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"Taming Tradition": Medicalized Female Genital Practices in Western Kenya

This article considers the question of female genital practices at the hands of health workers in western Kenya. Recent articles in Medical Anthropology Quarterly *have critically engaged with the biomedical arguments condemning such practices. This article studies the case of medicalized circumcision in which biomedical concerns over health risks have become incorporated in their vernacular practice. Although some suggest that medicalization may provide a harm-reduction strategy to the abandonment of the practice, research in one region challenges this suggestion. It argues that changing and conflicting ideologies of gender and sexuality have led young women to seek their own meaning through medicalized practice. Moreover, attributing this practice to financial motivations of health workers overlooks the way in which these "moral agents" must be situated within their social and cultural universe. Together, these insights challenge the view that medicine can remain neutral in the mediation of tradition.* [female genital practices, female circumcision, Kenya, harm reduction, medicalization]

> We must have the guts to end the practice and allow children to get circumcised in hospital. Subjecting children to pain totally contravenes the UN Convention on the Rights of the Child, which Kenya has signed. Let us agree that any cultural practice that subjects people to pain is obsolete and should be either abandoned or reformed. This is not a call to ban circumcision as a practice. It is only a wake-up call against inhuman methods used. Traditional circumcision does not fit in with today's world. People need to be taught that there are more hygienic ways of circumcision. We should not allow a tradition to play poker with children's lives.
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> —John Kamau[1]

The female circumcision controversy that set ablaze the passions of Christian missionaries, nationalist leaders, and inhabitants of Central Province in 1929 have been rekindled in Kenya once more over the medicalization of female genital

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practices. Arguments that polarized groups in the past endure today but their appropriation by a new set of actors reveal an interesting paradox in the alignment in interests. Biomedical arguments used by church missionaries in the 1930s to frame their moral disdain for female genital practices have been appropriated today by health workers in defending their moral virtue in the performance of the procedure. The language of rights through which Jomo Kenyatta once asserted the primacy of cultural practice for the preservation of identity in the move toward independence has been borrowed today by nongovernmental organizations and government agents in their condemnation of cultural practices that violate universal tenets of the human person.

As a result, the contestation of rights, health, and cultural primacy in the debate over female genital practices in Kenya remains strong. But this conflict has not been solely confined to female genital practices. Rather, as highlighted in the introductory newspaper article, recasting the rights of children has called for new social imaginaries in the rites of male and female circumcision. For both boys and girls in practicing communities, medicalized circumcision has become a new reality.[2]

Advocated throughout this past century by local health, religious, government, and development practitioners as a pragmatic solution to fatal tetanus infections and hemorrhage, medicalized circumcision has become an increasingly negotiated practice across sub-Saharan Africa. By medicalized, I mean the practice of genital tissue cutting either performed by a health worker or under medical conditions. The introduction of health workers in the performance of the practice has added a new dimension to the debate, as the "right to health" argument forwarded by those that campaign against female circumcision is asserted by those that advocate the performance of the practice by medical personnel. In this article, I examine medicalized circumcision from the perspective of Gusii community members and health care workers in western Kenya, among whom the practice of female circumcision continues to thrive.

Background

Recent Demographic and Health Surveys (DHS) from African countries that include modules on female genital practices report a slow decline in their prevalence, but point to the rapid rise in the practice by health personnel (DHS 1997). In Egypt, the 1995 survey testifies to this trend, with 13 percent of ever-married women aged 15–49 years choosing a nurse or a doctor as circumciser, whereas among their daughters, this figure climbs to 46 percent (DHS 1997). Studies from southwest Nigeria (Caldwell, Orubuloye, and Caldwell 1997) and Sierra Leone (Koso-Thomas 1987) describe a similar trend toward medicalization. In Kenya, the 1998 survey indicated that up to 38 percent of ever-married women aged 15–49 years had undergone a form of female genital practice (DHS 1998). One-third of these women reported being cut by a health worker (34 percent). Among those ethnic groups surveyed, Gusii members were notable for their near universal practice of clitoridectomy (96 percent). Moreover, in this strongly Christian ethnic group in southwestern Kenya, nearly half of all women had undergone medicalized circumcision (49 percent). It is in light of these figures that the AbaGusii have received

considerable advocacy from NGOs and faith-based organizations over the last 10 years to reduce the prevalence of the practice.[3]

Despite this trend toward medicalization, few studies have examined medicalized female genital practices (see Njue and Askew 2004; Shell-Duncan 2001). In part, this trend reflects the view that female circumcision is so embedded in local structures of class, gender, politics, and economy that it remains impervious to change (Koso-Thomas 1987). Such a position underestimates the power of perceived forces of change—defined locally as educational, religious, political, or economic—and overlooks the critical ways in which individuals and their communities negotiate their livelihoods when faced with such choices. The persistence of female genital practices in the context of increasing medicalization challenges the static and ahistorical representations of the practice that prevail in the literature.

This article outlines the political, economic, and social conditions that have led to the emergence of medicalized female genital practices among the AbaGusii in three generations. Drawing from Bourdieu (1978) and van Gennep (1965 [1909]) in recognizing that rituals cannot be understood in isolation of their social context but demand consideration of the ways in which actors embody their system as well as live within it, I carried out participant observation and interviews at the World Health Organization (WHO) in Geneva, at a university and community hospital in western Kenya, and in two districts of Kisii for 3 months in 2002. Bringing these narratives together in conversation highlights the "webs of significance" that have been spun in the gendered and transnational history of female genital practices in Kenya. I explore three aspects to this history in this research.

First, within a multilateral organization such as the WHO, female genital practices have been framed in different ways at different times: it was a nonissue in the 1950s–60s, a cultural issue in the 1970s–80s, and a medical issue in the 1990s; more recently, it has become the focus of global discussions on violence against women and reproductive rights (see Commission on Human Rights 1995; ECOSOC 1958; General Assembly 1986, 1993; WHO 1995).

Second, female genital practices have figured prominently in the political evolution of the Kenyan state: from colonial attempts at purifying the body in the building of an empire; to the appropriation of the practice within the discourse of the independence movement; to its political significance during Kenya's development as a modern secular state; to its current status as criminal and prohibitive act. Throughout the last century, female genital practices have been an issue around which the battle between traditionalism and modernism has been waged (see Kenyatta 1953; Ministry of Health 1999; Murray 1976; Smith 1926; Thomas 2003).

Third, among the AbaGusii, female genital practices have evolved in form and meaning in response to broader social and economic changes in the region, but are practiced nearly universally in medicalized form. It was the persistence and renewal of the practice in the context of social change that drew my attention to the need to investigate the practice in greater detail.

Within the community, research among three generations of AbaGusii revealed a human warmth that had been missing in readings on female circumcision. The rise of medicalization is often attributed to the supply of willing nurses and clinical officers whose financial situations might encourage complicity in the contemporary practice (PATH 2002). Yet, this perspective fails to situate the moralities

of female health workers within the gendered universe that characterizes Gusii society. It also ignores the ways in which the decision to export circumcision into the medical sphere may reflect an active choice on the part of community members. Mindful consideration of the scope of individual agency in the community and the health sector cannot be overlooked. Without this consideration, any understanding of the contemporary practice marginalizes the subtle ways in which people with seemingly little power to effect change in their lives do so in very concrete ways. The use of biomedicine may represent one way in which traditions are reconstituted locally to make sense of concerns that have risen globally.

From this research, this article suggests that the medicalization of female genital practices articulates the conflicting gender ideologies and norms of sexuality that are taking place in the context of social change. To illustrate this concept, I include select narratives and questionnaire results from health workers and community members in Kisii district.[4] This research is particular to the practices in Kisii, but it raises many of the ambiguities that underlie the formation of identity and gender worldwide. Although much of the debates over female genital practices have centered on the language used to describe the practices—female genital mutilation, female genital cutting, female circumcision, or genital surgeries, depending on one's ideological stance—this article seconds Boddy's (1998:80) proposal that we "un-name" the procedures as an essential exercise to loosen the perception with which these designations have become tightly associated. In this way, discussion of "feminization rites" within a continuum of body-altering practices may avoid exoticization (Sheldon and Wilkinson 1998:264).

Ultimately, challenging the disciplining of female bodies to the dominant social, cultural, and political aesthetic should not be limited to the practices of female circumcision (see Scheper-Hughes 1991), but should include the surgical "purchase" of femininity through tummy tucks, "Botox" and nose jobs, purification of the feminine face through whitening treatments, and the obsessive waxing, plucking, and dieting that support the beauty myth of women the world over (Boddy 1998; Bordo 1993; Morgan 1991). However, theorizing the interstices of postempire, globalization, nationalism, gender, class, and religion in the local "making" and "remaking" of women remains a central challenge for anthropologists today.

The terminology I use in this article is deliberate. The term *female genital practices* is used to capture the spectrum of body-altering practices involving the female genitals, and *female circumcision* is used to refer to the practices AbaGusii perform in the initiation of young women. The simultaneous usage of these terms should convey the fluidity in the meanings ascribed to the practice and highlight the ambiguities that remain in the discussion of this subject. Additionally, drawing from Obermeyer (1999:85), I avoid the frequently used acronyms of "FGM" and "FGC" so as not to lose the meaning in the words or objectify the practice as if it were some rare medical syndrome.

History of Medicalized Female Genital Practices

The medicalization of female genital practices is not a new phenomenon. Despite its newfound identity as a possible harm-reduction strategy within public health discourse (Shell-Duncan 2001), this strategy can be traced historically as pragmatic responses by health personnel to the practice of female circumcision.

Murray (1976) describes the medicalization of the practice at the hands of Christian mission nurses in Kenya in the 1920s, while Boddy (1998) notes a similar development in the Sudan taking place with the encouragement of British midwives between the 1920s and 1930s. In the more recent past, traditional birth attendants in Somalia have received formal training on the importance of aseptic technique in female genital practices (van der Kwaak 1992) and have been encouraged to practice a milder form involving the symbolic pricking of the clitoris only (Obiora 1997). In Egypt, government efforts to curtail the inhumane conditions under which female circumcision was performed led to the brief legalization of medicalized circumcision in 1994 at the hands of physicians in private clinics (El-Gibaly, Ibrahim, Mensch, and Clark 1999).[5] In Mali and Nigeria, medical personnel have become the preferred operators for urban and middle-class dwellers in the circumcision of their daughters (Caldwell, Orubuloye, and Caldwell 2000; Population Council 2000). Outside the African context, proposals for the symbolic circumcision of Somali immigrants have been raised and vigorously opposed in the Netherlands and in the United States (Shell-Duncan 2001:1019). Within the current debates on accommodating new European identities, medical officials in Italy recently proposed alternative forms of circumcision such as pricking the clitoris with topical anaesthetic in order to mediate the tensions that prevail in the "co-existence of cultures" (Bruni 2004).

Such proposals have assumed that when medicalized, female genital practices remain meaningful to the practicing community in the short term and will lead to the abandonment of the practice over time.

Although such discussions are grounded in the hypothetical, in the last two decades, medicalized circumcision has been an institutional practice at Kisii District Hospital carried out openly by nurses and clinical officers. Until 1994, the National Health Insurance Fund covered the practice (*Daily Nation* 2002). From 1994 onward, the practice continued, but with fewer families able to afford the costs of admission, the hospital practice and the period of seclusion declined. A shift in the practice from the hospital to the dispensary and the initiate's home began and became more firmly entrenched with the rise in health concerns. Today, with the passage of the 2001 Children's Act, which, among other things made female circumcision a criminal offense, a shift in the practice continues to be observed.[6] From its course in the community, to its hospitalization and present move within the privacy of homes, medicalized female circumcision in Kisii may provide some valuable insights in contemporary debates about the mediation of biomedicine in matters of the body and tradition.

Research Approach

To gather these insights, I worked as a physician in the busy gynecology ward of Kisii District Hospital, Kenya. At the same time, with the assistance of three research assistants,[7] I carried out 120 structured interviews among the AbaGusii in the urban setting of Kisii town and the lush agricultural division of Suneka within Kisii district. These interviews explored aspects related to change in health services, gender roles, female circumcision practice, government and NGO initiatives, and attitudes related to medicalization. An equal number of grandmothers (20), grandfathers (20), mothers (20), fathers (20), young women (20),

and young men (20) were sampled randomly and purposively. During the period of study, 13 informants drawing from the medical (4), nursing (7), and administrative staff (2) at Kisii District Hospital were interviewed to capture the ways in which health workers have interpreted the medicalized practice of female circumcision. Selection was based on seniority so as to capture the institutional memory of the hospital with respects to the practice of female circumcision.

Before considering the findings of the research, this next section will outline the social context in which female genital practices are found in Kisii.

Social Context

In Kisii district, evolving economic conditions have placed a greater burden on women for the care and maintenance of families. The vast tracts of land over which Gusii clans competed and claimed wealth and prestige through polygamy, polygyny, cattle herding, and agricultural expansion have, over several generations, become parceled into smaller plots of land that today leave most households unable to support themselves on no more than 1.5–2.0 acres each (Silberschmidt 1991:28). The resulting inability of sons to secure inherited land has had significant implications on marriage practices in Kisii. In the past, sons depended on their inheritance of land for the payment of bridewealth. Such bridewealth was necessary in recognizing the legitimacy of conjugal unions and the role of men and women as fathers and mothers. For men, payment of bridewealth accorded them the right over the production and reproduction of their wives. In return, women gained managerial and use rights in the land, right of maintenance for herself and her children in her husband's home, and the right of her sons to become the legal heirs to the land allocated to her (Silberschmidt 1999:77).

In the absence of payment, men today must delay their own wedding and seek other sources of wealth or elope. Faced with competition from their brothers for resources and confronted with a cultural ideal that does not acknowledge the existence of unmarried women, modern Gusii women elope (Håkansson 1988). Indeed, cohabitation and elopement are the hallmarks of contemporary Gusii wedding unions. Although these alternatives may seem to offer greater advantages to men, it is an undesirable situation for men and women alike as it undermines norms that legitimate their social roles. Men must concede rights over the custody of their children and productive labor of their wives, while women live in fear that estrangement from their boyfriends will leave them without financial security or rights of inheritance to their sons.

All these changes have had a transformative effect on the social fabric of Kisii with regard to ideologies of gender and norms of sexuality. Femininity, defined and reified through circumcision, marriage, agricultural work, and polygyny, was also strongly influenced by a moral code that dictated obedience and submission to elders and husbands and respect for sexual norms of behavior. Economic conditions have greatly challenged the basis for such distinctions in gender roles with their erosion of agricultural activities and formal wedding unions.

At the same time, these same economic conditions have reinforced gender distinctions. For example, the larger investment in daughters' education today means that a greater emphasis is placed by parents on their daughters' sexual restraint—such as not eloping, not mixing with boys, avoiding pregnancy—so as not to

jeopardize much needed bridewealth payment within the household. Additionally, the gradual dissolution of male networks of power and the growing alienation from agricultural activity would have predicted greater opportunities for the relaxation in sexual conduct, but more than ever, sexual modesty remains a critical component to the construction of feminine morality. Situating the emergence of medicalized female circumcision in relation to changing economic conditions and norms of marriage, gender, and sexuality is the focus of this article. To lead the discussion, the following section begins—appropriately enough—with a conversation with one grandmother and her granddaughter.

Outline of a Practice

Sitting in the shade of her veranda, Mary,[8] a 72-year-old grandmother, recounted with considerable enthusiasm the day she was circumcised. She described waiting in anticipation each year for her turn to come when she would not only partake in the community celebrations for newly circumcised boys and girls, but would be the center of such celebrations herself. As she told me,

> A few days before my special day, my parents informed me that this year, I would be joining my cousins in becoming circumcised. I think I was 15 at the time. I remember staying up all night, amidst the loud songs and dance in the community and very early in the morning moving into the forest with 30–40 other girls in the community—cousins, friends, and neighbors—as well as the sponsors selected by our parents to watch over us. We wore very little. Just a small piece of cloth covering our private parts. We said very little. The women accompanying us sang many songs. They told us "you will not be running around with boys anymore or sitting with your father." We bathed in the river first. After, the women held us down to give adequate space for the signature cut by the knife of the circumciser.[9] Back then, it was one knife shared between all girls. I could think nothing else than to keep quiet. That is what we had been told. Fortunately, many of the women holding us placed their hands over our mouths to dampen those few whimpers that we could not control. No anaesthetic was used. We knew it was supposed to be painful. It was. I bled . . . just a little bit . . . but I bled. Some maize flour was sprinkled over to make the bleeding stop.
>
> After, I walked away on my own to await the completion of the ritual by the rest of my age-mates. I returned home with family age-mates to the welcoming hug of my mother and aunts. We celebrated all day over homemade brew, a slain goat, and plentiful bowls of maize. The older women started the sacred fire outside the hut where we would remain for the next few weeks. My cousins and I were responsible for maintaining the sacred fire during our period of confinement. Keeping this fire alive was to test our ability to concentrate fully on something else. We were paining a little. But we had to think about feeding the fire. This is what it is like to be a good Gusii wife and mother. For 30 days, I was confined to the house, prevented from meeting any of my male relations and left to learn of the importance of becoming a good woman through ongoing discussions during that period with a traditional personal trainer. Women who had joined in the festivities on the day of circumcision returned during that time to sing and talk with very lewd comments about our future roles as wives to our husbands. During these 30 days, I did not bathe and intermittently rubbed ashes from the sacred fire onto my skin, until the last day when I would walk with the rest of my age-mates to the river to bathe and return home in new clothes to meet my whole family, and

> settle into my new place in the home which is always in a part of the compound that was removed from the father. I stopped my schooling then as I now had more important duties in the home. Like this we waited until we married.

As Mary described this, her granddaughter Lydia stared blankly onto the street. At the age of 18, Lydia works as a cashier in a shop and lives at home with her parents and grandmother. In her words she recounted,

> I don't remember it very well. I was 9 years old at the time. My mother came to tell me that I was going to be circumcised the next morning. I had heard about this before and felt rather scared all night. I could not sleep very well. The next morning, we woke up early, took some porridge to eat, and my mother and I went to the hospital in town. It is a private hospital. There, a handful of mothers and their daughters were waiting on the ward. That is what they did back then. A number of women from the neighborhood would agree on a particular date and would go to the hospital together. We were placed in rooms on the ward and asked a few questions about our age and health. My mother explained to me that I was in safe hands here at the hospital. My older sister had been circumcised here as well. Later in the day, the nurse came to get me. I went to a small examining room that was called a minor operating room. I walked in. I told her my name. She did not ask me any questions. Except she told me that this would make the women in my family proud. My mother said a few words to the nurse and then she remained at the door, her back facing me. I lay down and lifted my skirt. I spread my legs as she asked and without warning, some cold liquid flowed between my legs. Then a small pinch and then she asked me to stay down for a few minutes. It all happened so fast. She went to the sink to throw away some metallic utensil. I sat up eventually, found my skirt and shoes and was helped off the table by my mother. As I left, I turned and saw a small pool of blood in which I assumed a small piece of me lay.
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> Later, my mother told me that she had instructed the nurse to remove as little as possible. I went back to the ward and stayed there for a week. Normally, during that period of confinement, one is not allowed to see any male relations. However, as I was not the first to be circumcised, I think the rules were relaxed. My brothers were allowed to visit. I did not speak very much with the other girls. At the end of the week, I bathed and my mother surprised me with new clothes. I walked home with my mother and an aunt that had joined us along the way. When I returned home, I was happy to see my father. He seemed proud. There were no celebrations. As I said, I was not the first to be circumcised. For my sister, the whole extended family had come for dinner. On that night, we had a simple dinner just the seven of us. I was told that I had to move my things to another part of the house, as I could not sleep so close to my father. I moved my things. That was it. A few weeks later, I went back to school and learned that many of my friends had undergone the same over Christmas. It seemed like the younger kids in the school were most excited by it. As much as we had feared, there was something appealing about being circumcised when we went back to school.

Although these two narratives do not necessarily represent the experiences of all grandmothers and granddaughters circumcised in Kisii, they echo the experiences that respondents in this study shared.

Indeed, female circumcision as Lydia described fits the view held by most regarding the contemporary practice.[10] At the hands of health workers, respondents in this study describe a practice in which the extent of the physical cut is less

and the ensuing pain significantly less than that their mothers and grandmothers experienced. Such a procedure is believed to incur fewer side effects than that done traditionally without use of sterile equipment. When performed in a health facility, instruments such as surgical blades, thongs, and scissors are cleaned after each initiate, while razor blades are discarded after each procedure. Some nurses use injected lidocaine as anaesthesia, but they generally prefer to limit their intervention to cleaning the perineum with an alcohol-based substance and remaining vigilant in removing as little a piece of the clitoris as possible or simply making a "nick" in it.

The overwhelming majority of community members identified nurses (97 percent) as the main circumcisers today, followed by clinical officers (28 percent), traditional circumcisers (28 percent), and midwives (15 percent).[11] Whereas the public hospital was once regarded as the institution of choice, the introduction of user fees toward the middle of the 1990s led many families to seek attention at the local dispensary. Lydia's experience in a private health facility is particular to a subset of families in Kisii that can afford the circumcision fee of KSh150 (∼US $1.93) and the admission fee of Ksh250 (∼US $3.20) per day. Such costs are beyond most people's reach. Combined with the rise in costs, the government ban on circumcision passed in the 2001 Children's Act appears to have shifted circumcision from the dispensary to the home of the initiate. Circumcision today most often takes place in the initiate's home (83 percent), private health facility (79 percent), public dispensary (63 percent), and occasionally at the circumciser's home (44 percent). At the same time, the costs appear to have remained stable, with most respondents paying KSh250–350 (∼US$3.20–$4.50) for the procedure.

Although such costs are nearly twice as high as that charged by traditional circumcisers, savings are accrued from avoiding the elaborate festivities that accompany traditional circumcision. However, the higher costs associated with medicalized practice act as a minimal deterrent to those families wishing to pursue female circumcision for their daughters, as evidenced by the continued practice in the district. This research contends that it is precisely this economic insecurity that contributes to maintaining the practice in place.

Tracing Meaning in Practice

The present-day medicalized practice taking place on girls as young as 6 years of age devoid of any celebratory aspect is described by many as a "useless practice"; grandparents in particular are apt to point out that the perceived painlessness of female circumcision today conflicts with past meanings associated with the practice. The necessity of "unmaking and remaking" girls through a painful experience was strongly invoked by grandparents, who believe that "the community must know on whom it can depend." Grandparents qualified this by describing the multitude of demands made on young adults and that testing the values of "courage," "strength," and "self-sacrifice" was necessary for women who would face the hardships of working on the land, bearing children, coping with periods of famine and drought, and living away from their husbands. Womanhood was therefore not so much constituted by an assertion of sexuality as an ability to withstand the hardships of life in Kisii.

The highly individualized practice of female circumcision, without community celebration nor communal teachings, challenges the basis on which the earlier practices were made meaningful and transmitted between generations in the past. As well, the fact that for parents female circumcision was tied to the arrangement of formal wedding unions, the rise of informal wedding unions has displaced the meaning attached to female circumcision.

In considering the change in the meanings associated with the practice, a number of contradictions emerge between generations. For grandparents and parents, the present practice appears infused with little meaning. Despite this, a persuasive logic continues to lurk that influences young people to pursue circumcision. Indeed, although the ways in which meaning was formed in the past may be antithetical to contemporary demands young people face, the values they underwrite are not. Young people in both urban and rural areas challenged the notion that the continued practice of female circumcision could be attributed to its medicalization, yet were most supportive of this change. They did not deny the importance of sexual modesty in the behavior of young women today, nor that the protection of such modesty was the responsibility of young women.

It is clear that outside the confines of the practice of female circumcision, daily reminders reinforce the importance of "preserving onseself" and "being responsible" through attendance in school and membership in the Seventh Day Adventist or Catholic churches. From the perspective of young women, the persistent practice of female circumcision was attributed to the discrimination uncircumcised women face in social and marital situations.

The heavy stigma uncircumcised women bear made young women especially fearful of not being circumcised. They cited instances in which uncircumcised girls are made to feel uncomfortable, such as being discouraged from mixing with circumcised girls in social situations and being ridiculed by classmates with such insults as being called a Luo or simply *egasagane* (uncircumcised girl).[12] Today, as such humiliating situations do not arise for those medically circumcised, many young people pressure their parents to circumcise them.

Inquiries into male preferences in marriage revealed significant differences between generations about marriage preferences. Grandparents were more likely than parents and young people to endorse the view that marriage preferences should not be based on circumcision status. Given the loss of meaning in the practice, grandparents seemed to attach little consideration to its importance in the decision to marry. On the other hand, parents and young people remained divided over their preferences but were convinced that circumcision status did influence their choice in women.

The majority of the men who favored circumcised women as marriage partners expressed the fear that they might be "cultural outcasts" and would be looked down on for marrying an uncircumcised woman. According to them, circumcised women were "mature and complete" and "respectable." However, the strength of their conviction seems to lie in their beliefs regarding the differences in sexuality determined by circumcision status. Unequivocally, circumcised women were preferred on account of their "sexual coolness," which seemed to offer the promise of faithfulness that husbands seek. Additionally, it was felt that in light of their "sexual timidity," circumcised women would be "easy to contain and easy to

satisfy." Similarly, uncircumcised women were thought to be "more sexy," "necessitating lesser energy," and "remaining sexually active beyond the menopause." Overall, the trend among men appeared to be moving away from circumcised women to preferring uncircumcised women as marriage partners, but the optimal choice appeared to be marrying a circumcised woman while engaging in sexual relations with uncircumcised women. Among respondents, a number of men and women described the pattern of first marrying a circumcised woman and either engaging in extramarital relations with a circumcised woman or taking a second wife who was uncircumcised.

Aware of this, young women and their parents have little option than to play by the cultural rules in the "game" of circumcision. As Boddy notes, "women know what they must do to succeed in a world whose terms they did not set but which their own actions help to ensure" (1998:96). Young women today face a moral dilemma. On the one hand, they are expected to be sexually passive. On the other, their passivity is implicated in their husband's acquisition of extramarital girlfriends. They are praised for their obedience to male figures, but their leadership is necessary for the maintenance of households. They are expected to mother many children, while earning substantial income to raise their family. They are expected to support the family without demanding a personal share of family inheritance.

It is my contention that in choosing medicalized circumcision, young women are gaining valuable social capital in the mediation of such tensions. Although this was not purposely investigated in this research, a number of young people did highlight the ease with which they were able to secure their marital unions and education goals, after assuming their sexual responsibility in having undergone circumcision.

This parallels changes in the institution of bridewealth in the region. In the case of bridewealth practices, employed women still view the importance of bridewealth in legitimating their roles and depend on it for access to resources. However, such women also enjoy greater support from their father and brothers in their wish to wait for suitable men to pay bridewealth, and in other demands such as insisting that a church union take place or that their income be partially allocated to their natal family. Employed women can exercise such leverage vis-à-vis their suitors in the payment of bridewealth as their incomes are viewed as precious assets in a social context in which wealth is increasingly being defined by monetary accumulation, education of children, and investments outside of the agricultural sector.

The continued practice of bridewealth between the few families able to afford it points to a paradoxical situation. Daughters whose educational and familial pedigrees would predict strong financial security and merit social respect show continued attachment to a practice that largely defines their status through formal marriage arrangements that communicate female dependence on their husband. The paradox seems especially acute as many such women now raise the income of their own bridewealth for the future use of their grooms (Håkansson 1988). Thus, despite changes in women's roles today, practices such as bridewealth and female circumcision still play critical functions in the moral construction of female identities.

Revisiting the Hospital

These tensions extend to the culturally constructed universe in which health workers work in Kisii. In discussing the performance of circumcision with nurses in the hospital, a senior nurse in the hospital recounted,

> Friends of mine that work in some of the private centers still practice, but now they agree only to perform psychological circumcision. The girls get washed down there, and the nurse pricks the clitoris with a syringe needle. Soon they won't even bother with that. The psychological circumcision is just as good. It still sends the message that the girl must take responsibility.

These statements betray the neutrality biomedical health workers are assumed to hold in the care of patients. Widening the analytical gaze to examine the ethical decision making of health care workers suggests the presence of plural medical moralities in the practice of biomedicine. Indeed, contrary to the prevailing biomedical view condemning female circumcision,[13] many nurses tended to characterize the contemporary medicalized practice as "meaningless" and of little consequence to the short- and long-term health of the child and dismissed concerns that they were complicit in legitimizing this tradition. They saw themselves as safeguards of tradition and surrogate parents to the girl being initiated. Reflecting on their own experience being circumcised, they recounted how today their involvement spared unnecessary harm in the overall process and avoided complications that might arise later.

Central to the health workers' justification in their practice in the community was the perceived risk of HIV transmission from traditional circumcision. Persuaded that traditional circumcisers exposed young girls to "unclean knives" and "rusty razor blades" that were shared among them, they firmly believed that if circumcision had to be done, it should take place within a health facility.

This position acknowledges that health workers in the hospital cannot be viewed in isolation to their membership in the community. Health workers involved in the practice are circumcised women who identify themselves as Gusii. Within the small sample of health workers, among those who had children and were Gusii (12), with the exception of one nurse, all had circumcised their daughters medically. This does not mean that their circumcised status motivated their performance of the practice. Rather, this research highlights that their membership in the community and their exposure to women—pregnant, HIV infected, or otherwise—are propitious in negotiating their "subtle authorization of harm" through the performance of this practice (Boddy 1998:79).

Health workers who genuinely do question the necessity of female circumcision in the preservation of feminine morality have a tenuous position. In each case, appreciating the highly gendered networks that exist in Gusii society is necessary in explaining their position. Their professional status in the community may grant them the legitimacy to carry out circumcisions among girls, but it is insufficient in commanding the decision making within the household and in the community at large over the significance of female circumcision in "making moral women." As in the past, circumcision provides the means to validate the gender and

generation conventions that exist in Gusii society. But, as in the case of medicalized circumcision, contradictions in these ideologies are increasingly untenable, given its recent criminalization.

Conclusion

"We must not allow a tradition play poker with the lives of our children," writes the author of the newspaper article that introduced this paper. Such concern for the welfare of children has been expressed in Kisii over the last two decades, as grandparents and parents have acknowledged the threats of HIV transmission, tetanus infection, and hemorrhage at the hands of traditional circumcisers. During this time, features in the practice have changed that largely reflect the economic and social circumstances through which the Gusii cultural universe is constituted. In the meantime, however, circumcision has retained its role in offering a medium through which meanings regarding sexual conduct and gender roles are made. From the perspective of health workers, female circumcision—in whatever shape or form—still serves to remind girls of their sexual responsibility. Despite their assumption of roles within the hospital, these health workers remain tied to the tradition and to the community from which they are drawn. Their practice of female circumcision demonstrates that medical moralities produced in the clinical context cannot be studied in isolation to broader social experiences. From the perspective of grandparents and parents, medicalized circumcision has displaced the original meanings intended in the practice while young people negotiate their livelihoods through medicalized circumcision. That young people continue to discriminate on account of circumcision status likely fuels their perception that no alternative exists in replacing the meaning of the cut and that medical refusal to perform the practice will nonetheless lead to its perseverance.

On the basis of these arguments, it is unlikely that medicalized practice fuels the persistence of the practice. Although biomedical discourses on female genital practices have contributed in persuading parents to seek the care of health workers, this research argues that this has not been the most important factor. Rather, it suggests that the undercurrents of change manifest in the contradictory ideologies of gender and sexual conduct have led young women to seek their own meaning through medicalized practice at a time in which they face social, economic, and health insecurities. Moreover, attributing the performance of medicalized circumcision to the financial motivations of health workers also overlooks the way in which these "moral agents" cannot be studied in isolation of the social and cultural universe from which they are drawn. Together, these insights challenge the view that medicine can remain neutral in the mediation of tradition and highlight the difficulties that lie in "taming tradition."

NOTES

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1. Culture or Torture?, *Daily Nation*, Friday August 2, 2002.

2. Although the evolution of male circumcision has paralleled the medicalization of female circumcision, its most recent history has diverged from this shared trajectory as a result of recent epidemiological research suggesting the protective effects of male circumcision against sexually transmitted infections. Although the findings of such research remain contested (for a recent review, see Siegfried et al. 2005), research is under way examining the renewal of this practice. This development cannot be separated from the evolution of female circumcision among the AbaGusii, but a critical analysis of medicalized male circumcision is beyond the scope of this article. Earlier ethnographic accounts of male and female circumcision among the AbaGusii can be found in Mayer 1953 and LeVine 1959.

3. According to Njue and Askew (2004), these include the Program for Appropriate Technology in Health, Maendeleo Ya Wanawake Organization, the Seventh Day Adventist Church, Female Guild Organization, Federation of Women's Groups, the Pan African Christian Women's Organization, Julikei International, and the Coalition on Violence against Women. Through public campaigns depicting the harmful effects of female circumcision and the positive benefits of abandonment, the organization of anti-circumcision groups in schools and churches and public demonstrations denouncing the practice, their strategy for abandonment is largely guided by Mackie's work on convention change (1996). More recently, an "Alternative Rites Program" has been designed through participatory research to provide a "harm free" way to initiate young girls. For more information on this initiative, see Chege, Askew, and Liku 2001 and PATH 2001.

4. The AbaGusii dominate the three districts of Kisii, Gucha, and Nyamira of Nyanza province in Kenya.

5. This law was rescinded within a year, due to pressure by domestic and international women's groups.

6. The Children's Act passed in December 2001 prohibits the performance of female genital practices on persons less than 18 years of age and makes persons found guilty punishable by a KSh 50,000 fine and/or a 12-month prison sentence.

7. The three research assistants were chosen on the basis of their prior experience carrying out research on female genital practices in Kisii. Two were female and one was male. All identified themselves as Gusii.

8. To respect the anonymity with which women in the study agreed to share their experiences of circumcision with me, pseudonyms are used in the identification of informants.

9. In this study, interviews with community members were not followed up by physical exam to determine the extent of tissue removal. Moreover, drawing from my own experience and that of other colleagues researching in this field, women's self-reporting of tissue removal does not correlate well with physical exam. As a result, I assume in this case that the grandmother had a clitoridectomy, but I cannot exclude the possibility that she might have had more tissue removed.

10. Similar findings were also suggested in a recent study carried out by the Population Council that collected in-depth interviews from 100 health personnel and 48 key informants, 10 focus group discussions with community members, and interviews with 727 health service providers in Nyanza province on the medicalization of female genital practices (see Njue and Askew 2004).

11. Informants were asked to identify providers of female circumcision without restricting themselves to a single answer. As a result, the percentages are not cumulative.

12. The Luo, the country's second most populous ethnic group, live to the west of the AbaGusii. Since their settlement in the highlands four centuries ago, the AbaGusii and Luo have encountered each other in conflict and trade. Threat of domination by this group is said to have inspired Gusii ancestors to circumcise their children to differentiate them from the Luo. Given the relationship of sexual modesty to the practice of circumcision from the perspective of AbaGusii members, Luo are stereotyped as "sexually promiscuous" for their lack of circumcision practices and are generally perceived to embody sexual values that are antithetical to those the AbaGusii hold.

13. For a review of arguments outlining the biomedical view of female genital practices, see WHO 1995, 2000a, 2000b. For a recent debate about the validity of such arguments, see Mackie 2003; Obermeyer 1999, 2003.

REFERENCES CITED

Boddy, Janice
1998 Violence Embodied? Circumcision, Gender Politics and Cultural Aesthetics. *In* Rethinking Violence against Women. E. E. Dobash and R. P. Dobash, eds. Pp. 76–110.Thousand Oaks, CA: Sage.

Bordo, Susan
1993 Unbearable Weight: Feminism, Western Culture, and the Body. Berkeley: University of California Press.

Bourdieu, Pierre
1978 Outline of a Theory of Practice. Cambridge, Cambridge University Press.

Bruni, Frank
2004 Doctor in Italy Tries to Ease Pain of an African Tradition. New York Times, February 1, p. 3.

Caldwell, John C., Israel Olatunji Orubuloye, and Pat Caldwell
1997 Male and Female Circumcision in Africa from a Regional to a Specific Nigerian Examination. Social Science and Medicine 44(8):1181–1193.
2000 Female Genital Mutilation: Conditions of Decline. Population Research and Policy Review 19(3):23–55.

Chege, Jane Njeri, Ian Askew, and Jennifer Liku
2001 An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya. Washington, DC: Population Council.

Commission on Human Rights
1995 Harmful Traditional Practices Affecting the Health of Women and Children. Geneva: Office of the High Commissioner of Human Rights.

Daily Nation
2002 How Government Foots the FGM Bill. Daily Nation. Nairobi.

DHS
1997 Female Genital Cutting: Findings from the Demographic and Health Surveys Program. Calverton, MD: Macro International Inc.
1998 Demographic and Health Survey, Kenya. Calverton, MD: Macro International Inc.

ECOSOC
1958 Ritual Operations. New York: United Nations.

El-Gibaly, Omaima, Barbara Ibrahim, Barbara S. Mensch, and Wesley H. Clark
1999 The Decline of Female Circumcision in Egypt: Evidence and Interpretation. New York: Population Council.
General Assembly
1986 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York: United Nations.
1993 Declaration of the Elimination of Violence against Women. New York: United Nations.
Håkansson, Thomas
1988 Bridewealth, Women and Land: Social Change among the Gusii of Kenya. Uppsala, Sweden: Acta Universitatis Upsaliensis.
Kenyatta, Jomo
1953 Facing Mount Kenya: The Tribal Life of the Gikuyu. London: Secker and Warburg.
Koso-Thomas, Olayinka
1987 The Circumcision of Women: A Strategy for Eradication. London: Zed.
LeVine, Robert A.
1959 An Attempt to Change the Gusii Initiation Cycle. Man (179):1–4.
Mackie, Gerry
1996 Ending Footbinding and Infibulation: A Convention Account. American Sociological Review 61(6):999–1017.
2003 Female Genital Cutting: A Harmless Practice? Medical Anthropology Quarterly 17(2):135–158.
Mayer, Philip
1953 Gusii Initiation Ceremonies. Journal of the Royal Anthropological Institute 83(1):9–36.
Ministry of Health
1999 National Plan of Action for the Elimination of Female Genital Mutilation 1999–2019. Nairobi: Government of Kenya.
Morgan, Kathryn Pauly
1991 Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies. Hypatia 6(3):25–53.
Murray, Jocelyn M.
1976 The Church Missionary Society and the "Female Circumcision" Issue in Kenya. Journal of Religion in Africa 8(2):92–104.
Njue, Caroline, and Ian Askew
2004 Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya. Nairobi: Population Council.
Obermeyer, Carla M.
1999 Female Genital Surgeries: The Known, the Unknown, and the Unknowable. Medical Anthropology Quarterly 13(1):79–106.
2003 The Health Consequences of Female Circumcision: Science, Advocacy, and Standards of Evidence. Medical Anthropology Quarterly 17(3):394–412.
Obiora, Leslye Amede
1997 Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign against Female Circumcision. Case Western Law Review 47:411–422.
PATH
2001 Promoting a Healthy Alternative to Female Genital Mutilation: A Tool for Program Implementers. Washington, DC: Program for Appropriate Technology in Health.

2002 Evaluating Efforts to Eliminate the Practice of Female Genital Mutilation: Changing Awareness and Changing Harmful Norms in Kenya. Washington, DC: Program for Appropriate Technology in Health.

Population Council
2000 Mali Female Genital Cutting: FGC Excisors Persist Despite Entreaties. Washington, DC: Population Council, Frontiers in Reproductive Health.

Scheper-Hughes, Nancy
1991 Virgin Territory: The Male Discovery of the Clitoris. Medical Anthropology Quarterly 5(1):25–28.

Sheldon, Sally, and Stephen Wilkinson
1998 Female Genital Mutilation and Cosmetic Surgery: Regulating Non-Therapeutic Body Modification. Bioethics 12(4):263–285.

Shell-Duncan, Bettina
2001 The Medicalization of Female "Circumcision": Harm Reduction or Promotion of a Dangerous Practice? Social Science and Medicine 52:1013–1028.

Siegfried, N., M. Muller, J. Deeks, J. Volmink, M. Egger, N. Low, S. Walker, and P. Williamson
2005 HIV and Male Circumcision—A Systematic Review with Assessment of the Quality of Studies. Lancet Infectious Diseases 5(3):165–173.

Silberschmidt, Margrethe
1991 Rethinking Men and Gender Relations. Copenhagen: Centre for Development Research.
1999 "Women Forget that Men Are Masters": Gender Antagonism and Socio-Economic Change in Kisii District, Kenya. Stockholm: Elanders Gotab.

Smith, Edwin W.
1926 The Christian Mission in Africa, a Study Based on the Proceedings of the International Conference at Le Zoute, Belgium, September 14–21. London: IMC.

Thomas, Lynn. M.
2003 Politics of the Womb: Women, Reproduction and the State in Kenya. Berkeley: University of California Press.

Van der Kwaak, Anke
1992 Female Circumcision and Gender Identity: A Questionable Alliance. Social Science and Medicine 35(6):777–787.

van Gennep, Arnold
1965 [1909] The Rites of Passage. London: Routledge and Kegan Paul.

WHO
1995 Female Genital Mutilation: Report of a WHO Technical Working Group 17–19 July. Geneva: World Health Organization.
2000a Female Genital Mutilation: A Handbook for Frontline Workers. Geneva: World Health Organization, Department of Women's Health.
2000b A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth. Geneva: World Health Organization, Department of Women's Health.