

RESEARCH REPORT

The Mwomboko Research Project: The Practice of Male Circumcision in Central Kenya and its Implications for the Transmission and Prevention of STD/HIV

B M Ahlberg, *Department of Public Health Sciences, IHCAR, Karolinska Institute, Stockholm, Sweden and Department of Sociology, Uppsala University, Uppsala, Sweden*

V N Kimani, *Department of Community Health, Nairobi University, Nairobi, Kenya*

L W Kirumbi, *Reproductive Health Research Unit, Clinical Research Centre, Kenya Medical Research Institute, Nairobi, Kenya*

M W Kaara, *Centre for the Study of Adolescence, Nairobi, Kenya*

I Krantz, *Department of Public Health Sciences, IHCAR, Karolinska Institute, Stockholm, Sweden and Nordic School of Public Health, Gothenburg, Sweden*

(Correspondence: Beth Maina Ahlberg, IHCAR, Karolinska Institutet, S-171 77 Stockholm, Sweden)

Introduction

This paper focuses on circumcision as practiced in Central Kenya, and discusses its meaning, organisation, recent changes and implications for HIV/AIDS. Among the Kikuyu, circumcision is a universal pubertal ritual for boys. In the past, it used to be universal for girls. Some girls still undergo clitoridectomy. However, this latter is performed in utmost secrecy. The report is therefore confined to male circumcision and will refer to clitoridectomy only in so far as it is linked to sexuality. The paper is based on empirical data gathered during 1992-96, in the Murang'a District of Central Kenya, an agriculturally high potential, densely populated area inhabited by Kikuyu people.

Circumcision and STD/HIV

Circumcision has been implicated as a risk factor in HIV transmission. It is for example argued that sexual intercourse causes lacerations and bleeding in women who have undergone clitoridectomy and infibulation thus increasing their risk of infection (Linke 1986, Gunn et al. 1988, Padian 1987). In both females and males, use of instruments during the operation without proper sterilisation is considered to be a possible transmission route.

However, results from surveys at STD clinics (Hira et al. 1990), have suggested that male circumcision may lower the rate of transmission of sexually transmitted diseases (STDs) including HIV. This has led to the conclusion that male circumcision should be considered a necessary precaution, especially in Africa where condom use is low (Johnson and Laga & 1988, Bongaarts et al. 1989, Marx 1989, Caldwell 1995):

The findings suggest that circumcision should be advocated, just as we advocate condoms.... We've got to do everything we can to decrease the rate of transmission of this disease. (Marx 1989:p.471)¹

There might be an argument for male circumcision for hygienic reasons, particularly in the kind of poorer areas where most studies seem to have been carried out. However, to institute a widespread cutting of foreskins as a preventive measure against the spread of HIV, is to run the

risk of ignoring the social complexity of circumcision, its meanings and associated practices. It is also, as argued by Conant (1995:p.109), to assume that

...The African countryside and its peoples are in some way immune to change and that cultural practices such as circumcision (or no circumcision) and degrees of sexual permissiveness are fixed for all time. Such a view of rural populations is not too different from assuming that the populations of the African countryside beat to a kind of heart of darkness.

For the circumcised and the uncircumcised, associated practices may be more critical in the transmission process than just the presence of a foreskin. This paper presents findings from studies in Central Kenya indicating that male circumcision in its current form is closely associated with practices, and is organised in ways, which are of direct relevance to the spread of STDs including HIV.

The Mwomboko Research Project

This study was carried out in the context of the Mwomboko Research Project, whose aim was the prevention of HIV/AIDS among young people. Our point of departure was the growing evidence that despite increased knowledge about the transmission of HIV, adoption of behaviour that reduces the risk of infection has only been modest (Van Dam 1989, Carael et al. 1992, Romer and Hornik 1992, Lule and Gruer 1991, Levine 1991.). The present situation regarding adolescent sexual and reproductive health in Kenya, with high rates of early and unwanted premarital pregnancy and school drop-out, as well as induced abortion and related complications, indicates that unprotected sexual activity is very prevalent. Although the link between knowledge and behaviour change is more complex than is generally accepted in HIV/AIDS information, education and communication (IEC) campaigns, young people lack proper information on sexuality and have no access to preventive services. This is a reflection of the prohibitive silence from the adult world which says no to sex before marriage, and therefore to sexuality education in schools and to preventive services. Young people are thus torn between prohibition and silence from adults, a peer ethos of romantic love that dictates that sexual activity is acceptable as long as people are in love, regardless of marital status, and incidents of sexual exploitation, especially of young girls by elderly men.

For any attempt to prevent the spread of HIV among young people, this paradoxical situation and particularly the prohibitive norms and values would have to change. Since HIV is invisible, we used teenage pregnancy, abortion and school drop-out as tracers for unprotected sexual activity. These are not just visible consequences of sexual activity, but are also problems of great magnitude and of major concern to the community. Our assumption was that using what is visible and of concern to the community could promote dialogue and create space for people to reflect on their values and norms. We consider this to be an important prerequisite for preventing the spread of HIV.

Research methodology

This project utilised an open design and started by mapping the community to identify relevant community groups and networks, to explore locally based knowledge, meanings and issues around which more relevant research could be carried out, and to consider tools and methods to

facilitate dialogue and preventive behaviour in the community. The term *Mwomboko* was adopted during this mapping process. *Mwomboko* appeared in a local poem 'Words of wisdom' (Ngugi Wa Thiong'o 1987) which we used in workshops to break the ice and pose the problem. It is a local dance of young people where a couple moves two steps forward, stoops and makes a turn. In the context of our research, *Mwomboko* symbolically denoted a movement involving data collection using interactive analytical methods, each stage of analysis defining the movement in the next stage.

The information gathered at each stage was fed back to different community groups and was used as an entry-point into the next stage. In the process, new information was generated, and observations were validated, while ideas of possible preventive actions started emerging. Our assumption was that using locally grounded knowledge would enable the people to discuss this rather sensitive issue. In this way, we attempted to create a participatory process and involved the community in the research process (Cornwall and Jewkes 1995).

Data on circumcision first emerged from questions generated in schools. During the course of the open exploration, the difficulties of obtaining reliable information on issues of sexuality from adolescents became obvious. In our attempts to find more appropriate methods, we stumbled on what we called a question and answer method. Instead of interviews, we requested the adolescents to write down questions they could not openly ask or discuss with adults. This method elicited more intimate information which then formed part of the grounded knowledge used in subsequent interviews and group discussions with the adolescents themselves, health workers, parents and teachers. (Ahlberg et al 1996).

The School Youth

Questions were generated from 4195 girls and boys of whom 2875 were from a sample of 15 primary and 1320 from 14 secondary schools, purposefully selected from the seven zones in the study Division. Zones are administrative units of the Ministry of Education. The schools are further grouped into smaller units of 3-4 schools based on geographical proximity, to enable teachers from each unit to assemble in one school for marking exams or other joint activities. For a project that intended to be participatory, distance between schools was used as a criterion in selecting the sample.

The school youth in classes 6-8 (11-17 years) in primary schools, and forms 1-4 (14-20 years)² in secondary schools, were encouraged, by writing on a piece of paper, to pose questions on adolescence, sexuality, growing up, and related problems which they were afraid to discuss with their parents, teachers and other adults. To enhance freedom of expression, they could ask the questions anonymously, using any of the three languages - Kikuyu (mother tongue), Swahili and English, the last two of which are taught in schools.

This approach had a number of problems. To avoid interrupting the school routines, we made a single visit to each school. This meant having all the pupils in one hall. Most schools had an assembly hall, but were poorly furnished and pupils had to bring their bulky desks with them. Although we stressed the need for privacy in this exercise, the seating arrangements were not really conducive to this end. The alternative, however, would have meant taking a class per day, which would have increased the Hawthorne effect (Morse and Field 1996).

The questions generated nevertheless reflected varied and real concerns of the school youth in the area. Also of significance were the style and the language in which the questions were framed. Where we have quoted the questions in the text, we have tried as much as possible to

present the original form in which they were expressed.

Unexpectedly, circumcision emerged from our data as a major concern of the school youth. The questions suggest that the adolescents undergo a practice they do not fully understand. It thus became necessary to generate more information on circumcision from the health workers, teachers and parents who could be considered concerned with the practice of circumcision.

The Health Workers

In this category we mainly focused on private clinicians. This is not because other health workers were not involved in circumcision. Rather, it was more to understand what might be termed a 'peripheral' health system which we observed in the district and which despite its status constituted an important and rapidly expanding health resource. Private clinicians comprising of clinical officers, nurses and nurse midwives, scattered all over in shopping centres and markets, performed a great many of the circumcisions on boys.

The question of circumcision was included in a survey of private clinicians. More qualitative information was gathered during three 3-day workshops with private clinicians spaced over an interval of six months (Krantz et al. 1996). Information regarding which clinicians performed the operation, their workload and periods when they operated, the management of the wound, the use and care of instruments, the organisation of circumcision, the information given to the initiates and the persons involved (particularly the *mutiri* - supporter and counsellor) was elicited. Elderly clinicians provided valuable information contrasting the traditional operation they themselves went through and the type they currently performed at their clinics.

The Parents and Teachers

Parents of children from four schools were invited to discussion sessions through the parent/teacher associations. Since many teachers were also parents, those who could join the discussion sessions were encouraged to do so.

Data from the school youth and private clinicians were summarised as follows and used to facilitate discussion:

We have asked your children to ask those questions they would be ashamed or fear to ask you as a parent or adult. The questions indicate that your children have little knowledge about even the simplest facts about their bodies; they have a lot of wrong information and myths regarding sex but are actively involved in sexual activity even though you stress they should complete their education and are married. Moreover, your children are very concerned about circumcision and wonder why they go through it. They have a *muriika* (peer) for a *muturi* (counsellor) and they have their own rituals for example buying the road licence, undressing the wound before the time they are instructed by the doctor and applying medicines they buy at the shop or market, causing the erection of the penis in order to make it painful. The initiate is advised to and is pressured to *kuhurwo mbiro* (have sexual intercourse) immediately after circumcision in order to fully become a man. The initiate is instructed by the *muturi* and other peers on how to negotiate with girls for sex. As parents you are involved only in providing money for the operation, for medicines (which are unnecessary) and for food during the convalescence period. You know little of what goes on in the *thingira* or *kiumbu* (small rooms) which you offer the initiate and his peers.

Parents were then asked whether this was a true representation of what they and their children experienced. They were encouraged to discuss the contemporary organisation of circumcision and to contrast it with the past.

Male Circumcision in the Past

Prior to the colonial and Christian missionary interventions at the turn of this century, all boys and girls were circumcised. Circumcision was an elaborate ceremony that brought individuals, relatives, and the entire community together. As it constituted the start of adulthood, care was taken to impart the socially prescribed code of conduct and discipline.

The ritual was associated with the acquisition of social status for the initiate and the parents. The parents were elevated, the mother moving from the low status *Kang'ei* to high status, authoritative *Nyakinyua* age group (Ahlberg 1991) and the father moving up the various ladders of the council of elders (Kenyatta 1938). The initiates then came of age and were then expected to behave as adults. The boy could be called upon to perform duties such as defending the country, while the girls assumed the many roles of an adult woman.

The operation was preceded by elaborate ceremonies and education which included periods of seclusion. It was marked with great jubilation including singing, dancing, beer drinking and exchange of gifts. This was one time when women were allowed to collectively and publicly participate in dances, songs and chants which in normal circumstances would be considered extremely obscene. It was an occasion the society allowed public obscenity meant to teach the new adults what was expected of them in their sexual life.

When the time for initiation approached, the parents identified a respectable and knowledgeable man to be the *mutiri*. The *mutiri* was a counsellor who was supposed to advise and prepare the boy for initiation, take him through the operation by physically supporting him, nurse the wound and guide him thereafter. The bond established lasted for life.

On the day of circumcision, the boys in groups were escorted to the river very early in the morning and were dipped in the cold water after which they were circumcised. The cold water served as local anaesthesia as well as a vasoconstrictor to reduce bleeding. The *mutiri* supporting the boy from behind encouraged him not to cry even if the pain was unbearable.³

After the operation, groups of initiates lived together in a separate house with the *atiri* (plural). During this time, they were well fed and learned from the *atiri* until they *kumira* (emerged) as adults.

The initiated boys were instructed how to relate to women but also how to maintain discipline in sexual matters. After initiation, girls and boys were involved in dances and were allowed to engage in *ngwiko*. *Ngwiko* is a type of controlled sexual activity which allowed newly initiated girls and boys to sleep together the whole night, to explore and enjoy each other without penetration. During a group discussion with teachers, one elderly teacher explained that:

Andu metikiritio kugwiko ciero ciika (people were allowed to play with thighs only).

To this extent, sexual activity was not, as is often claimed, indiscriminate. For young people to sleep together a whole night without sexual intercourse required strong sexual control and discipline, and can be said to be an example of the inductive moral education system where, instead of lectures, individuals were presented with concrete situations to serve as ethical analysis of themselves and others (Mugambi 1989). Sexual discipline was instilled and maintained through social control mechanisms such as taboos and related beliefs, peer pressure and social organisation.

Although full sexual intercourse was not sanctioned, there still were attempts by men or rather, men were expected to try their luck on the initiated girls. The most commonly used form of wooing girls into sexual intercourse was to scare them into thinking that unless they agreed to *Kuhurwo mbiro* (a metaphor referring to cleaning the soot that gathers around the cooking pot), they would never give birth, sexual intercourse with their husband would be extremely painful, and the husband could even die during the first intercourse. The girls then were equally empowered to resist by their peers, older girls and their *atiri*. Many elderly women in this study talked about this as a common experience during their time:

Even in the past men cheated newly circumcised girls that if they did not agree to have the *mbiro* (soot) cleaned before marriage, their husbands would die during the first intercourse... My friends and I were cheated only to find from older, married girls that this was a lie.

Peer pressure was used to maintain the prescribed sexual discipline. When there was a breach of conduct or where one was even suspected, heavy punishment was meted out to those involved. Girls had a way of finding out which of their agemates may have had full sexual intercourse. If, during dances, a man showed a favorable attitude to a girl, she was suspected by the others of having given in to the man. She was punished by being ostracised or fined (Ahlberg 1991).

In addition, taboos and prohibitions were extensively used to prevent breach of conduct including sexual conduct. It was believed that the breach of conduct could lead to a breakdown of harmony and social balance leading to catastrophe, misfortune and disease. The disease or misfortune could be experienced by persons in the family, clan and the community, other than the one breaching the code of conduct. This ensured collective responsibility. When a sexual taboo was broken, elaborate cleansing ceremonies took place. If for example a girl had had full sexual intercourse, she was not allowed to enter her mother's house because by having sexual intercourse, she herself became a *mutumia* (full woman) and no house was allowed to accommodate two such women. She could only enter after elaborate ceremonies through which her sexual activity became public knowledge.

Besides peer pressure and taboos, the society was organised in ways which minimised the possibility of breaching the codes of conduct. *Ngwiko*, for example, was collectively organised where groups of young people slept together in one room to discourage those who may have been tempted to have full sexual intercourse.

Given the strict rules and associated punishments, *kuhurwo mbiro* or the attempts by men to have sexual intercourse with newly initiated girls must have been part of the open discourse in sexuality or a test of the moral discipline. Nevertheless, the Christian missionaries forbade *ngwiko* as they could not visualise young people sleeping together without sexual intercourse (Ahlberg 1991 and 1994).

Contemporary knowledge and beliefs concerning circumcision

Five hundred and eighty (580) of the questions obtained at the schools were about circumcision. They were asked by 445 (16%) of primary school and 91 (7%) of secondary school youth. The most frequent questions were:

- why are people circumcised?
- can uncircumcised boys impregnate girls?

- who gives more sexual pleasure, circumcised or uncircumcised girls?

From the questions it was clear that the main concern was what circumcision is and why young people have to go through it. Most of the questions, including those concerning clitoridectomy, were asked by boys. About 4% of the 580 questions concerned behavioral change after circumcision.

Beliefs and knowledge concerning female circumcision

Concern was expressed about female circumcision. However, compared to male circumcision, where the question was simply why boys were circumcised, the concerns about female circumcision were expressed in a variety of ways:

- Why are girls circumcised?
- Why are girls not circumcised?
- Is it bad for a girl to be circumcised?
- Why did girls stop being circumcised in some areas and in others they still did it?
- Why is circumcision of girls discouraged?
- Why has the government prohibited clitoridectomy when traditionally it was practised?

The fact that only some girls underwent the operation seems to have created confusion on the issue of sexual pleasure. Most of the questions on sexual pleasure (70%) were asked by the more mature boys 16-20 years. Although a few questions suggested that uncircumcised girls were considered more pleasurable, the major concern was however to find who gave more sexual pleasure - the circumcised or the uncircumcised woman:

Why don't circumcised girls enjoy sex, i.e. why do guys prefer uncircumcised girls? Is there any difference between circumcised and uncircumcised girls? Who is better to have sex with - a circumcised or an uncircumcised girl? Does a girl without a clitoris reach orgasm while having sex? Who enjoys sex most between circumcised and uncircumcised? Who is the best girl to marry between circumcised and uncircumcised?

Beliefs and knowledge concerning male circumcision

A major concern which emerged from the questions was why boys were circumcised. Other concerns included the role of circumcision in fertility and sexuality. Of the 580 questions, 112 (19%) raised the issue of fertility. There seemed to be some confusion about a connection between circumcision and fertility. Some of the questions suggested that the adolescents simply wanted to know whether there was a link between circumcision and the production of sperms or the possibility of impregnating:

Can an uncircumcised boy make a girl pregnant? Can an uncircumcised boy fertilise? If a person is not circumcised can his sperms produce a baby? Can a 15 year old uncircumcised boy make a girl pregnant? Can the foreskin of uncircumcised boys hinder sperm secretion?

There seemed to be a general impression that a *kihii* (uncircumcised boy) could not make a woman pregnant:

Why is it that when an uncircumcised boy fucks a girl she can't conceive? Why is a boy

unable to cause fertilization unless he is circumcised? How is it that an uncircumcised girl can conceive and an uncircumcised boy cannot make a girl pregnant?

There appeared also to be an impression that an uncircumcised boy could neither achieve an erection nor penetration. Circumcision was believed to cause the development of secondary sexual characteristics and an increase in sexual desire.

Why do girls say that circumcised penises are sweeter than the uncircumcised? Why does an uncircumcised person not know how to penetrate his penis through the vagina and reach the uterus? Why is it that a boy who has not undergone circumcision cannot enter through the vagina when mating? For good penetration of the penis through the vagina, why must a boy be circumcised? When a boy goes for circumcision why does he begin loving girls? Why do boys desire sex after circumcision? What makes a boy after circumcision increase his desire for sex? Why do boys befriend girls after circumcision? Is it true that when a girl gets circumcised she gets big breasts?

Behaviour change after circumcision was another concern raised in 25 of the 580 questions:

Why is it that when a girl gets circumcised she pretends she cannot give a boy to do her? Why do people boast after they are circumcised? What happens at circumcision to make boys change their behavior so much? Why does a boy after getting circumcised no longer sleep in the same house as his parents? When a boy is circumcised why can't girls go to his hut? How would I tell my parents that I want to go for circumcision?

These questions indicate the meanings and beliefs associated with circumcision. They furthermore reflect the level of knowledge on sexual matters, conception and fertility. It is clear that the young people have little knowledge, and a great deal of misinformation, on the subject. The way the questions were expressed moreover indicated that there is a silence about the issue of circumcision and that many changes have taken place around it.

Contemporary circumcision practices

To be able to locate the concerns of young people, the seeming confusion, the silence, the changes taking place and the implications regarding transmission of STDs including HIV/AIDS, contemporary circumcision practices are now considered.

All boys undergo circumcision which still marks *kugimara* (entry into adulthood). The operation is mostly performed during school holidays in April, August and December. December is more popular because, being a longer school holiday, boys have sufficient time to heal. Furthermore, it is a period when boys after graduation from primary school are waiting to join secondary schools. It is important that they are circumcised to avoid being punished and bullied by older boys in the new schools.⁴ Besides the academic qualification for entering secondary schools, there is also a demand for social adulthood defined through circumcision.

The operation is now commonly performed at private clinics. Of the 35 private clinicians in the study Division, seventeen (49%) carried out circumcisions. It is largely performed by male clinicians, although female clinicians may employ males to operate in their clinics.⁵ The role of the traditional *muruthia* (circumciser), and perhaps also the rituals he performed, has diminished.

The initiate is escorted to the clinic by his *mutiri* on the appointed day. After the operation, the

clinician dresses the wound and instructs that the dressing should not be removed before the seventh day. According to the private clinicians, the instruments used for circumcision are sterilised first in a detergent and boiled after every operation. The chances for the transmission of HIV through the instruments accordingly seem remote to the clinicians.

Unlike in the past, there seem to be few elaborate preparations. Involvement of adults and the community in general and therefore the related ceremonies and sexual education have diminished. As the school data indicate, the most frequent question raised by boys is why the operation is done. As in the past however, the initiate is given a *thingira* or *kiumbu* (small room) detached from the parents.⁶ Food is taken to the initiate in most cases by the mother or a sister. According to parents, the mother only hands over the food and by tradition is not expected to enter the room. Initiates whose parents do not respect this norm risk punishment. Parents have therefore little knowledge of what takes place in the small rooms.

The *Mutiri*

The role of the *mutiri* has also changed. Parents no longer fulfil the important role of identifying a *mutiri*. This means that the practice of parents choosing a person who commands respect and was knowledgeable about codes of conduct has been abandoned. This is another instance where the link between the youth and the adults around the practice of circumcision has weakened. The youth turn to their peers and usually choose those who underwent initiation in the preceding season. Families may identify an elder to whom the boy may be sent for advice. This however is often a one-time interaction. The rest is left to agemate *mutiri*. In addition, circumcised agemates and at times those of the *mutiri* visit the initiate regularly. The convalescence room or house is thus more or less monopolised by the young people.

The care of the wound

According to clinicians the wound should not be interfered with before seven days, by which time it should have healed. However, it is a normal practice for the *mutiri* to remove the dressing on the second day and sprinkle powder from a capsule (antibiotic) or a crushed tablet of cotrimoxazole (suta) on the wound.

It appears that the *mutiri* is still performing the duties which he was supposed to in previous times, when the wound required to be cared for and dressed at home, except that he now may undo what the health professional has done. This type of development has been possible because of the diminished involvement of the adults.

Pain-inducing practices

Other practices may include sexual arousal and erection of the penis. Initiates in addition may be forced to drink large amounts of water and tea to make them urinate frequently. These practices result not only in the pain which they are intended to induce. They may also lead to the swelling, bleeding, and delayed healing of the penis. Clinicians suggested that infection of the wound and bleeding are not uncommon.

There was teasing in the past, and certainly, boys who had been naughty were usually teased into erection and pain. But this did not apply to everybody as seems to be the case today. Bearing pain was part of becoming a man in the past. Compared to the traditional operation popularly

known as 'going to the river' where cold water was the only anaesthesia, hospital circumcision is less painful because the initiates are fully anaesthetised. The clinic operation is thus considered less painful and is similarly accorded lower status. The new pain-instilling rituals are perhaps understandable in this context.

Most parents told of their experience with these new pain-inducing rituals. It was one of the few occasions during which parents might attempt to intervene.⁷ However, such intervention could result in more bullying of their son for having a mother who poked her nose in the affairs of men. Many parents expressed their dilemma in this regard.

The road licence

A ritual that seems to have developed in recent times is that of buying a 'road licence'. Here the initiate is expected to provide a chicken, cigarettes and beer.⁸ The initiates are popularly referred to as *thigara* (cigarette). The road licence allows the newly circumcised man to interact socially with other circumcised men and talk to girls without risking punishment or bullying.

Kuhurwo mbiro or cleaning the soot

Perhaps the most important practice as far as potential STD/HIV transmission is concerned is that of *kuhurwo mbiro*. In the past, this metaphor which symbolised the cleaning of soot around a cooking pot was used by men to woo women into sexual intercourse. It was thus women not men who had to have soot cleaned.⁹ However, full sexual intercourse rarely took place because of the strict rules for maintaining the prescribed sexual discipline. The metaphor has now been appropriated by men and with the breakdown of social controls soot is cleaned through full sexual intercourse.

During the convalescence period, the initiate is trained by the *mutiri* how to negotiate for sex. This is normally dramatised, the initiate being told to pretend that the *mutiri* is a girl whom the initiate should *kuha* (woo) for sex. If he makes a mistake, he is corrected until he gets it right. Despite such training, there are indications that the peer pressure to have sex as part of the process of becoming a man, combined with the difficulties of actually negotiating for sex with girls in their age group, forces the newly circumcised boys increasingly to turn to older women, especially those in commercial sex work who have wider sexual networks. The risk of exposure to STDs and the AIDS virus is thus great.

Conclusion

Male circumcision is still the norm among Kikuyu people and marks *kugimara* (becoming adult). A great deal of change has however taken place. The ceremonies that marked the occasion and the open discourse that imparted knowledge, combined with strict social controls regulating sexual behaviour, no longer exist. The rapid social change experienced in this society has created discrepancies between cognition and practices. Parents still believe that sexual intercourse should not take place before marriage and, certainly, that their children should complete their education. However, without the corresponding mechanisms for regulating sexual behaviour, they have resorted to a prohibitive silence. The young people have on the other hand re-interpreted some of the old practices associated with circumcision and created new ones to meet the demands of a paradoxical social reality.

The effect of the parental silence on sexual matters is clearly indicated in the school data which suggest that the youth have little sound knowledge of sexual development. Consequently, they link circumcision to the development of secondary sexual characteristics. This is perhaps not surprising given that the operation is performed at the age of spermatogenesis, when there is a physiological increase in the production of male sexual hormones resulting in increased sexual desire. In the past, *ngwiko* was accepted in this period, both to satisfy the sexual needs of young people and to confront them with real life situations which they had to learn to manage. It can be argued that the concept of 'safe sex', now being advocated in HIV/AIDS prevention, was well understood. Today, the adolescents are left thinking that it is circumcision which causes their physiological development, hence the belief that uncircumcised boys cannot erect, penetrate or impregnate a woman.

Circumcision takes place in the clinics where sterilisation of instruments is possible. The chance of transmission of HIV through the use of one infected blade is thus reduced. The danger lies more in the emerging youth sub-culture and practices associated with circumcision. It is currently believed that in order to fully become a man, sexual activity should follow soon after circumcision. There are practices which socialise the initiate for the new sexual roles. The pain-inducing practices are meant to create a tough man while the road licence provides space for the newly initiated to engage in sexual activity. One disturbing outcome of these practices is the recourse of the young men to commercial sex workers.

While the *kugimara* traditions of the past aimed at integrating the young male adults into the community, the contemporary forms seem to separate young people from the rest of society. Many parents expressed their dilemma for being expected to discipline their circumcised sons who, according to social norms, are considered adult men. Parents feared being beaten by their circumcised sons or of their running away from home.

The challenge of disciplining circumcised men is experienced at school as well. Most primary schools discourage circumcision because teachers feel that such pupils are less controllable. Women teachers in particular face enormous difficulties in disciplining circumcised boys who consider that female teachers are just like any other women with whom they may wish to have sex.¹¹

In this context, the idea that circumcision should be promoted as a preventive measure against HIV transmission may be extremely counter-productive. Thus, before cutting foreskins as some advocate, the contemporary meaning of circumcision and its associated practices and their link to sexual behaviour need to be understood.

In the course of our research process, we noted that the issue of circumcision became an appropriate ice-breaker for discussing taboo subjects such as sexual pleasure. As an old and universally accepted practice among the target population, circumcision was relevant to men and women of all generations, who thereby were enabled to confront this cardinal social issue. Elderly people in particular contrasted the past and the contemporary practice and blamed the youth for misbehaviour. The younger generations in turn considered that older people had relinquished their responsibilities.

In the process, a more critical reflection on the changes taking place helped parents better to comprehend the complex context within which adolescent sexual activity took place. Parents discovered that what they had regarded as intact social customs were mere skeletons of their former self. This too enabled them to discern some of the concrete interventions which families, schools and communities could undertake to break the chain of transmission.

Notes

1. Although no systematic research has been carried out, there are indications that men, including elderly men from different parts of Africa, have taken the advice seriously, and are undergoing the operation in a bid to protect themselves from the infection. A similar phenomenon seem to be emerging where married women are being forced to undergo the operation as a measure of reducing their sexual lust, again in a bid to prevent the spread of HIV.
2. The age range was wide in both primary and secondary schools because many children repeat in different classes.
3. Crying during the operation was the most feared thing because it lowered respect and status for the initiate and his family.
4. Boys from areas where male circumcision is not practiced are similarly bullied and forced to undergo circumcise if they join secondary schools in this district.
5. A female clinician who had gained respect in the community might nonetheless operate on boys herself.
6. One parent described how she had to move her son's bed into the granary adjacent to the house as she did not have a separate room.
7. One mother reported how she heard her son groan in pain only to find out that his penis was swollen from unnecessary erection. She became furious and ordered the young men out of the room.
8. Hard drugs - *ciakurebia* - are also known to be used for this purpose.
9. One can understand such a metaphor when applied to girls because it is they who use the cooking pot after marriage.
10. One young popular *mutiri* claimed that his popularity lay in the fact that he advised the initiates to delay sexual intercourse for three months, which is considered a long time.
11. Our attempt to separate circumcised from uncircumcised boys in order to create groups with similar characteristics for focus group discussions proved unacceptable, the headmasters arguing that schools were working hard to discourage such divisions.

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