The Relevance of Intangible Cultural Heritage in Modern Times: Evidence from Babukusu Male Circumcision

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Abstract Male circumcision is a common practice in many cultures. In Sub-Saharan Africa, it is practiced as a rite of passage performed around adolescence. In clinical settings, it is normally done as a quick outpatient procedure using local anaesthesia (USAID 2003). Despite some controversy, circumcision has been widely practiced in modern times and in most parts of Africa, Asia, Europe and America (Columbia Encyclopaedia 2004). In Sub-Saharan Africa, about two-thirds of men circumcise, while in Kenya male circumcision is practiced by many different cultures all over the continent. In the predominantly Muslim northern Africa, circumcision is practiced by many different cultures all over the continent. In the predominantly Muslim northern Africa, circumcision is practiced by many different cultures all over the continent. In the predominantly Muslim northern Africa, circumcision is practiced by many different cultures all over the continent. 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procedure in areas thousands of miles apart, indicate that the circumcision ritual has an old tradition behind it and its present form is the result of a long process of development that permeates human change and progression. Marck (1997), describes the general cultural background of male circumcision for the Bantu speaking peoples of Sub-Saharan Africa based on Wagner’s claim. The prevailing universality of circumcision indicates that the practice, whose origins are time immemorial, has contemporary relevance and this is the point from which this paper makes its argument. Today, circumcision is being introduced and scaled up in communities that have not practiced it worldwide and in Africa because it has recently been associated with reduction of HIV transmission in heterosexual males (Auvert et al. 2005, Bailey et al. 2007, Gray et al. 2007, Egesah 2009). It is thus apparent that the importance of circumcision continues to be non capricious even in communities such as Babukusu who have traditionally practiced it for long. In Africa and especially in Sub-Saharan Africa, it marks the entrance into manhood and where it is practiced, it is regarded as the most solemn occasion in the life of every male. The practice has already been described in many ways (Marck 1997, Egesah 2009). This paper focuses on its prevailing significance despite confluence factors associated with changing times and modernity. Today many Babukusu men are going to hospital, to private clinics or turning to clinical surgical circumcision at home.

Despite this introduction however, overall Babukusu still practice traditional circumcision hence they undertake both traditional and clinical circumcisions. Two different techniques of traditional male circumcision are practiced among Babukusu of western Kenya. Both procedures are performed by a traditionally trained male circumciser. Traditional male circumcision is performed outdoor, outside the boy’s parents’ house and it is done at dawn. In the most common procedure, the circumciser pulls both the outer and inner foreskin of the penis and by clip of both between the thumbnail and the first finger, they make a sharp cut. In the second procedure which is relatively slower the circumciser pulls the outer foreskin and by the same means makes the cut, and immediately slits the inner foreskin and graces with the special circumcision blade; lukembe round the glans to the mark where the outer skin has been chopped from. Both operations are preceded by a helper who dusts the foreskins with a special brick or sand baked dust referred to as; litukhuulu for firm and precise grip of the inner and outer foreskins in readiness for the cut. In addition to these, Babukusu also practice clinical circumcision. This form of circumcision is conducted by a biomedical trained male clinician as an outpatient practice. On such occasion, the boy is accompanied by a male parent and/or close male relative to the clinic of the parent’s choice for the (mid) morning operation. In the clinical set up, the circumciser administers local anaesthesia at the base of the penile shaft, draws the foreskin using forceps, cuts off both inner and outer foreskins simultaneously using a pair of scissors and stitches the raw edge together with the drawn outer skin with sutures, after arresting bleeders. On some occasions the clinicians do not use sutures.

Figure 1. Global Prevalence of Male Circumcision (Source: Hankins, 2006)
**Case narrative by researcher:** Babukusu traditional male circumcision climaxes with the circumcision cut. One week of preparation, courage songs, dance and bells, and teasing end with an intense readiness ceremony lasting the entire night on the eve of circumcision; *khuminya*. Outside his father’s hut, at dawn and in front of a hushed anxious gathering, the boy meets the traditional circumciser accompanied with his assistant. The assistant dusts and rubs the penis outer and inner foreskin with special baked brick/clay dust and draws out and holds both the outer and inner foreskin of the penis. In less than ten seconds the circumciser makes the sharp cut and instantly blows a whistle to mark a successful circumcision cut. The whistle is met with ululation, cheers, song and dance from the gathering. This is followed by gifts and presents offered abundantly by the gathering to the boy. After this the boy is escorted to the house and the father spreads banana leaves for him to sit on. Next and besides him, the chopped foreskin, the circumcision bells; *chinjimba* and the mud crown the boy was decorated with are placed on a traditional grass and mud tray; *luteru*. This is symbolic of what the boy must put aside, never to associate with again after the iconic cut. The tray contains millet, a bunch of banana and groundnuts to symbolize production, prosperity and tenacity. After one or two hours, as the gathering continues with song, dance, presents, feast and drink, the circumciser who had ran off immediately after the cut, returns to give the boy his first meal after circumcision; *khulumia*. This symbolizes rebirth to a new life.

Numerous factors are contributing to the emergence of changes in the circumcision practices of Babukusu of Western Kenya. Many Babukusu are continuing with some form of traditional circumcision practice that involves the procedure being performed by a traditional circumciser in the context of traditional ceremonies and ritual. The nexus of this pattern of circumcision is explained by the meaning, significance and value of Babukusu circumcision which is ceremonial and ritualistic initiation of boys into adulthood. The circumcision process outcome aims at inducting new moralistic, normative and value laden messages and skills into the new male adult in line with the cultural demands and expectations of the community. Other Babukusu are turning to clinics for circumcision. Such, are undertaking male circumcisions in public or private health facilities with little or no involvement of extended family and community members. Still this group is managing to initiate their young males into adulthood albeit not following the traditional circumcision procedure. Importantly, this paper describes the factors that explain the emergence of clinical circumcision in an environment where traditional circumcisions have prevailed and are still practiced. From this point of view, the paper argues that modernity factors: cost of circumcision, health concerns, education priorities and religion are prevailing to influence introduction and rationalization of clinical circumcision. This is despite the immense attachment Babukusu people hold for traditional male circumcision. The rationale of this study lies in attempts to describe the meaning and significance of male circumcision among Babukusu especially when gradual gain in clinical circumcision practice is challenging value ascribed to traditional male circumcision. The aim of this study was to assess factors of cost, health, education and religion and how they influence the role, function and significance of male circumcision in a community that has been practicing it traditionally over generations. While traditional circumcision is the norm in the community, many parents are turning to clinical circumcision and this paper explains why. The paper argues that this shift corresponds with realities of changing times but it further analyses implications these changes bear to the value and significance of male circumcision.

### 2. Explanatory Model

Literature shows that circumcision is probably one of the oldest surgical procedures although currently only 30% of the world's male population is circumcised (Caldwell 1995, Columbia Encyclopaedia 2004, Hankins 2006). Approximately two-thirds of adult males in Africa are circumcised and especially at childhood and adolescent (Moses et al. 1990, Bailey and Halperin 2000). Babukusu are not an exception to this trend given that almost all communities in Kenya circumcise their males (Dodge and Kaviti 1965, Brown et al. 2001). According to UNAIDS/CAPRISA (2007), there are three common factors that influence the trends and significances of male circumcision and these are; costs associated with the procedure, fear of pain and health safety concerns. These three variables are further studied and reported in this paper. In addition, circumcision and its changing significances has been widely studied in relation to factors that link it to health complications, adverse health effects, socio-economic effects, pain, safety and lately the HIV threat (Crowley and Masner 1990, Aldeeb 1994, Mayatula and Mavundla 1997, Ahmed et al. 1999, Magoha 1999, Khalifa 2000, Bailey and Halperin 2000, USAIDS 2003, Mattelaer 2003, Darby 2003, Auvert 2005, Bailey and Egesah 2006, Westercamp and Bailey 2006, Bailey 2007, Gray 2007, WHO/UNAIDS 2007, Bailey, Egesah and Rosenberg 2008) among others. Further, studies indicate that religiosity is a key influence to the significance and function of circumcision (Aldeeb 1994, UNAIDS/CAPRISA 2007, Egesah 2009). In fact, Egesah (2009) highlights the influence of the four factors of cost, health, education and religiosity on the significance of circumcision. The literature summary provides the basis from which we can argue an explanatory model for this paper. The assumption is that amongst Babukusu circumcision has been redefined using William Thomas’ theoretical and conceptual model of “definition and redefinition of the situation” (Thomas 1965), that is supported by the assumptions made by Weisner et al. (1997). To explain this study using the redefinition model, we argue that Babukusu circumcision is being redefined from traditional to clinical due to changing influences of cost, education, health and
religion. The paper further argues that regardless of modernity drivers Babukusu circumcision is still redefined to realistically suit its purpose of initiating Babukusu young people into adulthood. To augment and further cement this explanation, is modernization theorizing which argues that the latency process inherent in progressive change of societies explain how and what cultural groups evolve using drivers of change such as education, wealth and technology (Lerner 1958, Rostow 1960, Black 1966, Sarup 1993). This paper portrays how education, cost, health and religion are change determinants responsible for shift in paradigm from traditional to clinical circumcisions in a rural agricultural community in western Kenya.

3. Methods

The cross-sectional study was conducted amongst Babukusu of Western Kenya; also referred in some literature as The Bukusu; one of the eighteen sub-ethnic groups that constitute one of Kenya's three largest ethnic groups, Abaluhya, a Bantu-speaking people of Western Kenya (Were 1967). Babukusu comprise more than one hundred clans, which share common backgrounds and customs, including male circumcision, strongly kin-based social networks governed traditionally by their lineage and clan elders (Osogo 1966). They largely inhabit Bungoma County with an estimated population of 1,290,682 people (Bungoma District Development Plan 2002-2008). Male circumcision is universal and obligatory among Babukusu. Most young men are circumcised by a traditional surgeon, but increasingly families are turning to Western-style clinical circumcision for the procedure.

Sampling and Data Collection

Through triangulation of results from three methods of data collection, both validity and reliability were adequately achieved by the study. The study developed data from populations in two sub-Counties; Kanduyi and Bumula. Participants for this study were recruited by a two stage cluster sampling method. In the two sub-Counties 75 households were selected randomly in the 15 administrative units (locations). Two to three months prior to the circumcision month of August researchers enquired by survey at each sampled household if there was a boy present who would circumcise during the August 2004 circumcision season. Boys numbering 1103 were identified and 1099 re-contacted in August out of which 1007 (91.6%) who circumcised were reached for interview using a semi-structured questionnaire. This instrument provided information about the age of the boys, their age by circumcision type, choice between traditional and clinical circumcision, their education level, their religion, their residence, days since they circumcised and their wound healing process. Focus group discussions (FGDs) with community members were undertaken for two primary purposes: First, to explore how Babukusu talk about and view male circumcision both in the historical previous, contemporarily and in future. This included how they categorized different circumcision practices, how they categorized and viewed traditional and clinical circumcision choices, activities surrounding each circumcision practice, and how they viewed the risks and benefits of various circumcision techniques done by various types of practitioners. Second, they were conducted, to determine the range of factors Babukusu of different ages took into account when considering different circumcision options for their sons. Special interest was laid on the cost involved and health regard including the HIV threat. FGDs totaling 13 were conducted with men while 8 additional FGDs were conducted with women. FGD participants were a convenience but purposive sample recruited at homes, markets and other public places. In-depth interviews were conducted with 32 male and female parents of the boys that had circumcised to determine the reasons behind choice between traditional and clinical circumcision. The in-depth interviews used probes to explore the core variables of the study including education, cost, health and religiosity. Importantly, in-depth interviews generated information used in this paper to understand the significance and meaning of male circumcision amongst Babukusu. Sixteen male and 16 female parents of the circumcised boys were interviewed. Stratification was made to reach 16 parents each of boys circumcised both traditionally and clinically. The parents were selected in a stratified random manner from each location of the sub-County to reach a total of 32 consenting respondents. The research protocol was approved by the Moi University, Institutional Research and Ethics Committee (IREC).

Analysis

Data from the 1007 interviews were entered in MS ACCESS database and converted to SPSS for analysis. Descriptive summaries of sociodemographic characteristics were based on frequencies and proportions. Qualitative data were exported into a qualitative data analysis computer software; QSR Nudist from MS Word and they were analysed by coding for salient points and for constructs and themes of importance based on the five key variables of study- significance of circumcision; explained by modernity factors of cost, health, education and religiosity.

4. Results

4.1. Sociodemographic Characteristics of Respondents

Of the 1103 eligible boys contacted by the study in April-June 2004, 1007 who circumcised July-August 2004 were interviewed using a semi-structured interview instrument post circumcision and their sociodemographic characteristics are summarised by circumcision type in table 1 underneath:
Those boys who were circumcised traditionally were significantly older (14.7 against 13.2 years). They were more likely to reside in a rural area (87.2% against 76.5%) and they were more likely to be Catholic, while those circumcised clinically were more likely to be Protestant.

Out of the 32 parents who responded to the in-depth interview, 16 were female and 16 were male. These were parents of the boys who had circumcised both traditionally and clinically. Most respondents were aged between 30-40 years and those who had clinically circumcised their boys tended to be relatively younger than those who had traditionally circumcised the boys. All respondents were married people who lived with 6 (mode) children in their households. On average each household had one boy circumcised during the year 2004 (mean = 1). Apart from 4 cases (n=32) who were extended family, all respondents were biological parents to the circumcising boys. Parents of clinically circumcised boys had a relatively higher education than those of traditionally circumcised boys. All parents were either farmers, unemployed or in temporary and low income employment. There was no marked distinction between the occupation and preoccupation of parents of boys who circumcised either traditionally or clinically. Likewise, there were no differences in religious affiliation of parents of traditionally circumcised and those of clinically circumcised boys and even between the boys and the parents. Notwithstanding, asked how important religion was to them, parents of clinically circumcised boys reported that religion was very important to them while parents of traditionally circumcised boys reported that religion was least important to them.

5. Key Findings

Decisions to circumcise a male Bukusu are made in close consultation across family members. Each family member plays a role in the decision to circumcise although the father is cardinal in making the optimal final decision. Babukus decide to circumcise their males on the basis of several factors which include the following; antecedent customary tradition over generations, financial and material resources, prestige and esteem, ripe age of boy, readiness, compassion and willingness by the boy, peer pressure from the boy’s peer and pressure from the circumcision age set members of the male parent to the boy referred to as; Baboki. The parents, maternal uncle and the boy are crucial decision makers before a circumcision happens and when they do this, they consider the above factors. To underscore the objective of this study, this paper presents the influence of modernity factors namely, education, cost, health, and religiosity on the choice by Babukusu between traditional and clinical circumcision.

Education

Asked if schooling was a factor considered when making a decision to circumcise the boys, an overwhelming majority of respondents reported that schooling was not a factor at all. Twenty seven out of 32 parents did not consider schooling as a factor to consider here. This implies that the boys were to be circumcised in spite of all prevailing factors, their education included. However, a few parents (<5, n=32) considered education a factor in the decision to circumcise. For example, they reported that they wished to have the boy circumcised before they joined secondary school to avoid interfering with their education schedule and to avoid the humiliation of a boy joining secondary school uncircumcised.

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Furthermore there was indication that education was a real concern while deciding to circumcise:

“...it forced me to have the boy circumcised at an early age so that he heals up quickly to resume studies” Wafula.
Nearly all Babukusu boys circumcise while they are in primary school (traditional = 99.3% and clinical = 98.9%) without regard of whether they are circumcising traditionally or clinically. However, looked at critically, parents of clinically circumcised boys were more likely to consider education as a choice factor. Five (n=16) parents showed that schooling had an influence on the decision to circumcise their boys clinically. They asserted that as a result of choosing a clinical circumcision for their boys, the education of the boys was not interfered with as summed up here:

“This is because the procedures for clinical circumcision are minimal” Wanjala.

These parents also chose clinical circumcisions for their boys since the wound healed quickly and the boys got ready fast enough to revert to their learning process, including attending schools in time after the August holidays:

“Yes. In clinical circumcision healing is faster thus it cannot interfere with the schooling process/education of the boy...since it was clinical, there was no time wasted and as such the boys went back to school as usual” Welima.

Whereas the value attached to education cannot impede Babukusu from circumcising their boys at a period seen suitable because of factors such as ripe age of the boy, it is clear that the need to adhere to school timetables and routines underpins consideration and choice for the type of circumcision the boy has to undergo. Babukusu parents opt for clinical circumcisions in order to fulfill the obligation to circumcise but still be able to ensure that by clinical circumcision their boys are able to adhere to programmed education schedules. It is therefore, not surprising to find here that parents whose boys circumcised clinically and who are also relatively more educated than those choosing traditional circumcision take cognizance of education as a factor in opting for clinical circumcision for their sons.

Cost

The cost of a circumcision is an important factor considered by Babukusu when making a decision to circumcise a boy. Decisions to circumcise or not to, are heavily pegged on the ability to afford both financial and material cost of a circumcision. Asked whether cost is specifically considered for choosing between a traditional and clinical circumcision, Babukusu parents who circumcised their boys traditionally reported nonchalantly that cost was “not a factor” because cost notwithstanding, Babukusu males circumcise as an overriding gold standard tradition. This however, should not be misconstrued to mean it is cheap to undergo a circumcision. Parents who circumcised boys clinically concurred with their counterparts that clinical circumcision was cheaper than traditional circumcision and as a result they chose to circumcise their boys clinically as a result:

“It is very costly to circumcise the boys at home traditionally as compared to clinical circumcision...It was expensive to have him circumcised traditionally so we took him to hospital. This was so because we were concerned about raising school fees for the brothers who are in secondary” Wasike.

In the matrix below (table 2), this paper compares financial and material cost of carrying out both a traditional and clinical circumcision. This gives us a true picture of both financial and material costs of Babukusu circumcision:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Traditional circumcision</th>
<th>Clinical circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financial cost</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior to circumcision</td>
<td>9,000 ($112) food and alcohol brew</td>
<td>4,200 ($53) food</td>
</tr>
<tr>
<td>During circumcision</td>
<td>23,840 ($ 298) fees, food, alcohol and ceremonial bull</td>
<td>4, 200 ($ 53) fees and food</td>
</tr>
<tr>
<td>Soon after circumcision</td>
<td>3,790 ($ 80) cloth, loin; <em>leso</em>, fee and wound medicare</td>
<td>510 ($ 6) for cloth, loin; <em>leso</em>, fee and wound medicare</td>
</tr>
<tr>
<td><strong>Material cost</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior to circumcision</td>
<td>Sugar, wheat/maize flour, beer, bed sheets, <em>leso</em>, soda, local brew, meat, goat, paraffin, blanket, bread, milk, bull</td>
<td>Bed sheets, <em>leso</em>, blanket and mattress</td>
</tr>
<tr>
<td>During circumcision</td>
<td>Bull, goat, sheep, chicken, bread, sugar, milk, maize, bed sheet, meat, alcohol, local brew</td>
<td><em>Leso</em> and simple meal</td>
</tr>
<tr>
<td>Soon after circumcision</td>
<td>New clothes and shoes, blanket, bed sheets, mattress, baking flour, chicken, meat, milk, maize/wheat flour, sugar, brew and wound care</td>
<td>Clothing, maize/wheat flour, beef, meat, eggs, fruits, and wound care</td>
</tr>
<tr>
<td>By and after graduation time</td>
<td>Maize, brew and food, new beddings, clothes, shoes, beef, sugar, bread and rewards</td>
<td>Clothes, beddings, food and rewards</td>
</tr>
</tbody>
</table>
Health

Parents circumcising their sons traditionally do not express health fears while those circumcising sons clinically express health fears resulting from and surrounding circumcision. Parents who traditionally circumcised their sons reported that since the traditional circumcisers were using a different circumcision blade; lukembe for each circumcising boy, there was no health fear of HIV infection from one candidate to the other as it may occur if one lukembe was to be shared. Yet one case reported that since they underwent traditional circumcision themselves and there was no health threat, they did not have any health fears while deciding to circumcise their son traditionally. From this point of view, therefore, the study found out that a majority of parents of boys that were circumcised traditionally did not consider health as a decision factor to circumcise their boys. However, these parents when asked about the HIV transmission threat they showed that traditional circumcision is more risky in terms of HIV transmission compared to clinical circumcision. This is in spite of the fact that they actually went ahead to circumcise their sons traditionally. Again this tells us that these parents perceive male circumcision to be universal and paramount hence according to them there are no any reasons that can deter its occurrence.

The following are what emerged as health factors that influence parents to traditionally circumcise their sons:

a) Parents were concerned that if blades are shared between more than one candidate HIV could be transmitted. However, this health fear was discounted since most parents thought adequate safety precaution was taken. Circumcising more than one boy in the same compound or adjacent ones means there are only seconds between one cut and the other. In such situations some parents assume that blood carried by a blade can contact with the fresh wound of the next candidate resulting into HIV passing on from the previous to the next candidate. This point of view is contentious amongst HIV/AIDS researchers. Researchers have argued that sharp cuts such as the one done using the circumcision blade; lukembe which is always razor sharp and given the manner in which circumcisions are done i.e., sharp hazing often not involving rubbing nor grazing, blood from the wound gashes out to the blade and not inward into the wound. If this is true, chances of infection are remote. Moreover, the chances that the boys were HIV positive are very remote, since the HIV prevalence rates of boys less than 18 years was much less than 1% at the time of this study. However, parents did not present this argument but rather they reported that they took precaution to ensure that traditional circumcisers had first, a blade for each initiate for the day. And second, that the traditional circumciser sterilized lukembe commonly using glowing charcoal overnight before the morning circumcisions. Driven somewhat with this confidence therefore, parents chose traditional circumcisions for their boys.

b) Boys who circumcise traditionally pass through tough and painful practices and experiences prior to, during and soon after circumcision. These conditions are perceived to harden the boy for endurance in oncoming adult life challenges. It is planned and expected therefore, that Babukusu male undergoing traditional circumcision experience pain. Such are considered man enough and therefore, are not ridiculed nor socially stigmatized in society. Thus this dimension adds a psychological health advantage, regardless of the pain undergone by the boy.

On further probing of this point, the paper reports that there are three health factors that influence choice for clinical circumcisions of boys. First, is the perceived fear of HIV transmission if the blades were to be shared. Second, are the health complications feared to likely arise from traditional circumcisions. Third, is the perception that boys circumcised clinically heal faster than those circumcised traditionally. The three health factors are summed up in the following quotation:

“The boy is healthy but we feared the transmission of HIV and fear of the health complications relating to traditional circumcision. Our concerns were how to have the boy heal faster and this is why we circumcised him at the clinic” Kuloba.

Parents of clinically circumcised boys when probed further for health factors that make them choose a clinical over a traditional circumcision they gave the following reasons:

a) Fear of HIV infection through shared lukembe.

b) Fear of tetanus infection through use of unsterile tools and unhygienic conditions.

c) The advantage of fast healing in clinical circumcisions.

d) Health complications perceived to be associated with traditional circumcision. They reported cutting of blood vessels resulting in over-bleeding, infection of the wound and severing of the glans also referred to as mutilation. They reported that such complications may lead to death or impotence as a result of traditional circumcision procedure.

These findings about health determinants of clinical circumcision choice show that parents make rational health decisions that put into consideration the HIV transmission threat and adverse effects likely to result from circumcisions. In contrast, parents who choose traditional circumcision still believe that there are no real health fears associated with traditional circumcision. Despite this quandary of arguments, health complications do arise from both traditional and clinical circumcisions as observed in table 1 above; rates of 35.2% in traditional and 17.7% in clinical circumcisions and as depicted in the following case narrative:
**Case narrative by researcher:** The one very serious, life threatening case was of a 16 year old boy who was first circumcised by a “clinical” practitioner who actually had no documented clinical qualifications (he was a cleaner at a hospital in a neighbouring County), but had set up a make-shift circumcision clinic in the area. Upon circumcision, the bleeding was so profuse, that the young man was transferred to a nearby health centre where the bleeding was arrested and he was put on intravenous (IV) fluids. The medical staff in-charge at the health centre decided that the circumcision was incomplete. Not being qualified himself to perform the procedure, he called in a traditional circumciser who proceeded to re-circumcise the young man. When the research team visited the young man three days after the procedure, he was still in the health centre; the wound was infected and unhygienic. The research team Clinical Officer cleaned up the wound and provided antibiotics and bandaging as part of the research project obligation. They did this again eight days post-surgery when the boy was visited in his home as part of the research design. When the research team revisited the young man 14 days after the procedure, the wound had become necrotic, and the young man was anemic and in severe pain. The team decided to take the boy to the County hospital, where he was admitted and retained for 5 days. Under general anesthesia, the wound was re-explored, the cut cleaned and re-sutured, ample supply of bandaging was provided, and food and new clothing were provided. When the subject was visited at home 30 and 37 days after the original procedure, he was found to be progressing well, and at 56 days post procedure the wound was fully healed, the subject had gained weight, and he had resumed most normal activities. The research team believes that the boy would likely have died had there not been an immediate intervention.

**Religiosity**

Nearly every person who circumcised their boys through the traditional circumcision did not regard religion as an influence to their decision to circumcise the boys this way. First of all, they did not value religion much to have an imposition to their choice for traditional circumcision. Second, they did not think that their religiosity could influence their option. This means that either they did not think religious affiliation can influence circumcision decisions or they believed that choice for a traditional circumcision overwhelms their religiosity.

In this study, all the respondents and their circumcising boys were Christian either Catholic or Protestant. Even though, some (4, n=16) parents of traditionally circumcising boys indicated they had no value for religion. They regarded religion as just an identity mark and a process of respecting God that cannot influence them against their choice for a traditional circumcision. One case reported that because of their religious influence they had considered their son for a clinical circumcision as parents, but the boy unexpectedly chose to join others for a traditional circumcision without the parents’ knowledge and consent. They learnt of this a few moments when the boy was already traditionally circumcised against their decision to have him circumcise clinically.

A weaker religious influence in traditional circumcisions is also attributed to people’s traditional uphold. They espouse their traditional beliefs and values and as a result they sustain the tradition of male circumcision by practicing circumcision traditionally:

“Christian religion is not a culture of Babukusu thus it cannot interfere with a cultural tradition such as circumcision” Waluke.

Further to this, the study observed that there were cases where the parents and perhaps the entire lineage were tradition bound not to contravene such an important cultural practice as male circumcision. In a case where the grandparent of the circumcising boy was actually a traditional circumciser, the grandson was obligated to circumcise traditionally and this is exactly what had to prevail:

“I do not know of any religion that encourages people to be circumcised clinically. Circumcision is just Babukusu custom that has to be observed regardless of religion” Wekesa.

Diminished influence of religiosity in influencing choice for traditional circumcision notwithstanding, clinical circumcisions was largely influenced by religion. Twelve (n=16) parents of boys circumcised clinically reported that religion was important to them, thus it influenced their lives and hence their decisions over matters in their lives, including circumcision choice for this matter. Christianity is the religious affiliation that most Babukusu parents ascribed to and which generally preaches against most of the African traditions including male circumcision. Christian teachings often proscribe most African traditional beliefs and practices which for this matter are characteristic of Babukusu traditional male circumcision. Because traditional circumcision and the religious teachings and philosophies are in some respects at loggerheads, it is not surprising to find in this study that people’s religiosity favourably influenced their choice for clinical circumcisions which indeed are devoid of indigenous traditions manifest in ritual.

This point of view is represented by the following quotation:

“We chose clinical circumcision since we are quite religious and do not adhere to tradition much...I am a born again Christian and did not want to mix tradition with Christianity... I just informed church members that the boy was going to be clinically circumcised and they gave him a go ahead” Nanjala.

This means that parents chose clinical and not traditional circumcision for their boys in order to avoid elaborate ritual and ceremonies that accompany traditional circumcisions and which do directly contravene religious expectations. Such ceremonies were reported as follows:
a) Invoking superhuman; both ancestral and spiritual powers.

b) Sacrifice to superhuman beings including ancestors during the expansive traditional circumcision ceremonies.

c) Dance and music that accompanies pre circumcision preparations, seen as immoral and contravening expectations.

d) Use of vulgar sex language during ceremonies surrounding traditional circumcisions.

e) Wanton and yet permissible and sanctioned destruction of property including foodstuff during the ceremonies.

f) Alcohol consumption during traditional circumcision ceremonies and related security, moral, safety and health fears.

Fundamentally therefore, religiosity influences choice for clinical circumcisions because people subscribing to this pattern of circumcision are governed by Christian morals which do not accommodate norms that characterize and showcase traditional circumcisions.

6. Discussion

<table>
<thead>
<tr>
<th>Variable</th>
<th>Advantages of traditional circumcision</th>
<th>Disadvantages of clinical circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional norm</td>
<td>-Rational initiation messages about role in production and reproduction conveyed to the boy</td>
<td>-Against the community norm, boys are ridiculed for not undergoing the traditional rites</td>
</tr>
<tr>
<td>Sense of identity and community</td>
<td>- Feel of community identity and solidarity</td>
<td>- Void sense of community and identity</td>
</tr>
<tr>
<td>Making of Babukusu man</td>
<td>-Adherence to norms and expectations of Babukusu</td>
<td>- Unable to associate and participate in rites that are an important part of adult Babukusu</td>
</tr>
<tr>
<td>Material gain</td>
<td>-Rewards offered to the boy by community, extended family, fathers age set group; bakoki and friends (cattle, goats, chicken and money)</td>
<td>-Rewards offered to the boy only by close family</td>
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<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>-Boys heal fast in order to resume school -Non protracted ceremony that does not disrupt education</td>
<td>-Elaborate ceremonies that disrupt schooling -Slower healing of wound interferes with schooling -Poor focus on education between May-December, circumcision period</td>
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<td>Cost</td>
<td>-Lower cost allows parents to save for school fees and other household needs</td>
<td>-Higher cost propagating a sequel of poverty</td>
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<tr>
<td>Health</td>
<td>-Healthier and safer; less pain, hygiene, lower risk of infection, wound heals faster, lower HIV infection risk, lower risk of mutilation thus no fear of infertility, more clearer sex messages conveyed</td>
<td>-Relatively higher health risks; unsafe, painful, prolonged wound healing, high risk of adverse events (bleeding, mutilation), fatigue during convoluted ceremony, chances of HIV infection especially if reproductive role onset is misconceived and through partying</td>
</tr>
<tr>
<td>Religiosity</td>
<td>-Guided by Christian morals and support associated with rational choice decision on education, cost and health</td>
<td>-Guided by traditional belief and practice associated with irrational choice decision that disregard; education, cost, health and religion</td>
</tr>
<tr>
<td>Social norm and value</td>
<td>-Process devoid of lawlessness, destruction, vulgarity and opportunity for sexual activity exploit -The boy is initiated into obedience</td>
<td>-Process is characterized by destruction of property, rowdiness and opportunity for seduction and sex -Boy grows arrogant and contemptuous especially to women and people who do not circumcise and who do not circumcise their way -The boy is initiated into masculinity</td>
</tr>
</tbody>
</table>
Babukusu traditional male circumcision has upheld its significance over changing times. In this paper, its implication and worth is explained through two values; the key importance is its role as a platform on which cultural, social, moralistic, political and economic messages pass from one generation to the other thus forming the initiation package (Bettelheim 1954, Whiting, Kluckhohn and Anthony 1958, Van Gennep 1960, Katam 1996, Egesah 2009). Circumcision is a process by which the traditional norm of initiation through lessons about roles, functions and community expectations especially for production and reproduction pass to a young man as they change from childhood to adulthood. These initiation packages simply put:

“Enable an individual to live well with all people, provides chance to, marry and to own and produce property.”

Lungwa.

Traditional male circumcision process achieves the initiation objective better than the clinical circumcision process which is less normative. This is why traditional Babukusu circumcision has persisted despite modernity influences. Besides the value of traditional circumcision, this paper also describes the value attached to clinical circumcision. Clinical circumcision is gradually taking root amongst Babukusu because of rational benefits that are gradually weighing down benefits of traditional circumcision (Bailey and Egesah 2006, Bailey, Egesah and Rosenberg 2008). Male circumcision practice is valuable, important and significant to Babukusu since it embraces judicious persistence of tradition and custom through traditional circumcision and it also embraces rational choices that regard the realities of contemporary life through clinical circumcision.

7. Conclusions

Male circumcision is an important cultural heritage of Babukusu of Western Kenya. The significance of Babukusu circumcision lies in its function in society. Traditionally, Babukusu male circumcision has served as transitional turning point in lives of men and women at around teenage. Recently though, there has been gradual introduction of clinical circumcision as an additional option in offer to the same practice. This paper concludes that the role of Babukusu male circumcision is being reshaped not only to continue serving its traditional purpose of initiation, community identity and social bondage but also to do so within acceptable realities of contemporary modern life. This synergetic equilibrium by application situates and redefines the relevance of an important cultural heritage for the future. The paper visualizes continuity of male circumcision adoptable to serve its function within realistically cogent social, economic and health environments.

REFERENCES


