come out to the road) by talking to the girls on their behalf. There is an assumption by mentors that an initiate is a novice in this area and the fear of rejection could make it difficult for him. The initiate may, therefore, look for any girl who is available and the one who will accept him. This was more about learning the skills of approaching girls. This skill was deemed important probably as a preparation to acquiring a suitor and also indicated that this may not be about wiping the soot. Wiping the soot is discussed under section 7.2.5. An initiate who does not have a girl is seen as stupid. This notion could put pressure on the initiates to find a girl in order to be like the rest. This is demonstrated by the quote below:

This might be difficult but when you walk with him and see a girl you can ask him to “talk to this one” or you talk to the girl and ask her “talk to this one so that he stops being stupid (ahingarite) here” (M11).

The advice of approaching the girls “airitu”¹⁰ is sometimes done practically by bringing a girl to the initiate as the mentor and his age mates watch and listen to how the initiate interacts with the girl. In other cases, he is given examples of how to behave in certain instances. This was like a test of communication skills between a girl and a young man. This gives the impression that there was a certain method and system for the young men in communicating with girls. This was sometimes done a few days after the physical cutting before the wound was healed, and thus, the young man was not able to engage in sex. The narratives did not make it clear to whether or not there was an assumption that the girl was ready to engage in sex if the initiate was completely healed and whether the girl had the choice to engage in sex. The part of the initiate’s inability to engage in sex is emphasised in the quote below while oblivious to the girl’s consent:

You just bring the girl, to teach him how to talk to girls. Since he (kiumiri) just got healed there is nothing much they (initiate and the girl) can do. (M9)

Not every initiate took the young men’s advice about sex. A Form One student reported that he took the uncle’s advice on sex which suggests that male relatives can advise the boys before circumcision. This was because the uncle informed him of the possibility of contracting diseases during sex:

I did not take any advice about sex because my uncle told me about the man who was forced to by others and had very many diseases. (f1 19b).

The mentors also said that they advise the initiates against some teachings of young men. Sexual matters and relationships appeared not to be freely discussed especially with parents. It appeared that relationships are meant to be kept secret from parents until when the young man and the girl are ready to stay together. There is also a suggestion that a young man should not be seen together with a girl by the parents as shown in the quote below:

¹⁰ Airitu is a Kikuyu word for girls, while a circumcised man are referred to as mwanake, a circumcised girl is referred to as muiritu (singular) and airitu (plural) which translate to girls while a woman is mostly used for married women

For example, when my father sees me with a girl, I was not supposed to run away but would have to go away slowly from that girl. (f1 15)

7.2.5. Circumcision Ceremonies

The two circumcision ceremonies discussed by the participants were wiping of the soot and the road license. According to Njuki, a 54 year old man (see chapter eight, section 8.22), these two practices used to be part of the circumcision ritual in the past. However, according to Kirika, a 103 year old man (see chapter eight, section 8.2.1), wiping of the soot was non-existent but “*ngwiko*” was carried out as discussed in chapter two. Njuki mentioned witnessing “*ngwiko*” being practiced by young men and women circumcised when he was a small boy. The findings suggest that the end to the practice of “*ngwiko*” and evolvement of wiping of the soot may have taken place sometimes prior to Njuki’s circumcision. In comparing the discourses of Kirika who represents the older generation with Njuki who represents the younger generation, circumcision is shown to be the beginning of responsible sexual behaviour and a gateway to sex. It was, however, confirmed by the initiates and the circumcision mentors that the practices were undertaken differently in the past compared with today. The ceremonies followed after the cutting of the initiate and were, therefore part of the male circumcision ritual and practice among the Kikuyu people. The two ceremonies, especially the road license, were portrayed as agencies for violence where initiates were coerced and pressured to comply or otherwise face the consequence of isolation and stigmatisation if they failed to adhere. Although most mentors responded to the questions on wiping of the soot, one of the mentors seemed uncomfortable discussing it. He also avoided using the expression ‘wiping of the soot’.

Wiping the soot

Wiping the soot entails having sex with a girl immediately after “*kumira*”, ‘coming out’, after circumcision. The first sex after circumcision is referred to as “wiping the soot” where the exposed inner part of the penis, after the removal of the foreskin, must be wiped. In order for the soot on the penis to be wiped, condoms should not be used.

The mentor’s role in wiping the soot is central since he sometimes chooses the girl with whom the initiate should train and practice “wiping the soot”. The first girl can be the same age as the mentor’s age mate and her task is to show and explain to the initiate how to wipe the soot. An older girl is chosen probably because they are more sexually experienced than the initiate. Circumcision, thus, acts as a precondition to accessing women. It was also interesting to note that the term friendship, “*Urata*”, was used to denote a sexual relationship. This is suggestive of the sexual taboo in the Kikuyu culture that encourages a discreet use of sexual terms. The following conversation illustrates how wiping the soot is organised among the young men:

M9: You first bring one from my [mentor] age mate so that she can teach him but the one with whom they [initiate and the girl] will make friendship with, is his [initiate] age mate R: Why do you bring the first girl?

M9: Training and we call them for wiping the soot

According to Njuki, a group that is circumcised together is referred to as a “*riika*” age set and people in the same age set are referred to as “*akini*” (age mates) regardless of their age differences. He explained that age gap between age mates can be between three to five years although this is not an established rule.

Although mentors reported that any girl was used for the wiping of the soot, students wrote about meeting virgin girls. It seems that most of the male students were also virgins at the time of circumcision. The narratives implied that most initial sexual intercourse between young men and girls is likely after an initiate is circumcised as insinuated by the Form One in the quote below:

When I came out, they bring a girl, who was a virgin. They told me it is time to “kuhura mbiro” (wiping the soot) - I asked them how to do this. They teach me how to have sex. (f1 17c).

Young men used their girlfriends to wipe the soot. There were contradictions concerning rules about how and with whom to wipe the soot while some said that a girlfriend was not for wiping the soot:

After three months I wiped the soot with my girlfriend to prove that I’m a man. (f4 18c)

To the mentors, this was a very important ritual that should not be abolished. During stitch removal from the wound, the mentors examine the penis to see if the initiate is able to have sex. According to most mentors, it is important for the initiates to wipe the soot. The mentor even assembles his age mates to persuade the initiate to participate in this practice. Those who refuse to participate are referred to as foolish and stubborn and are “left alone” in isolation. This signifies stigmatisation, pressure and coercion to comply. The interviews suggested that mentors endeavour to find out who has and has not wiped the soot suggesting sexual matters as non-private among the young men. Mentor 11 suggested that any girl can be used to wipe the soot as the initiate is only supposed to take one of his “lady friends”. He does not explain any criterion for picking this girl. The following conversation with one of the mentors relates to this:

M11: Yes this is an important issue, and if you had lady friends you have to take one.

R: Do you give them this advice?

M11: Yes I do because he has to do this although there are some who decide to stay like goats.

Mentor 11 reported that mentors already test to see that if the initiate is able to engage in sex. However, the mentor takes it as his responsibility to send a girl to the initiate. This is a way of ensuring that the initiate wipes the soot. The initiate is portrayed without freedom of choice and has to comply as led and guided by the mentors, as illustrated by the following conversation:

M12: We talk to a girl and ask her to find out if he is able to do anything. However, when we are removing the stitches we see if he is erecting.... By the time we send the girl we know his status

R: What if he refuses

M12: I get the riika [age group] of mentors and they talk to him R: Is it possible for him to refuse?

M12: It is not possible for him to refuse and the one who refuses, we get to know

R: If he adamantly says no to it...

M12. We leave him alone and look at him as a foolish person

The students wrote about wiping the soot as a forced practice. The statement “one is brought a girl” suggests that the initiates are led and guided into the wiping the soot. It also appears that the young men play a core role in ensuring that the initiate wipes the soot. Some reported having participated in wiping the soot because they were forced to. The Form Four student below describes the wiping the soot as unhealthy for him, maybe because of the infections related to sexual practices without condoms such as HIV and Sexually Transmitted Infections (STI) as the following quote shows:

I participated in it and I was forced to do it because I found it unhealthy for me. (f4 19b)

There were different reasons why many initiates did not participate in wiping the soot. A number of students stated in the narratives, that they were not aware of the practice. Those who did not participate in wiping the soot were either Christians or not aware of the practice. It appears that some of the mentors did not advocate the wiping the soot and, therefore, did not advise the initiate on engaging in it, as implied by the mentor in the following quote:

About wiping the soot, I'm not aware as I did not participate. (f4 18e)

Others were Christians and, therefore, did not agree with wiping the soot, probably because it was against their Christian faith as shown in the quote below:

I didn't participate in wiping the soot. I refused because I was a Christian. (f4 19b)

In addition, mentors who were not introduced to this practice did not see the need to introduce it to the initiates they mentored and deemed the practice as irrelevant. It also depended on the location [village] that an initiate came from and the mentor's influence and directions. It is probable that some of the locations in Muranga County do not practice wiping of the soot. Some of the initiates, therefore, preferred to get circumcised away from their home in another location, to avoid harassments and pressure to engage in some of the practices. In the quote below, the initiate described the possibility of being forced to wipe the soot in "Mininka" [not the real name]:

I did not participate in kuhurwo mbiro (wiping the soot) because that is not common in our culture but it depends on the mutiri, or the people around you, home for example in Mininka they will force you in this. (f1 17d)

The students who hated wiping the soot distanced themselves from it and referred to the penis as “a thing”, which suggested embarrassment and shame of sexual matters. In the quote below, the use of the expression ‘*they said*’ gives an impression that that wiping the soot is foreign to the initiates:

I hate it, kuhurwo mbiro, they said is to have sex by a certain girl to clean your thing.... (f4 18)

The male students reported participating in wiping the soot after receiving the advice. Probably it was out of curiosity that they wiped the soot, however, the sense of urgency seems to reflect on engagement on the act of wiping the soot as a fulfilment of laid down rules as in the quote below:

After circumcision, one must have the experience of kuhurwo mbiro. I participated in it and did not have to be forced because I really wanted to do it quickly. (f1, 17)

Similarly, the Form One below confirmed that he was not forced to do it and did it willingly. I wondered if the initiates would have participated in wiping the soot if the mentor had not told them. It is possible they did it because their role model (the mentor or other young men) recommended it:

I was not forced because I wanted it. (f1 14)

For mentors, diseases today were a concern and this prevented them from advising the initiates to wiping the soot. Some of the mentors advised the initiates against wiping the soot but also noted that the initiates had the freedom to do whatever they want. The likelihood of getting diseases was used by some initiates to scare initiates away from the practice as shown in the conversation below:

R: They (student) also brought the issue of Kwihura mbiro, what would say about that?

M1: Laughs...ehhh this is difficult because I was not taught such things: I would tell someone that, you know salvation is in different types' would tell them they have freedom to do whatever they want but there are diseases. I would never insist such things.

The students reported varying waiting times before wiping the soot; three months, six months and some weeks. While some were aware that they had to engage in sex after the complete healing of the wound, others were not. The mentors had mixed ideas on how long an initiate had to wait after the cut to wipe the soot. This ranged from weeks to three, four and six months. According to the conversation below, the mentor advised the initiate to wait two or three weeks after coming out before participating in wiping the soot:

R: How long does he have to wait before wiping of the soot?

M12. It depends with the healing of the wound but we tell them to wait at least for two weeks before carrying out such

M12: After kumira (coming out) he can stay for three or two weeks

Mentor 9, in contrast, advised the initiates to wait three months after circumcision to engage in the practice as shown in this quote:

R: After how long do you advise him to wait before wiping the soot?

M9: after three months.

A Form One student reported being advised to wait for four months after circumcision before engaging in wiping the soot in this quote:

They advised me to break my virginity before four months were over. (f1 19)

Another Form One, however, reported being advised to wait for six months after circumcision prior to wiping the soot, as shown in the quote below:

*I was advised not to do sex with girls until six months are over or one year.
(f117)*

Factors such as isolation and acceptance enhanced compliance with the wiping of the soot by the initiates. There was also the impression that the fear of being sidelined and the need for acceptance led to participation in practices such as wiping the soot. The initiates were reported to lie to be accepted, to impress or to be part of the group of 'real men'. Even with circumcision, the other practices are part of the proof that one is a real man. It was also alleged that the initiates would be stigmatised for not wiping the soot as in the following quote:

If people or grown up and the people ahead of you know that you have not done that [wiped the soot], they may side line you because they know you are not a real man and you are not able to trick a girl and bring her to you "thingira" (man's house). It is not that people feared much but that people will say that... people will give you challenge and sideline you. (M7)

Apart from the use of isolation and acceptance, myths and taboos are also used to ensure compliance to wiping the soot by the initiates. Myths are used to control when and what kinds of girls are appropriate for wiping the soot. It appears that mentors expected the wound to heal after two months and, therefore, used myths to ensure that the initiates did not engage in sex prior to the two months. As for the taboo, the consequence is defined. To discourage the initiates from engaging in sex before the two months were over, they were told that if they do, that the tip of the penis will come off. One mentor confirmed this in the following quote:

It is just normal sex and it was advised that it should not be done before two months are over. They said that you will leave the head there since it is not healed.... (M8)

While some mentors said that they told the initiates to go with an older girl, others advised against it which denotes conflicting information depending on the mentor and probably the location. Two mentors who said they advised initiates against older girls were from the same location. It was reported as a taboo for an initiate to relate and have sex with an older girl as shown in the quote below:

Yes, he should not go with a girl, who is older than him, this is “mugiro” (taboo) she should be your age-mate. (M12)

There was a suggestion that in order for girls to agree to participate in wiping the soot, they had to be paid. In addition, it appears that it is the initiate in need of wiping the soot rather than the girls and, therefore, he has to pay:

Today, if a young man has 50 shillings they just pay it and because he has been told to go and wipes the soot he just goes ahead. (M6)

Condoms and Disease

Participants discussed the use of condoms during wiping the soot, although wiping the soot is supposed to be done without condoms. According to most mentors, no one can claim to have wiped the soot when they have used condoms since condom covers the soot to be wiped. However, it was suggested that most did not use condoms because it was probably because they were unaware of their purpose, as illustrated by one of the Form Four students in the following quote:

I did not use condoms, what for? No mbiro (soot) can be wiped with condoms and it was very nice (f4 18).

The initiates were advised, that sexual pleasure could not be achieved with condoms. The pleasure gained from sex appeared to be more important than the use of condoms. There is a suggestion that covering the penis with a condom

would not result in the same sexual experience as when condoms were not used as in the quote below:

We advise him that if you want to feel nice you must not use condoms because it is like eating a sweet with the cover on it. (M12)

Some misconceptions about condoms were also reported. In one narrative written by a Form Four student, it was implied that only the sick should use condoms. There was the notion that the initiate himself was not sick and neither was his partner and therefore, there was no need to use condom as the Form Four student implies in the quote below:

I did not use condoms because you cannot use condoms, condoms are for the diseased. (f4 19a)

For other students, sex was not good as it was meant for married couples. Condoms were also associated with bad health for the young men, although they did not explain why condoms were not good for health. They students viewed condoms as disease carriers, as shown in the quote below:

I did not use condoms because condoms are not good for our health. And I know that sex is not good. Sex is for the married man and woman. (f1 19b)

The participants did not specify the diseases of concern. One Form One student wrote about “dangerous diseases” which could be an euphemism for HIV in Kenya where terms such as “*kagunyu*” [small worm] are synonymous to HIV and AIDS. This is especially the case with HIV due to the stigma associated it:

I used condoms to protect myself against dangerous diseases. (f1 17b)

Some of the students knew that condoms could protect against HIV and AIDS. This suggests that they practiced safe sex by using condoms as indicated in the quote below:

I used condoms to protect me from HIV and AIDS... I use condoms when doing sex to prevent HIV/AIDS. (f1 17a)

There was the impression that it was only the “dame” that could infect the initiates with HIV and not the initiates infecting the girl. A girl is referred to as a “dame” in Sheng language. It thus appears that the condom is used for the benefit of protecting the initiate as shown in the following quote:

...Yes, I used condoms because a dame can infect you with AIDS if she had it. (f1 14)

There was an impression that circumcision protects the young men from becoming infected with HIV or even from impregnating a girl after a particular time. The quote by the Form One below depicts lack of knowledge about the effect of circumcision and how a child is conceived during sex:

Of course, yes I get a girl friend and I told I love her and ask if you want to kwihura mbiro [wipe the soot]. After two weeks do not get a baby or HIV. (f1 16f)

Road License

Road license is a practice where the initiates pay a fine to be “on the road” and usually results in an organised ceremony. Going on the road or ‘coming out’ refers to the initiate’s freedom to leave the “*Kiumbu*” after recuperating. Prior to the road license ceremony, the initiate is not allowed to go out of the “*kiumbu*” unless going to the toilet. During Kirika’s time, road license was voluntary and was only given to the mentor. However, in Njuki’s time, road license was compulsory and was given to the mentor and his age mates. Different road license ceremonies were reported by the participants in different locations (villages) in Muranga County. In one of the

villages, the eating of a cockerel (chicken) together with other young men, coupled with a question and answer session marks the road license ceremonially. The cock is referred to as “*nguku ya murangano*”, the “*road license cockerel*”. In some places, celebrations and feasting are essential for the road license but do not necessarily involve the slaughtering of a cockerel. The latter depends on what the parents can afford for the feast.

One of the mentors told me that they give out a local brew to the mentors and his agemates instead of a cockerel. However, there is uniformity in all locations regarding giving cigarettes for the road license. Cigarettes are a must in the road license regardless of whether a cockerel is given or not. Only a few young men attend the “cockerel ceremony” and act as representatives for the whole community of young men. The mentor said that he chose the men to attend the “road license cockerel ceremony”, although, in some areas, other men can attend uninvited. The ceremony takes place after a certain number of days following the cutting and the young men can easily predict when the ceremony is likely to take place. Different reasons for giving the road license were mentioned ranging from proof that you are circumcised, to show that you are a man, to gaining company, acceptance and respect. Giving of the road license was also one of the ways for proving that initiates are men:

I'm aware of the road license because I removed it and gave to the men [gave/paid the road license by buying cigarettes and cockerel]. The road license is given so that they could know that you are a man. You give items such as cockerel and cigarettes. (f1 16c)

Giving the road license was also described as a way of respecting the young men receiving it:

The meaning of “murangano” was amount of money, something like cigarettes that could show that the person you have respect for him or not. (f1 17d)

On coming out to the road, those not invited to the cockerel ceremony demand cigarettes and make it difficult for the initiates to go on the road. It is, therefore, irrelevant whether an initiate hosts a ceremony and a feast since he is likely to be asked for cigarettes, especially by those not invited for the ceremony. To stay on the road, the initiates have to buy cigarettes for the young men, as in the case below:

M3: If you came out (kumiira) to the road you were always waited for R:

By whom?

M3: Those who were circumcised before you, so once you "kumiira" (come out) they ask you for cigarettes.

There was no guarantee that the initiates could avoid paying the road license. A sense of helplessness and frustration among the initiates regarding the road license fines was evident. The initiates gave the opinion that they had no choice but to pay it. It is presumably viewed as compulsory and even if the initiates did not want to pay it, they were forced to do so. One Form One student equated this to a career, probably because of its popularity and the young men using it to "earn" money:

I participated by giving five men 20 shillings (£0.1) each. I was forced because this has become a career in our village/culture. (f1 17d)

The vulnerability of the initiates is sometimes taken advantage of when their mentor is away and when the initiates are in bed recuperating as they are not a match for other young men. Although the road license should be asked for when an initiate is ready to come out, but it is apparent from the quote below that some young men are asking for the road license prior to an initiate coming out:

Yeah, there are two guys, who were even arrested and given fines of about

10 thousand shillings (£73.8) not sure the exact amount but it had reached 10 thousand. The 2 guys got hold of a boy and beat him and took the money he had been sent to the shop with, saying it's "murangano". (M10)

7.2.6. Violence through the ceremonies

The theme of violence emanates from almost all the subthemes. However, it was more prominent in the circumcision ceremonies, especially in the road license. Many study participants described how young men use the road license as a means of getting money or cigarettes from the initiates. Violence was used to orient the initiates into manhood, as well as act as a means of compliance with the practices in the circumcision ritual. Violence manifesting mostly in the physical form was reported. One of the mentors preferred to accept and even defended and made excuses for the harassment of the initiates from the men:

They don't do that because they hate you. (M8)

Violence is exercised in diverse ways. The young men take advantage of the initiates' recuperation state and reach for the exposed part of the body especially the thighs which is very painful. Sticks are commonly used to beat the initiates. The young men beat the "*ciumiri*" or the initiates as replication of what they had experienced. I was under the impression that they were working to pass on the violent practices to the next generation of initiates:

It depended onothers would mostly be slaps, but not their legs (mateke). They could also beat you with a stick (rucamiu). Again when you are in the room you stayed half naked and most parts of your body are exposed. The thighs, for example, were very painful. (M7)

Physical fights sometimes occur when a kiumiri (one who has come out) goes on the road without money for cigarettes for the young men he meets on the road. If an initiate had any money, this would be taken from him. According to the mentors, different tools and weapons of violence are used, such as sticks and slippers and by different people at the same time. Refusal to give the road license confirms this:

If you would not give the road license, you were beaten up. (f4 20)

The harassment includes pressing the penis which is not fully healed. The interviews suggest that the young men would also ensure that the penis erects and, with a wound that is not healed, this is very painful. Although harassing for the road license is viewed as an acceptable culture among the men, some ended up in the police station, as the next example illustrate:

There is one young man who asked me for Murangano, but he was lucky because my mentor was not nearby. He started harassing and pressing me. I was in pain and screamed until my mother came. The young man was taken to the police station... (f1 19)

Another reason given for violence is a refusal by a young man or initiate to respect the parents, resulting in beatings from his mentor and his age mates. This, however, depends on the location as in some locations they left him alone. Other tools of violence included car tires and wires as reported in the quote below:

The parents informed the mentor and they (mentors) talked to him together with his age mates for almost an hour. They gave him good examples of ten good men. If he failed to change you use sticks, car tires and wires to beat him. (M13)

The mentors advise initiates not to give any cigarettes after the ceremony but the pressure to conform to the road license is great. Besides, the mentors and his age mates may not always be present with the kiumiri. It seems that employing tactics given by the mentors such as telling the young men asking for the road license to “*go and get the cigarettes from the mentor*” or “*I don’t have money*” or “*wait*” puts the initiates at risk of physical harm. In addition, they would take all the money the initiate had by force. The following conversation shows what is likely to take place when young men said that the road license was with the mentor when asked:

R: What happened when you told them to go and ask your mentor? M3: That is when the fight erupted, especially if the mentor is not around, it would mean that he cannot help you out R: What would they do to you?

M3: This was a physical fight since you have no money and if you had said you had no money they would take all the money you had R: How would they beat you?

M3: You would be beaten with sticks; another would take your slipper and beat you with it.

Wiping the soot was another avenue of perpetrating violence. Refusing to participate in the wiping of the soot could result in torture and beatings as in the quote below:

I was told when I was fine I will get sex and they are finding me a girl but I refused to get sex with that girl yes I was tortured by beaten with sticks. (f4, 18)

The initiates also prepared to return in kind by fighting back if beaten. It seems that initiates who were good fighters were not victims of violence since the young men were afraid of fighters. Being a good fighter appeared to accord the boys popularity prior to circumcision and acted as a basis for exclusion from violence as indicated in the quote below:

I was not harassed by any one for they all knew me even when I was a boy; I was a good fighter so they feared. (f4 18)

With the theme of violence emerging throughout the participants stories, it follows that the theme of protection would have been inevitable. The boys and parents sought protection from the prevailing violence. Some of the mentors endeavour to protect initiates under their care.

7.2.7. Protection and protective network

It was interesting to note that protection was a very important issue for the young men. It was indicated as one of the most important factors in choosing and having a mentor by the students. The interviews with the mentors suggested that mentors were mostly the choice of the parents. However, one of the mentors said that sometimes the boys would choose the mentor who they thought would protect them, but the parents had to endorse the boys' choice. At the same time, a mentor would decide to protect the initiates without being asked. A mentor would, in this case, call for reinforcements from his friends (age group members) to confront anyone attacking the initiate under their care. In addition, if you attacked a "kiumiri" and you were not from his location (village), a group of mentors would organise retaliations. However, protection of the "kiumiri" (one who has come out) is not possible all the time because the mentor cannot be with him throughout as discussed in the previous sections. Even if the mentor could protect them in the "kiumbu" (room), the mentor did not stay in the room throughout as in the past. The mentors had to go to work amidst mentoring the initiates. However, during observations of circumcision meetings, police were reported to be more involved in punishing the perpetrators when victims reported those who harassed them to the police. The position and status of the mentor in the community were also factors considered for protection of the initiates as in the quotes by the Form One below:

He was a teacher and protected me during healing. (f1 14)

It is a paradox that some mentors circumscribed to violence and others to protection. The mentors were aware of their importance in protecting the initiates and "ciumiri". When a mentor accompanied a "kiumiri", this provided protection for him. Mentors

were so committed to the protection that they were willing to accompany the “ciumiri” for a whole month on the road. The young men responsible for harassments avoided approaching a “kiumiri” who was accompanied by a mentor. If they wanted cigarettes they approached the mentor, as suggested by the quote below:

Yes, but if I don't want him to pay for it (murangano), I can go out with him for a whole month. That is when he wants to come out on the road, I accompany him and when they ask for cigarettes they will ask me instead of him. (M12)

The mentors, however, felt that they could not protect the initiates if they (initiate) did not report the harassment to them. The advice was to report the harassment immediately so that an action could be taken. Mentor 1 compared an initiate to a Form One student probably because the two, an initiate and the student are starting a new stage in life. The Form One student is starting a new life in secondary school while an initiate just started a new stage of adulthood. According to the mentor, once a person is reported of harassing the initiate, he is confronted by the mentor

All the ones I have mentored, I tell them “ it is just like in Form One once you are harassed, you are free to report, if you keep quiet you are the one to suffer” but if you report immediately there is an action that will be taken. (M1)

Not only is protection given by a mentor when the initiate comes out but sometimes, he also controlled the people who visited the initiate. A mentor is called “Baba” (father), signifying a father figure and would, therefore, take on the responsibility of protecting the initiates. The role of the mentor was also to maintain peace perhaps between young men who came to the room. A strong and feared mentor is able to restrict the people who visit the initiate. The word “guard” was used in the quote below by the Form Four students to explain the watchfulness of the mentor to ensure that an initiate is safe as in the quote below:

His work is to guard me so that there is nobody who can harass me and to maintain good peace in the house. (f4 17)

The strong and brave mentors were deemed the best ones to invite to the cock ceremony since they would protect an initiate. The initiates were said to be confident if they were aware of the backup of the strong men behind them. If an initiate was asked for the road license and directs them (other young people) to the strong mentor as the one to be asked for the road license, they would not attack the initiate for fear of being beaten if reported to the mentor. The fear and insecurity of being on the road are minimised when the *ciumiris* are confident of this protection. This provided a protection network for the initiate as it is not just the mentor but even the mentor's age mates who protected him as reflected in the quote below:

You take people who are "akumu" (brave, hard headed and tough) who can protect them. They could be eight or five. You will, therefore, be confident to tell them that "I was told that if you ask for a beer you should go and ask so and so." This way you win. At this particular time you are told that "if anyone will ever touch you just let us know"(M7)

From my observations, most of the mentors related these stories of harassment and torture light heartedly; with laughter as it seemed this had become a norm and was not viewed as violence. The mentors had gone through it and, therefore, insinuated that the other initiates should go through it as well.

Although the mentor is depicted as a protector by many of the young boys, there were times when a mentor sent people to harass the initiate, which contradict his role of protection. If the initiate as a boy had been rude or done something bad to the mentor, the mentor would wait for the circumcision period and mentor the boys, hoping to take revenge on the initiate when he is recuperating:

No, however if you had done something to me(mentor), I can send a girl to you to hold you and touch you and this way your penis will erect and bleed because the stitches are stretched. (M12)

The mentors did not elaborate whether the initiate knew the reason why he was being harassed. However, the initiate took revenge implicitly since he did not want the parents to know he was responsible for the punishment. The data suggested that most initiates did not report to their parents the punishments and harassments that they experienced. It seems that the initiates take it or are taught by the mentor and other young men that this is the way of life. It is also a paradox that a mother or boy approached a mentor hoping for protection while the mentor might be planning to harass him.

7.3. Conclusions

This chapter presented first theme “*Maturing into adult men*” from data collected from male students in school, mentors and two elderly men and observation meetings in the churches. The students’ experiences included pressure to get circumcised, coercion in wiping the soot and road license. Students showed that male circumcision was described as a process rather than just an operation or cutting and of maturing into adulthood. Pain was also depicted as important in proving that an initiate is a man and that they were ready to face anything. The role of the mentors was that of protection while others organised harassment of the young men. Overall, the practices and ceremonies differed slightly depending on the location. The next findings chapter will discuss second theme “*Changes in cultural values and practices in the ritual*”.

Changes in cultural values and practices in the male circumcision ritual

8.1. Chapter Introduction

The previous chapter discussed the first theme of the findings “*maturing into adult men*”. This chapter discusses the second theme of the findings “*changes in cultural values and practices in the male circumcision ritual*” which focuses on changes in the circumcision ritual. Changes are highlighted by comparing specific aspects of the ritual in the past and today. These changes are discussed below under church, the hospital and urbanisation as the drivers of change. Some of the changes and differences that have occurred in the male circumcision ritual over time are illustrated through the stories of two older men Kirika, aged 103 years and Njuki, aged 54 years.

8.2. Recounting the past

Two men Kirika, aged 103 years and Njuki, aged 54 years were interviewed because they had been circumcised much earlier prior to all the other participants interviewed in this study and could, therefore, recount the past practices in the male circumcision ritual. When Kirika and Njuki were circumcised, both girls and boys were circumcised. Their stories are related below.

8.2.1. Kirika’s story

When I got circumcised there were 28 of us. Of course, before one gets circumcised, a goat must be slaughtered so as to “guciarwo na mburi” [to be born with a goat]. This means that a goat must be slaughtered at the venue where he will get circumcised. There was no set age for circumcision if you wanted and declared an interest to be circumcised then you could join the group that was getting circumcised

that year. In preparation for circumcision we [the group to be circumcised] were allowed to go round the village singing indecent songs which would not be allowed apart from during the circumcision period. This song was referred to as “mararanja” [those who sleep outside] as we would do this during the night.

All 28 of us were surrounded by people, anyone was free to come and witness circumcision by the river. The crowd would watch from the upper part of the hill. Boys stayed on the “naiguru” [upper side] while girls stayed at the “nakianda” [southern part] of the “Itiirini” [the place where cutting took place]. “Itiirini” had to be a flat area by the riverside. You were not allowed to cry at the “Itiirini” but afterwards and if you cried you were called “kiguoya” [coward]. If you flinched during the cutting, you were held tightly by the two men by your side and one of the men would step on your legs. We used to cry at night, so when we were sleeping you could hear people sobbing. Men were circumcised with a “kahiu” [knife] and women were circumcised with a “rweji” [razor blade]. After cutting by the river, we went to the “muruithia” [circumciser’s] house and stayed in “baanda” which was a temporal make shift house made of “matharara” [dry banana leaves] and “macoya” [fresh banana leaves]. However, some slept in a permanently built house. The first four, 2 men and 2 women to be circumcised stayed in the house while the rest stayed in the “baanda”. We queued in a single file for the cutting and yes then we used to lie [sleep] in a single file. “Mashuka” [sheets] were used by the initiates for clothing until they were healed. It was the work of the mutiiri to dress you up with the “shuka” [sheet] and he also checked and ensured that you were healing. After the eighth day, we left the circumciser’s house and each initiate returned home.

The circumcision fee was six Kenyan shillings those days. Three shillings was for “mutiiri” [mentor] and three shillings was for the circumciser for the cutting (pauses) but I did not pay 3 shillings to the “muruithia” [circumciser] because they said I was too small(laughter...). They just allowed me to go without paying. The advice we were given was against lying and sexual violence. You were told you are a man and cannot do anything childish. All initiates gave “murangano” [road license] in the form of a goat to the mutiiri and his age mates. The only part of the

goat meat the initiates got, were the legs.... (laughter)... yes, the legs. During our time we had pain killers, the mutiiri ensured that you had “suta” [powder like medicine to apply on the wound]... smelly but healed the wound quickly.

After circumcision, you could wipe the soot but this was not suggested by the mentor but was something shared among age mates. This means sleeping with a woman for the first time after circumcision and it was not compulsory. We however knew how to “kuohithia nyeki” [approaching a girl in preparation for marriage]. The soot represented the past life that needed to be wiped away in order to start the new life. “Murangano” [road license] was not compulsory either and was given to the mentor. If you never gave the mentor the road license he would not be offended. Just remember that at the onset of circumcision you had already paid him. As for the road license you could pay him six shillings, or if you met him in the restaurant you could buy him a soda [soft drink such as fanta, coke and pepsi]. Now, a mutiiri was chosen for his behaviour because he never made a mistake. The marital status of the mentor was not a prerequisite for being a mutiiri.

There was a difference between “irua ria Kiambu” [Kiambu circumcision] and “irua ria Muranga” [Muranga circumcision]. The difference was that with Kiambu¹¹ circumcision a small part of the foreskin was left out known as “ngwati” after the cutting but today nothing is left out. Prior to circumcision, you had to get permission from your uncle to get circumcised and you had to give him a goat. If you failed to tell your uncle you were reported to your family. If you had no goat then you could give it to him later.

A boy could not be circumcised before his father, this was impossible, it was a taboo. Let me tell you, I had a friend who I met in the city of Nairobi. We used to work there and he stayed there for a long time without going home. One day we went to their home village, and in the middle of the night, we were woken up by noise. It was a lot of noise and they wanted us to open the door. We opened the door and were asked to remove our trousers. I did not know that my friend was not circumcised.

¹¹ Kiambu and Muranga were districts in Central Kenya but are counties since 2012.

He was circumcised that night... laughs...I received so many gifts from those men. They were saying thank you for having brought my friend home.

8.2.2. Njuki's story

Njuki's started his story by telling me about the Mungiki; an outlawed militia group in Kenya and their involvement in the male circumcision ritual. He described the violent way in which the Mungiki group recruited the initiates in the past but not at the time we met. The Mungiki group was no longer operational in that location according to Njuki. He did not say if the Mungiki group operated in other locations of Muranga (it was only Njuki and one mentor from this location who talked about the Mungiki group). Njuki went on to narrate how male circumcision was organised at the time when he was circumcised.

During our time, there was expensive circumcision where a part of the foreskin is left during the cutting and is stitched in the form of V shape and the cheap circumcision involved in the removal of the entire foreskin. Those who had expensive and those who had cheap circumcision were said to have been circumcised like father and mother respectively. The expensive circumcision required a lot of work because the "ngwati" the remaining part of the foreskin would need cleaning every day to remove the pus. This was a painful experience, however, to avoid being looked down upon most boys chose the expensive circumcision. If a boy underwent an expensive circumcision he returned home holding a unique walking stick. Women would welcome him with ululations for his courage. Such a man had many women interested in him and mostly ended up a "kiumbani" adulterer.

Wiping the soot was done after the mentor confirmed you were healed. It took seven days for the wound to heal as long as medicine and salty water were used on the wound. After seven days an initiate was given two more weeks to ensure that the wound was completely healed. We ensured that the wound peeled off after the wound dried completely. If the initiate did not have a girlfriend, the mentor had to get a "wirunde" easygoer type of a girl for him. "Wirunde" translates directly in Kikuyu

as one who drops her/himself down. Once a girl was brought, if the initiate did not know how to engage in sex he was shown by the “mutiiri” [mentor] or the girl would teach him. The mentor demonstrated first how to have sex and he [initiate] followed after his mentor in order to wipe the soot. An initiate rarely admitted that he had a girlfriend because if it was known that he had had sex before circumcision he was fined a second cockerel. However, the doctors knew if a boy had been having sex because his penis would be darker than usual.

Stitch removal was important for pain but you were not supposed to cry, one could grimace in pain but not cry. Crying brought a lot of disrespect on the initiate. A mentor did not remove the stitches but invited his age mates to do this work. The mentor would, however, choose a close friend for the stitch removal who would not spread the word if the initiate cried.

Wiping the soot involved having multiple partners because there were no diseases apart from syphilis and gonorrhoea which were just minor diseases. They were treated using capsules, and 16 tablets were enough. One would take eight of them at once, and 2 tablets per day for next four days. These were our own prescriptions as we used to treat ourselves. I became a very famous doctor here. I would buy the tablets for 30 cents and sell each for 50 cents. People really used to get sick since one had sex with this person and then have sex with the next person and so on. We had sex with many partners which made the disease spread widely.

The girl who was used to wipe the soot was paid two shillings or sometimes she could ask to be bought “mutura”; a type of sausage or “Mandazi” doughnut. Since she had accepted these items she had to wipe the soot. A girl took a lot of pride in having sex with a mentor in front of his initiate especially if the initiate was her boyfriend. A mentor was a very important person then and was referred to as a father. If the two, the initiate and the girl got married, the mentor had the honour to come and eat the first meal in their home. When a mentor visits me... even today...ehh... I have to slaughter a cockerel and if I don't have one in my house, I have to look for one. Honouring the mentor was so important such that if my mentor

enters into a pub where I'm drinking... ohh.... I have to leave that pub... to avoid getting drunk and saying a bad word in my mentor's presence. Nowadays, they even call their mentors dogs. "Since you took care of me, what did you give me?" A mentor was not paid anything apart from the respect that you gave him. To reduce erection of the penis, a mentor gave you a padlock that was used to cool it. However, a mentor could also harass initiates especially if they had done something bad to him prior to the circumcision.

A mentor could send a girl to undress in front of the initiate as a form of harassment as this caused bleeding when the penis erected. Other harassments included being given lots of tea and water so that you felt pain when urinating. When I got circumcised some young men would visit when the mentor was gone and would ask my sister to prepare more tea. And I would be forced to drink the whole kettle of tea all by myself even though we had already drunk more tea earlier. Sometimes parents had to run to the "Kiumbu" [room where the initiate live in until they recuperate] to stop fights but that was not the case with my son. I think harassment is coming to an end and circumcision is losing its value since pain is important in the ritual.

Below is a conversation between Njuki and me on sex before circumcision when I asked him a question on "Ngwiko"?

R: I have read that the Kikuyu society had order and sex before marriage was not condoned apart from "ngwiko"[sexual play in a group described in chapter two].

Njuki: That was a long time ago. When I was a small boy those who were circumcised used to meet here at this corner (he points behind us) in a shed made of banana leaves ...and we used to watch (peep) them through the openings on the shed. The initiates would dance from eight in the night to the morning and no one would engage in the real act (sex). They used to sing a song "from the waist upwards is for my lover but waist downwards is for the one who will pay goats (dowry)". They were so much disciplined and none would leave the dance room in the middle of the night to go to their "Kiumbu" (room). They would touch breasts, waists and even kiss but not the real act. Today no one can wait, once a boy gets a girlfriend by the third day..... laughs.

Table 8.1 below displays the trend in the male circumcision practice as summarised from Kirika's and Njuki's story and the information from the young men during the interviews. During Kirika's time, a goat was slaughtered prior to the cutting, but today a cockerel is slaughtered after the cutting. It was the mentor who was given the goat and cockerel in both cases to eat with his age mates. This signified a new birth: "*one had to be born with a goat*" (first slaughter a goat). Circumcision was communal in Kirika's time and the cutting was done by the river in the presence of many witnesses. It is more of a private issue in many aspects today than it was in the past. Today the initiates wear trousers from the first day of circumcision instead of tying a sheet. There was a compulsory circumcision fee in the past (six shillings) just like today although the fee today depends on the type of stitch used. The advice given was against stealing, lying or having sexual violence amidst other advice, "*You are a man and you cannot do anything childish.*" The teaching compares to the teaching given to the initiate today on ending childhood behaviours.

"*Murungano*" [road license] was not compulsory, unlike today where young men are forced to pay it. The "*mutiiri*" was paid three Kenyan shillings then, unlike today when he is not paid but can be given a token of appreciation. A "*mutiiri*" was chosen for his behaviour and because he never made mistakes. He was like a father and if you made any mistake he was called to talk with you. "*Kwihura mbiro*" [wiping the soot] was not compulsory and was not directed by the "*mutiiri*" [mentor] but was an issue raised by his age mates. Mentor 8 said that advice on "*Kwihura mbiro*" comes from the other men rather than the mentor himself. However, other mentors such as (M10) reported that it is the mentors who drive the practice of wiping the soot. Although some of the practices have changed, some of the old practices have been replicated. Today circumcision of girls is not allowed in Kenya and, therefore, seems not to be practiced among the Kikuyu people (Government of the Republic of Kenya, 2011).

Table 8.1. Circumcision trend dating back a hundred years to 2012

Circumcision Aspect	Informant 1 Kirika, 103 years old	Informant 2 Njukil, 54 years old	Forms one and four students
Circumcision period	Circumcised in 1935 at age 25	Circumcised in 1975 at age 16	Forms ones circumcised in 2011 and form four students circumcised in 2008
Circumcision (cutting) site	Itiirini [by the river] Cold water acted as anaesthesia	Hospital local anaesthesia	Hospital and/or church used local anaesthesia
Circumciser	A traditional circumciser	Medical officers	Medical officers
Stitches	Non absorbable stitches	Non absorbable stitches	Absorbable and non-absorbable stitches
Preparation	1). Mararanja songs 2). Slaughter a goat	No singing	No singing
State of the ritual	Circumcision was communal and public	Personal and private	Personal and private
Clothes	Tied sheets after the cutting until healed	Used sheets	Wear trousers and loose shorts
Murangano [road licence]	Goat for murangano Not compulsory	Cockerel slaughtered	Cockerel slaughtered Forced on some of the initiates
Crying and pain	Could cry at night/ not on circumcision site	Not allowed	Not allowed
Circumcision fee	Ksh6 (£0.04)	Ksh15(£0.10)- Ksh 20 (£.126)	Ksh700 -Ksh900 (£5.15 - £6.50)
Mutiiri [mentor]	Paid circumcision fee Ksh3(£0.02)	Not paid	Not paid
Wiping of the soot	Not compulsory Never suggested by mutiiri	Not compulsory organised by mutiiri	Sometimes forced, organised by mutiiri or organised by other young men
Circumcision candidates	Boys and Girls	Boys Some girls	Boys
Age of circumcision	Any time you felt ready	No set time, when ready	After class 8

8. 3. Drivers of change

Although the roles of the young men in effecting changes in male circumcision have been highlighted in the previous chapter, the church, hospital and urbanisation emerged as drivers for change as discussed here. It was the women who were associated by most mentors with the changes in male circumcision as a result of urbanisation and churches' and hospital's' involvements in male circumcision ritual.

8.3.1. The church

The church has recently become involved in the male circumcision ritual especially in the running of the supervised male circumcision programme. The boys are taken to hospital for the cutting but recuperate in the church premises. Other churches, however, organise for a doctor to operate on the boys in a make shift hospital in church premises where the initiates also recuperate. Traditional circumcision was reported by mentors to have been "overthrown" by the church signifying the great role played by the church, in male circumcision amidst opposition by the community. The traditional circumcision was, however, described favourably by most mentors compared to the church. This also signifies unexpected cultural changes in the ritual which was organised by the council of elders rather than a church.

The church was described as being against most cultural practices that were considered pagan in the past. Traditional circumcision seems to have been the circumcision that took place at home yet this contradicts Kirika's story. It seems that what the young men today have adopted from past practices during Njuki's time represents the traditional practices for the young people. One mentor felt that the church was not supposed to organise circumcision since it is not a religious ritual:

The times are gone and the church has come in. Even when I was going in the traditional way and there was a lot of opposition as the church told you godly things which are according to them, or to me at that time, it was not important because this is not a religious practice but has to do with the stage of life. Just because it was "overthrown" by the church doesn't mean it was

bad and I would say it was a health experience. The church would not have moulded me the way I was moulded. (M8)

Male students expressed disinterest in getting circumcised in the church because they claimed that the teaching in the church was insufficient. According to the Form Four student below, circumcision in the church entailed just cutting and did away with practices that take place at home. The church was seen to advocate teachings that excluded sexual matters such as wiping the soot, which, in contrast, were part of the advice in the traditional male circumcision ritual. In the past, more emphasis was on ngwiko, a form of non-penetrative sex. The following written quote relates this:

I could not go to a church for I thought it not to have good counselling i.e. apart from experiencing the act. Could not know about the other manhood things e. g sex handling etc. (f4 18f)

The boys, however, preferred to go to church, because they were Christians. The churches hire facilities, such as hospital premises, which demonstrates a sense of commitment in running male circumcision programmes. There is a suggestion that the church views this as a spiritual mission which is more important than the cost of running the male circumcision ritual. Although the parents¹² pay a circumcision fee to the church, most church leaders said the church also contributes money on top of what the parents pay in order to make the programme a success. The Form Four boy narrates in the quote below that he was circumcised in the church:

I was circumcised in 2007 at age 16 when I was in class seven. My circumcision took place at a hospital which I think was good place and it was sponsored by the churches. I was a Christian so I decided to go there. On that day, I was with my older brother and one of my cousins who took me to the venue where it was taking place. (f4, 21c)

¹² The term parent in Kikuyu muciaru (plural) or aciari (singular) is unisex and refers to either male or female. I used the word parent when a participant used the word muciaru/aciari

The mentors were concerned about what they viewed as the financial exploitation of a traditional practice by the church. They suggested that the practice in church compared to a contract since, at the end of the proposed time, the initiates return home irrespective of their health conditions. In these circumstances, the parent especially a father, may not be prepared for any mentorship roles or organised for a mentor. The father having been circumcised many years ago may have forgotten the mentorship skills in male circumcision. It is interesting to note that the mentor referred to the penis as 'the thing' which emphasises the silence on reproductive health matters especially with parents and even a father. The quote also highlights the private nature of discussing sexual matters even related to the sexual organ, the penis, especially with a father. There are no mentors in the church circumcision programmes, whom an initiate can turn for help, especially when the initiate returns home from church. It seems that there is a strong bond between the initiate and the mentor which is lacking among the boys circumcised in church since they have no mentors. This is demonstrated in the mentor's quote below:

*In 2005, my classmates opted for the church. They used to pay three or five thousand shillings and they will say they will hold your son for two weeks you know it is business and after the two weeks you must go back home. My friend came back totally unhealed and he was showing me the thing (penis)...you know he does not have a mutiiri [mentor] now. He had to tell his father which is not nice ...and you know at a certain age you do not have to show your father your private thing..... he is now left alone you know his father does not know what they used to do those days and
But a mutiiri in a traditional setting the bond doesn't have to break. (M8)*

The initiates in the church did not have a mentor but had strong men to guide and protect them. Protection for the initiates in the church was equally important just like for those who got circumcised at home. This is related in the quote below:

For me, I didn't have a mentor but we had some strong men to control us on what to do or caution us. These men were chosen by the churchmen. (f4 19c)

Although the church does not have mentors, paid counsellors are hired instead. This contradicts the norm where the mentor counsels the initiate without pay. In looking at Kirika's story, the mentors used to be paid but with a "mutiiri" [mentor] not paid today, the issue of the church paying the teachers becomes a concern for the mentors who were unpaid. Today, circumcision is much more commercialised than in the past as the quote below illustrates:

But those are paid people, and this is like a doctor who is paid. This is just business so how does the child gain? (M6)

Having observed the male circumcision meetings in the church, I understood that there were no mentors in the church. The counsellors and teachers invited to the churches are specialised in different topics and each one is given an honorarium at the end of each session. In contrast, the teachings given by young men at home were reported to be haphazard, misleading and untrue. The initiates in the church were taught about HIV and AIDs, reproductive health, environment and culture, development and growth and, at the end of the recuperation period, the initiate got a certificate outlining the training they had received in church. In the male circumcision meeting, they had planned to slaughter a goat and the initiates were going to do it with the guidance of the men in the church. In addition, the initiates were to give road license on arriving home in the form of a feast which everyone was invited. The advice given to the initiates is that those who asked for the road license should be reminded that they should have attended the road license feast.

The church was also criticised for taking many boys in one place with only one teacher. The circumcision organised by the church is regarded as ineffective since a mentor is supposed to have one initiate for effective training. The notion that effective teaching is not possible when more than 20 initiates are taught together was common. The mentors were considered to do a better job of instructing the initiate compared with the programmes provided by the churches. This is illustrated in the quote below:

Nowadays, they are being taken as a group of twenty and are put together and they are given one person. Eeeeh ... he comes to just see them,...eeehhh... what advice can such a person give....no there is none. It has become as a church teaching and you are taught about the Bible. It is not like I used to tell someone... don't do this and that. (M5)

The church, however, compares with the traditional circumcision ritual where initiates stayed in one room after the operation. However, in the traditional circumcision each person had a mentor unlike in the church as explained in the quote below:

No they (initiates in the past) used to go to a particular home (circumcisers home). They would bring all food to be cooked in that house. Each person had his own mentor. (M5)

Not every mentor criticised the church organised circumcision. Mentor 3 seemed to advocate the advice given in churches rather than those given by mentors. The church was depicted in this case as a safe haven for the boys compared with circumcision at home. Mentor 3 suggested that the advice by mentors were incorrect. It also seemed that the mentor had taken time to accept the changes on male circumcision ritual through the church:

What I can add is that these days there is a mission and churches organise to have boys in the church. After thinking much on this I have realised that the reason why parents take their children to the church is because after circumcision the mutiiri [mentor] are not advising them but rather mislead them. (M3)

I observed that it was mostly the mothers who accompanied the boys for circumcision in the church which is not culturally acceptable. Being accompanied by the mother distorts the meaning of the ritual “moving from one stage of childhood to

that of manhood". This likens the mother to a mentor yet those circumcised at home are not allowed to be near their mothers. There was a suggestion that boys circumcised in the church were considered uncircumcised, since according to the mentors, the initiates are unable to realise what has happened to them. The mentors were against women escorting the boys for circumcision:

Again, the person who takes the boy to the church is the woman. So, such a boy is not able to see that he has moved from one stage to another. During our time, we knew we had moved to another stage, and this was a huge difference. (M6)

The church, however, preferred to have men escort the boys to church for the ritual. In the Catholic Church, for instance, the chairman of the organising committee asked the women to talk to their husbands to get involved in the circumcision meetings organised by the church. In the traditional circumcision ritual, however, the father did not accompany the son to the Itiirini (circumcision ground) since the boy had a mentor and a circumciser. It was not only having the women as mentors that seemed to counter the cultural practices but it was also evident from the observation in the male circumcision ritual that the initiates were not in complete seclusion as in the "Kiumbu" at home because the mothers were free to visit the initiates during the second week. In addition, the counsellors who spoke to the initiates on different topics were chosen on the basis of their expertise, regardless of their gender.

The option of the church was seen by the mentors as a quick fix shortcut and evasion of responsibilities by mothers such as cooking for the initiates which the mentors said was time consuming. In most situations, the mother has to be at home throughout the day unless the daughter is at home. The mothers, therefore, were seen to neglect their duty of cooking and feeding their sons by taking them to church as insinuated by this mentor:

Parents [mothers] ¹³are also very negligent. They always try to take the boys to church so that the responsibility is not on her. (M5)

In observations carried out in the male circumcision meetings, the organisers of the meeting said that the parents brought their boys to church. The boys had no idea of why they were there because they were not informed and prepared in advance for the ritual. However, the church leaders still expected them to discuss and prepare the young men for circumcision, which suggested that the church overlooked all taboos and parents' shyness to talk about the circumcision ritual with their children. The church leaders in the quote below were addressing parents who were mostly women. In this meeting, there were only two men.

Parents let's do our work, It is wrong for your son to be finding out the last minute that a part of their flesh is going to be cut. Last year some boys were asking why they were queuing, to see the doctor, just before they were circumcised (mature) and this is a very difficult position for the boys. (Chairman, Fieldnotes 3)

The burden of ensuring the boys are prepared for circumcision appeared to be left for the women since they were the main attendees at the male circumcision meeting.

The women's choice of the church for their sons' circumcision was attributed to their godliness and serving in the church. They were viewed by the mentors to be neglecting their duties of cooking and taking care of their sons, by instead taking them to church. According to mentor 5, the women were willing to have the boys in circumcised in the church at any cost. The mentors seemed to link the women rather than the men to the circumcision of the boys in the church. Perhaps this was the reason why most men avoided taking their sons to church for circumcision since it was suggested to be a form of betrayal to what was referred to as cultural circumcision. This was also confirmed by women's overwhelming attendance of the male circumcision meetings in church:

¹³ See footnote 9. The participant used the term "aciari" [parents] in reference to female parents

...They have to go to a meeting somewhere, they were the ones (women) to dig for the flowers in the church and I'm not saying this is bad. But even when they want to take the child to church, once they are charged Ksh10, 000 there is nothing else they need to do.... Again if he goes away, he will not be around and you have no responsibility, but, in the end, you have punished him. (M5)

The mentors viewed circumcision of the boys in the church as a punishment while the parents viewed circumcision of boys at home as a punishment. The data depict tension between those who advocate for circumcision at home and circumcision in the church.

The mother was depicted to be making the decision of circumcising the boy in church. In addition, it is the woman who seems to make the payment of circumcision fee in the church. It was also suggested that mothers defied the cultural norms regarding the required procedure prior to circumcision. It appears that although the women were interested in the male circumcision ritual, they were not interested in maintaining some of the practices in the ritual, which could explain why they chose the church. The church selectively maintained the cultural practices in the ritual:

Yes, there were clans where you had to ask your uncle for permission. I don't think this is followed at all. If the mother feels the son is ready she just pays Ksh 5000 and takes the boy for circumcision. (M6)

It was not only in the circumcision taking place in the church where the woman is actively involved but even in circumcision taking place in the home. The woman appears to be the main decision maker on when and where the boy is to be circumcised and who is the best person to mentor the son. The woman seems to be the mediator between the mentor and the boy prior to circumcision. The woman is also depicted as a respectable figure in that a mentor cannot refuse a woman's request as indicated in the quote below:

After I came out (kumiira) my neighbour's son came and said: "I would like you to be my mutiiri". I said, "no, please look for an older person". He said,

“my mother said...”. “If you ever hear someone say that my mother told me that if it is not you, she will not get another person in this location” I therefore went to the parent [mother] and told him “your son came and asked me to be his mutiiri but I’m finding it very difficult to do it”. The parent [mother] said, “it is you that I want to be my son’s mutiiri”. (M12)

Mentor 10 described changed procedures in the preparation for circumcision, which involved the mother approaching the mentor directly without sending the son to ask. It also appears that the mothers are the ones who approach the mentors for mentorship and discuss how the circumcision will be organised rather than the fathers as in the quotes below:

The parent came home and asked if I would be available. Most people thought that I would not be around because I had just completed Form Four... After the mother has talked to me the boy will also ask me. He cannot ask me such a thing on the road; he has to wait when he can find me at home...(M10)

The church is suggested to offer protection to the initiates from harassment and the advice on practices such as wiping the soot. Observations of the church meetings suggest that initiates are isolated and bullied for going through circumcision in the church on their return home. The church male circumcision organisers had come up with strategies that would protect the young men after they left the church from any harassment. In one of the parental church meetings on male circumcision, the chairman of the meeting was the chief of the village who promised to protect the young men as the field notes show:

The organisers promised to protect the boys once they leave the church. They were given the chairman of the organising committee’s telephone number to call if their sons were harassed. The chairman was the chief of the area and was going to liaise with the police for protection. (Field note, 3) The chairman of the organising committee not only promised that the church

would take part in protecting the initiates but also emphasised dangers and harassment that were taking place at home. The church appeared to be against some of the practices in the male circumcision ritual such as wiping the soot and forced road license and practices such as giving cigarettes and 'spreading the feathers' as illustrated in the speech below:

"The advice is bad out there". "At this time there is recruitment at "maiini" (a location in Muranga) and there is recruitment into "...." you all know. (he were referring to mungiki but did not mention the word"... Another boy was circumcised in Mairu 7 (another region) and his bandages were removed prior to the healing, he was pricked with toothpicks on the whole body. He also had to give a cockerel and spread feathers outside the house (Field note, 3).

The impression was that the parents who brought their children to church wanted the best for their children, and to protect them from harassments and traumas the initiates go through in what the mentors referred to as the traditional circumcision ritual. Even the few men who escorted their boys to church defied the norms of the ritual of enduring pain by bringing their boys to church. The church thus acted as a breakaway from the cultural norms and practices.

Most male students went to church to get circumcised because their parents were Christians. The narratives also suggest that parents also made the decision about the venue of circumcision rather than the boys themselves. The quote below indicates that the parents are playing the main role in decision of where circumcision should take place:

I was circumcised at age 14 when I was in class five. My circumcision took place in the church because my parents are Christians, so they (parents) decided to take me to church for my circumcision. (f1 16c)

The desire to go back to the old way of circumcision was echoed by two mentors. In the church, the initiate is only taught church issues and it was a business according to mentor 5, which he said was not the case in the past. However, they seemed not sure if this was possible and uses the word “*if they would listen*” due to the big role the church was playing in circumcision. This is highlighted in the quote below:

I would say that if it is my wish that if people would stop going together as a group this could come to an end if they would listen.....Those people are doing business....(M5)

Similarly, mentor six expressed the desire for the male circumcision ritual to be practiced as in the past:

I would say it would be good if we went back to... you know history repeats itself, so it would be nice if everything was done as in the past. (M6)

8.3.2. Hospital

Only one mentor, mentor 10, raised the issue of circumcision and recuperation taking place in a hospital, while a few students wrote in the narrative to have been circumcised in the hospital. Most of the boys circumcised at home have the operation in the hospital but return to recuperate at home. However, recently the hospital had begun taking a role similar to that of the church. For the boys circumcised in the hospital, the cutting and the recuperation took place in the hospital. They could organise to have extra mentorship at home after leaving the hospital before they came out. However, the parent’s financial abilities influenced such decisions as illustrated in the following quote:

It depends on the parents’ ability. Let me say that during our time there were no such things. It was after I was circumcised that I learnt that one can be circumcised in the hospital and stay there until you are healed. Those ones in the hospital will stay there for one week and will stay here (home) for some

days. However, they cannot just come straight from the hospital and come out (kumira) move on without getting some advice. (M10)

The hospital also challenges the old circumcision ritual as a nurse who is perhaps female could act as a mentor. Recuperation in the hospital may have failed to provide the seclusion provided in the “*Kiumbu*”. This may fail to ensure that women do not come into contact with the initiates, which may also compromise the cultural practices of the male circumcision ritual. Similar to the church, the hospital stance on sex is abstinence until marriage, as illustrated in the quote below:

I had a counsellor, my nurses. To teach me moral behaviour ... Not to have sex and abstain until marriage (f4 18d).

The reasons for using the hospital were cited by male students as safety, having a qualified doctor and avoiding HIV and AIDS. The interviewees gave an impression that young men were concerned about HIV and AIDS although they did not explain how going to the hospital would prevent them from getting HIV. The hospital was, therefore, associated with health and avoiding diseases. This is illustrated in the quote below:

I'm 16 years old and was circumcised in the hospital because there are no chances of transmission of HIV (f4 20d).

Similarly in the quote below, a Form Four male student was circumcised in hospital because hospitals were viewed by other people in the community as safe and reporting few HIV and AIDS cases:

I underwent circumcision at the age of 15 years in a nearby hospital. I choose this venue because I was advised by a relative that the hospitals have minimal cases of HIV/AIDS spread (f4 18h).

8.3.3. Urbanisation

Only three mentors referred to the issue of urbanisation. However, there was a suggestion that urbanisation influenced the changes in male circumcision such as the process of male circumcision, space, time and money. Due to the small houses in the city, it is not possible to have an initiate living alone in a “*kiumbu*” as the customs dictate in the Kikuyu culture. Having a “*kiumbu*” was mentioned by mentors in this study as one of the prerequisites to take a boy for circumcision. The parents are left to have the boys circumcised in the main house which defies the cultural norms or to take them to the home village of the male circumcision ritual:

..., but even in town, space is limited, and if I take him home (village) it will be easier. (M5)

There were suggestions by one mentor that circumcision in the urban areas was only about a cutting that has no meaning attached to it. This was also attributed to cases of single motherhood and lack of father figure guidance on the right process and order of conducting the ritual. The mentor suggested that male circumcision was a male issue and was better addressed by men than women. However, mentor 6 suggested that it was during their time that the father gave permission for a son to be circumcised. At the time of the interview M6 was 43 years old:

During our times, we had parents, a mum and a dad. Today, there are many single mothers. If your father said no then you could not get circumcised. (M6)

In contrast, other mentors said that the matrimonial uncle was the one who gave permission for the boy to be circumcised, which made up for a single mother since she could involve the uncle for a man’s decision in the ritual.

Urbanisation was also suggested to be the reason why most mothers chose to have the boys circumcised in church because of the limited room space. However, mothers in urban areas preferred to take their sons to the home village for circumcision. However, even in the village, the women were said to be very godly

which was viewed as bad since this was suggested to be responsible for their actions of taking the boys to get circumcised in the church. In both cases, the main reason for sending the son away for circumcision was said to pass responsibility to other people and not leave it with the mother:

No even in that village, most of these parents became too godly which even spoils. ... the child is no longer in her care. So it is not just in town... but even in town...and if I take him home it will be easier. (M5)

There was a suggestion that problems related to the circumcision ritual and practices, such as the road license and wiping the soot, did not exist in urban areas, as people were educated and were doing away with some of the practices in the male circumcision ritual. According to mentor 7, road license and wiping of the soot are practices associated with problems and he was against coercion on initiates to participate. Educated people were also portrayed as living in the city centre. Three of the mentors interviewed were living in a rural area, were educated up to secondary school and university level and confirmed to have wiped the soot and paid the road license and were not opposed to these practices, in contrast to the quote below by M7:

In the urban areas, we don't have that problem because most people are elite and those who could ask for it are no longer there. However, in the rural areas, there are some places we go to and we have to give out the murangano. (M7)

In summary, circumcision as a cultural practice has been presented as continuous in this study. The role of culture in the male circumcision ritual was shown as central in this study and was evident across all themes in the findings. Some components of cultural practices in the circumcision ritual have been maintained for a long time while others have been changed. It appears that young men in this study had inherited their cultural practices since the time of Njuki. However, the mode and style of some of the practices have been modified from generation to generation and time to time, to fit young men's interpretations and contexts. This is reflected in male

circumcision practices running through Kirika's (103 year old man), Njuki's (54 year old man) and the young men's circumcision periods. Such changes include wiping the soot and the road license. The respect accorded to the mentors has also dwindled away as highlighted by Njuki. According to Njuki, the young men's reference to a mentor as "*baba giko*", "dirty father" was disrespectful. The name dirty father could be argued to play down on the caring role of the mentor in cleaning and bandaging the wound of the initiate. In Njuki's time, a mentor was regarded highly. The involvement of the church and the hospital in the ritual were also highlighted as some of the changes that have taken place in the ritual.

The findings show that circumcision takes place in the hospital today unlike in the past as described by Kirika when circumcision took place by the river. The boys not only got circumcised in the hospital but also recuperated in the hospital until the wound was healed. This featured the latest change in the circumcision ritual among the Kikuyu people. It seems that the cultural aspect of the ritual, which required the mentors to be male, has been taken away as the initiate may be assigned a female doctor or nurse in the hospital while complete isolation of the initiate from females in the hospital is unlikely. On returning home from the hospital, the initiates are kept in seclusion, and participate in the male circumcision rituals and ceremonies just like other initiates who recuperate at home. Cutting in the hospital was portrayed as insufficient without the cultural practices articulated by the participants as necessary in making of the man. Male circumcision is not just the cutting but the whole hierarchical process starting from a boy to an initiate, then a kiumiri (one who has come out) and finally a young man. The church highlights spaces and places where women effected changes in the male circumcision ritual. Urbanisation was linked to the women and changes in the ritual such as circumcising boys in church and the disregard for procedures required in male circumcision. Women emerged as the main agents of change as mothers and single mothers. The process is of cultural significance as each stage confers the man a different status.

8.4. Conclusions

Male circumcision is depicted in the findings as a cultural practice that has been changing and is still changing. The church, hospitals and urbanisation emerged as drivers of change in the male circumcision ritual through which changes were effected mostly by the women. Most of the practices adopted by the church contrast those adopted in the past. Young men today have adopted practices from the past described by Njuki but have further modified practices to fit their context. The ceremonies and the road licenses today compared with Kirika's story portray far reaching changes. The next chapter discusses the main issues that emerged in the findings in relation to public health practice, policies and theory.

Discussion

9.1. Chapter Introduction

The previous chapters described and discussed the findings of the study. This chapter is a discussion of the main findings in relation to theories, policies, practice and further research. The implications of the study for public health, health policies are discussed and proposals for further research presented. The figure 9.1 below shows the key findings discussed under “Changes in the male circumcision ritual”, “Recruitment into manhood and challenges in the male circumcision ritual” and “Barriers to changes in the male circumcision ritual”. The findings highlight women as key players through churches, hospital and urbanization in a male circumcision ritual that has been reserved “traditionally” for men. In addition, the findings depict the practice of wiping the soot as a practice that has been passed through generations and groups of men who shaped it and adapted it further before handing it over to the next generation. Despite being barred from the “*kiumbu*”, this study found that a mother’s role in bringing about changes in the ritual is critical. The findings suggest that women today identify the church and hospitals as spaces where circumcision of their sons can take place. Urbanization was also identified as a driver of changes such as women taking the boys to the church for circumcision or allowing them to recuperate at home in absence of a separate room for seclusion. Challenges in the male circumcision ritual are depicted in the pressure for the boys to circumcise, lack of sexual education and secrecy and silence in the ritual.

Figure 9.1. Summary of discussion themes



9.2. Changes in the male circumcision ritual

The findings suggest that women are the main agents of change in a male ritual. The women played this role through the spaces of churches and hospitals which acted as the drivers of change. It was also through urbanisation that women advocated for circumcision in the church. In addition, urbanisation allows the breaking of cultural practices followed during circumcision.

9.2.1. Women as agents of change in the male circumcision ritual

Male circumcision was presented by the mentors as a non-female arena, but women's involvement in the ritual highlights one of the changes in the ritual. As Kirika noted, women are not allowed to view the cutting as they did in the past by the river. Today the mentor accompanies the boys to the hospital for the cutting after which they are kept in seclusion. It was, however, mothers rather than the fathers who approach or send their son to the mentor to request his mentorship for circumcision. This contrasts with my previous findings in 2009 -2010 and Ahlberg *et al.* (1997) that boys chose mentors who were circumcised recently. It could be a shift in the male circumcision ritual or possibly reflect what happens in a particular location of a study which is different from the locations where this study took place. The mother was specifically mentioned in the in-depth interviews as not allowed in the "*kiumbu*" where the young man stays in isolation. The role of a mother in circumcision taking place at home was establishing contact between the mentor and the son, but she is later excluded from other practices. This is common among the Xhosa people where women are denied access to the central knowledge of the ritual and to the initiation schools (Gwata, 2009). In addition, it is heinous to discuss the Xhosa initiation ritual with women.

Interestingly, the mentors only mentioned isolating the initiate from the mother yet the father was also not allowed in the Kiumbu. The separation of the mother from the initiates is meant to break the strong bond between a mother and an initiate during the rite of passage (Gilmore, 1990). Gilmore (1990) asserts that the cross ties between a son and a mother poses a challenge to the achievement of greater gender attributes of full male status in men and thus requires greater cultural interventions to socialise men than women. The initiation ritual thus serves to cut the maternal ties and reinforce the male identity (Burton & Whiting, 1973; Gilmore, 1990). This involves the separation of a boy from a mother at the adolescence stage which is described by Hooks (2004) as severing the boys from the mother too early in order to turn them into men. Most of the initiates are circumcised in adolescence, a stage which Khamasi *et al.* (n.d.) refer to as psychologically stressful for a boy who is suddenly released from the care of the mother to a mentor. In this study,

however, the initiates knew the mentors as they lived in the same locality, although they may not have been well acquainted with each other. In addition, a mentor may not have had a close relationship with the boy since circumcised men are not meant to relate to the boys.

Urbanisation as a driver of change in this study was also used by the women to effect changes in the male circumcision ritual. Some of the mentors linked single motherhood with urbanisation and changes in the circumcision ritual. Owing to limited space in the urban areas, women allowed the initiates to recuperate in the same house. The same "*kiumbu*" the women were denied access was undermined by the some of the women who had their sons circumcised in their urban homes. Some women in the urban areas were suggested by mentors to send their sons to the village either to be circumcised in the church or at home. Despite being barred from the "*kiumbu*", women were observed to take a central role in church organised circumcision and were equated to "mentors" during the in-depth interviews with mentors. The "*kiumbu*" seems to be the impenetrable special space symbolic of men's unchanged power. Women's role in male circumcision rituals among other societies has been highlighted in other studies. Among the Balante people of West Africa, women play a role in enhancing sexual privacy control and integrity among the male initiates (Niang & Boiro, 2007).

In the church's parent circumcision meeting, there were more women than men. This was also suggestive of their key role in the boys' decision to be circumcised in the church. The role that women played in the ritual is highlighted in African feminism which claims that African women uphold vital concepts such as the family, mothering and nurture (Acholonu, 1995). From a feminist perspective, the women as mothers in the church meeting seemed more concerned about their son's status in the society as circumcised men and aimed to achieve this safely through the church. One woman reported that the husband was at work and was, therefore, not able to come for the meeting in the church. The roles and position of men and women in their involvement in the ritual may have been complementary according to Maduka's (nd) description of African feminism. African feminism posits that, instead of

confronting men, women's actions should challenge men to see the harmful issues they were avoiding in the ritual by choosing the church (Mekgwe, 2008).

The tension between the mentors and the women who advocated for changes was depicted in this study. The mentors viewed circumcising the boys in the church as a punishment while the women viewed circumcising boys at home as a punishment. Nevertheless, there were many women who chose not to have their sons circumcised in the church but rather to have them circumcised at home. In addition, the church chairman (a man) suggested that it was possible for the men to come to the meeting and, therefore, requested that the women should convince their husbands to come for the next meeting. According to Bruno (2006) instead of waiting for the men, women in this study strive for equality in society. In the previous research I conducted on male circumcision, church elders in the Anglican Church similarly said that it was unacceptable for the men to have left the work of bringing the boys for a circumcision meeting to the women. It was purported by the church leaders that most of the men were in the shopping centres drinking, leaving all the work to the women.

Women are known to make up the largest number of church congregations in sub-Saharan Africa (Falola & Amponsah, 2012). It may be that the boys' decisions to be circumcised in the church could be attributed to the women's Christian beliefs. Researchers have argued that there are gender differences in religiosity, with women displaying greater religiosity than men (Aalsma *et al.*, 2013), which might, therefore, influence decisions that favour their religious beliefs. For instance, the women's role was crucial in the adoption of medical male circumcision among the Bukusu people in Kenya, as they viewed traditional circumcision as unchristian. Men, on the other hand, were suggested to be more inclined to uphold traditional circumcision because of cultural celebrations and rituals that accompany it (Bailey & Egesah, 2006). Observations of mothers bringing the boys to church in this study suggest a shift in the cultural practice of the male circumcision ritual.

The women's role in ensuring the sons are circumcised may also accord them social benefits in the way society perceives them. In the past, the woman's social hierarchical status changed from "kangei" to "nyakinyua" age group as a result of the circumcision of her first son (Ahlberg *et al.*, 2000). Although the hierarchical change of status is no longer emphasised for the women today, their position in the family makes them key in influencing decisions regarding the members of the family. Pintak's (2013) work on the promotion of health among the Somalian, Burnamese, Eritrean, Latino and English speaking people in Washington, USA showed that the involvement of the woman in the project had a great impact in reaching the whole family. Women's role is also significant in influencing uptake of male circumcision in non-circumcising communities. A study in Tanzania showed women to have convinced their partners to circumcise or not to circumcise their sons (Down *et al.*, 2013). Similarly in Nyanza, Kenya, women from noncircumcising groups were reported to have played a major role in the decision making of their partners' participation in VMMC programmes (Lanham *et al.*, 2012). As many men are circumcised, women whose partners are not circumcised may feel the pressure of being like other women whose partners are circumcised, thus influencing their partner to get circumcised.

Women may also be inclined to relate with circumcised men especially with the recent debate on VMMC and HIV prevention. This is mirrored in a study carried out in Kisumu Kenya in non-circumcising communities where women preferred to have circumcised men because they were believed to be cleaner, carry fewer diseases and would take their time to reach ejaculation (Riess *et al.*, 2014). The data gathered and evidence presented in this study show that women are playing a role in affecting changes in the male circumcision. This could also explain Hewlett *et al.*'s (2012) suggestion that more women should be involved in the VMMC campaigns to enhance the reduction of the risk of early sex resumption after circumcision.

9.2.2. The place of the hospital in the male circumcision ritual

Circumcision occurred by the river in the past, but the findings show that the hospital is the main circumcision provider today. The hospital has recently emerged not just as a male circumcision provider but also as a place and a space where the healing of the wound takes place¹⁴. Only one case where both the “cutting” and recuperation took place in the hospital was cited by a mentor. However, some of the male students narrated getting circumcised and recuperating in the hospital. This is comparable with the church supervised male circumcision. It is possible that this is a practice only in the location where the practice was reported and would, therefore, require further research.

Even for those circumcised at home, the reasons for choosing the cutting in the hospital were cited as safety, having access to qualified doctors and avoiding HIV and AIDS. The hospitals, thus, acted as a place of safety according to the male students. However, the safety of the medical male circumcision that the hospital offers in Kenya is also questionable. For instance, 19 per cent of the medical cases compared to 24 per cent of the traditional cases of male circumcision among the Bukusu people of Kenya were not healed by the 60th post-operative day. The findings on Bukusu people of Kenya contrasts with the findings from an RCT on the male circumcision carried in Kisumu where almost all the wounds were healed by the 30th day after circumcision (Bailey *et al.*, 2008). Choosing the hospital as a place for cutting and recuperation was perhaps to avoid any potential risk arising from mentors’ nursing roles such as administration of pain killers, wound dressing, and stitch removal. Mentors are not trained but only get advice on wound dressing and removal of stitches in a one-off interaction with the doctor as he performs the operation on the boys. Only one mentor in this study reported having received training from the Department of Health and was in turn training other mentors. The training of the mentors signifies another change in the male circumcision which previously allowed for the training of mentors through apprenticeship. The trained mentor M7 indicated that he was in turn training other mentors at home and also

¹⁴ The boy is “cut” in the hospital and stays in hospital until he recuperates.

visiting churches. He thus acted as a link between the church and those circumcised at home since he is invited to the two places.

The hospital also seems to take the symbolic place of the “*kiumbu*” where recuperation takes place but is devoid of seclusion that an initiate is meant to have, especially from the women. One of the male students wrote of being counselled by a nurse who could be a woman during the recuperation period. This is another change in the ritual that defies the norms of keeping the initiates secluded from the women. The concerns about the safety of initiates are suggested to be more important than maintaining the cultural practice of segregating initiates from the women. One of the motivating factors for most parents in Kenya to opt for medical circumcision rather than traditional male circumcision is the use of local anaesthesia (Ginsberg *et al.*, 2014). Modern anaesthesia was lacking during Kirika’s time. However, cold water from the river where the Kikuyu circumcision took place acted as anaesthesia.

Although the cutting and recuperation in the hospital are a demonstration of the shift in male circumcision practices, a part of the cultural components of the ritual were still maintained by the initiates once they returned home after they had recuperated in the hospital. Traditional male circumcision providers were not mentioned by the participants in this study, but it is still practiced among communities such as the Bukusu people of Western Kenya, although many of them are turning to medical circumcision (Bailey & Egesah, 2006; Bailey *et al.*, 2008). The hospital is depicted as the main provider of male circumcision in the findings. However, in Kenya apart from the medical officer, clinicians do not receive in-theatre surgical supervised training and nurses are not trained to deal with male circumcision (Bailey *et al.*, 2008). This is significant especially for the promotion of the VMMC for HIV prevention in Kenya. An increase in demand for VMMC services may be burdensome to the already strained health care system in Kenya (IRIN, 2014).

9.3. Recruitment into manhood

The research findings indicate that circumcision is an avenue used to reinforce the masculine characteristics of the men. Discussion about masculinity must, however, begin with the issue of gender (Horrock, 1995) especially since male circumcision transits men into the male gender identity. The foreskin of the penis is said to possess a feminine aspect which must be removed during circumcision to enhance the masculine part of the foreskin (UNAIDS, 2007). During seclusion, the initiate keeps away from the company of the mother and the sisters, as a way of inhibiting any feminine influence (Khamasi & Kibue, 2010). The whole process of circumcision in this study was shown to facilitate construction of masculinities in the boys. The findings indicate that the initiates' masculinities were enhanced by the young men during seclusion. The boy becomes a man not just by the cutting but by the instructions that are given in seclusion (Kamau-Rutenberg, 2008). Young (1965) states that the seclusion period is meant to resolve sex identity conflicts especially for boys who slept with the mother during infancy. Not only do the rites of passage aim to break maternal ties but also to enhance male identity (Whiting, 1973; Gilmore 1990). In order to enhance manliness in the initiates, pain culture and bullying are employed on them by mentors and young men. It is mostly at the time of seclusion that initiates undergo pain during the cleaning of the wound and stitch removal. In addition, manhood is enhanced through male gender identity and assignment of gender roles that align with manhood and initiation to the sexual world. Male circumcision thus becomes a rite of passage for an androgynous boy to a "well-shaped" manhood (Kamau-Rutenberg, 2008).

9.3.1. Culture of pain

The culture of pain refers to the perception of pain as a norm, which should, therefore, be endured. The endurance of pain was emphasised by the mentors and was expected of the boys during the male circumcision process. Pain was in the past viewed to be a test of having transitioned to a man (Kenyatta, 1938). This is echoed by Connell (2000) who states that enduring pain through rites of passage is part of masculinities. The mentors' roles involved testing the newly circumcised boys' "hardness" and toughness through pain as a way of enhancing the masculine identity. Although not explicitly articulated by the participants in this study, the reason for pain endurance could be drawn from the Xhosa traditional initiation ritual, where the main role of circumcision is to separate boys from the men and prove that they have become men by subjecting them to severe physical pain (Gwata, 2009). Feeling pain is essential and viewed far more important for the Xhosa young men than changing behaviours after the initiation (Gwata, 2009). In this study, enduring pain was not depicted more important than changing behaviour; both were viewed equally important in the ritual. The culture of pain may be a test for the young men to prove their ability to endure pain and a preparation for future challenges.

Unlike the Xhosa initiates who undergo traditional circumcision, this study found that pain was lessened in the medical setting by the use of anaesthesia for the Kikuyu initiates. It was in the dressing of the wound and the removal of stitches that initiates were subjected to pain. The pain allowed through the dressing of the wound and stitch removal is possibly a way of compensating for any pain inhibited by the use of anaesthesia during the cutting. The endurance of pain also comes with privileges and promotion which may be a motivating factor for the initiates to endure the pain. In the past, benefits gained after circumcision included power shift and respect (Herzog, 1973). Circumcision thus subscribes power to men and constructs them as invincible (Khamasi *et al.*, n.d.). However, for a man to gain power, the admission of pain is not acceptable (Kaufman, 1994).

Despite the pain, crying is looked down upon as feminine. According to Hooks (2004), the culture dictates that men should not show emotional expression, but should conceal it. She described it as masking of feelings which is enhanced through patriarchy masculinities. It appears that once becoming a man, crying is prohibited. For instance, among Ghanaian men, crying is a sign of weakness and unmanliness (Adinkrah, 2012). Yet pain is one of the main barriers to VMMC programmes among the non-circumcising people (Westercamp *et al.*, 2012) although the programme is carried out in a medical setting. Even with anaesthesia and pain killers that may be recommended in the medical setting, pain cannot be fully eliminated before the complete healing of the wound.

The role of the mentors was depicted as one of promoting hegemonic masculinities, by interpreting what is culturally prescribed as a way of being a man. The expectation in the past was that initiates would endure pain stoically to demonstrate their masculine strength (Herzog, 1973). Nonetheless, enduring of pain was also narrated by Kirika as one of the expectations in the past, although in Kirika's time, initiates were allowed to cry at night probably because it was out of the public gaze. This study found out that who chose circumcision organised by the church rejected the pain practices and some of the practices of proving one's manhood. Sometimes hegemony can be achieved by distancing one from the hegemonic masculinity (Wetherell & Edley, 1999). This was demonstrated by the young men undergoing circumcision in church and thus distancing themselves from the men circumcised at home, which Connell (2005) refers to as passivity. Similarly, medical circumcision among the Xhosa boys appears to carry a stigma of its own (Gwata, 2009) as it is an alternative and contrary to the usual initiation.

The initiates' willingness to suffer and endure pain relates to the mockery and contempt of pain among the Balante and Fulber of West Africa who display to the circumciser their index finger after the cutting, saying: "you can also cut my finger" (Niang & Boiro, 2007). Use of pain endurance strategies is common in other communities and is used to reduce tension between the circumciser and the boy and also prepares the boy for when to expect pain. Among the Xhosa of South Africa, the initiate shouts, he is a man at the instance of cutting (Mogotlane *et al.*,

2004; Vincent, 2007). In Senegal, a circumciser asks the boy to forgive him, just before the cutting and the boy responds that he forgives him (Niang & Boiro, 2007). Although among the Kikuyu boys such incidences were not described owing to differences in culture, some mentors described the pain lightly amidst laughter. However, the findings seem to indicate that it is the young men that have inherited most of the pain culture from past practices as noted in Njuki's stories. Paradoxically, some mentors in this study employed pain reduction strategies by use of pain killers and absorbable stitches, thereby not allowing the young men to experience pain in its fullness. This was done secretly so that the initiates who took pain killers were still looked upon by the other young men as 'real men' who had endured pain.

9.3.2. Institutional bullying

Male circumcision was depicted in this study as an institution through which bullying was enhanced. The findings show that initiates are beaten, their penis pressed and they are coerced into the cultural practices. Students wrote in their narratives of being harassed, beaten and tortured. Power and powerlessness were evident in the findings where the powerful young men bullied and harassed the powerless. Masculinities rest on a man's ability to exercise power and control, however, it is in the same men that exist the state of power and powerlessness (Kaufman, 1999). For the young men, hegemonic masculinity becomes a resource described by Connell (1987) from which to exercise power against the initiates as depicted in the findings of this study. In addition, the initiates are in the process of recruitment to men, thus, occupy a less masculine position with less power, while the young men (who have already gone through the circumcision process) occupy the masculine position and are, thus, more powerful and dominant (Whitehead & Barret, 2001). It seems that it is after the initiates go through the whole process of circumcision that they acquire the full status of a man as described in figure 7.1. Male circumcision thus becomes a rite of passage for an androgynous boy to change to a "well-shaped" man (Kamau-Rutenberg, 2008). The state of power was physical but also in terms of hierarchical status. The young men had an advantage, due to their status, in comparison to the newly circumcised. The hierarchy of status compares to the

hierarchy of masculinity and masculine behaviour in each setting (Connell, 2000). In reference to figure 7.1 in chapter seven, young men are at a higher hierarchical level in the circumcision process than one who has come out “kiumiri” and the initiate (kirui). Pain from the circumcision wound may restrict the movements of the initiate, which makes him powerless and more vulnerable to harassments than a kiumiri. According to Pyke (1996), men exercise power over other men just as they exercise power over women since masculinities are social constructions not only in relation to femininities but also in relation to themselves. In addition, due to seclusion and lack of other options, the initiates are forced to do what other young men dictate.

Some of the mentors played contrasting roles of protection and enacting violence against the initiates especially on the road when the road license is demanded from the initiates by other young men. The mentors narrated that they could take revenge against an initiate who had wronged them or behaved badly prior to circumcision, by sending a woman to sexually harass the initiate by enticing him sexually. In such a case the woman becomes the mentor’s object of violence while she also becomes the perpetrator of sexual harassment against the initiate. This scenario may exemplify traumatised masculinities with the initiate’s masculinity challenged by a woman without putting up a defence. This can also be referred to as “feminisation of men” (Kamau-Rutenberg, 2009) and masculinities can be demasculinised leading to humiliation and rejection (Reeser, 2011). Traumatized masculinities result from the traumatised experiences such as torture and harassment during the male circumcision practices described by Khamasi *et al.* (n.d.) among the Bukusu people of Kenya. According to Jaffe *et al.* (2005), an emotional or psychological traumatic situation is when someone is too helpless to prevent it, done unexpectedly and repeatedly or one that happened in childhood. Jaffe *et al.* (2005) suggest that it is not male circumcision that causes trauma but rather the experiences of individual boys going through it. Different concepts of masculinities such as traumatised masculinities are displayed in this study but in relation to hegemonic masculinities. Hegemonic masculinity (Connell, 1987; 2000) presented itself in this study in the form of leadership where the mentors were on a higher hierarchical level of authority,

but also in the form of power where the initiates appeared powerless to defend themselves from the harassment and bullying in the institution of circumcision.

Bullying and harassment of the initiates compare to institutional harassment used in the recruitment of new members as in militarised cultures or college organisations (Taylor, 1996; Giga *et al.*, 2008). Although socialisation into any institutions can enhance comradeship and acceptance, if misused, it can result in physical and mental harm (Waldron & Kowalski, 2009). In this study, there were no reports of major harm caused by harassment related to initiations, but one study participant reckoned that there had been cases of hospitalisation in the past. Road license was shown in this study to enact more violence, which ranged from beatings and lack of freedom on the road if an initiate did not have money or cigarettes to give to the young men. Although the initiates in church and those at home had already participated and given out the road licence to be allowed on the road, they were harassed to give more to other young men waiting on the road. Of concern in this study is that most of the initiates were not able to confide their experiences to adults, although some may have been eager to subscribe to all the rituals in order to join the group of “*ciumiri*” (initiates). This shows that although masculinities exist from an individual level, it is also collective. The social collective of gender can be seen in institutional friendships, families and networks (Connell, 2007).

It is the sense of belonging to these groups that may encourage the initiates to endure pain and violence. Although Kirika mentioned the endurance of pain mainly by the river side, bullying and harassments were only mentioned by Njuki. The findings indicate that some of the male students were not comfortable with the bullying and harassments they went through. Some of them referred to the pain culture as torture. Failure to fit into the institution of circumcision that imbibes violence led to the marginalisation of the initiates through isolation. It is only through a reconfiguration of their performance identity that initiates are accepted to the hegemonic institution of the male circumcision ritual (Corrigan, 1988). This is why some of the initiates conformed to some of the practices in the ritual to gain acceptance by the other young men.

From a public health perspective harassment and bullying of the initiates may be viewed as violence. The WHO definition of violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (Krug *et al.*, 2002, p.5). Violence is, therefore, not just physical violence or abuse (Hearn, 1998) but consists of verbal, emotional and psychological violence that may be related to bullying and harassment experienced by the initiates. The young men in this study depict most men as using violence to assert masculinities and accepted that this is the only way to display masculinities or manhood (Beirne & Messerschmidt, 2000).

Most mentors had gone through similar violent experiences and viewed them as culturally acceptable norms. They may have internalised masculine norms and, thus, viewed violence and coercion as acceptable (Wallace & Wilchins, n.d.). The initiates were socialised by mentors and young men into violence during the circumcision ritual, with a suggestion of a cycle of passing over the violent culture to the next generation. The light way in which most mentors described the harassment suggested an ongoing cycle of violence. This echoes Sev'er, (2012) who states that those who are able to overcome harassment and violence are likely to become perpetrators of violence themselves. Jasinki (2001) suggests that exposure to violence for a long time results to an imprint of aggressiveness in the mind which is repeated when there is a threat. The length of violence perpetration did not emerge in the findings, although it was clear that initiates are subject to harassment at any time by the young men until they are promoted to the status of young men when another group of boys are circumcised to take their place. Some of the mentors, however, insinuated that the ritual was becoming less violent than when they were initiated.

9.3.3. Gender identity, roles and responsibilities

Circumcision rituals allow cultural constructions of male gender identity. The new identity after circumcision was shown in the findings to come with new social expectations including acceptable behaviour that distinguishes the newly circumcised as mature men. After circumcision, an initiate is given greater responsibilities such as taking on more supervisory roles than the household chores. Hergoz's (1973) assertion that the new stage came with more responsibilities was reflected in the findings. One of the mentors said that the initiates were expected to watch and follow other men's behaviours. This may have required the initiates to follow social cues, affirmation and disapproval of behaviours from those who had already become men as argued in the Social Learning Theory (Thorne, 2004). Social Learning Theory emphasises the use of punishment to disapprove unacceptable behaviour and to praise and reward the initiates for acceptable behaviours (Ryle, 2014).

Adults may send subtle messages on what is acceptable. Initiates, on the other hand, may be able to notice the differences between young men and boys and know how they are supposed to act. As reflected in Social Learning Theory, imitation and observation were used to enhance learning (Ryle, 2014) among the Kikuyu boys and initiates. The findings suggest that the young men were not verbally taught about all gender roles specific to their new status. The findings, thus, demonstrate that circumcision is an institution of socialising boys into the male gender. As the research by Tang & Tang (2001) shows, socialisation of gender roles and role differentiation is maintained through prescriptions of social norms. The main agents of socialising shown in this study were the peers, the mentors, and the church leaders.

After circumcision, the initiate is not supposed to wash utensils, is taught how to slaughter a cock, while those in the church slaughter goats, thereby aligning with expected gender roles. In the Kikuyu culture, slaughtering is generally considered to be the work of the man. The ritual, thus, acts as an institution through which gender roles are clarified. Research shows that traditional gender roles dictate that chores such as washing utensils, cooking and care work belong to the women while

men are the providers (Strebel *et al.*, 2006; Hojgaard, 2002). The term “tradition” refers to a custom or a belief that has existed for a long time among a group of people (Nyaundi, 2005). In addition, the mother, accepting the rules laid by the mentor on what chores to give the son, indicates culturally acceptable gender role divisions. The women may also be accepting the gender roles as dictated by the culture, which agrees with the African feminist theory on gender roles and cultural perspectives (Kako, 2008). In the African context, women accept gender roles that incorporate femaleness and maleness. Nevertheless, cultural feminism may be more applicable here where women’s qualities and roles such as cooperation, connectedness and caring are celebrated and accepted as unique instead of seeking to change them (Worrell, 1996). For instance, the women cooperated with the mentors to delegate duties such as washing utensils to the women and appeared to accept this as a way of life. Instead of the young men instructing the initiates not to wash utensils, they instruct the mother not to give this chore to the initiate. However, the findings suggest that respect for parents is crucial especially for the initiates. This includes obedience to the mother’s instructions. Thus, it was acceptable for the mentor to explain to the mothers how to treat the initiate since the initiates might not accept orders from the mother.

Divisions of roles along gender lines are common in most societies with women managing domestic work and taking lower paying jobs than men while men specialise in non-domestic activities (Inglehart & Norris, 2003; Khan, 2011). This requires the men to be the head of the family while women are home makers. Szabo (2014) argues that although most men share in the kitchen work, it is still referred to as a woman’s job. However, not all cultures involve men sharing kitchen work with women especially in the patriarchal cultures, such as the one in which this study took place. However, the gendered pattern of jobs require the women to cook in the kitchen at home while most professionally paid cooking jobs are mostly taken up by men as chefs (Konkol, 2013). Thus, the professional kitchen jobs are male dominated. Women would have to resolve the work -family conflict which is also gendered by delaying to having children or not having children to be successful in the male dominated professions (Harris & Giuffre, 2010). Nevertheless, the findings

illustrate that gender roles are so much embedded in the Kikuyu culture such that although the women are not allowed in the “*Kiumbu*”, the initiate’s sister could be allowed for the sole purpose of serving food. It is possible that the young men can instruct the sister as they wish, which they cannot do with a mother. It is the responsibility of cooking that the women were said by some of the mentors to be avoiding in taking the boys for circumcision in the church. It is the mother as opposed to the father who organises the cooking especially tea for the initiate and any other young man that visits daily until the initiate comes out.

The mentors said that all the young men who visit the initiates are served food or, at least, tea by the sister to the initiate. Nevertheless, in cases where the initiate has no sister, the situation warrants the mentor to serve the initiate after receiving the food from the mother. Connell’s (1987) theory of gender identifies social roles where the women cook and take care of their families while men as providers are at work as suggested by one of the women in the church meeting. This aligns with feminist theory, which views gender as a social construct and includes ideologies that guide male and female actions and behaviours (Mikkola, 2012). Gender roles in this study reflect the influence of unequal power relations between men and women that are emphasised in feminist theory. One of the major concerns of feminism is that women hold the lowest paying jobs and do most of the household chores (Kiger & Riley, 1996) such as those highlighted in this study: cooking, serving food and washing utensils. The feminist theory posits that in patriarchal societies similar to which this study took place, males’ contributions are viewed more valuable than the contributions of females thereby marginalising and dominating the women (Boundless, 2014). Among the Igbo of Nigeria, for example, gender roles are so well defined such that going into the other gender’s space is considered to be abominable (Ozumba, 2005). In Ghana, role reversal such as the woman being the main provider leads to ridicule and dishonour of the man (Ampofo & Boateng, 2007). Thus, whether the woman is a higher earner, the man is still regarded as the main provider of the house (Adinkrah, 2012). Evidence of women as care takers is exemplified by a study in Nigeria which portrays the woman as the one who stays by the husband’s bedside while he recovers from an illness but the husband does

not have to do this when the wife is sick. However, the woman still has to support their husband so that he can get well and start providing for the family (Mbonu *et al.*, 2010). In developed countries, however, cases of men as carers for their wives are common (Baker *et al.*, 2010; Baker & Robertson, 2008).

The display of gendered behaviour in this study reinforced female stereotypes and male stereotypes (Wharton, 2004). From a feminist perspective, it is these gender roles and socialisations into gender stereotypes and hierarchies that African feminism struggles against in order to attain gender equity by challenging the status quo (Aniekwu, 2006). The findings depict patriarchal structures which differentiate between male and females in a way that disadvantage men and women (Bruno, 2006). In order to fight patriarchy, the gender division of labour have to be challenged (Connell, 2000). However, in this study, the women did not resist the gender division of labour probably because the study was carried out in a rural location, where women carry a different identity. This is because the modern African woman is viewed differently from a typical African woman (Chidam'odzi, 1994) and fights for different issues such as male circumcision practices in this study.

9.3.4. Sexuality and sexual norms

Male circumcision marks the transition of boys into the sexual world. Sexual matters were described by one of the students as the most common information given to the initiates by the young men. Male circumcision was and is mostly timed around the adolescent stage. According to Beidelman (1997), sexuality is reinforced during adolescent initiation. This agrees with a WHO (2009) report on traditional circumcision, which suggests that sexual education is part of the training given to initiates during the healing period. Although the young people in this study were not practicing "traditional" circumcision, they seem to have negotiated the tradition to fit their current contexts. For instance, they had incorporated some sexual education elements into the ritual as had been done in the past. Vincent (2008; 2007) asserts that the circumcision ritual is a time of imparting cultural knowledge on sexual education and courtship as a preparation for marriage. This is reflected in the findings, which indicate that mentors taught the initiates in the form of a role play

how to approach a girl for a relationship. Culturally, circumcision is timed round adrenarche as it is associated with initial sexual desires among adolescents (Herdt & McClinton, 2000). Bodily development and ejaculation of seminal fluid in boys during adolescence was seen as a mark of the end of childhood and the beginning of the biological ability for procreation (van Gennep, 1960). Therefore, most circumcision rituals encourage the initiates to engage in sex after circumcision.

Another aspect of sexual education that the students wrote about in this study, involved using 'bad names' to describe the female reproductive organs. This could be explained by a study on gender and texting where boys, as opposed to girls, were associated with cursing and using vulgar language as a way of displaying toughness and roughness, which is supposed to characterise men (Ogletree et al., 2014). It could also be a demonstration of adaptations taken by the boys from the past male circumcision practices. In the past, the use of sexually explicit expressions in songs and dances during the ritual by Kikuyu boys was allowed as a means of educating the initiates on sexuality (Middleton & Kershaw, 1965). The songs were meant to orient the boys and girls in rules and codes governing sexuality (Cavicchi, 1977).

Initiation to the sexual world

This study found that some of the initiates were advised by the mentors to engage in penetrative sex with a girl after circumcision in the form of wiping the soot to prove their manhood. This echoes findings from a previous study carried out among the Kikuyu people, which also showed that initiates were encouraged by peers to have sex with a girl after circumcision to prove their manhood (Kamau *et al.*, 2006). Another study on Kikuyu young men shows that they conformed to wiping the soot because of myths shared among the young men, such as enhanced healing, prevention of illness and death (IrinPlusNews, 2007; WHO, 2009). In the past, it was the girls who were meant to have the soot wiped rather than the young men (Ahlberg *et al.*, 1997), which may reflect a distortion of the past practices described by Kirika. "Kwihura mbiro" was used to scare girls that unless they wiped the soot

they would have painful sexual experiences during their first sexual intercourse with their husbands.

The findings in this study indicate that mentors played the greatest role in ensuring that young men wiped the soot. Njuki similarly, noted that wiping the soot was encouraged and demonstrated by the mentor. Some studies have shown that this is part of the initiation teachings and encourages adolescents to experiment with sex after the initiation (Malawi Human Rights Commission, 2005; Zulu, 1996). Wiping of the soot was also depicted in this study as a way of introducing the initiates into the sexual world by mentors and other young men with the assumptions that most were not sexually active.

For the Kikuyu circumcision ritual, “*ngwiko*” was encouraged during Kirika’s time for sexual pleasure through fondling despite having non penetrative sex. “*Ngwiko*” was banned by missionaries as they could not comprehend that young men and women were sleeping together in one room without having sexual intercourse (Ahlberg, 1991; Ahlberg, 1994). The abolition of “*ngwiko*” may have led to the practice of wiping the soot before Njuki got circumcised. Njuki justified wiping the soot when he was circumcised to the non-existence of diseases, probably referring to HIV and AIDS, while at the same time saying that syphilis and gonorrhoea were common but were not viewed as “serious” diseases. Men taking health risks similar to the ones explained by Njuki is a signifier of masculinities in negotiations for power (Courtenay, 2000). Refusing to subject themselves to diseases is also a rejection of femininities which is associated with weakness (Evans *et al.*, 2011). The diseases were, therefore, undermined as not serious in comparison to probable HIV and AIDS. It has been suggested that HIV transmission among Africans is as a result of the suppression of African traditional sexual practices by missionaries such as “*ngwiko*” since it was done under strict rules of conduct (Ahlberg *et al.*, 1997). Prohibition of sexual penetration was enhanced through peer pressure, myths and taboos in the past (Ahlberg *et al.*, 1997). The ban of “*ngwiko*” which was morally regulated sexual play resulted in a private, silent and unregulated sexuality (Ahlberg *et al.*, 2000). A feminist perspective acknowledges the existence of realities based on historical

contexts, such as the influence of missionaries, implicated for the spread of HIV and AIDS (Hall & Stevens, 1991). Colonialism, for instance, is seen to have fuelled subordination of women and the collapse of most of the traditions in Africa leading to gender hierarchies that perpetuate HIV and AIDs transmission (Kako, 2008). The experiences of women in developing countries, such as Kenya, must be viewed through the lens of postcolonial deconstructions (Anderson, 2004) which is linked to the colonial influences. In this study, Njuki said post-circumcision sex was allowed when he was circumcised, however, Kirika's discourse shows that only marital sex was permitted. This is in contrast with Ahlberg *et al.*'s (1997) and my previous research findings in the field, which showed that wiping of the soot had been adapted by young men to fit their realities. The findings in this study show that wiping the soot became a practice about the time when Njuki got circumcised.

Today the initiates are encouraged by the mentors to have penetrative sex to wipe the soot. This leads to a cultural contradiction with boys permitted to be sexually active while girls are being told to uphold virginity and avoid pregnancy (Njue & Kiragu, 2006). This is implied in Connell's (1987) theory of gender structure, where social norms prescribe sexual roles of men and women in the society. As this study indicates, social norms place expectations on women to be faithful and maintain sexual discretions while men can have many sexual partners. Njuki notes a similar scenario of many sexual partners after been introduced to wiping the soot. The issue of multiple sexual partners among the male students did not emerge in the narratives. However, mentor 12 suggested to the initiates to wiping the soot with different girls without any prohibitions. The findings in this study depict sexual licentiousness among the circumcised young men. This involved mentors bringing girls to the "*kiumbu*" for the initiates to engage in sex. Some mentors in this study encouraged the young men to wipe the soot with any girl or woman as wiping the soot does not lead to a long term relationship. This compares to what Vincent (2008) refers to as "gateway to sex" or a "license to sex" rather than providing a time to engage in responsible sexual behaviour such as controlled sex in "*Ngwiko*" among the Kikuyu people.

The students' narratives illustrated that varying waiting times prior to wiping the soot were recommended, which were inconsistent with the times mentioned by the mentors. In a study among the Kikuyu men in Kenya, boys were encouraged to have sex within three months of being circumcised (IRINplusNews, 2007). Delayed post circumcision sex is important for HIV prevention as it allows the healing of the wound (UNAIDS, 2007). The WHO recommends 42 days of abstinence before engaging in post circumcision sex, yet, some of students' waiting time prior to post-circumcision sex was short of this recommendation. Roger *et al.*, (2013) assert that the 42 days are sufficient for the healing of the circumcision wound. Odoyo-June *et al.*, (2013), however, argue that some men may not be healed by the end of 42 days and, therefore, recommend 42 days of abstinence and use of condoms for three months after resuming sexual activities. The length of the healing period of the wound was cited as one of the barriers for men to participate in the VMMC in another study carried out in Kisumu (Westercamp *et al.*, 2012), perhaps in anticipation of resuming sexual activities or work.

Some of the reasons cited in this study for not wiping the soot were Christian beliefs and advice from family members. One of the parents' reasons for opting for the church supervised circumcision for their sons was to keep away from practices such as wiping the soot. Similarly, teachings during 'initiation rites' supervised by the Christian churches in Malawi, include sexuality, without encouraging sexual intercourse (Kishindo, 1995). It is the teachings by mentors that explicitly encourage sexual activities among the initiates that have led to many Christian groups to run their own initiation programmes. Religion can be used as a reference point to enhance sexual conservatism and is used to reduce debut before marriage owing to conservative ideals on sexuality (Rostosky *et al.*, (2003). This could be explained by the reference group theory Aalsma *et al.*, (2013) which alleges that as religiosity increases, sexual conservatism increases because as people use religion as a reference point, their attitudes and behaviours tend to align with that of the religion. There are, however, doubts about whether on returning home from church, the initiates are able to resist the pressure from peers to abstain from wiping the soot.

Coercion in wiping the soot

There were indications that some of the young men were coerced into the wiping the soot. Myths were some of the means by which compliance in the practice was enhanced. Myths were also used by the mentors to ensure that instructions were followed strictly. To discourage the initiates from engaging in sex before the given period of abstinence was over, they warned that engagement in sex earlier would result in the tip (head) of the penis coming off. Myths are commonly used in different societies to enhance conformity to different rules. Boys from the Meru ethnic group in Kenya, for example, are encouraged to engage in sex shortly after circumcision. In contrast, the Kikuyu young men in this study were warned that they risked having their penis remaining soft forever (Grant *et al.*, 2004). This is because the power of cultural myths may enhance conformity because myths have enormous power over people's beliefs. Different cultures seem to have different myths governing similar actions. Once a myth is circulated within a group such as among the Kikuyu young men, it becomes accepted as truth which cannot be questioned (Garner & Hancock, 2014). The myths used on the initiates represent a distortion of reality (Garner & Hancock, 2014). The mentors said that some of the initiates participate in the practice of wiping the soot to avoid isolation and enhance acceptance. A study on circumcision of Kikuyu young men cited fear of violence and isolation as the reasons for conforming to wiping of the soot (IrinPlusNews, 2007). It is, however, arguable that peer pressure may have influenced the initiates in this study to wiping the soot. Some of the mentors said that they assisted the initiates to get a girl for wiping the soot. While some mentioned that any girls could be used for wiping the soot, others advised the initiates to get younger girls.

The driving force of having sex is indicated to be able to wipe the soot irrespective of what kind of girl/woman this was done with. The women and girls in the practice of wiping the soot are, thus, viewed as sexual object which is a display of hegemonic masculinity (Connell, 1995). This raises the question that Dixon-Mueller (2008) asks "how young is young?" Dixon-Mueller (2008) claims that physiologically, a girl is not ready for sex at the age of 14. The male students in this study reported to have been circumcised at the age of 13-19 years and may have

been sexually active prior to the circumcision. Use of skilled bodily activity in sexual performance is an indicator of masculinity since bodies are both objects of social practices and agents in social practices (Connell, 2002). The findings suggest that the girls mentioned in this study may have been less than 13 years old, the youngest age of the student participants in this study. In addition, mentors and the young men used visual judgement, which could be deceptive, in deciding what age a girl was. Dehne & Riedner (2005) argue that young adolescent girls' biologically immature reproductive and immune systems make them more susceptible to health problems including sexually transmitted infections. Some of the older initiates may have already been sexually active and were possibly HIV and STI carriers.

Previous research has found girls aged 15-17 years infected by young men four years older than them (UNICEF, 2008). Hegemonic masculinities can explain health problems owing to risk taking sexual behaviours by men (Sabo & Gordon, 1995) as indicated in these findings. Since condoms are not used in wiping the soot, this could expose not just the initiates but also the girls to HIV infection. Apart from HIV infections, adolescent sex may also lead to other STIs and unwanted pregnancies. Perhaps the younger men have similar reasoning to the older men for having sex with younger girls. For instance, older men may choose young girls for sex because they are believed not to be infected with HIV while others believe they can be cleansed from HIV by young virgin girls (Tigawalana, 2010; United Nations Children's Fund, UNAIDS & WHO, 2002). Girls may also agree to engage in intergenerational sex for other reasons. In Botswana, young girls engaging in intergenerational sex did this for financial gain, while others did it for pleasure (Nkosazana & Rosenthal, 2007).

The initiates in this study may not have been financially well off as they were students and not working. Mandazi (doughnut) and mutura (sausage) were said to be given to girls for sexual exchange during Njuki's time. It can be speculated that gifts used for sexual exchange in wiping the soot would need to be affordable for the initiates in this study. Connell's theory of gender (1987) explains the structure of

financial inequality that may exist between the girls and the initiates in this study. In a patriarchal society similar to the one described in this study, girls and women are financially disadvantaged compared to men, creating a power difference, which makes it difficult for girls and women to, for example, negotiate condom use. The power differences may render women and girls vulnerable, as they are unable to afford or access female condoms. Nevertheless, wiping the soot may be an acceptable cultural norm and, therefore, girls may feel obliged and perhaps honoured to take part in it as a cultural obligation in practice today. The reasons why young girls participate in wiping the soot would require further research.

Knowledge about Condoms

Condoms remain an important component of HIV prevention (Siegler *et al.*, 2012). Students in this study reported having engaged in wiping the soot after circumcision without condoms. However, some wrote that they used condoms during the wiping the soot. Those who did not use condoms appeared not to know the purpose of condoms. Knowledge about HIV prevention is associated with condom use (Maticka-Tyndale & Tenkorang, 2010). Other studies have, however, found no relationship between knowledge about HIV prevention and condom use (Kabiru & Orpinas, 2009; Zellner, 2003). Those who did not use condoms wrote that they avoided condoms in order to fulfil the cultural obligation of wiping the soot and the mentor's instructions. In wiping the soot, for the soot to be completely wiped off, condoms are not used (IrinPlusNews, 2007). This implies that some of the participants may have had knowledge about condoms but cultural obligations dictated that they do not use them.

Findings show that even with the knowledge that condoms protect against HIV, wiping the soot was practiced by many young men without condoms as the cultural practice dictates. Research carried among Kikuyu men suggests that young men advise the initiates not to use condoms in order to completely "clean the soot" from the penis (IrinPlusNews, 2007). This could explain why the latest data on condom uptake show low condom demand, rather than low condom supply, as the main reason limiting condom uptake in Eastern Africa (Papo *et al.*, 2011). Yet, the sexual

practices of the young men during circumcision may pose a challenge to HIV campaigns. The young men in this study endeavoured to keep up with the cultural practices although they adapted a different format of what the practice was in the past.

Some of the initiates who used condoms during the wiping of the soot did so because they had the perception that the girl was the HIV carrier and would, therefore, infect them. Similarly, participants in a study carried in Nigeria articulated, that females are often seen as HIV transmission agents while men are portrayed as victims of HIV infections (Mbonu *et al.*, 2010). The perception implied that the initiates could not infect the girls but that girls could infect them. Other initiates associated being in love and having sex with a girlfriend with safe sex, thus not requiring condoms. Not using condoms may, therefore, be seen as a sign of commitment to the partner in a relationship. In a previous study in South Africa, lack of perceived risks, peer norms, sexual prowess and gender power relations hindered condom use among the young men and women (Macphail *et al.*, 2002).

There was no indication in this study that girls were involved in the decision on condom use during the wiping of the soot. However, suggestions of why girls may engage in unprotected sex include not having considered contraception, (Gomes *et al.*, 2008), fear of possible side effects (Abiodun & Balogun, 2009), being misinformed about the risk of pregnancy or STIs posed by unprotected sex (Adedimeji *et al.*, 2007) or being more concerned with the risk of condoms than their safety of an unintended pregnancy. A patriarchal society, as in this study, promotes domination of women by men even on the use of condoms. The power imbalances explained in Connell's theory of gender (1987), are dictated by social norms which may prevent women from asking questions in relationships. It would have been a challenge for subordinate women and girls to negotiate for condoms especially if it was a transactional sex exchange. The theory also shows that men have more authority and oppressive attitudes towards women which could have influenced them to use any means to ensure they wiped the soot with the women.

Wiping the soot was presented in the interviews as fundamental to proving one's manhood irrespective of the women's conditions and positions.

Some of the male students had the notion that circumcision protected them from HIV and, therefore, did not use condoms. This suggests that some circumcised men may be involved in more risky behaviour, such as not using a condom, in the belief that circumcision in itself protects them from HIV and AIDs (Westercamp *et al.*, 2014). Sex after circumcision could be a way of sexual experimentation especially for those who were sexually active prior to circumcision. This has been a challenge for the VMMC programmes, where some men circumcised under this programmes have reported participating in riskier sexual behaviours (sometimes referred to as 'risk compensation') after circumcision, with the 'new penis'" (Grund & Hennik, 2012). However, a study conducted in Kisumu, Kenya shows that circumcision carried out for HIV prevention does not always lead to risk compensation (Riess *et al.*, 2010) when counselling is given prior to circumcision. Nevertheless, circumcision that is not performed for HIV infection may be devoid of counselling since the nurses and the doctors undertaking it may not be trained to do the HIV counselling. In addition, some of the young men demonstrated an awareness of the recent discourses on the health benefits of male circumcision. This is of significance in the ongoing VMMC campaigns. Different interpretations of the WHO policy on male circumcision (WHO/UNAIDS, 2007) by different communities could reflect misinformation or lack of details in the dissemination of information on male circumcision and HIV information. The Balante of West Africa are said to believe that male circumcision protects the individual from a "dangerous" disease, "Pusoonu", as its symptoms compare to those of AIDS (Niang & Boiro, 2007). These findings highlight that without addressing the cultural practices and misconceptions in the male circumcision ritual, circumcision may not provide the protective benefit from HIV infection as expected by the WHO's policy.

9.4. Barrier to changes in the male circumcision ritual

Secrecy and silence in the ritual were depicted in these findings as one of the impediments to researching the topic of male circumcision. Parent's role in sexual education even in discussing reproductive organs such as the penis was not possible. Secrecy, silence and lack of sexual education for the young men may act as barriers to intervention for changes in the ritual. The pressure to circumcise is a challenge to those who would like to forfeit the practice.

9.4.1. Secrecy and silence in the ritual

The secrecy surrounding the ritual, as emphasised by the male students in this study, needs to be understood contextually. In responding to the questions about their experiences in the male circumcision ritual, some of the male students wrote that they had broken an oath of secrecy by narrating their experiences. The use of oaths to keep rituals secret is alleged by Simmel (2009), to be a way of enhancing intimacy among the initiates who share an oath. There is a suggestion that after taking an oath that an initiate is ushered into the group secrets creating a common bond. Although this study did not explicitly show *why* secrecy is emphasised in male circumcision, a WHO (2008a) report states that initiates are sworn into an oath of secrecy during circumcision, as a way of perpetuating the harmful practice of the ritual. Among Xhosa men, for example, details of the circumcision ritual cannot be revealed to outsiders, including women (Vincent, 2007; Meissner & Buso, 2007: WHO, 2008a). Nyaundi (2005) asserts that secrecy sworn through an oath among circumcising communities in Kenya keeps the next group of initiates from knowing what happens in the ritual, thus keeping it a mystery. The high level of secrecy is in the sacredness and the mystery of the ritual. Secrecy being internal as it is held among groups of people is one of the ways of controlling information (Simmel, 2009), which could be another reason why secrecy is maintained among circumcised men in the male circumcision ritual. This could be a way of distinguishing the adults and the manly from non circumcised and women (Vincent, 2007).

The findings in this study indicate that secrecy is enhanced by the isolation period, for those circumcised at home. Parents and boys are barred from entering “*kiumbu*” where the young man is recuperating. It is only other young men including the mentor who are allowed to visit the initiates. Barring the parents from the “*kiumbu*” appears to give the young men freedom to engage in activities unknown to the parents. Findings from field work I conducted in a previous study in 2010, echo a similar issue where a mother interviewed discovered three years after circumcision that the son had been initiated into smoking during the seclusion period. Yet this woman had broken the cultural codes by visiting the “*kiumbu*” every day where the young men used perfume and chewed gum to suppress the cigarette smoke that would betray their activities in the “*kiumbu*”. Khamasi & Kibui (2010) argue that the secrets in male circumcision are used to mask men’s vulnerabilities which could explain why initiates may prefer to keep quiet than report the harmful actions perpetrated against them. Although the male circumcision ritual is meant to be a secret especially from the women, confidentiality and anonymity assured in the narrative writing may have motivated the students in this study to break the oath of secrecy to narrate their experiences.

9.4.2. Role of the parents in sexual education

Observations in the field research illuminated the lack of parental contribution in sexual education of the young men. The male circumcision meetings in churches were overwhelmingly attended by mothers, with a few men attending. In addition, one of the men who attended was not a father to the boys but a cousin. The church leaders were concerned about the lack of parental involvement in preparing the boys for the cutting and the whole circumcision process. Even for boys circumcised at home, apart from helping in choosing the mentor and paying for the “cutting”, the parents’ role in educating the initiates was lacking. Research carried out in some sub-Saharan countries shows that parent and teenage communication on sexual related matters is rare and uncomfortable especially with fathers (Biddlecom *et al.*, 2009). The parents seem to leave the initiate in the hands of the mentor or the church to educate the boys for them. Based on past cultural norms and beliefs of the Kikuyu people, parents were not expected to take the role of teaching sexual

education to their children. This could further explain why parents were reported to be shy of communicating circumcision with their sons. Direct involvement of parents in communication about sexuality in the past was minimal and it was the extended family, grandparents, aunts and uncles who communicated about sexuality to the children in most Sub-Saharan African countries (Fuglesang, 1997). However with urbanisation, this is changing (Bastien *et al.*, 2011) since sex educators in extended family maybe living in a village far away from the nuclear families living in the urban areas. Furthermore, discussions of sexual related matters between parents and adolescents in many parts of Sub Saharan Africa is a taboo (Campbell & MacPhail, 2002; Amuyunzu-et *al.*, 2005; Paruk *et al.*, 2005), which resonates with the cultural norms and beliefs of the participants in this study.

According to Costos *et al.* (2002), talking about sex is a taboo in most societies including Western societies. In Ghana, for example, traditional norms and taboos prohibit discussion of sexual matters between adolescents and parents (Adu Mireku, 2003). Many of the parents in this study may have never had open communications on sexuality in schools or from their parents and, thus, may, in turn, find it difficult to discuss sexual matters with their own children. Similarly, a study in Tanzania concluded that parents are shy talking to their children on sexual matters due to cultural inhibitions which in turn reduces young people's trust to be open with their parents (Wamoyi *et al.*, 2010). Lack of knowledge and skills may act as barriers to communication (Bastien *et al.*, 2011). In addition, some parental communications with adolescents have been shown to be authoritarian and uni-directional, scolding, judgemental, coupled with vague warnings instead of a direct, open discussion (Bastien *et al.*, 2011; Phetla *et al.*, 2008). This may deter young people from initiating discussions about sexual matters with their parents.

Some parents are of the view that communication about sex may encourage their children to engage in sex, thus, they may avoid communicating with them (Mturi, 2003). Parents' failure to prepare their children suggests that the parents in this study expected the church or mentors to prepare for the sexual world. Religious affiliations have been said to encourage silence in parent-child communication. A study in Kenya showed that religious influence limited the language that parents used in sex communications thus leading to use of metaphors as sexual terms were considered dirty (Mbugua, 2007). Parents' communication with their children on sexual matters has significance for their children's health since parents can communicate both facts and emotional dimensions of social and sexual matters with their children (Perrino *et al.*, 2000). However, this may be dependent on other factors such as parental monitoring, closeness with the adolescence and the timing of these communications (McNeely *et al.*, 2002).

9.4.3. The pressure to circumcise

The findings in this study depict pressure on the boys to get circumcised leaving them without a choice to remain uncircumcised. This depicts male circumcision as an event where the boys are powerless to make a decision for themselves. The pressure seemed to emanate from peers, mentors and parents. Social pressure in this study amounted to stigma, shame, bullying, isolation and rejection by others. One of the mentors insinuated that parents also ensured that their sons were circumcised prior to joining the high school to protect them from stigmatisation. This aligns with Lagade *et al.* (2003) findings that peer pressure is one of the most influential factors in deciding upon circumcision among boys in South Africa. Pressure from the families was one of the major factors for Xhosa boys to get circumcised traditionally rather than medically, as boys who get circumcised in the hospital are looked down upon (Gwata, 2009).

The young boys in this study were socialised to get circumcised after class eight regardless of age. Most boys who have not repeated a class in primary school are about 13 years of age by the time they are in class 8. This is contrary to what happened in the past as described by Njuki and Kirika. In the past, a boy was circumcised between 15 to 18 years of age (Wambugu *et al.*, 2006). However, some boys got circumcised earlier, especially if their father was rich as the father had to be willing to pay the circumcision expenses. It was suggested by the mentors that boys must get circumcised otherwise they would not be able to concentrate in high school. The findings also highlight the stigma associated with an uncircumcised man, which acts as pressure for men to get circumcised. Stigma is said to result in shame and discrimination of the person who is seen as imperfect (Scambler & Paolli, 2008) which may be what every Kikuyu boy tries to avoid by getting circumcised. Goffman (1971) suggests that stigma is discrediting and as in the case of the Kikuyu boys prevent an uncircumcised individual from full societal acceptance. Although Goffman (1971) asserts that stigma is a matter of an individual's perspective, young boys such as those who participated in this study may not be in a position to overlook stigmatisation especially from peers and parents who are the main socialising agents (Chaplin & John, 2010). Not only does stigma affect an individual but also the family members (Link & Phelan, 2001) which could explain why the mothers also wanted the boys circumcised prior to joining high school. The authors add that stigma involves labelling and stereotyping which emerged in the findings where an uncircumcised man derogatorily was labelled as a "*kihii*" [boy] or a dog as an insult.

The pressure to circumcise is not just experienced by the Kikuyu people. The derogatory remark of a "*kihii*" has been used by Kikuyu politicians to emasculate other politicians from non-circumcising cultures during campaigns insinuating that they are not circumcised and thus, cannot be leaders (Kamau-Rutenberg, 2010).

The term *kihii* being an insult is meant to undermine other men's masculine strength, and feminising them (Flood *et al.*, 2007). Similarly, the Maasai people of Kenya view an uncircumcised man as a coward regardless of the community of origin (Tangwa, 1999). Therefore, circumcision can be said to be mandatory for Kikuyu boys and other communities such as Xhosa and Maasai in Africa. The uncircumcised status

is not rewarded but undermined. As attributed by the theory of social learning, the rewarded behaviours and actions are likely to be repeated while unrewarded actions are avoided (Ryle, 2014). Since the action of circumcision is rewarded with celebration and recognition, the Kikuyu boys might view it as a compulsory action. According to WHO (2009) reports, male circumcision is not optional for an individual boy although the decision on when to get circumcised is entirely up to an individual or the family.

In this study, male circumcision was portrayed as a cultural ritual that is compulsory for the participants. There was also a suggestion that if it was known that a man was not circumcised, he would be forcibly circumcised by the other men. This is exemplified by Kirika's and mentor 5's stories of two men who were forcibly circumcised. The young people in this research did not, however, report forcible circumcision during their period of circumcision which highlights a gap in male circumcision research. However, a recent story about the enforced circumcision of a Kikuyu man by his friend (Mugo, 2014), might signify that some Kikuyu men would prefer to remain uncircumcised but are left without a choice.

Male circumcision can have legal implications especially when the pressure to get circumcised leaves the boys without an alternative option but to be circumcised (Hinz & Hangula, nd). From a human rights perspective, circumcision performed on children can be termed as a violation of human rights (UNAIDS/AIDS Law Project, 2008). The majority of the male students in this study were below 18 years old at the time they wrote the narratives and are classified as children according to the UN Conventions on the Rights of a Child (CRC) article 3, which Kenya has signed up to. Therefore, any adolescent boy circumcised under the age of 18 is qualified as a child under this article (UNAIDS/AIDS Lawproject, 2008). However, in this study, the boys' pursuit of cultural identity and acceptance by peers was portrayed as paramount in the decision to circumcise. Although it is the cultural rights of the boys to get circumcised and engage in the cultural practices (National Centre for Arts and Culture, 2011), some of the so called cultural rights may have a negative impact on personal health and wellbeing (National Centre for Arts and Culture, 2011) such as

FGM and early child marriages (28 Too Many, 2013). In addition, even with cultural rights, according freedom for everyone to participate in a culture, cultural practices should be respected and protected by the government as long as they do not infringe upon other human rights (Stamatopoulou, 2007, 2010; Vadi, 2007; Commission for the promotion and protection of the rights of cultural, Religious and Linguistic communities, 2010). Therefore, exercise and enjoyment of cultural rights such as male circumcision should not impinge on an individual's wellbeing. The tension of exercising cultural rights by a child may be the stigma and pressure to be accepted as a circumcised.

This study showed that cultural rights seemed to override the human rights of the uncircumcised boys due to the pressure mounted on them to get circumcised. The law is not meant to deny the children their cultural rights but to enable them to make independent decisions. It is a challenge for a child to make an independent decision if the parents and peers are advocating a certain practice for him/her as the findings in this study suggest. This is because children are said to have less developed cognitive abilities and may, therefore, not be able to process information and make decisions like adults (Archard, 2010). In addition, with the use of myths and pressure depicted in this study, the boy is conditioned to look forward to the ritual with anticipation. However, the consent of a child is never sought in the culturally circumcising groups (Nyaundi, 2005). Ethical considerations in male circumcision, therefore, only apply to the non-circumcising communities during the VMMC programmes excluding the circumcision communities. To enrol in the VMMC programme, assent is required for the boys. Applying ethics in the ritual may be plagued by challenges such as parents getting discouraged to give consent especially if it involves communicating and giving information about sexuality and HIV and AIDS of their son during circumcision. It may also be a challenge if the boys refuse to give assent yet parents may want them circumcised. In addition, obtaining assent and consents may be alien in many cultures (Rennie *et al.*, 2007) such as the Kikuyu study.

In summary, women are central in the construction of masculinities as girlfriends and sexual partners during wiping the soot and mothers in playing a role in organising the circumcision of their sons (Connell & Messerschmidt, 2005). The women in this study aimed to protect their sons from the culture of pain, institutional bullying and practices such as wiping the soot. The women seemed to have been contesting the hegemonic masculinity that demands that a boy gets circumcised at home, uses no pain killers and uses non-absorbable stitches (Lusher & Robins, 2010). In the existence of hegemonic masculinity, there is likely contestation by the subordinate masculinities, which undermines the goal of hegemonic masculinity. In this case, the women position themselves as the subordinate gender that undermines the dominating gender (Connell & Messerschmidt, 2005). This, according to Lusher & Robin (2010), is a way of illegitimizing the dominating masculinities. For those who chose to get circumcised at home, this was a way of supporting the dominative masculinities.

Although the women bearing the subordinate powers contested and challenged the dominant forms of masculinities in male circumcision, the mentors who positioned themselves as the hegemony gender contested the involvement of the church in the ritual. However, the hegemonic forms of masculinities in this study seemed to incorporate masculine powers that are contesting and challenging them such as the group getting circumcised and recuperating in the hospital. After the cutting and recuperation in the hospital, those circumcised at home return to participate in other practices of the ritual, which depicts an incorporation of hegemonic and non-hegemonic masculinities (Connell & Messerschmidt, 2005). This is a way of recognising the agency of a subordinated group as well as of the dominant power groups. On the other hand, exclusion, violence, abuse and discrimination, which are features of marginalised masculinities, are some of the issues those circumcised in the church may have to go through (Howson, 2006).

9.5. Conclusions

The findings in this study portray women as key agents of change using spaces and places in churches, hospitals and urbanisation as a driver to effect changes in male circumcision. They act as agents of change in that they want a different circumcision practice in order to protect their sons from the endurance of pain and violence through wiping the soot and road licence that the circumcision institution enhances. The mentors and other young men perpetrated violence on initiates in the form of bullying, harassment, coercion to give the road licence and engage in wiping the soot. Women's involvement is also seen as a cultural breakdown as they are seen to presume the role of a mentor which defies the cultural norms. Male circumcision as a ritual conferring a cultural identity to the young men seems to leave the boys without an option of opting out of circumcision. The pressure for the boys to circumcise may enhance a cultural practice that impinges on the child human rights to consent to the circumcision ritual. The findings highlight implications of policies in public health such as the WHO policy on male circumcision, whose implementation appears to have failed to take into account the cultural practices in the male circumcision ritual. In addition, the VMMC implementation to the non-circumcising communities leaves the circumcised groups like the Kikuyu people without the counselling that would be essential in the prevention of HIV transmission. The next chapter will conclude the thesis and give recommendations for the research practice and policy.

Conclusions and Recommendations

10.1. Chapter introduction

This chapter brings the thesis to a conclusion by highlighting the main findings and the contribution to the knowledge of the study. Implications for public health practice, policies and research are drawn in this chapter. In addition, there are recommendations for further research.

The study set out to explore the meaning and the changes taking place in the male circumcision ritual in Central Kenya and their implications for public health practice. The study found that women were more actively involved in the male circumcision of their sons, not just in the church, but even for those who got circumcised at home in a ritual that has been described as a male only arena. The only role described for the women by Njuki in the ritual was cooking for the initiates and young men who visited them. However, in this study, the women were depicted as having moved beyond this role. The spaces and places through which the women effected these changes was the church, the hospital, and urbanisation. Lately, the hospital acted as space through which the women effected changes. Urbanisation as a driver of change allowed the women to do away with some of the male circumcision practices such as having a “*Kiumbu*” [room where the initiate recuperates] for the boy. In addition, some of the women in the urban places preferred to take the boys to the churches for circumcision. The mentors acknowledged that the church is greatly involved in the male circumcision ritual, which may possibly shape the male circumcision ritual in the future.

The findings suggest a constantly changing practice of male circumcision ritual that is central in the life of a Kikuyu man. The study also highlights concerns for HIV infection, the culture of pain and institutional bullying that the women endeavour to protect their sons from by opting for the church as space for the ritual. The findings suggest that women were not willing to endure the pressure and stigma of having an uncircumcised son but were willing to risk the pressure and stigma of choosing the church circumcision for their son. It is the quest for change in some of the cultural

practices that is depicted in the choice of places and spaces of circumcision such as hospitals and churches. Some of the cultural components of the male circumcision ritual are still valued and maintained by the church such as the road license. In addition, the importance of getting circumcised is still eminent today as it was in the past based on the choices the women make for their sons' circumcision. Thus, although it would seem that the women want changes, it is not to end the circumcision ritual but to change some elements of the ritual.

As described in the findings chapter some mentors also wanted change. For instance, one mentor was already trained and was training others on male circumcision practices. The theme of change in the male circumcision ritual was prominent in this study although it was a format of slight adjustments of what the practices were in the past. The changes effected through the women were, therefore, not the first changes ever in the ritual as noted in the practice of wiping the soot from Kirika's generation through to Njuki's generation and the current young generation. This is relevant for policy makers, and the public health sector, as there are possibilities for negotiations of more changes in the male circumcision ritual. This study found that male circumcision is not absolutely a voluntary practice for the boys owing to the pressure for them to circumcise. Even some of the boys circumcised in the church were not given the opportunity to choose circumcision as they were not aware of why they had been left in the church by the parents and guardians.

10.2. Contribution to knowledge

This study provided a forum for students, young men and two older men to share knowledge and experience on the male circumcision ritual as a cultural practice.

This study describes a new and greater dimension of women's involvement in the male circumcision practice. No previous study has discussed women's roles and their place and space in the male circumcision ritual among the Kikuyu people beyond the kitchen and being allowed to observe the boys' cutting by the riverside in the past. It is the women who seem to advocate for the involvement of the church in the male circumcision ritual, an issue that was contested by most mentors. The

findings depict women as key change agents who seem to go beyond past norms in a male arena of the male circumcision ritual. Their involvement in the male circumcision ritual was suggested as inevitable owing to the changing contexts in the presence of the AIDS epidemic, the culture of pain and institutional bullying of the initiate by the young men. In addition, with a collapse in the governorship of the custodians of the cultural practice in the past, the ritual appears to have been left to the young men. In the past, circumcision was organised by the elders in the Kikuyu community (Kenyatta, 1938). The church, as a driver of change advocated for by the women, has removed the role of a mentor, an important figure in the male circumcision ritual. Even the women who opted for circumcision at home influenced greatly the selection of the mentor for their son in a male practice.

The study shows that the hospital is not just a male circumcision provider but a place and space of recuperation that a “*Kiumbu*” would normally provide. This is another change in the male circumcision practice that has not been discussed in other studies. Hospitals have only been shown in the literature as places where the cutting take place while healing takes place at home. Although this is one of the major shifts in the male circumcision ritual that defies the cultural norms such as keeping the women away from initiates and the culture of endurance of pain, the initiates return home to complete all the other rites and practices that the initiates circumcised at home take part in.

This study adds to previous studies on male circumcision and the body of ethnographical literature on initiation rites by providing details on the male circumcision ritual among the Kikuyu people. Again, with the changing practices, meanings and values in the male circumcision ritual among the Kikuyu people, this study provides a vital record of the distinct practices and rites in the male circumcision ritual at this point in time. Moreover, reflecting these practices against the broader cultural context and theories on initiation rites, it provides a significant explanation of the cultural and theoretical significance of these practices. The study also adds to the literature that has used written narratives as one of the methods of data collection. In order to explore the experiences and meanings of male circumcision for the young men, narratives were used to enhance disclosure of information by the male students and method triangulation. Khamasi *et al.* (2011)

used a similar method where boys in the primary school in Western Kenya were asked to write stories as a part of a school competition and some of the stories highlighted concerns on male circumcision. However, the main objective of the school competition was not on male circumcision practices.

Based on the literature review conducted on male circumcision practices in the past, it is the first closely researched in-depth study with an aim of exploring male circumcision in Muranga, Kenya. The study shows that wiping the soot that involves sexual penetration began around Njuki's time as opposed to past research suggesting that the practice began with the current generation of young men (past research I conducted in 2009-2010; Ahlberg *et al.*, 1997). The stories of Njuki and Kirika portray the trend of the practice of the wiping the soot and that the practice has been shaped differently by each generation. The practice of wiping the soot has undergone a changing process through Njuki's generation to the young men's generation in a way that affects the way young men negotiate their sexuality.

The study shows that male circumcision is unlikely to be voluntary for the boys. Although most young boys look forward to getting circumcised, there is no provision for them to make the choice to be circumcised or not. In addition, the findings suggest that the pressure for the boys to circumcise is great. Even for the boys circumcised in the church, there was an indication that they were not making an informed decision as some reported to have found out at the last minute why the parents and guardians had left them in the church. In addition, the forcible circumcision on the Kikuyu man recently highlights that some of the Kikuyu men would prefer to remain uncircumcised. The findings from this study may contribute to improvement in the scale up of male circumcision in culturally circumcising communities in the HIV prevention efforts while at the same time identifying potential areas for intervention in the male circumcision practices among Kikuyu men.

10.3. Implications for policy and practice

The findings have implications for public health policy and practice. The findings suggest that some of the young men are wiping the soot without condoms since that is what the cultural practices dictate. In order to wipe the soot clean, the initiates are advised to have sex with girls without condoms which put them at greater risk of HIV Infection than those who use condoms. In addition, some of the initiates wiped the soot immediately after circumcision, before the complete healing of the wound, which increases the risk of HIV prevention. Resuming sexual intercourse before complete healing of the wound increases the risk of HIV infection especially for the women (Kigozi *et al.*, 2007). Some of the initiates took less than the 42 days recommended for complete healing of the wound. In addition, Odoyo-June *et al.*, (2013) suggest three months of condoms use after resuming sex from the 42 days abstinence period. Based on the findings, the promotion of male circumcision among the non-circumcising communities may leave the circumcising communities more vulnerable to HIV infections. If the men get infected then their sexual partners are likely to be infected as well.

The findings show that some of the young men believe that they cannot get infected with HIV once they are circumcised. The findings have implications for the dissemination of information and communication on male circumcision for prevention of HIV such as duration of sexual abstinence after circumcision as suggested in the WHO male circumcision policy and that male circumcision is a replacement for other HIV preventive measures. Male circumcision is an additional prevention strategy rather than a replacement of other prevention strategies. The WHO circumcision policy is significant for the cultural practices and norms linked to male circumcision among the culturally circumcising groups such as the Kikuyu people.

The study indicates that there are different types of circumcision, where the full portion of the foreskin is removed “*irua ri kiambu*” [kiambu circumcision] and in other instances where a portion of the foreskin is folded “*irua ria muranga*” [Muranga circumcision]. It was not clearly indicated by the participants if “Muranga circumcision” still takes place today although it was noted to have been taking place

during Njuki's time. However, the WHO policy requires a complete removal of the penis foreskin for HIV prevention measures, which emphasises the importance of clear and proper communication that is culturally sensitive on male circumcision and protection of HIV.

Promotion of male circumcision practice raises cultural, legal, human rights and ethical issues. Regulations of circumcision practices to promote safe circumcision among Kikuyu boys but also maintains the traditional practices in Kenya are lacking. It is however, the implementation of the policies that may be a challenge since Kenya is a signatory to the Convention on the Rights of the Child. Lack of proper policies on male circumcision suggests that human rights are violated by social norms and cultural rights. The relationship between HIV and AIDS and human rights reflect that some people are more vulnerable to HIV because they are not able to realise their civic, political, economic and cultural rights. Denial of the right of freedom of participation and access to certain information may exclude such groups from taking preventive measures against HIV infection.

The human rights based approach in VMMC programmes requires that male circumcision is carried out in a safe manner, under informed consent without coercion or discrimination (WHO, 2007). This requires the provision of full information on male circumcision to allow informed decision making. Importantly, this is also significant in the culturally circumcising communities, which do not take into account the legal, ethical and human right factors. The policy allows for the non-circumcising groups to get HIV counselling services prior to the cutting but excludes the circumcising communities like the Kikuyu people. The success of the WHO male circumcision policy may be curtailed by some of the factors discussed in this section. The policy, therefore, should include the circumcising communities' needs especially HIV counselling services during circumcision. However, the challenge of the high demand for VMMC suggested in this study could be aggravated if the culturally practicing communities are included in the programmes. There is a need for male circumcision regulations, especially in curtailing male circumcision providers that may impede the HIV prevention efforts and the safety of VMMC programmes.

10.4. Recommendations

In order to promote the health of the young men, the study has recommendations for future actions. Recommendations outlined below also point to the key places and actors suggested for intervention as outlined in the Socio Ecological model (SEM).

10.4.1. Legislation and policy and training on male circumcision

Circumcision was depicted as compulsory in this study for the boys and without rights to make an informed choice to get circumcised. In addition, some of the practices advocated for the initiates such as wiping the soot without condoms, pain endurance and violence through bullying and pressure to comply with the practices may be detrimental to young men's health. Laws and policies that regulate male circumcision among the circumcising groups are lacking but exist for the non-circumcising groups. Laws and regulations of the cultural male circumcision practices may be crucial in enhancing the Conventions on the Rights of a Child Legislation and policies can be central in changing cultural norms and practices related to risky sexual behaviours and violence (WHO, 2010). Although there is a regulation banning FGM in Kenya where girls cannot be circumcised prior to the age of 18 years old, there is no equivalent regulation on male circumcision. The success of these regulations is still a challenge since FGM continues to be a common practice amongst the Somalians, the Kisiii and Maasai people of Kenya despite being an illegal practice (28 Too Many, 2013), although the rates have declined. In addition to curtailing male circumcision practices that are detrimental to the boy child, the boys should be able to make an informed choice to get circumcised. Ethical considerations should, therefore, be taken into account with the non-circumcision communities, such as obtaining assent from the boys and consent from parents and guardians making. Since culture is continuous, people can change behaviours with an understanding of harmful practices and the harmful practices can be abolished without sacrificing the meaningful aspect of the ritual (WHO, 1997).

The findings show that initiates in the Kikuyu community may be involved in risk compensation after circumcision and before the complete healing of the wound. The

initiates' notion that with circumcision one cannot get infected with HIV undermines efforts by young men to engage in protective sex. risk compensation may increase the risk of HIV infection of the newly circumcised adults undermining the benefits of VMMC programmes (Rennie *et al.*, 2007). Dissemination of information on VMMC programmes should integrate cultural practices in order to accommodate both the circumcising and non-circumcision groups. In addition, the information should be clearly communicated and disseminated widely to avoid misinformation that may misguide actions of those excluded from the VMMC programmes. However, attempts by the government to regulate male circumcision practices among the circumcising groups may be considered an intrusion.

Government initiatives in regulating male circumcision practices can be enhanced through mobilising and engaging in dialogues with community representatives especially the women and church leaders. The findings show that women advocated for church circumcision because the church did away with wiping the soot, culture of pain and institutional bullying. Women should be targeted in the dialogues since they are likely to influence changes in the whole family. In addition, the findings show that it was the women who decide where the boys are to be circumcised. Women emerged as agents of change in the ritual and were discussed as active participants involved in the promotion of VMMC in Kenya. Women can help to advocate for circumcision practices that are safe and devoid of any form of violence among the Kikuyu people and other circumcising communities. Since the church is depicted in the findings as a driver of change in the male circumcision, a collaboration of the churches and FBO leaders in regulation of the male circumcision programme may be worthwhile.

The findings show that the mentors play a central role in influencing young men's behaviour and most of the initiates' experiences. The initiates are also likely to hold

them as their role model. Based on the findings from this study, the role of mentors requires revision in line with the changes in the Kikuyu circumcision ritual especially in the teaching given, the bullying and the culture of pain they promote.

In addition, mentors should be trained in public health knowledge prior to mentoring the initiates while taking into account the cultural practices beneficial to the ritual such as a voluntary road license. The findings suggest that the mentors trained through the Department of Health taught initiates at home and in churches. Mentors can also be involved in VMMC programmes to reach the circumcising communities for greater achievements in male circumcision as part of the HIV prevention strategy.

10.4.2. Provision of sexual education

Comprehensive school based sex education that involves the community has been suggested effective in changing behaviour in middle income countries (Fonner *et al.*, 2014). The study shows that Kenyan schools are already running HIV education programmes but sexual education is not implicitly taught by teachers who are described as shy and lacking the methods that fit sexual education best. In addition, the findings show that parents are shy to discuss male circumcision with their sons prior to circumcision. Although the church provides sexual education for the initiates it excludes any mention of the use of condoms and emphasises abstinence for the young people. Those circumcised at home receive instructions from mentors on wiping the soot without condoms posing a risk to HIV infections. Sexual education should be availed to young people in primary school before they encounter misinformation and any other sexual education from the other young men. The boys get circumcised after class eight and the findings show that some are already sexually active prior to circumcision. According to Wanyonyi (2014), sexual education is only directed to the Form Four students excluding the primary school students. However, most of the young men are introduced by the mentors into the world of sex after circumcision. Thus, sexual education would be more beneficial to young people before class eight. Parents and teachers should be given skills and information to enhance their communication skills on sexual matters. In addition, exploration of the use of elderly people in the community to talk to the young people

rather than parents including mothers who were reported shy and unable to communicate sexual matters is recommended (Biddlecom *et al.*, 2009; Fuglesang, 1997). This may also be more appealing within the cultural norms, which make sexual discussions with parents and teachers a taboo but not for the elderly. This would, however, require that the elderly are trained in public health messages associated with male circumcision practice, due to the changes in the public health environment that they may not be acquainted with. Although this study was about young men, the issue of girls emerged especially in wiping the soot.

10.5. Strengths and limitations

The field research I conducted in 2009-2010 with the initiates during the circumcision season guided me in the choice of the research methods to use. Previous focus groups and in-depth interviews in the churches proved unsuccessful in eliciting responses from the initiates. In focus group discussions some of the initiates did not contribute while two or three initiates dominated the discussion. I sensed shyness and embarrassment from the initiates in the discussion of male circumcision practices. Anonymously written narratives were used in this study since they eliminated the need for initiates to talk in the presence of others initiates and the researcher. In addition, two male students wrote of being under oath not to disclose information on male circumcision. The anonymous narrative method may have given them the confidence to disclose the practices in male circumcision.

Nevertheless, there were limitations in that some of the emerging issues in the narratives required probing, which was not possible as in focus group discussions or in-depth interviews. However, the method elicited rich data compared to previous research I conducted in the past. In addition, triangulation of research methods was employed with narrative writing taking place first and emerging issues discussed with mentors in the in-depth interviews. The in-depth interviews with mentors clarified issues and meaning of terms that emerged in the narrative writing. Additional data collected from the two elderly men also allowed comparison of practices running through Kirika's, Njukis and young men's time and further clarified

the pre-knowledge that informed my research and issues raised by male students and mentors.

I was an insider in this study since I speak the local language of Kikuyu people which was crucial as this eliminated the need for a translator. Most of the mentors spoke in Kikuyu and eliminated the feeling of inadequacies related to illiteracy. I understand the general culture, local values, and taboos of the Kikuyu people which eased access, entry and relationships with community members as I knew how to approach the different participants, which may have otherwise taken some time to learn and negotiate my way through during the research. I was, on the other hand, limited in that I am an outsider in the topic of study, which is considered a male arena. I became aware after the narrative writing that some of the men had taken an oath not to disclose information on circumcision, which creates uncertainty whether there was full disclosure of information during the interviews. I endeavoured to be personal, humane and kind while being professional and ethical at the same time. Being friendly, building trust, provides a comfortable setting for research participants (Blodget *et al.*, 2005) while researchers who are otherwise impersonal, and detached from the participants are likely to encounter resistance (Roth, 2005). The question of whether some of the mentors were not able to disclose some of the information because of my outsider's position remains unanswered. However, having pre-knowledge of the male circumcision practice allowed me to probe on issues that had not been described in the participants' response.

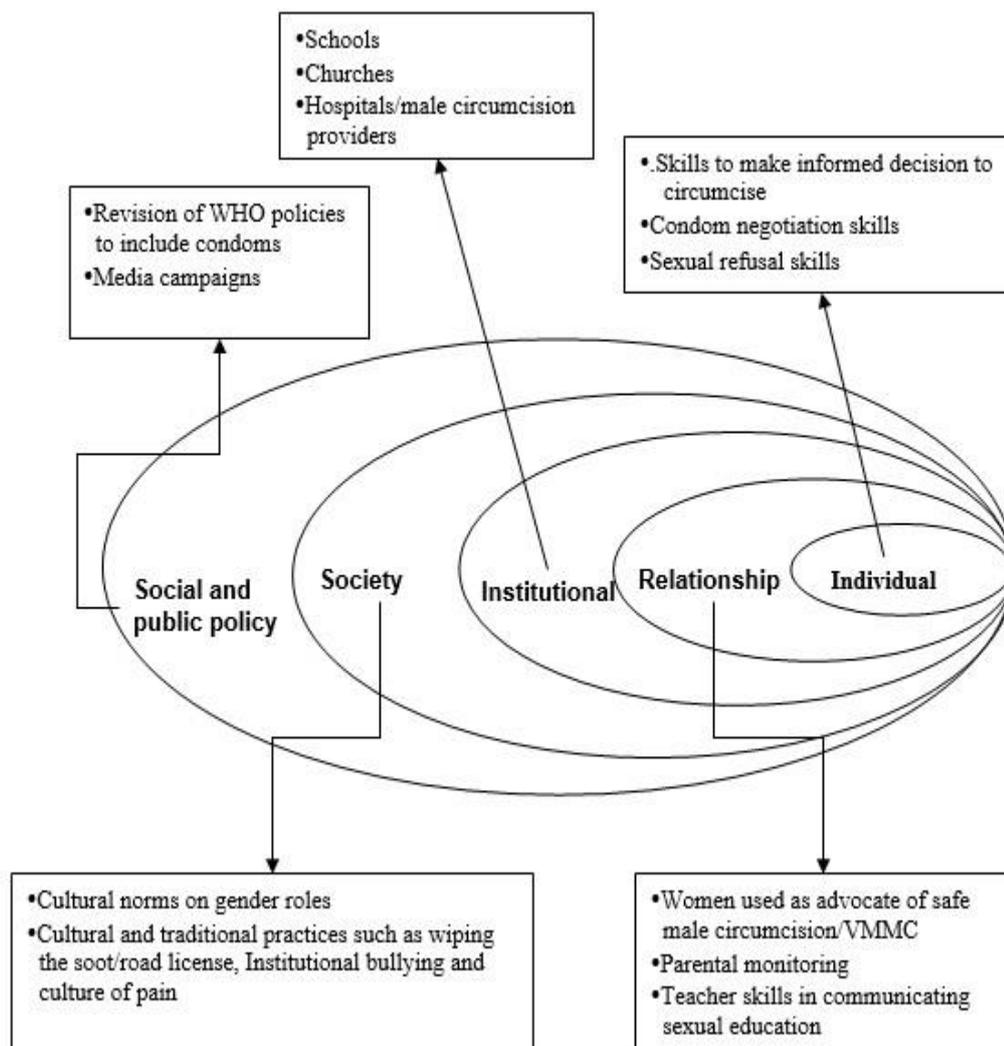
Being a qualitative study, it is not possible to generalise the findings to others studies, although it is possible to transfer the findings to other settings. Common in most qualitative research the study participants were few limiting the representativeness of the study as in snow ball sampling. However, this allowed for in-depth descriptions of individuals' experiences in the male circumcision ritual. Replication of similar findings using similar methods in a similar context is possible. In addition, the research highlights young men's sexual context in a rite of passage that encourages sex after circumcision which could be applied in other communities with similar practices. This is significant in Kenya, which is a multiethnic country and has almost all ethnic groups practicing male circumcision apart from the Luo ethnic

group and would probably be applicable in an African context amongst the traditional circumcising groups.

10.5.1. Social Ecological Model

The Socio Ecological Model (SEM) was used to highlight different levels of varying contextual factors that may influence individual behaviour in chapter three. Due to its descriptive nature, SEM could not be used in the interpretation of findings in this study. In addition, there is a paucity of literature on the application of SEM (DiClemente *et al.*, 2007). However, SEM can provide an ecological approach for interventions that focus not only on the individual but on the contextual factors that may influence the young men during the male circumcision ritual. Figure 10.1 below outlines factors and actors that emerged in the findings and are likely to influence the initiates' and young men's actions. These factors and actors are recommended for inclusion in interventions that would improve the health of the young men. However, designing an Intervention was not an objective of this study. Based on the core tenet of SEM, none of the levels should operate in isolation and, thus, a successful intervention requires a design that takes into account all or most of the levels in the ecological model.

Figure 10.1. Factors and actors recommended for inclusion in an intervention programme



10.6. Gaps in research

The study has identified the following research gaps that need to be addressed in future studies.

- One of the findings that depicted a major change in the ritual was circumcision and recuperation in the hospital. This was, however, reported by one mentor towards the end of the research. Further research is crucial to understand the role of the hospital in the changing ritual and implications for public health practice and policies. In addition, the Ministry of Health's role in training the mentors warrants further research as this adds another dimension of change to the ritual.
- Kirika and mentor 5 noted forced circumcision during their time. This was not discussed by the young men in this study although the pressure to circumcise was suggested. Further research is needed on the practice of forced circumcision among the Kikuyu young men.
- Traditional male circumcision among the Kikuyu people was not discussed in this study. Circumcision was reported as taking place in the hospital and hospital setting¹⁵. Both medical and traditional male circumcision is practiced among the Bukusu people of Kenya. The existence of traditional male circumcision among the Kikuyu people would necessitate further research.
- Wiping the soot was discussed more from the men's perspectives who were the participants in this study. However, since wiping the soot was reported in heterosexual relationships, the girls' perspective is lacking as this was out of the scope for this study. Girl's perspectives on the wiping of the soot are recommended for future research.
- The findings depict pressure and harassments on the initiates who return from church to comply with the cultural practices excluded in the church organised circumcision. However, the initiates in the church are prepared in advance to expect this pressure but whether they are able to resist these

¹⁵ Make shift hospital is a representation of a hospital for instance, in the church premises a room is set up just like what should be in a hospital and a doctor comes there for the cutting.

demand is unknown. The impact of the church on the young men's behaviour after their return home warrants more investigation.

- Urbanisation as a driver of change in the male circumcision ritual was suggested in the findings. However, this was referred by only one mentor. More information is required to identify changes in the male circumcision ritual that urbanisation is driving.

10.7. Conclusions

The study has shown that the male circumcision ritual among the Kikuyu people has undergone changes that have implications for public health. Women are key agents of change in the male circumcision ritual, especially through the church, which provides space and a place where the changes can take place. Women also used urbanisation to enhance changes in the practices with an aim of protecting the initiates from a culture of endurance of pain and of the male circumcision ritual. The women were depicted to advocate for changes that contrasted with some of the cultural practices in the ritual in the past. The hospital being used as a place where the cutting and recuperation of initiates takes place was a major shift in the male circumcision practices among the Kikuyu people. The male circumcision ritual was also depicted as non-voluntary for the Kikuyu boys because of the pressure and the stigmatization of uncircumcised boys, which has implications for the cultural and human rights of the boys and young men. Some changes were brought about by the young men such as the practice of having sex before the wound is healed or/and without condoms, which may have an impact on HIV prevention contrary to the WHO male circumcision policy's intention. A revision of the WHO policy is suggested to ensure that the impact of male circumcision in the prevention of HIV and AIDS among the circumcising communities is effective. Women should be engaged in advocacy for changes in the male circumcision ritual that are significant to the health of young men through institutions such as hospitals and churches.

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Appendices

Appendix 1. UNICEF campaigns to end violence against children

END violence against children

HOME ABOUT GET INVOLVED IN ACTION FACTS STORIES PARTNERS REPORTS

Findings from Cambodia's
Violence Against Children
Survey 2013

PROTECT OUR CHILDREN CAMBODIA

social f SIGN UP

English Español Português

unicef

Appendix 2.

Appendix 2. Explanatory Statement for the parents/guardians



Explanatory Statement for the parents/guardians

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

Contact: Tel (will supply a Kenyan number)

Email: Kezia.njoroge@northumbria.ac.uk

Professor Paul Mbatia

Department of Sociology Nairobi University

Email: dept-sociology@uonbi.ac.ke

Tel: +254-20-2158549

My name is Kezia Njoroge, a student at Northumbria University, UK. I'm doing a research on Male Circumcision which is a common practice in this region. I am going to give you information and invite you to allow your son who is in Form..... (**Form one or form four**) to be part of this research. You do not have to decide today whether or not you want him to participate in this research. Before you decide, you can talk to anyone you feel comfortable with about the research.

The information given below explains what will happen in the study if you choose to have your son take part in the research. This information will also enable you to decide if you want your son to be in the research. It provides a summary of the information the researcher will discuss with you. If you decide that your son will take part in this study, you will sign a form to confirm your decision. If you sign this form, you will receive a signed copy for your records.

Feel free to take notes, write questions or highlight any part of this form.

- This form explains what would happen if your son joins this research.
- Please read it carefully. Take as much time as you need.
- Please ask the researcher questions about anything that is not clear.
- You can ask questions about the research at any time.
- If you choose not to have your son join the research, it will not affect him in the school in any way
- If you say 'Yes' now, you may still change your mind later.
- You can choose to have your son leave the research at any time.
- Your son will not be penalized in any way if you decide not to have him take part in the research or leave the study later

What is the goal of this study?

A research study is a way to learn information about something. The research focuses on the young men's experiences in male circumcision during healing, immediately after healing and how this relates to their health.

Why is my son selected?

Your son is a young Kikuyu man at the secondary school. His knowledge and experiences of going through male circumcision in the Kikuyu society can contribute a lot to research on the understanding of male circumcision practices and the health of young men.

Is the study voluntary?

The study is voluntary, if you agree to have your son participate in the research now and you change your mind later you can still withdraw your assent. All you have to do is to inform the researcher through the contacts above. If you agree to have your son join the research, your son will also make his decision of whether to participate independently. If he does not want to participate in the research, he can say so without being penalised in any way

How many students will take part in the study?

About 40 male students in form one and form four will take part in this study.

How will my son be contacted?

The researcher will get permission from the head teacher to contact your son if you agree that he should participate in the research. The researcher will meet your son together with all the other students whose parents will agree to have their children participate in the research. This meeting will be in school at the playfield or a class where the researcher will give the information about the research in details. Your son will have a chance to ask questions for further clarifications. He will not have to decide at that moment if he will participate in the research but he could decide later.

What's the duration of the research?

The narrative writing will take 30-60 minutes of your son's time. This will be done out of the school timetable.

If I agree to have my Son join this study, what would he need to do?

If you agree to have your son join the study, your son will also decide independently if he wants to participate. If he does not want to participate in the research, he can say so without being penalised in any way. If your son wants to participate he will be asked to narrate his experience on male circumcision in writing. He will be asked to share very personal and confidential information. He will get some topic guides for the narrative writing. If he feels uncomfortable writing about some of the topics he does not have to write those parts or take part in the narration if he doesn't wish to do so, and that is also fine. He does not have to give any reason for not responding to any topic, or for refusing to participate in the narrative writing.

What are the potential benefits if my child joins this study?

Your son might not benefit directly from this research but he might contribute some knowledge that will help other young men during male circumcision in the future. Your son will not be paid for participating in this research.

Appendix 3.

Appendix 3. Parental/guardian Consent form



PARENTAL/GUARDIAN CONSENT FORM

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

Contact: Tel (will supply a Kenyan number)

Email: Kezia.njoroge@northumbria.ac.uk

Please indicate

Y N

I have read and I understand the Research explanatory Sheet dated

I have had a chance to ask questions which have been answered to my satisfaction.

I agree to have my son.....(name) in form.....(1 or 2)
participate in the research.

I understand that my son does not have to take part in the research. If he does take part
he may withdraw at any time, without giving a reason for the withdrawal.

I understand that it will not be possible to identify my son from the information he will
have given in this research and this information will also be kept confidential.

I understand that any information that may identify him will be removed or replaced with a number or pseudo name.

I understand that the information that my son gives in this research might be used in the future as part of further work on this subject.

I understand that the published information will not be attributed to my son's name or be used to identify him in any way.

I understand that no third party will see the information that my son has given.

I understand that after participation my son will receive a summary of the results of the study.

I understand that my son will not receive any form of payment to participate in the research.

Name of Parent/guardian **Date** **Signature**

Name of Researcher **Date** **Signature**

Statement by the researcher

I have accurately read out the information sheet to the parent/Guardian, and to the best of my ability made sure that they understands the research

I confirm that the parent/Guardian was given an opportunity to ask questions about the research.

All the questions asked by the parent/Guardian have been answered correctly and to the best of my ability.

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

I confirm that the parent/ guardian have read and understood the explanatory statement, and they have agreed that their son may participate in the research

A copy of the consent form has been provided to the parent/Guardian.

Print Name of Researcher _____

Signature of Researcher _____

Date _____

Appendix 4.

APPENDIX 4. Research Information Sheet for the male students



Research Information Sheet for the male students

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Contacts

Researcher: Kezia Njoroge

Contact: Tel (will supply a Kenyan number)

Email: Kezia.njoroge@northumbria.ac.uk

Professor Paul Mbatia

Department of Sociology Nairobi University

Email: dept-sociology@uonbi.ac.ke

Tel: +254-20-2158549

My name is Kezia Njoroge, a student at Northumbria University, UK. I'm doing a research on Male Circumcision which is a common practice in this region. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

Please ask me to stop as we go through the information and I will take time to explain any word or information you do not understand. If you have questions later, you can ask me using the contacts above.

What is the research about?

The research looks at Male circumcision and the effect this has on health in Muranga region. The focus of the research is on the practices; during the healing and immediately after the healing

period, and the changes taking place in male circumcision. The research aims at addressing the sexual health of young men during male circumcision.

Why have I been selected?

You are invited to take part in this research because your experiences and knowledge on male circumcision as young man in the Kikuyu society can contribute a lot to the understanding of young men's health during circumcision.

What I am being asked to do?

You're being asked to participate in a narrative writing of your experience during male circumcision. You will be asked to share very personal and confidential information. If you feel uncomfortable writing about some of the topics, you do not have to write them or take part in the narrative writing if you don't wish to do so, and that is also fine. You do not have to give any reason for not responding to any topic or refusing to take part in the narrative writing.

What happens if I do not want to participate?

Participation is voluntary and only if you want to participate will you be involved in the research. Refusal to participate will not affect you in anyway.

What would happen if I agree and then change your mind?

You do not have to take part in this research if your do not wish to do so, and choosing to participate will not affect you in anyway. You may stop participating in the narration at any time you wish to without giving any reason for this. You may also submit a blank sheet of paper if you change your mind during the narrative writing if you do not want anyone to know that you did not participate.

What's the duration of the study?

The narrative writing will take 30-60 minutes to write. The narrative writing will be done outside the school hours.

How will the data be collected?

You will narrate your experience of male circumcision in writing. This will take place in the classroom. You will get some guiding questions for the narrative writing. If you do not wish to answer any of the questions in the narrative, you can skip that part and move to next guiding questions. There will be no school staff in the class during the narrative writing but the researcher and your classmates who will participate in the narrative writing will be in the classroom. You will not write your name, but you will write your age and class during the narrative writing. The narratives will be kept private and confidential as it will not be shared to a third party.

What are the benefits if I participate in the study?

There will be no payment or any direct benefit to you, but your participation is likely to help the researcher find out more on male circumcision practices that may be important in the health of young men.

How will the confidentiality and be maintained?

If you choose to participate, other people in the community/school may ask you questions about the research. The researcher will not be sharing information about you to anyone else in the community. The information that you give in this research will be kept private and confidential and will not be shared to a third party. A study number will be assigned to your name. Only the researcher will know what your number is and that information will be locked up in a safe drawer. The list with the link that connects your number to my name will be stored safely in secured computer files.

What will happen to the data that is gathered?

The information that you will give in this research will not be shared with anybody outside the research, and none of this information will be attributed to your name. Any information that could identify you will be removed and replaced with pseudo names (a given name that is different from your original name. Hard copy records such as paper documents, signed forms, tape recordings, and storage disks will be stored in locked drawers. If the information is to be held longer it may be sent to the University storage provider after the completion of project where it is also locked for three years before it is destroyed. The recordings will be destroyed after the analysis and writing of a report that will be made available to the public.

How will the research report be shared?

The summary of the results of this research will be shared with you before it is made available to the public. Each participant will receive a summary of the results. The results will be published in the future and made available to the public so that other interested people may learn from the research.

Who do I contact if I want to ask more questions about the study?

If you have any questions, you can ask now or later. If you wish to ask questions later or need further clarifications, please use the contacts above.

Appendix 5.

APPENDIX 5. Male students' assent form



MALE STUDENTS' ASSENT FORM

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

Contact: Tel (will supply a Kenyan number)

Email: Kezia.njoroge@northumbria.ac.uk

	Please indicate	
	Y	N
I have read and I understand the Research Information Sheet dated _____	<input type="checkbox"/>	<input type="checkbox"/>
I have had a chance to ask questions which have been answered to my satisfaction.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I do not have to take part in the research. If I do take part I may withdraw at any time, without giving a reason for the withdrawal.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that it will not be possible to identify me from the information I have given in this research and this information will also be kept confidential.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that the information that I give in this research might be used in the future as part of further work on this subject.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that the information published in the future will not be attributed to name	<input type="checkbox"/>	<input type="checkbox"/>

or be used to identify me.

I understand that no third persons will have the information I have given and any

information that may identify me will be removed or replaced with a number.

I understand that I will not receive any form of payment to participate in the research.

I understand that after participation I will receive a summary of the results of the study.

Date

Signature

Name of Researcher

Date

Signature

Statement by the researcher

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the study

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving participating and has assentedn freely and voluntarily.

I confirm that the parent/ guardian have read and understood the explanatory statement, and they have agreed that their son may participate in the research

Appendix 6.

APPENDIX 6. Research Information Sheet for the MC mentor



Research Information Sheet for the MC mentor

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

Contact: Tel (will supply a Kenyan number)

Email: Kezia.njoroge@northumbria.ac.uk

Professor Paul Mbatia

Department of Sociology Nairobi University

Email: dept-sociology@uonbi.ac.ke

Tel: +254-20-2158549

My name is Kezia Njoroge, a student at Northumbria University, UK. I'm doing a research on Male Circumcision which is a common practice in this region. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

Please ask me to stop as we go through the information and I will take time to explain any word or information you do not understand. If you have questions later, you can ask me

What is the research about?

The research looks at Male circumcision and the effect this has on health in Muranga region. The focus of the research is on the practices; during the healing and immediately after the healing period, the changes taking place in male circumcision and the role of mentors in male circumcision. The research aims at addressing the sexual health of young men during male circumcision.

Why I'm a being selected

You are being invited to take part in this research because of your experiences and knowledge on male circumcision as a young man in the Kikuyu society, and male circumcision mentors can contribute a lot to the understanding and knowledge on male circumcision practices and the effects on health.

What I am being asked to do?

You are being asked to participate in an interview on male circumcision voluntarily. You will be asked to share some personal and confidential information. If you feel uncomfortable talking about some of the topics, you do not have to answer any question or take part in the interview if you don't wish to do so, and that is also fine. You do not have to give any reason for not responding to any question, or for refusing to take part in the interview.

"What happens if I do not want to participate?

Participation is voluntary and only if you want to participate will you be involved in the research.

What would happen if I agree and then change your mind?

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect you in anyway. You may stop participating in the interview at any time that you wish without giving any reason for this. You will get an opportunity at the end of the interview to review your discussions and comments, and you could ask to modify or remove portions of the interview. You can ask to have portions or your interview deleted at any time. It will however not be possible to identify information that you have given once data is analysed (examined and interpreted) so at that time the information you have given cannot be deleted.

What's the Duration of the study?

The interview will take 30-45 minutes. You will meet with the researcher at least two times prior to the interview. You will not have to decide whether to participate on the first day but you can decide this later.

How will the data be collected?

The interview will be tape recorded but all the information will be kept private. During the interview, you will sit down with the researcher in a comfortable place in the Faith Based Organisation facilities or school. If you do not wish to answer any of the questions during the interview, you may say so and the researcher will move on to the next question. No one else but the researcher will be present unless you would like someone else to be there. The information recorded is private and will not be accessed by a third party.

What are the benefits if I participate?

There will be no payment or any direct benefit to you, but your participation is likely to help find out more on practices in male circumcision that may have effect on health.

How will the privacy and confidentiality be maintained?

If you choose to participate, other people in the community may ask you questions about the research. The researcher will not be sharing information about you to anyone else in the community. The information that you give in this research will be kept private and confidential. A study number will be assigned to your name and any other information that may identify you will be removed and replaced with pseudo names. Only the researcher will know what your number is and that information will be locked up in a safe drawer. The list that would link the number to your name will be kept separately and in secured computer files. This information will not be shared with a third party.

What will happen to the data that is gathered?

The data gathered will only be used for the research purposes and information used will not be attributed to your name. The knowledge that the researcher gets from this research will be shared with you before it is made available to the public. Each participant will receive a summary of the results. Hard copy records such as paper documents, signed forms, tape recordings, and storage disks will be stored in locked drawers. If the information is to be held longer after the project completion, it may be sent to the University storage provider where it is also locked. The tape recordings will be destroyed after the analysis and writing reports for public.

How will the research report be shared?

The results will be published in the future so that it is available to the public so that other interested people may learn from the research. However, the results published will not be attributed to your name or identify you in any way.

Who do I contact if I want to ask more questions about the study?

If you have any questions, you can ask now or later. If you wish to ask questions later or need further clarifications, please use the contacts above.

Appendix 7.

APPENDIX 7. MALE CIRCUMCISION MENTORS CONSENT FORM



MALE CIRCUMCISION MENTORS CONSENT FORM

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

Contact: Tel (will supply a Kenyan number)

Email: Kezia.njoroge@northumbria.ac.uk

Please indicate

Y N

I have read and I understand the Information Sheet dated _____

I have had a chance to ask questions which have been answered to my satisfaction.

I understand that I do not have to take part. If I do take part I may withdraw at any time, without giving a reason for withdrawing.

I agree to participate in the interview which will be tape recorded.

I give the researcher permission to use this information for further analysis.

I understand that it will not be possible to identify me from the information I have given in this study and this information will also be kept private and confidential.

I understand that the information I have given in this study may be used in the future as part of further work on this subject. But the information used will still not identify me.

I understand that no third persons will have the information I have given and any information that may identify me will be removed or replaced with names that are not real.

I understand that I will not receive any form of payment to participate in the research.

I would like to receive a summary of the results of the study.

Name of Participant Date Signature

Name of Researcher Date Signature

Statement by the researcher

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the study

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of the consent form has been provided to the participant.

Print Name of Researcher _____

Signature of Researcher _____

Date _____

CONTACT DETAILS FOR SUMMARY OF RESULTS

I would prefer to receive the results by (please tick one):

Post

Email

Postal address:
.....
.....

Email:

Appendix 8.

Indepth Interview Protocol



Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

Guiding questions

1. Please could you describe the organisation of male circumcision practice in this area?
2. What is the importance of male circumcision in this society?
3. If you think back to when you were circumcised, what is your opinion of male circumcision today?
4. Would you please share your experience as a male circumcision mentor from the beginning to date? How did it start? What led to it? Is it the boy himself or the parents who contacts you?
5. What is your role as a male circumcision mentor? (follow up question if this was not explained in the question raised earlier)
6. Could you say something more about the male circumcision mentors in the male circumcision ritual? (probing)

Probes

What does that mean to you? What else?

Help me understand....

Closing Questions

Is there anything more you would like to add? Thanks very much for your time.

Appendix 9.

Narrative Writing Guide A

Narrative Writing guide for Male Students A



Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

The students will not have to answer the questions in this order and they have the freedom to skip any question in the narrative writing

Guiding questions

7. Where you were circumcised (home, hospital, Church, other place not mentioned),
8. Why you were circumcised at the venue you mentioned above?
9. Please describe your experience of going through circumcision from the day of circumcision through healing and after healing
 - Did you have a mentor? Who chose the mentor and why
 - What was the purpose of the mentor and what did he do?
 - What was your routine from morning to evening of each day of the healing period
 - What did you learn?
 - Are there learning experiences that you would like to pass over to others which ones and why
 - Are there learning experiences you would not want others to go through (which ones and why?)
 - Were there learning experiences that were not voluntary (thing you did because you had to do them). Which ones? Why did you not want to do them?

Thanks very much for your time.

Appendix 10.

Narrative Writing guide for Male Students B



Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Researcher: Kezia Njoroge

The students will not have to answer the questions in this order and they have the freedom to skip any question in the narrative writing

Topic: Male Circumcision and the Shaping of Masculinities: Implications for public health

Please narrate (write a story of your experiences in male circumcision) for example, At what age were you circumcised? Where were you circumcised (home, hospital, church or any other place)? Why did you choose this venue of circumcision? Where did you stay during the healing period or after circumcision? How different was the place/house you stayed during circumcision from the place/ house you lived in before you were circumcised? Did you have a counsellor (mutiiri)? Who choose your counsellor (mutiiri)? Why? Which qualities did you consider when choosing a counsellor (mutiiri)? What was his role (work)? What did he do for you? How did you spend your day during the healing period or what was your routine like each day? Please write on any visitation you received from other men during the healing period? What advice did they give you? Please write on any advice given on sexual matters? Were you harassed or tortured? How and in which ways? Why? What specific male circumcision rituals were performed on you during the healing period? What was the meaning of this ritual? Are you aware of the term road license or Murangano? Please write your experience of road license/Murangano? Did you participate in it? Were you forced? Why? Are you aware of the term “kuhurwo mbiro” Please explain your experience of “kuhurwo mbiro?” did you participate in it? Were you forced? Why? Did you use condoms? Why?

Appendix 11.

Appendix 11. Sample of a written narrative

Form 1 14 years

I was circumcised at home when I was 13 years old. I choose this venue because our Agikuyu tribe started this a long time ago. During the healing period, I was at the house. This is different from where I was staying because of becoming an adult you must stay separately from your parents' house. I chose a counsellor who was a friend with good characters. He was a teacher and protected me during healing. I would spend in my house watching movies. They told me not to be afraid of anything, anybody and to have good manners. He advised me to be a good player of sexual matters, be telling my girl lover about sex, and do anything I want with her. I was not harassed in any way. Some people asked me for murangano (road license) and if I had anything I gave them. I participated in it. I was not forced to give murangano because those people were my friends. I participated in kuhurwo mbiro. I was not forced.

Form 4 age 19

I was circumcised at age 18 years and I was circumcised at the hospital because it was a good place for this and doctors are qualified for this rites of passage. I had to go home after the operation where the parents can take care of mine. In home, it was different from hospital because I managed to be taught by a mentor how to move from childhood to adulthood.

I managed to choose my counsellor for mine before I went for the operations because he was a role model person. His qualities were that he was a disciplined person loving and caring. He washes clothes for me and even cleaning the house and others. In each day I was feeling tired for being kept in the home for three weeks where I had started feeling well, the other men were giving me hope that those are the steps of a true man. The harassing was there because after healing my wound, other men ask me for murangano. I participated in because I had nothing to do and I didn't participate in kuhurwo mbiro (wiping of the soot). I refused because I was a Christian.

Appendix 12. Not Men Enough to Rule! Politicisation of ethnicities and forcible circumcision of the Luo men during the post election violence in Kenya

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'Not men enough to rule!': politicization of ethnicities and forcible circumcision of Luo men during the postelection violence in Kenya

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Background. As a contribution to ongoing research addressing sexual violence in war and conflict situations in the Democratic Republic of Congo, Kenya and Rwanda, this paper argues that the way sexual violence intersects with other markers of identity, including ethnicity and class, is not clearly articulated. Male circumcision has been popularized, as a public health strategy for prevention of HIV transmission, although evidence of its efficacy is disputable and insufficient attention has been given to the social and cultural implications of male circumcision.

Methods. This paper draws from media reporting and the material supporting the prosecutor at the International Criminal Court case against four Kenyans accused of crimes against humanity, to explore the postelection violence, especially forcible male circumcision.

Results. During the postelection violence in Kenya, women were, as in other conflict situations, raped. In addition, men largely from the Luo ethnic group were forcibly circumcised. Male circumcision among the Gikuyu people is a rite of passage, but when forced upon the Luo men, it was also associated with cases of castration and other forms of genital mutilation. The aim appears to have been to humiliate and terrorize not just the individual men, but their entire communities. The paper examines male circumcision and questions why a ritual that has marked a life-course transition for inculcating ethical analysis of the self and others, became a tool of violence against men from an ethnic group where male circumcision is not a cultural practice.

Conclusion. The paper then reviews the persistence and change in the ritual and more specifically, how male circumcision has become, not just a sexual health risk, but, contrary to the emerging health discourse and more significantly, a politicized ethnic tool and a status symbol among the Gikuyu elite. In the view of the way male circumcision was perpetrated in Kenya, we argue it should be considered as sexual violence, with far-reaching consequences for men's physical and mental health.

Keywords: sexual violence; male circumcision; masculinities; negative ethnicity Gikuyu; Luo

Introduction

Sexual violence during the postelection conflict in Kenya shows distinct similarities when compared with sexual violence in the Democratic Republic of Congo and Rwanda in terms of the rape of women. However, the act of forcibly

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circumcising men from an ethnic group that does not have male circumcision as a cultural practice, as occurred in Kenya, presents a hitherto unknown or at least undocumented, form of sexual violence and its health ramifications, therefore, remain largely unknown. The Rome Statute's crimes against humanity provision does not list forced circumcision as a prohibited act (Oosterveld 2011, 331–334), so the International Criminal Court in the Hague categorized forced circumcision under 'other inhuman acts' against two of the four Kenyans accused of having orchestrated the forcible circumcision of Luo men. While forced male circumcision or the way it was perpetrated is indeed an inhuman act, not to categorize it as sexual violence means, as argued by human rights advocacy groups, a failure to take into account the element of force and the purpose for which the crime was committed (IRIN News 2011). According to Corey-Boulet (2011), forced male circumcision was intended as an expression of political and ethnic domination.

Ironically, male circumcision is one of the most important rites of passage, 'the making of men' through which manhood, adulthood and related responsibilities as well as the expectations of masculinity are conferred on to the next generation for many ethnic groups in the region (Ahlberg 1994; Kenyatta 1938; Beidelman 1997; Kitutu 1994). In the case of forced circumcision, the meaning of the ritual was reversed and used to humiliate, traumatize, inflict lasting bodily harm, intimidate and hence emasculate the men in question.

This paper is based on media reporting on the postelection violence as well as material supporting a prosecutor at the International Criminal Court, involved in the case of four Kenyans accused of orchestrating the postelection violence (Mars Group Kenya 2010). This material is linked to published research to explore how a cultural ritual of transition, meant to confer adulthood, manhood and citizenship, that is, therefore a basic element of societal organization, became a political and ethnic tool of violence. The paper thus takes a historical look at the development of Kenya into what Ndegwa (1997) describes as a 'multi-ethnic democracy' and the challenges involved in establishing the electoral process. For any discussion of the ritual of male circumcision, it is also necessary to reflect on the emerging health discourse that has popularized male circumcision as a public health strategy for preventing HIV transmission. This paper seeks to interrogate the meaning of such health promotion discourse in a multicultural context, where male circumcision is a marker of cultural or ethnic identity for some ethnic groups but not for others. Does the promotion of male circumcision enhance existing ethnic stereotypes, stigma or chauvinism? Wafula (2008, 1) notes that:

Although the policy which has been titled: Policy on Male Circumcision in Kenya 2008, recommends that males of all ages will face the cut in line with their cultural values, traditional experts have warned that the stigma among the uncircumcised communities will rise.

The emerging public health discourse

Promotion of male circumcision as a public health strategy for the prevention of HIV transmission has gained momentum in past years. The evident enthusiasm for

implementing male circumcision is based on results from randomized control studies conducted in Kenya (Bailey et al. 2007), Uganda (Gray et al. 2007) and South Africa (Auvert et al. 2005). These studies reported a 50–60% reduction in female–male HIV transmission during a follow-up period of 21–24 months after circumcision (Wamai et al. 2008; Klausner et al. 2008). It is believed that the removal of the foreskin makes the remaining outer layer of skin tougher for HIV to penetrate (Rosen 2007), although there are conflicting views about the role of Langerhans cells in HIV transmission. Green et al. (2008) have argued that Langerhans cells in the foreskin have a protective effect against pathogens while Klausner et al. (2008) argue on the contrary that the langerhans cells are, uniquely vulnerable to HIV. It is also argued that circumcision makes it easier to keep the end of the penis clean, which may be significant, given that the areas where male circumcision is being promoted have poor sanitation and lack adequate water to maintain cleanliness.

Doubts have been expressed regarding the long-term effect of male circumcision as a strategy for the prevention of HIV transmission, arguing that the studies on which the strategy is based were not conclusive (Green et al. 2008). The studies were terminated early and thus had short duration of experimental conditions and perhaps insufficient data for real-world settings. Green et al. (2008), moreover, argue that there is no guarantee that men will abstain from sex before the circumcision wound heals, thereby facilitate HIV transmission. This in turn could reinforce the prevailing tendency to blame women as the carriers of HIV (Green et al. 2008), since the health discourse creates the impression that male circumcision is a secure form of HIV prevention (Wamai et al. 2008). Okwemba (2009), for example, reported how women in Kenya feel vulnerable, since after circumcision, men have sex with multiple partners thinking they are immune to infection.

Bahinyoza (2008) similarly argues that the idea that male circumcision is a form of HIV prevention may encourage unprotected sex among circumcised men. Studies in South Africa indeed show that 30% of circumcised men believed they could have sex with multiple partners without getting infected (Deacon 2008), while in Swaziland it was similarly reported that men, may be interpreting circumcision to mean, they are vaccinated and do not, therefore, need to use condoms (IRIN News 2008). In Kisumu, the main area in Kenya where the policy of male circumcision is implemented, similar observations have been made (Mathew et al. 2010; IRIN News 2012).

From another perspective, studies indicate that HIV incidence and prevalence do not follow patterns of circumcision. Nyanza Province where 48% of men are circumcised has 15% prevalence of HIV, the highest in Kenya. Recent surveys in areas where circumcision is a common cultural practice show that the rate of new HIV infection has steadily increased. In central Kenya where male circumcision is universal, HIV infection increased from 3.7% in 2005, to 4.7% of the population five years later (Kariuki 2010). In the Coast Province where 97% of men are circumcised, HIV prevalence increased from 5.8 to 8.3% of the population from 2003 to 2007 (Okwemba 2009). In Malawi male circumcision has reportedly been hard to sell as a strategy for combating HIV transmission because HIV prevalence is higher in the southern part of the country than the north, even though the south is where male circumcision is more widespread (Tenthani 2010).

Uganda had by the end of 1990s, succeeded in reducing HIV prevalence from 21 to 6% of the population through political will and an openness which supported

changing sexual behavior including increased condom use (Epstein 2007). By 2004, this seems to have changed with the embrace of more restrictive strategies, linked to Uganda's receipt of the US President's Emergency Plan for AIDS Relief (PEPFAR) and associated funding. According to Mawazo (2011), Uganda was the only country among the 34 other countries that received PEPFAR funds that is experiencing an increase in the number of new HIV infections. Booker and Colgan (2004) argue that Uganda was forced to retreat from its openness in dealing with the epidemic as a condition for receiving the PEPFAR funds. From an openness which had been unique in the region, the Ugandan president began to preach virginity, moral conduct and sexual abstinence until marriage as African values (Epstein 2005, 4). While most of the PEPFAR funds went to treatment and care, one billion US dollars was earmarked for HIV prevention through a strategy of promoting abstinence-only-until marriage. Organizations receiving PEPFAR funds had moreover to sign an anti-prostitution oath promising to oppose prostitution. This selective funding or a type of carrot and stick strategy has led to a situation where organizations censure themselves regarding the activities they undertake, for fear of losing funding.

Uganda had to make many changes in order to qualify for PEPFAR funds. Country-wide billboards advertising condoms were taken down. Radio slogans advertising condom brands were replaced with messages from both the Catholic and the Anglican churches about the importance of abstinence and faithfulness within marriage (Epstein 2005, 9). Statistics from the ministry of health indicate that in 2010, 132,500 Ugandans contracted HIV compared to 110,000 people in the previous year, despite the institution of a policy of male circumcision (Mawazo 2011). El-Sadr, Meyer, and Hodder (2010) argue that if consistently used condoms, together with avoidance of promiscuity, can guarantee that a person remains uninfected and circumcision is therefore unnecessary.

Notwithstanding the contradictory evidence observed above, male circumcision has been promoted as a central means of HIV prevention in global public health discourse (Wamai et al. 2008; WHO/UNAIDS 2007). Apart from the false notion and belief that circumcision makes the penis free of infection, the health promotion discourse seems to have taken little account of the meaning of male circumcision as a cultural practice, or the forms in which it persists today and their implication for HIV transmission and violence (Ahlberg et al. 1997). Sidler, Smith, and Rode (2008), for example, highlight the breakdown of sexual socialization of the young people and the erosion of the role that circumcision initiation schools once played. They argue that circumcision is increasingly regarded as a gateway to unprotected sex, rather than a moment to assume responsible sexual behavior (Sidler, Smith, and Rode 2008, 763).

In trying to make sense of the contradictory evidence regarding the promotion of male circumcision as a public health strategy, the condition of postcoloniality, that is a condition or process that has generated a kind of double reality and double consciousness of power with new and old formations at work all at once, is relevant (Mbembe 1992). In an interview with Höller (2005, 3), Mbembe describes postcoloniality as a state of multiple temporalities where Africa is evolving in multiple and overlapping directions simultaneously. A postcolonial perspective should interrogate the present by questioning a fixed sense of the self and historical certainties to allow for exploring avenues through which subjectivities, are constructed, maintained and contested (Chambers 1999). This helps to reposition

the cultural discourse, challenging the representations of cultures in binary forms with essential, unchanging features (Narayan 2000). More significantly, it allows reflection on the specific ways that African systems, including those regulating sexuality, have been changing with the implications of these changes (Ahlberg 1994; Ani 1994). The complexity of cultural systems regulating sexuality should be reflected in health interventions, as part of taking into account the contextual, cultural and structural environment within which individual, as well as community, action and interaction with others, takes place. In the following section, we examine male circumcision among the Gikuyu, including patterns of persistence and change in the ritual and the implications for HIV transmission, ethnic identity and sexual violence. The section underscores some of the reasons why HIV incidence and prevalence does not necessarily follow circumcision patterns and that like previous HIV prevention strategies circumcision has failed to address contextual factors (Airhihenbuwa 2005).

Persistence and change in male circumcision and the *Mungiki* movement

Studies in central Kenya (Ahlberg et al. 1997; Kamau, Bornemann, and Laaser 2006; Kamau 2007) have reported how male circumcision has changed dramatically over time. Male circumcision was a ritual that imparted cultural values, knowledge, and communal moral standing, that is, the spirit of *umundu* (humanness) that recognizes the sovereignty of the human person and was a public moment for education and a demonstration of bravery on the part of the young boys involved. More recently, it seems that genital cutting, which is still universal in the area, has become devoid of the publicly performed educative functions. School boys about to undergo male circumcision, were for example, unsure why they should undergo circumcision (Ahlberg et al. 1997).

Yet, from another perspective, current practices of circumcision are not as devoid of cultural meanings as has been claimed and this is where the challenge for health promotion discourse seems to lie. A good deal of the traditional forms and meanings, for example, transforming a boy from a *kihii* (big uncircumcised boy) to an adult man still persists although after circumcision today, the initiates do not assume the same responsibilities as in the past. Nonetheless, *Kihii* was and continues to be the most derogatory and demeaning term that could be used to refer to a male as it insinuates his being of little value or having no manners. This is captured in a Gikuyu proverb that says *muici na kihii akenaga okiarua* (one who steals with an uncircumcised boy is happy only when he/(it) gets circumcised – because then he is not likely to divulge secrets). The term *kugimara*, or making a *kihii*, an adult man is still used, although the boys are circumcised before the age of 15 when, according to current age definitions, they are considered as children. Teachers in central Kenya reported that male circumcision is discouraged in primary schools because, once circumcised, the boys immediately become men and are difficult to discipline especially by women teachers (Ahlberg et al. 1997). Thus, even though the newly initiated boy is under the care of parents and/or is still in school, the old meaning of assuming adulthood and manhood and the related expectation of the onset of masculinity, nonetheless, applies.

The parents of circumcised boys, for example, still provide a separate room or house – *thingira* or *kiumbu* – where female relatives are not allowed to enter. The

counselor or *Mutiiri* – (a person similar to a God father in Christian baptism) used to be a highly valued man of immense cultural knowledge, was well-known to and chosen by the parents. Today choosing a *mutiiri* is mainly left to the boys, who mostly chose as their counselor, equally young men recently circumcised. The fact that circumcision is still universal has left a heavy burden on the young men who, as indicated further below, have interpreted the ritual of male circumcision in ways that fit their current contexts and realities.

There are a number of old rituals that the boys practice, albeit in adapted form to suit their current realities that are particularly important in terms of HIV transmission, masculinity formation, and sexual violence. In previous studies in central Kenya, it was observed that for a *mutiiri* to be seen to be performing his traditional functions usefully now that boys are mostly circumcised in hospital, under anesthesia, with the wound subsequently bandaged, undressing the wound prior to the time ordained by the doctor is not uncommon (Ahlberg et al. 1997). Parents may then be requested to provide money to buy medicine, known as *suta*, to be applied to the newly exposed wound. Moreover, because hospital circumcision is considered to be painless, pain-inducing practices such as feeding the convalescing initiate with lots of water or tea to make him urinate or getting the penis to erect are performed, all meant to test the bravery of the newly initiated to withstand pain. What these practices mean to the healing process is not well researched, but cases of infection in the penis were reported by health care providers in studies in central Kenya (Ahlberg et al. 1997).

Another ritual is what the boys call ‘buying a road license’ where the newly circumcised boy is expected to offer money or buy cigarettes for those boys who were circumcised earlier. This is a type of secondary initiation that gives the newly circumcised license to freely associate, talk and socialize with girls. Should the newly initiated man fail to conform to his peers’ expectations, violence may result. The final ritual is what is known as *kuhurwo mbiro* (cleaning the soot, a type of metaphor referring to the dark color forming after the healing of the cut that looks like the black soot forming under a pot cooking over an open fire). This is adapted from an older practice where young men and women who had been initiated together and had teasing relationships. The men teased the women on what would happen should they not accept to have sex or if their soot was not dusted before marriage. Since female circumcision is no longer practiced or is practiced secretly as it is outlawed in Kenya, there are no women to tease. Cleaning the soot is now justified as entirely a male practice. Previously, there were many socially instituted checks to prevent premarital penetrative sex which was not permitted. These included participating in *ngwiko* where young men and women initiates formed a *riika* (age group). They could sleep together, explore one another’s bodies, although not allowed to touching genitals and were dressed in a way to prevent this, they still could experience sexual pleasure without penetration. Apart from dressing in a manner, that prevented touching of genitals, many young men and women shared one room, thus discouraging those who may have dared to have full sexual intercourse. In other words, the Gikuyu society had a sexual regime that recognized the sexuality of young people and, unlike the current sexual regime of abstinence-only-until-marriage young people were then allowed to experience sexual pleasure without sexual penetration (Ahlberg 1994). Participation in *ngwiko* was thus a form of inductive moral education similar to that described by Mugambi (1989) where instead of lectures individuals are

presented with concrete situations, which serve as a case for ethical analysis of themselves and others.

In addition to such learning situations, formerly there were other ways of maintaining sexual discipline, including taboos and prohibitions, maintained in part, by the belief that if taboos were broken, this could result in social imbalance, one sign of which was illness or catastrophe in the family or community. Age groups, moreover, put pressure on one another by punishing those they suspected to have broken the rules (Ahlberg 1991, 1994).

Today boys have changed this practice such that they must have the soot cleaned through penetrative sex, soon after circumcision. Since this aspect of the ritual is a type of cleansing, condom use is discouraged (Kamau 2007). The boys argue that the condom is in any case also discouraged by Christian faith-based organizations, prominent in this area and have increasingly become active in the process of circumcision itself and counseling of the boys before and after circumcision. The boys use proverbs and songs for educating one another, but also for putting pressure on the newly circumcised and violence is not uncommon against those who may refuse to conform (Kamau, Bornemann, and Laaser 2006). Male circumcision may have become potential ground for recruiting the newly initiated young men into the *Mungiki* (meaning 'a united people' or 'multitude'), which was implicated in the forcible circumcision of Luo men during the postelection violence.

Mungiki is largely a movement of young men and one of its philosophies is to reinstate female genital cutting which has declined, as a result of which, *Mungiki* argues, society's good values have also declined (Landinfo 2010; Kagwanja 2003). The movement should, however, be understood broadly, in its political, economic and religious contexts including the peripheral position in which many young men find themselves in Kenya today (Wamue 2001). Although made up of young men, *Mungiki* is described by Wamue, as extremely well versed in the Gikuyu customs and language. Kamau, Bornemann, and Laaser (2006) too, note that the young men in their study had extensive and efficient use of language in the form of songs and proverbs both to educate and to put pressure on the newly initiated to conform to the new rituals. In this way, the young men or peers appear to have taken on the role of providing community education to accompany circumcision. However, under the former system, this education took the form of public performance where elderly people in particular danced and could name things in songs that they could not otherwise say in public because they would be considered extremely obscene (Ahlberg 1991).

The philosophy of reclaiming the Gikuyu traditions (Landinfo 2010), by the *Mungiki* appears to be a type of what Mbembe (1992) describes as double reality or what may be termed as cognitively living in an imagined past. As a movement that requires new members, male circumcision appears as reported by Maina (2007), to be a suitable moment and space around which to recruit newly initiated young men into *Mungiki*. While this is one area of our ongoing research, the question still remains as to why male circumcision was used as an ethnic-based tool of violence in a political context. This leads to another question namely how the political and economic developments in Kenya have shaped the *Mungiki* or alternatively how the political elite, has exploited the *Mungiki* movement and the next section addresses these questions. Before examining this, we describe how the *Mungiki* perpetrated forcible circumcision on Luo men.

The *Mungiki* and the forcible circumcision of Luo men

While *Mungiki* is the group implicated in circumcising Luo men forcibly; evidence from the International Criminal Court (ICC) on 15 December 2010, proceedings suggest just how the *Mungiki* attacks were orchestrated by the Gikuyu political elite. The postelection violence took an ethnic outlook, reflecting the political parties which had similarly strong ethnic links (Wanyeki 2008). Violence broke out in many parts of the country when Kibaki, as leader of the Party of National Unity (PNU) was declared the winner of the election. The Rift Valley Province, the ancestral home of the Kalenjin people, the majority of whom belonged to the Orange Democratic Movement (ODM) was the epicenter of violence. The Kalenjin were reportedly vocal on removing what they called the Gikuyu 'settlers' and 'foreigners' from the indigenous Kalenjin land, referred to as uprooting the 'snake.' Nonetheless, the content of the messages from the PNU, the party in power and the ODM in opposition, reflect the historical divisions, the politicization of ethnicities, the particular economic class formation in Kenya and related injustices (Somerville 2011). Evidence emerging from the ICC pre-trial proceedings paints a picture of how the political elite on both sides organized their local groups, mostly young men, for attack. The young Kalenjin groups attacked and evicted the Gikuyu who were considered to be supporters of the PNU from the Rift Valley. In retaliation, the *Mungiki* was mobilized and financed by powerful Gikuyu political leaders, for attacks on communities in Nairobi, Naivasha, and Nakuru that were perceived to be supporters of ODM. This violence led to the death of over 1500 people, the displacement of over 650,000 people while many were sexually assaulted and forcibly circumcised.

According to the ICC prosecutor's supporting material quoted by Oosterveld (2011, 331):

... while some of the rapes and sexual violence may be considered as opportunistic acts facilitated by the general climate of civil unrest and lawlessness, there are however instances of sexual violence encompassing an ethnic dimension and targeting specific ethnic groups.

For example, 'in the night from 30 to 31 December 2007 alone, 38 Luo men were forcibly circumcised and left bleeding to death' (Oosterveld 2011, 332). Forced circumcision was allegedly 'carried out in a crude manner with objects such as broken glass' (Oosterveld 2011, 331). The narrative of one Luo man, reported by Corey-Boulet (2011, 2) illustrates how Luo men were forcibly circumcised:

First, they took off my pants, and they started mocking me because I was wearing only my underwear. And they ripped off my underwear using a *panga* (machete). When the men had pinned me down, the man with the *panga* pulled my foreskin out and started to play with it. He would slice it a little, and then he started mocking me, and then he would slice a little more, and then mock me some more. This cutting lasted for five minutes, and it was the greatest pain I have ever felt in my life. It felt like a million little pins pricking my manhood.

The use of a machete, as described in the quote above, sometimes resulted in genital amputation. Infections arising from such crude operation may never be accounted for, given the poor access to health facilities, or the fear and stigma among men to

report the ordeal. Yet in other cases, families, including children, were forced to watch as the husband and father was being forcibly circumcised. Corey-Boulet (2011, 5) reports of an interview with the wife of a Luo man who was forcibly circumcised:

We were all forced to watch, including the children. They were saying that until all the Luos are circumcised they can't take part in the political process.

The husband according to Corey-Boulet had somehow managed to break free but was chased by a mob for about 200 m to a disused quarry filled with water. The wife said she had a clear view as her husband's genitals were chopped off entirely:

It was at that point that my husband threw himself into the quarry, maybe because he could not take the pain. The body was never recovered. (Corey-Boulet 2011, 5)

Men rather than women were hunted down and forcibly circumcised or had the penis cut or mutilated, sustaining long-lasting, and debilitating injuries (Waki 2008; Human Rights Watch 2008). The International Criminal Court (ICC) prosecutor Adesola Adebeyejo expressed during the hearing of confirmation of charges at Hague that:

Luo men were forcibly circumcised, others castrated in-front of their families in a move meant to degrade and deprive the victims of their dignity. (Kimutai 2011, 1)

The postelection violence needs to be understood in the context of historical developments and especially the real and perceived injustices and the politicization of ethnicities in Kenya.

The politicization of ethnicities and postelection sexual violence

Land ownership and the history of how the Gikuyu people settled in the Rift Valley is central in understanding the postelection violence. The history dates back to the colonial period when the Kenyan Highlands, which had been the home of the Gikuyu, Kalenjin, and Maasai were annexed for European settlement. This annexation and the introduction of the sanctity of title deed at independence meant, according to the Kenya Land Alliance (2004, 3) that those who previously owned land through customary land tenure, lost their land to private registered land holders.

This pattern of privatization of land continued after independence when, rather than resettling the landless poor, a free market principle of 'willing buyer-willing seller' was introduced, to the advantage of the middle-class elite (Kenya Land Alliance 2004). Land was also given away on basis of political favors (Atieno-Odhiambo 2002), in order to cement political alliances. This resulted in a situation where a small group owned large chunks of land, leaving the majority of Kenyans and especially young people, landless and in utter poverty, although some poor landless Gikuyu were settled in the Rift Valley on land that had belonged to the Kalenjin (McGreal 2008). These Gikuyu in the Rift Valley were some of those referred to as 'settlers' or 'foreigners' that the Kalenjin groups removed by force.

Male circumcision too is reported to have gone through a political and class-based metamorphosis. Atieno-Odhiambo (2002) has written a comprehensive history

showing how the Gikuyu and the Luo people were categorized and stereotyped differently by the colonial regime. They were also exposed to different experiences of the colonial rule within which the negative stereotypes of Gikuyu and Luo ethnicities were cemented. Subsequently, during the Kenyatta era, the emerging political elite continued entrenching a process where male circumcision was appropriated to mean somebody of wealth and power, thus further entrenching ethnic chauvinism. By the mid-1960s Kenyatta made his infamous rebuke of Bildad Kaggia, a Gikuyu man who had been jailed together with him by the colonial state. Kenyatta had publicly asked what Kaggia had done for himself, since his release from detention and wondered why he behaved like a *kihii* (Munene 2007). Unlike Kenyatta and some former freedom fighters, Kaggia refused to amass land or wealth for himself. Kenyatta also accused Kaggia of being a traitor to the Gikuyu people for joining the Kenya People's Union Party (KPU), then led by Oginga Odinga, a Luo, and a *kihii* (Munene 2007).

Kenyatta's advice was that those who wanted to get rich should work and get rich, but it appears he did not quite mean work in literal sense, for example, working in one's own farm or business. If this was the meaning, there should be no injustices or room for what Wamwere (2003) calls 'negative ethnicity.' The rebuke of Kaggia for not enriching himself and for acting like an uncircumcised man (*kihii*) and as a traitor to the Gikuyu for supporting a political party led by uncircumcised man implies that male circumcision has become a symbol of ethnicity, political, and economic power.

Interestingly, the *kihii* discourse had been played differently during the struggle for independence. Wamwere (2003) reports that, during that period (1950–1957), the Gikuyu people were told that prominent Luo leaders involved in the Kenyan struggle, were circumcised. The aim then, was to persuade the Gikuyu people, to accept Luo leaders as legitimate. The willingness to portray other groups in emotive terms that are badged by symbols of ethnicity, such as circumcision, thus seems to be motivated by political opportunism.

The media in general (Itumbi 2008), but especially the vernacular local FM radio stations, and the social media were used to orchestrate violence. According to Somerville (2011, 96), the vernacular radio stations such as Kass-FM that broadcasts in the Kalenjin area in the Rift Valley, set a tone of suspicion against those who could be labeled as 'outsiders' and those perceived to be supporters of political opponents. At times the broadcasts related to long-term grievances against a group and in some occasions, they prepared their people to 'defend' themselves and their community. Vernacular radio stations from other areas including Lake Victoria-FM among the Luo, Kameme-FM and Inooro-FM among the Gikuyu, broadcasted messages, to support candidates, and parties from their ethnic groups, while castigating those from other ethnic groups. One of the four Kenyans accused of crimes against humanity was then a vernacular radio journalist.

Some statements in the vernacular radio used, according to Somerville (2011, 91) stereotypes to malign political opponents. Raila Odinga and his Luo supporters were, for example, ridiculed as being mere 'boys.' In a study of the text messages exchanged between mobile phones, one message (Onyango 2008, 10) is particularly informative of the extent to which male circumcision had been politicized and appropriated not just as ethnic, but more significantly as class symbol. The message read:

Do you want to be ruled by a Luo to take us back to joblessness? Safeguard the kingdom. Let us ALL come out and give all the votes to Kibaki so that we are not ruled by an uncircumcised man who will make us wear shorts and plunder all the wealth. It's your vote that will prevent our country from going back to Egypt. May our God bless you. (Onyango 2008, 10)

The accounts above strongly suggest that the postelection violence in December 2007 is the product of the historical developments which strongly segregated the Kenyan society along ethnicity and wealth. It is, therefore, no accident that the violence had an ethnic outlook with the political elite orchestrating it, as is clear from the material supporting the case of the four Kenyans accused of crime against humanity. According to the Waki Report (2008) and Human Rights Watch (2008), as displaced people – mostly the Gikuyu – moved away from Eldoret, which was the epicenter of violence, bringing stories of brutality and atrocities of burning houses, looting, rape, and murder, tensions were heightened among the Gikuyu. The Gikuyu local leaders and elite are reported to have reacted by organizing the *Mungiki* for retaliation (Human Rights Watch 2008).

As already indicated, the aim of the *Mungiki* since the 1980s, was to revive indigenous Gikuyu culture and religion, but also to liberate the Kenyan masses from political oppression and economic exploitation. The group which had been outlawed back in March 2002 has had running battles with the police. Githongo (2000), for example, reports the way the police force has been used to disrupt what he calls *Mungiki* prayer meetings. In such circumstances, their anger is then diverted to other groups. They have, for example, attacked women deemed improperly dressed for wearing trousers which in turn has led to public outcry against them (Nation Reporter 2000). Other aspects of what Kagwanja (2003, 37) describes as the *Mungiki* crusade, for example, against drunkenness, drug addiction, broken families, prostitution, and HIV and AIDS resonate with many including 'its most ardent critics' (see also Frederiksen 2008; Mathangani 2002). From an economic perspective *Mungiki* has been seen as a welfare organization that offers unemployed young men a means of survival and protection especially in slum areas where security is critical (Landinfo 2010). Such protection often involves extortion especially from *matatu* (taxi) drivers who operate a system of public transport and shopkeepers in the rural areas. Such protectionism has been alarming for many, not least because of the *Mungiki's* manner of beheading those who cross them. The government in turn has unleashed extreme violence, including extra-judicial killings of *Mungiki* members (Landinfo 2010), something that has been deemed an abuse of human rights (Maathai 2009). By 2007, *Mungiki* had been driven underground partly by being outlawed as a terrorist and criminal organization, but also by being badly weakened through a violent government campaign where many supposedly *Mungiki* members were killed in a government's attempt to wipe out the *Mungiki*. Kiai (2009) provides a vivid picture of the extra-judicial killings by police, although he concludes that not all the young men who had reportedly been killed were *Mungiki*. They were just poor young people. Kiai (2009) also added that a Kenya Human Rights non-governmental organization had documented how the police had been killing criminals for not properly sharing their loot with the police. According to Oscar Foundation (2008), over 8000 young Kenyan men were executed or tortured to death by police since the banning of *Mungiki* in 2002. The issue of extra-judicial killing of the *Mungiki*

featured in the December 15, 2010 International Criminal Court case and is said to be the issue the *Mungiki* traded over with the Gikuyu politicians, requesting them to stop police killings. Notwithstanding this, the politicians and business elite have, at the same time, recruited and used *Mungiki* to help them settle their own scores against rivals or win election (Githongo 2000). Ruteere (2009, 26) similarly argues that rather than being one organization, *mungiki* has become a discourse, invoked by different groups whether in authority or other criminal gangs to achieve particular ends.

In conclusion, it is the complexity described above of the postelection violence in Kenya and the wider conflict situations in African contexts that need to be understood. People may use the cultural resources they have and the forcible circumcision of the Luo men could be seen to reflect not just a culturally based masculine construct, but one that is also politicized, as per the evidence emerging on the role of the Gikuyu political elite in mobilizing the *Mungiki* who in turn perpetrated forcible circumcision on the Luo ethnic group. The forcible circumcision of men during violent conflict cannot be understood without looking at the way male circumcision has been appropriated for political and economic ends.

There is thus a need for reflection on the institution of male circumcision and its changing forms, but more significantly for how it intersects with political and economic interests. Such reflection is opportune especially given the current political manifestations where the cutting or not cutting of the penis, health benefits aside, has become politicized in ways that make managing ethnic diversity, masculinities, gender, and sexual violence exceedingly complex in Kenya. When thinking of ethnicity and health, a broad array of factors not least political, economic and systems of justice need to be critically addressed. In our view, a policy on male circumcision as a strategy for prevention of HIV transmission should have been based on an understanding of its meanings for those ethnic groups practising the ritual. While circumcision as strategy for HIV prevention does not seem to have influenced rates of HIV infection, how the popularization of male circumcision may enhance ethnic chauvinism and violence is clearly an issue for research.

Key messages

- (1) The paper is about cultural change and in particular how the ritual of male circumcision has changed and assumed new meanings, and politicised in ways that e detrimental to health of men.
- (2) The paper is about how universalised development discourse and practice overlooks contexts and realities.

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Appendix 13. Voices unheard: Youth and sexuality in the wake of HIV prevention in Kenya.

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Voices unheard: Youth and sexuality in the wake of HIV prevention in Kenya

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ABSTRACT

Objective: The aim of the study was to explore the concerns of young people on sexuality in its social contexts in the era of HIV/AIDS in three districts in Kenya.

Study design: Young people in Kajiado, Kirinyaga and Meru Districts were requested to write questions on sexuality and related problems that later formed the basis for discussion in community dialogue meetings with adults. The social ecological conceptual model (SEM) was used to illuminate the contextual factors and actors influencing sexual behaviours among young people.

Results: The study suggests that young people and adults are concerned about honest and open communication on sexuality. Predominant concerns for the young people were love, sexual urge, desires or sexual wellness and condom use. Their questions suggest that young people are sexually active, yet have little knowledge on sexual matters. The results describe a prohibitive silence from adults, an issue reflected in the questions from the school youth.

Conclusion: This study suggests the need to move from seeing sexuality as a problem and focus on sexual wellness and the positive aspects of sexuality. The adult participants suggested that bringing men and women together for reflection and discussion in a participatory mode, transformative learning and change could be achieved. It is vital that the youth and adults have open communication as a foundation for youth to mature into adults. This can be achieved, if interventions including research address multiple contextual factors such as cultural norms, gender differences, as well as communication barriers.

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1. Introduction and background

Sexual behaviour among young people has been a subject of interest in many African countries [1], including Kenya since the advent of HIV and AIDS. Without vaccine, and cure not easily accessible, sexual behaviour change has been the focus in HIV prevention interventions. However, evidence indicates that the interventions have had limited impact on changing sexual behaviour [1]. In 2009, the Nairobi-based Centre for the Study of Young People (CSA) reported 40% of girls and 50% of boys as having had sex before 19 years of age [2]. Infection in young girls was at least twice that of boys with early pregnancy responsible for 13,000 school dropouts annually with about 17% of the girls having had sex before age 15 [3]. The World Health Organisation (WHO) defines adolescents, youth and young people, as those between 10–

19, 10–24 and 15–24 years of age, respectively. In this paper, the terms youth and young people are used to refer to the entire group 10–19 years. We have used the WHO [4], definition of sexuality, which is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Since the emergence of HIV and AIDS in early 1980s, Kenya has increased preventive efforts, gauged by resources invested by the government and external donors. Despite this, many challenges remain. There is lack of comprehensive sexual education although according to the curriculum both primary and secondary schools are expected to run a compulsory lesson on HIV and AIDS once a week [5]. Although introduced to young people early [6], this education has not been implemented in ways that help young people make informed decisions [7]. Efforts to introduce sexual education have been fiercely contested by many especially the religious groups [8]. Moreover, most teachers are reportedly embarrassed, lack training, or are ill-prepared [5]. Sexual education is not promoted either, as is evident from the name “AIDS Education” where the focus is AIDS, the disease, not sexuality.

Other challenges emanate from selective funding by some international donors. Notable here, is the President's Emergency Plan on

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AIDS Relief (PEPFAR) from USA whose funding is mostly through international organisations (mainly from USA) and faith-based organisations, which largely promote sexual abstinence until marriage [9]. Local organisations receiving PEPFAR funds are moreover, forced to vow not to work with prostitution, ignoring that AIDS is a disease that thrives best on poverty and powerlessness [10]. An evaluation report on PEPFAR by the US Institute of Medicine (IOM) criticizes the strict rules that limit how funds are spent [11], and the internal brain drain it promotes where health workers are lured to better-funded programs [12]. Through PEPFAR funds, a youth campaign popularly known as “Tumechill” (a slang word literally meaning, “We have abstained”) was initiated in Kenya. An evaluation of “Tumechill campaign” showed no direct effect on sexual abstinence among youth [13].

Lack of infrastructure to promote comprehensive sexual education, is mentioned as responsible for unsafe sex and unsafe abortions in case of pregnancy, the latter, an attempt to avoid, being condemned as promiscuous [14]. Furthermore, low condom accessibility aggravates the problem. The Kenyan government policy aims at providing contraceptives to all those sexually active. This has not however been a reality for the young people [15], although male condom promotion has been a vital element in HIV prevention [16]. Resistance from religious groups culminated in public burning of condoms in 1996 [8]. Inaccessibility [17], of the female condom, which is more costly and few women are knowledgeable about its use, is also a significant challenge [16]. Even with free male condoms distributed in some centres, young people avoid them for fear of being identified, not to mention that high quality condoms are more expensive and unaffordable for many [17].

Cultural and legal barriers restrict female sexuality by emphasizing virginity and innocence for girls while exonerating knowledgeable boys [16]. However, with industrialization and urbanization young people continue to experience confusion due to conflicting values and norms [14]. What United Nations Children’s Fund (UNICEF) et al. [18] say, that the young people are forgotten in the HIV and AIDS epidemiological surveillance in the African region seems true, although young people are more likely to adopt and maintain safe sexual behaviour, if knowledge is properly imparted [18]. It is therefore imperative to have a critical reflection on concerns expressed by young people. In doing so, we find the social ecology conceptual model (SEM) of behavioural change, articulated by McLeroy and colleagues [19], relevant as a framework for understanding the context within which sexual behaviour change is expected among young people. For McLeroy and colleagues [19], SEM is a health promotion model, which focuses attention to both the individual and the social environmental factors as targets for health promotion interventions. The SEM model below (see Fig. 1) illuminates the complex interaction of social contexts and actors comprising of intra- and inter-relationships, institutions or organisations, community, social and public policy levels.

The aim of the study was to explore the concerns of young people on sexuality in its social contexts in the era of HIV/AIDS in three districts in Kenya.

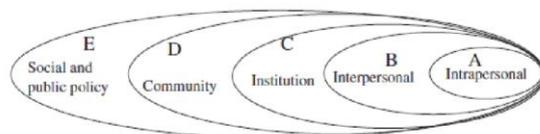


Fig. 1. A social ecological model for health promotion [19].

2. Methodological issues

2.1. Setting and participants

The study sites were in Kajiado, Kirinyaga and Meru Districts of Kenya. These three districts represent ethnic groups with varying cultural practices with implication for HIV and AIDS [20]. People from Meru and Kirinyaga are agriculturalists while the Maasai from Kajiado are pastoralists and nomadic. A study carried out in Kirinyaga found young people having premarital sex, yet avoiding HIV testing [21]. Among the Maasai, male circumcision ritual enhances a belief that a circumcised man does not need condoms [22]. In addition, sexual initiation among prepubescent girls by one or more young men of her choice, wife sharing and early marriage of young girls to older men are cultural practices that could promote HIV infection [22]. The Meru people are known for role modeling, male sexual prowess and female submissiveness [20], attributes which could increase vulnerability of the young people to HIV and AIDS.

This study has two groups of participants. The first comprised of 290 school youth (135 boys, 155 girls), 11–18 years old from 19 secondary, and 31 primary schools. Schools were, randomly selected from mixed or single-sex boarding or mixed-day schools in rural and peri-urban areas. The second included a broad range of about 250 adults/community members; teachers, parents and health workers participating in eight community dialogue meetings each comprising of 20–30 participants.

2.2. Data collection

Data were collected in two phases by the Social Science and Medicine Africa Network (SOMANET), a research and development NGO funded then by Sida/SAREC. In the first phase, the school youth wrote questions on sexuality, adolescence and related problems or those questions they could not ask their parents or teachers for fear or shame. To increase freedom of expression, they could use a language of their choice; ask questions anonymously, but included age and gender. Moreover, teachers left the classrooms, to minimise the feeling of intimidation among the pupils.

The second phase included eight dialogue meetings (three in Meru, three in Kajiado and two in Kirinyaga) with parents and other community members. The community dialogue meetings lasted for 45–60 min. Questions from the youth were grouped into topics including sexual relationships, condom use, Sexually Transmitted Infections, HIV and AIDS, physical growth and development, menstruation, pregnancy, abortion, marriage, circumcision and drug use that formed the topic guide for the discussion in dialogue meetings. The second and third authors moderated the community dialogue sessions which were tape-recorded except for two held in the open where detailed notes were taken. Questions from the school youth were mainly used to start a discussion, but whenever other issues emerged, the moderator followed up by rephrasing and probing for further information. Since the questions indicated that the young people had little knowledge as well as wrong information on sexuality, personal stories and experiences regarding communication with the youth on matters of sexuality were shared. Since dialogue with the community members was based on the questions generated from the school youth, this was a type of feedback to enhance participatory action learning. The assumption had been that the questions would help community members reflect on their silences and denials and raise awareness of their own perceptions and actions as basis for action to improve sexual health among the youth. The discussions were lively, but participants were surprised by questions from the school youth, which was a type of critical reflection on the self.

2.3. Data analysis

The analysis was in three phases. The two datasets were first analysed separately and later related to each other.

The first phase constituted the analysis of questions from the youth on sexuality and condom use, using qualitative content analysis inspired by Graneheim and Lundman [23]. This analysis involved reading all and identifying those questions related to sexuality and condoms use, which is the main focus in this paper. All identified questions were analysed separately and later condensed; shortened without losing meaning. These condensed questions were further shortened into codes, which were grouped into subcategories and categories based on similarities in content. To enable a comparison of gender differences in the ways questions on sexuality and condom use were asked all questions were sorted based on whether written by boy or girl.

The second phase involved the analysis of the data from dialogue meetings using thematic analysis according to Aronson [24]. All parts of conversations in the meetings that mentioned or implied youth's sexuality and condom use were identified and described.

In the third phase, the results from the youth's questions and community dialogues were compared, contrasted and described. See Table 1.

2.4. Ethical approval

Ethical permission had been granted to SOMANET in Kenya. SOMANET contacted the school heads in the participating schools, who in turn communicated with parents through the Parent Teachers Association (PTA) that all parents belong to by the virtue of having children in a school. The parental consent was given through the PTA and the school heads. Anyone below 18 years of age is regarded as a child in Kenya and cannot participate without a parental consent. Furthermore, indirect questioning and anonymity was an ethical consideration.

Table 1
A sample of the coding process of the youth questions leading to the category "Sexual wellness".

Questions	Codes	Subcategories
How can you prevent having a lover at an early age? I want to leave school because of a boy I love very much [14 yr girl]	Uncontrollable love	
"What should one do: to overcome sexual feelings and urges?" [13 yr boy], "When feeling horny?" [14 yr boy]	Sexual urge and feelings	Love, sexual urge, feelings and emotions
How can I stop thinking about boys all the time and concentrate in class how can we control our emotions when maturing?" [17 yr girl]	Emotions	Sexual wellness
If a boy I love very much and who is good company is pressuring me to have sex with him and "I don't want to lose him, what should I do? He promised to use a condom" [15 yr girl]	Pressure for sex	Pressure
How can one live without sex yet it tastes (feels) so good and was created by God? [15 yr boy]	Desire for sex	Desire

3. Results

The two categories: 'Sexual wellness' and 'Condom use and safety' are presented below. In each category, the concerns of the youth are described and are followed with conversations from the adults participating in the community dialogues to highlight how the concerns of the youth reflect adults' perspectives and discourses on sexuality.

3.1. Sexual wellness

The youth expressed concern over love, sexual feelings and sexual desires or the positive aspects of sexuality, which is what we refer to in this paper as sexual wellness. In addition, the youth were also concerned with the pressure on them especially from peers to have sex.

3.1.1. Love and sexual urge, feelings and emotions

The questions asked give the impression that; to many youth, love and sexual urge are uncontrollable. They express what they feel, but seem unsure of what is going on in their bodies or what to do about it. They wonder why they are, expected even advised to abstain from sexual intercourse before marriage by the adults.

- "How can you prevent having a lover at an early age? I want to leave school because of a boy I love very much." [14 yr girl]
- "When a girl has AIDS and I love her, what can I do to avoid such love?" [15 yr boy]
- "What should one do: to overcome sexual feelings and urges?" [13 yr boy], "When feeling horny?" [14 yr boy]
- "Is there any drug that can be taken to control sexual feelings in boys and girls?" [16 yr boy]
- "How can I stop thinking about boys all the time and concentrate in class how can we control our emotions when maturing?" [17 yr girl]

Sexual urge and desire is a common concern even among adults and, they too seem not to know what to do about it. The conversation below suggests how community members reason around marriage as the boundary for sexual activity. Furthermore, the ways the statements are phrased seem to indicate that women in particular are also telling about the recklessness of the men.

Woman A: All these men here have like ... 10 children each. If there is an injection, which can ... stop sexual urge we want it (Laughter).

Moderator: That is a good suggestion but there is no such medicine.

Woman B: At least the old men's sexual urge has gone down, but for the youth the blood is on fire. What can we do for them since they do not have spouses? [K1]

3.1.2. Desire

Questions raised by the boys seemed to focus on their need for sex. In addition, there is an impression that the boys wanted sex also to boast about and therefore appear tough among other boys, a norm that seem to be upheld in the society.

- "Why do boys boast to each other that they have had sex with a particular girl and then those other boys go to this girl to ask her for sex?" [15 yr girl]
- "How can one live without sex yet it tastes (feels) so good and was created by God?" [15 yr boy]

"Is it bad to have one girl for playing sex with and another one for true relationship?" [14 yr boy]

3.1.3. Pressure

Apart from the sexual urge and desire experienced by the young people, there is also the concern on how to achieve it in a context where there is silence. Questions raised by girls indicate that friends, partners and even relatives sometimes put pressure on them to have sex.

"If a boy I love very much and who is good company is pressuring me to have sex with him and "I don't want to lose him, what should I do?" "He promised to use a condom." [15 yr girl]

"All my friends are engaged in sex, they tell me to try it because it is enjoyable and that it can make me mature like them, Should I try it?" [15 yr girl]

"Sometimes some of my friends laugh at me and say that if I don't have sex at this age, when I reach marriage age it will be difficult and painful. They also say it will be difficult and painful during childbirth. Is this true?" [14 yr girl, 15 yr girl]

Lack of openness in communication on sexuality among adults and the ways they address the concerns of the youth, is reflected in the questions above. The conversation below also suggests that their communication is in a prohibitive form that seems to burden the girls while neglecting the boys. Fear of pregnancy is instilled mostly on girls, the aim being to scare them to avoid becoming "school-dropouts". HIV and AIDS is rarely listed on what to be avoided.

Woman D: *We are not used to talking to our children ... and how can we break the silence?*

Several: *We just tell our children that sex is bad ...*

Woman C: *Yes, I am encouraged that there is a group, which is open. Parents know that there is a monster but are shy ...*

Woman H: *When we talk to girls, we just tell them they can get pregnant and drop out of school.*

Moderator: *As you talk to the boys, do you only talk to the older ones or even the small ones?*

Man A: *We do not care about boys in primary we only talk to the older ones. [K3]*

The adults suggest that sexuality education could be organised similarly as the dialogue meeting in which they were involved. According to the participants, community dialogue could be a good strategy for breaking the silence and having open communication on matters of sexuality even for the youth out of school.

Man C: *It is being said that we are not transparent ... but we try ... I accept the challenge.*

Man F: *It is good that we have heard from this forum ... as we talk to our children, we are to be open and talk on AIDS.*

Woman K: *I also support videos. They help the children to reflect on what we teach. I also want all women and female teachers to come one day and talk to the girls and the same for men to talk to the boys. After, we can ... watch the video ... This should also be open to out-of-school youth or those in different schools. [M2]*

3.2. Condom use and safety

The concerns raised here draw attention to condom accessibility and availability, gender constraints and discourses that may discourage condom use.

3.2.1. Condom accessibility and availability

The youth expressed that they cannot afford condoms or that the society prohibits them. In the absence of condoms, they use alternatives in an attempt to protect themselves from infection.

The way the questions are phrased appears however to imply they are looking for affirmation of the efficacy of such alternatives.

"If the place you are doesn't have condoms, what do you do?" [14 yr boy]

"If you don't have a condom can you use a paper bag?" [16 yr girl]

"Is it all right to use a condom more than once?" [18 yr boy], [17 yr girl]

"If you can't afford a condom can one use a balloon instead?" [17 yr boy]

It is contradictory that even with condoms freely distributed in some places the youth are not expected to use them. Even a counseling teacher does not expect the youth to know how HIV is transmitted. Similarly, the youth fear being caught with a condom since the society believes condoms are for adults. It is moreover interesting that the same counseling teacher uses the commonly used phrase "two people sleeping together" instead of sexual intercourse. Although the teacher claims to be open as a counselor, the question is how he can counsel the pupils on sexual matters without being able to mention sexual intercourse.

"Personally, I talk openly because I am a counseling teacher. If you asked a class 2 child what are the causes of AIDS, he will say that it is by two people sleeping together. Imagine! And this is a child in Class two who knows all this. The child also believes that if he is caught with a condom in his pocket, the police will arrest him." [W1]

3.2.2. Gender power and condom use

The questions below suggest that the female condom could empower women. They wondered why the government does not supply the female condom. The questions seem to imply that the girls have little knowledge about female condom. Of all the questions raised on female condom, boys raised only one.

"Are there female and male condoms?" [10 yr girl]

"Why is the government gender-biased in as far as it issues only male condoms? Why are women discriminated against by having no condoms to use, leaving women with no choice if their man refuses to use male condoms?" "Why don't men like using condoms?" [15 yr girl]

"What are the uses of condoms and is it true it can prevent AIDS? And is it true that there are two types of condoms i.e. for girls and for boys? What's its limitation?" [18 yr boy]

Parents implied during dialogue that they communicate with the youth along gender lines as the cultural tradition has been. However, they stressed the challenge of communicating, especially with girls.

Man: *Though even younger ones are taught ... We take them all equally. From 18 we teach about the body and sex. At some point, these youth are divided per age and the elders will teach them ... though I accept the challenge that we are not transparent we tell boys but for the girls it is difficult. We leave that for their mothers*

Woman: *But their mothers do not tell them ...*

Man: *In the past we used to separate the sexes for advice and that's why we still do it... but now it seems imperative that we start mixing the two ...*

Man: *... we have to consult another hierarchy of elders who have the power to give us permission to start talking to girls. Because even the mothers may find it a burden ... [M1]*

3.2.3. Discourses and safety of condoms

Questions about condoms suggest that the information from mass media is too complex and burdensome for some youth, who may have no other source of information.

"What is 'Trust' (condom brand)?" [11 yr girl]

"What does the advert 'Je una yako' (do you have yours) mean?" [12 yr boy]

"What is the meaning of 'maisha iko sawa na trust' (life is okay with trust)?" [13 yr girl]

"From the radio I heard an advert say 'Use condoms for protecting yourself against AIDS, is that true?' [12 yr girl]

The questions on condoms largely focused on safety. The way they were asked reflects a public discourse that questions the safety of condoms.

"Is a condom 100% effective?" [16 yr boy]

"Some people say that condoms are unreliable and have small holes is it true?" [15 yr girl]

"Can a condom protect someone 100% from HIV, pregnancy and STDs? 'Parents tell us it does not.'" [14 yr girl]

The mistrust and confusion surrounding the safety of condoms among the youth seem to be reinforced by adults as indicated in the quote below from a woman during a community dialogue meeting.

"That is a lie! Condoms cannot work. . . Before people get married, they should be tested, and to me condoms promote AIDS." [W2]

4. Discussion and Implications

The self-generated questions from the school youth and discussions in community dialogue meetings with parents, teachers and other community members suggest that communicating about youth sexuality is complicated. For the youth, the positive aspects of sexuality (love, emotions, sexual urge and desires) were a major concern. Given however the prohibitive social context surrounding them, their questions seem also to underline some desperation, on how to comprehend and control their feelings and sexual desires despite being aware of moral rules and attitudes towards sexuality. Some of the young people described themselves as being so much love, that they even contemplated terminating schooling to join their lovers. The questions too, suggest that the young people could be sexually active, but seldom use condoms of which they have little knowledge. In addition, the questions appear to reflect on the public debates about condoms as ineffective and unreliable [25].

Some gender differences were evident in the questions. The girls criticized the government for not supplying the female condom, which was one of their concerns. Apart from low accessibility, the questions implied people are unfamiliar, with the female condom, which could increase women's negotiating power [16]. Most men dislike using condoms although they have more sexual partners than women [26]. Women are thus at a higher risk of HIV infection since the gender power inequalities within relationships restrain them from saying no to unprotected sex as is also clear from a study in South Africa [26]. This research portrayed the girls as more likely to succumb to sexual pressure than losing a boyfriend while boys gave an impression that sex was all they wanted subscribing to the norm of male dominance.

The community dialogue data suggest how adults reason around youth sexuality and highlights the prohibitive silences. Their conversations reveal the paradox of silence in the face of AIDS. However, the main learning was that dialogue forums were identified, as appropriate venues for enabling parents to communicate with their children. Facilitation by outsiders as well as use of

video as teaching aid was recognised as important. In this way, the parents seem to point to cultural practices or social organisation where children were previously counseled on sexual matters by persons other than their parents [15]. With the social support broken down, the burden of communicating on matters of sexuality has fallen on the parents who in turn find it difficult to communicate and hope teachers or other institutions such as the church and NGOs would do it [14]. This implies that there is great need to enhance teachers' communication skills. A study in Tanzania suggests that when young people communicated with teachers on sexuality and HIV and AIDS, they were likely to delay sexual initiation [27]. The study also indicated that teachers were more approachable and could play an important role in discussing HIV and sexuality with young people. On the other hand, another study in Kenya indicates that parental communication influences the young people in ways that help them to delay their sexual debut and reduce unsafe sex [28]. It is thus crucial to identify and involve different stakeholders in specific situations in the HIV prevention efforts among the young people.

The community dialogues also encouraged participation, critical thinking and enabled participants to express a readiness to take charge of their situation. This observation had not been highlighted in earlier analysis. Nonetheless, while it is clear that community dialogue has potential for change, this can be a long-term process given the many complex and interconnected factors to be considered as the concerns of youth in this study suggest. Even though only two areas of concern were analysed, they reflect the many actors and complex social contexts of the conceptual model that need to be addressed. This complexity is clear from a study in Jinja, Uganda, where it became imperative, for example, to address the economic and the social vulnerability of women and girls [29], during the process of the action research. Addressing behavioural change without meeting the community's socio-economic needs could not give maximum results in the HIV prevention efforts. Engaging in economic activities would also act as a meeting point for all the stakeholders to discuss issues of concern for the young people, crucial for their empowerment. In the process, the community can discover and plan around different activities to help deal with the sexual problems identified through community dialogue.

This paper questions the prevention interventions for focusing on individuals for sexual behaviour change. Such focus ignores that individuals, including the youth are influenced by the social contexts and actors at different levels as elaborated in the SEM model. According to the model; the individual (A), or the young person lack knowledge and skills during the adolescence phase: a time when they experience major biological changes. However, this perspective seems to imply that youth cannot make informed decisions on sexual matters. At the policy level, the young people mentioned the government (E) in relation to supply of condoms. The government plays a key role in making educational policies, curriculum and provision of education materials, which influences the sexual education taught in schools. The media (E) too was mentioned as one of the institution and major source of information for the young people. Given that the information from mass media was experienced as confusing, targeting this institution as part of the context for youth is necessary. The young people expressed concern over pressure from peers (B). This, in addition to other actors including parents, teachers and institutions such as the school were identified in the questions by youth and community dialogues. All these will need to be addressed for interventions aimed to promote sexual health among youth. This would, for example, require empowering teachers, in order to avoid the case of the counseling teacher observed in this study. The community dialogues but also the questions from school youth revealed the community factors (D) including, social and cultural norms such as male dominance and female submissiveness and the prohibitive

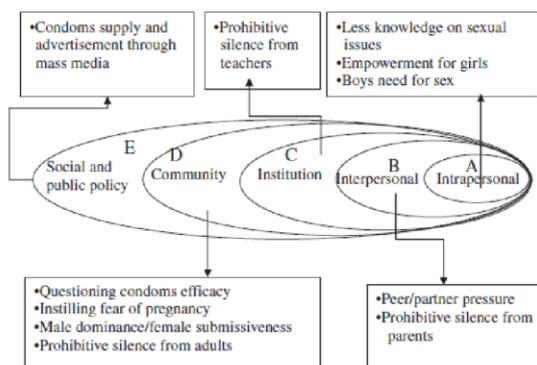


Fig. 2. Actors and factors influencing young people's sexuality.

silence that though cutting across all levels exerts pressure differently on boys and girls. It was suggested in the community dialogues, that information was meant to scare the girls to avoid pregnancy while the boys were largely neglected or as the questions implied one need for the boys was to boast about their sexual prowess to their peers. From these observations, the contexts within which the young people are expected to avoid infection with HIV and AIDS is as complex as the SEM model indicates and to achieve safe sexual behaviour this complexity should be addressed (see Fig. 2).

This study is not without limitations as it excludes youth-out-of-school especially those in rural areas who may not have reliable source of information. The findings may not be generalized, in the conventional way. Nevertheless, the results may act as a basis for reflecting on the conditions of young people in Kenya and in other contexts, as is the case in qualitative research. There is also the argument that secondary data may increase the risk of de-contextualization [30]. However, the first author (KN) is partly an insider and identifies with the context, a fact that could minimise this risk. Moreover, the raw data were made available and extensive discussions with one of the researchers involved in data collection, also helped indicate questions needing further analysis and interpretation.

In conclusion, this study suggests the need to move from seeing sexuality as a problem and focus on sexual wellness and the positive aspects of sexuality. The adult participants suggested that bringing men and women together for reflection and discussion in a participatory mode, transformative learning and change could be achieved. It is vital that the youth and adults have open communication as a foundation for youth to mature into adults. This can be achieved, if interventions including research address multiple contextual factors such as cultural norms, gender differences, as well as communication barriers.

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Glossary of Acronyms and Abbreviations

ABCC: Abstain, Be faithful, Condoms, Circumcision

AIDS: Acquired Immuno Deficiency Syndrome

ARV: Antiretroviral therapy

CMMB: Catholic Medical Mission Board

CRC: Convention on the rights of the children

CRE: Christian Religious Education

EO: Education Officer

FBO: Faith based organisations

FGM: Female Genital Mutilation

GoK: Government of Kenya

HIV: Human Immunodeficiency Virus

KAIS: Kenya AIDS Indicator Survey

MDG: Millennium Development Goals

NASCOP: National AIDS & STI Control Programme

NGO: Non-Governmental organization

RCT: Randomized control trials

SEM: Socio Ecological Model

STI: Sexually Transmitted Infections

UN: United Nations

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Funds

USA: United States of America

VCT: Voluntary Counselling and Testing services

VMMC: Voluntary Medical Male Circumcision

WHO: World Health Organisation