

Extracts from

ASSESSMENT OF CLINICAL AND TRADITIONAL MALE CIRCUMCISION SERVICES IN BUNGOMA DISTRICT, KENYA: COMPLICATION RATES AND OPERATIONAL NEEDS

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Babukusu in Western Kenya

The Babukusu are one of the eighteen sub-nations that constitute one of Kenya's three largest ethnic groups, the Abaluyia (or Luhya), a Bantu-speaking group of western Kenya. The Babukusu comprise more than two 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). The Babukusu are the largest ethnic unit of the Baluyia nation, comprising 17% of the Baluyia population or about 600,000 people (Wandibba 1977). Today they inhabit primarily the Bungoma District of Western Province. Their neighbours are the Luo to the south and southwest, and to the north and east are the Kalenjin. To the west near and across the Ugandan border live the Samia, Phadola, Bagwere, Teso and Bagisu, some of whom (e.g., Teso and Basoga) do not practice circumcision. Lubukusu, the language of the Babukusu, and other cultural traits, including circumcision practices, are closely related to those of the Bagisu of Uganda (deWolf 1977). The Babukusu have an agricultural economy, their main crops being maize, beans, sugarcane, coffee and tea. They also keep cattle, sheep and goats. Recently, many Babukusu have migrated to urban areas in search of work. There is a sizable Bukusu community in Nairobi, for example (Weissner 1997).

Male circumcision is virtually universal among the Babukusu. Most young men are circumcised by a traditional surgeon, but increasingly families are turning to western-style medical practitioners for the procedure.

Changing Practices

Various forces of change are exerting pressure on Bukusu families to adapt male circumcision rites and practices in ways that are congruent with the changing demands on their time, resources and social ecology. Population pressure on the land and other factors (deWolf 1977) have forced a shift away from agro-pastoralism to more purely agricultural or salaried and day labour subsistence. The need for jobs has resulted in greater emphasis on schooling and in changing residence between natal rural villages and cities and large towns like Bungoma and Nairobi (Weisner 1997), and these in turn have put more pressure on attaining sufficient resources to pay school fees and rents (Ogutu 1985). Emphasis on wage labour in the face of limited jobs has changed gender roles (Bradley 1977; Nasimiya 1985) as well as intergenerational roles (Killbride and Killbride 1997). Throughout, respect for family tradition, clan identity, and one's elders has eroded (Wandibba 1997). Finally, the HIV/AIDS epidemic has forced Babukusu, as others, to re-evaluate all their behaviours and practices, and to bring those things that used to be considered mainly in the contexts of culture, tradition and religion into the contexts of health, prevention of infection, education, and survival.

These factors have changed the circumcision practices. Boys are no longer sequestered for months at a time. The circumcision season is scheduled around the school calendar. Circumcisions take place in late July and early August, as boys finish school. This is to allow time to heal before resuming school in September. The "coming out" ceremony then occurs in

December, during the Christmas school holiday. Instead of a spear and shield, boys are given a new change of school clothing or schoolbooks and pens. Celebrations in many cases are not as elaborate (and costly) as in the past, since families care to save their money for school fees. And more and more Bukusu families are turning to medical circumcision to fulfil their cultural obligation to be circumcised. The main reasons are those of cost (traditional circumcision is more expensive because of the need to kill a bull and the feasting and celebrations that are sponsored by the family), need for rapid healing to return to school, fear of injury, desire to be “modern,” alternate ways to express manhood (graduation from school, getting a job, earning income), and reduced risk of infection, including HIV infection.

In summary, numerous factors are contributing to changes in the preferences of Babukusu for different circumcision practices. Many are continuing some form of traditional practice with the procedure performed by a traditional surgeon in the context of traditional rituals and ceremonies. Others are turning to medical clinics and having private operations performed with little or no knowledge of extended family and community members, while others may be pursuing a middle ground – having medical clinicians perform the operation, but otherwise engaging in traditional pre and post circumcision ceremonies. Just what proportion of Bukusu youth are being circumcised in clinics is unknown, but it is certainly in the hundreds each circumcision season and increasing. One church organization performed approximately 1000 procedures near Kitale in 2004. At one health centre in 2000, 120 circumcisions were performed. In the Bungoma District Hospital, the District Medical Officer told us “more than hundred” were performed, and they handled six cases of young men who were circumcised by traditional surgeons and came to the hospital with serious complications, one of which resulted in amputation.

Summary of Focus Group Discussions

The results of the 21 focused group discussions (FGD) will be reported in much greater depth by Omar Egesah in his doctoral dissertation and in papers submitted for publication. We here provide a brief summary of the results to provide qualitative information about the factors that Babukusu take into account when making the decision whether to seek circumcision from a traditional or medical practitioner. The results are summarized in bullet form.

The disadvantages of traditional circumcision

- Higher costs
- Much pain
- Fatigue experienced during the long period of ceremonies
- Distraction from school – lack of concentration on education over a long period – May through December.
- High risk of HIV infection through sharing of the knife
- Burden of hosting people for elaborate ceremony
- Traditional rites go against Christian teaching
- Destruction, rowdiness, seduction and sex

The disadvantages of medicalized circumcision

- Goes against community norms. Boys risk stigmatization and ridicule for not undergoing the traditional rites, as do parents of the boy.

- Unable to participate in some rites and rituals which are beneficial and an important part of becoming an adult Bukusu.

The advantages of traditional circumcision

- The boy receives advice on his role in society and his responsibilities as a man and husband.
- Adherence to the norms of the society, of making a man.
- Sense of community and solidarity with peers.
- Gifts and rewards that accrue to the boy and his family from relatives and friends.

Advantages of medical circumcision

- Lower cost allows parents to save for school fees.
- Healthier and safer: more hygienic; less risk of infection; less risk of mutilation; heals faster; no HIV risk; less pain
- No lawlessness, destruction, vulgarity, sexual activity, which is common during the activities surrounding traditional circumcision.
- Privacy

The High Costs of Complications

High rates of adverse events (AEs) impose costs on boys, parents, health facilities and civil society. The long periods necessary for proper healing take time away from school or from productive activities, such as helping in food production. The burden to parents and relatives for additional medical attention in this rural, high-poverty district can be financially crippling. The necessity for health facilities to address complications during the prolonged circumcision season diverts scarce resources from other essential services. Finally, the Babukusu and other societies that practice traditional circumcision undergo ridicule for adhering to practices that are perceived by others in Kenya and elsewhere as primitive, wasteful of human resources, and exhibiting disregard for the rights of children and adolescents. In a society where circumcision is universal, young people have no choice but to be circumcised. Under such conditions, they have a right to safe services and to be able to make informed choices about how the procedure is to be performed.

It became apparent that many AEs could be avoided if initiates and their parents were given clear and comprehensive instructions on wound care. Unhygienic conditions are a major problem in settings where access to water is difficult; however, most problems arose from lack of knowledge about how to care for the wound. Penicillin powder (gravacine) was very commonly applied to the wound; this was true in cases of both traditional and medical circumcisions and is a common practice in many African settings. The powder became caked in the wound, slowed healing, and resulted in thick scarring and in some cases discoloration. Bandaging often consisted of soiled cloth or gauze that was applied repeatedly. The wound often went many days without cleaning, and when bandages were removed, the wound reopened. In rural settings, leaves were sometimes used to dress the wound. Whether they have any medicinal properties is unknown.

Lack of Knowledge About Post-Operative Care

Despite having gone through it themselves, there appeared to be a lack of knowledge on the part of fathers and older men about wound care or detection of complications. The prevailing

approach to complications seemed to be to wait and see and hope for the best. This is likely in part because boys are expected to have difficulties. The older men themselves went through difficulties when they were circumcised, so excessive pain, swelling, slow healing, poor cosmesis, lack of erections, etc., may be expected. The threshold for determining when a boy needs medical care is very high under such circumstances. In addition, families are reticent to incur the costs of follow-up care, so they attempt to address complications themselves or with help from indigenous healers. Education of parents, guardians and the initiates themselves as to proper wound care and recognition of when medical assistance should be sought could reduce the frequency and severity of AEs significantly.

Early Sexual Activity

It is apparent from the results that interventions are needed to reduce the high rates of complications associated with both traditional and medical circumcisions. Additionally, the results show that this sample of young men was sexually active at early ages. The median age at sexual debut was between 14 and 15 years. Approximately half the young men were sexually active before they were circumcised, more in those circumcised traditionally (63.1%) than those circumcised medically (35.5%). The odds of having had sex before circumcision were 3.11 times greater for those circumcised traditionally than those circumcised medically, after adjusting for age at circumcision. And those circumcised traditionally were more likely to have resumed sexual activity 60 days after their circumcision than those circumcised medically. This is especially troubling because the wounds of 24% of those circumcised traditionally and 19% of those circumcised medically had not fully healed when they were observed at 60 days post-op.

These data regarding sexual activity before and after circumcision along with extended post-op healing times have the following implications:

- Behavioural interventions including the ABCs of HIV prevention should begin early - in primary school-aged children – before boys are circumcised.
- Consideration should be given to promoting earlier age at circumcision to ensure that the procedure is performed before onset of sexual activity.
- Improving the quality of medical circumcision services could reduce healing times and thus reduce risk of HIV infection in those who resume sexual activity soon after circumcision.
- Counselling males not to engage in sex until they are fully healed must be included in post-op instructions.
- Circumcision cannot be a stand-alone procedure; it must be integrated with behavioural and reproductive health counselling in order to minimize both complications and risk of HIV infections.

Preference for Medical Circumcision

Finally, during the focused group discussions and interviews with adults, it became clear that many – probably the majority – of the Bukusu would prefer that their sons and brothers be circumcised by medical practitioners. The advantages they cite are listed above. The two most salient reasons are the lower cost and the safety, but a prevailing sentiment is a general sense that traditional circumcision is backward, wasteful and no longer relevant in a day when families are struggling to scrape together school fees and placing increasing emphasis on education to enhance employment opportunities in a competitive economy. The partying, rowdiness and distraction from education that accompanies traditional circumcision,

combined with the pain and suffering experienced by the boys, reinforces the reluctance to spend limited family resources on an act that can be achieved quickly and privately at minimal cost. There was also the sentiment that traditional circumcision is anti-Christian, primarily because of all the rituals and ceremonies involved. These sentiments against traditional circumcision practices were expressed most often by women; whereas men, especially rural older men, were more likely to prefer to stick with the tradition of circumcising in the village with all the culturally appropriate fanfare. Nevertheless, our impression was that most Bukusu would prefer circumcision to take place in a medical setting. However, the prospect of social pressure and possible stigmatization was a powerful deterrent against change. Males especially were fearful of being stigmatized in their community for not going through the traditional rites. Women seemed less concerned about this and more concerned about safety for their sons and the costs to the family.

These findings are consistent with what was found by the Anglican Church of Kenya when they introduced mobile medical circumcision clinics. Initially, they found widespread reluctance on the part of Bukusu families to commit to medical circumcision. However, once several church leaders and local chiefs endorsed the program, there was a rush by literally thousands to sign up, and the providers had many more clients than they could possibly service. Their interpretation was that there was a hidden pent up demand for medical circumcision services that was released only once respected community leaders signalled that the practice was acceptable. This lifted the risk of ridicule and stigma from the shoulders of parents, and they embraced the program with open enthusiasm.

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