

For many years, cultural practices have been strongly linked with the rapid spread of HIV/AIDS. Such practices include polygyny, widow inheritance or levirate, and permissive pre-marital and extra-marital relations, all in relation to the aspect of sexual behavior and sexual networks. Male circumcision has been considered a high risk practice in the spread of HIV/AIDS, especially in the traditional context where a number of initiates undergo the ritual at the same time, sharing the same implements. Priscilla Reining, an American anthropologist, drew up a map of the African cities enduring the highest HIV infection rates and superimposed upon it a map of those places where the predominant cultural practices were to circumcise or not to circumcise. The correlation was striking: HIV was spreading fastest in places where circumcision was not routinely performed (Reining, 1989). Similar observations were made by the Caldwells (1996) when they noted that areas with large numbers of uncircumcised men were almost exactly the same as the regions with severe AIDS epidemic. In a 1998 review, Moses et al. found 26 studies that cited a correlation between lack of male circumcision and HIV infection. In cases where the association was not very apparent, there were significant relative risks of seroconversion for uncircumcised men. According to some studies, seroconversion for uncircumcised men ranges from 2.3 to 8.2, while that of circumcised men is approximately 0.5 (Halperin and Bailey, 1999).

Although they do not provide evidence for a causal relationship, the studies above provide strong evidence that male circumcision is significantly associated with lower risk of HIV infection. As such, large clinical trials to confirm this association have been underway the past few years. Randomized controlled trials (RCTs) have been conducted in Kenya (Bailey et al., 2007), South Africa (Puren et al., 2002), and Uganda (Gray et al., 2002). The Uganda trial also tested previous findings suggesting that MC may additionally protect the women partners of HIV-infected men. All the studies have now been discontinued due to overwhelming evidence that MC had a protective effect against HIV infection. The Uganda study was discontinued when it was found that men participating in the study resumed sexual activity too soon after circumcision and were not properly healed. Ethically, it was inappropriate to continue to expose these men's seronegative female sexual partners to undue risk. Also, the results of the study would be tainted since early resumption of sexual activity would negate the protective effect of male circumcision.

The UNIM Project, one of the RCTs mentioned above, was conducted in Kisumu, Kenya, where majority of the population is from the Luo community. Historically, Luo traditional initiation rites involved the extraction of lower incisors for both young men and women. This rite is no longer practiced to any significant extent. Male circumcision, an initiation rite for most ethnic groups in Kenya, was never practiced by the Luo. However, there is evidence that Luo men are increasingly getting circumcised (10%, according to Buve, et al., 2000) and most of those getting circumcised are in their adolescent years (Wawire, 2004). One study further shows that a large number of Luo male participants expressed a desire to be circumcised and an equally large number of Luo female participants expressed preference for a circumcised partner (Bailey et al., 2002).

Before 2007, anecdotal evidence showed that the increase in the adoption of male circumcision was partly a reaction to public messages and epidemiological evidence suggesting a significant association between the lack of male circumcision and risk of HIV infection. In Kenya, there are marked differences in HIV prevalence rates by province. Nyanza, the home province of the Luo, exhibits the highest rate (22%), compared with 15 percent for five of the remaining seven provinces (GoK and UNDP, 2003). Kisumu, the largest city in Nyanza province, exhibits the highest HIV prevalence rates in hospitals and the general population. The UNIM Project provided the scientific evidence that there was 54% reduction in HIV/AIDS infection after study participants were circumcised. Given the evidence of a strong link between male circumcision and lower risk for HIV infection, the World Health Organization (WHO), among other international health agencies, is now backing prevention strategies that promote and provide circumcision for men in Kenya, and other

African countries that have non-circumcizing communities.

In view of the UNIM study results supporting the preventive nature of circumcision against HIV/AIDS, high HIV/AIDS prevalence among the 'uncircumcizing' Luo, and the newness of male circumcision to the Luo culture, I carried out a study among Luo youth in Kisumu, in which I sought to understand the perceptions, attitudes and practices that may be associated with this new phenomenon, and how they impact the way the HIV/AIDS epidemic shapes up. This paper uses data from that study to establish the role women play in the uptake of male circumcision, and the perceived benefits that they get from the practice. The discussion in the paper addresses some of the concerns among promoters of women's rights and sexual reproductive health that such a male-oriented approach as circumcision would erode strides made to advance women's participation in sexual and reproductive health. Furthermore, there is no physiological or epidemiological evidence to show that women benefit from male circumcision for HIV prevention.

Method: Fieldwork for this study took place between July, 2006 and August, 2007. Initial male respondents aged 18-24 were drawn from the UNIM Project, after which the sample snowballed to include their social networks. The social networks included the youths' sexual partners, peers, parents, community and church leaders was selected. The main data collection methods were in-depth and key informant interviews with all in the sample, and participant observation. Through these methods, data pertaining to perceptions and practices associated with circumcision and HIV/AIDS, contexts in which these perceptions exist, and post-circumcision experiences, were collected. Pertaining to experiences after circumcision, focus was on circumcized youth's perceptions about their 'circumcized identity' and how it influences their interactions with women, including their sexual behavior. Participant observation involved participating in participants' daily activities and special occasions such as funerals, weddings, circumcision ceremonies and other recreational activities.

Findings: Results from my study show that women play an important role in decision-making when young men are faced with the choice of circumcision. There is evidence of cross-gender discussion regarding sexuality, HIV/AIDS and STDs. More men are consulting their sexual partners before making decisions about circumcision. Driven by concerns ranging from health to sexual pleasure, women discuss male circumcision with their sexual partners. In some cases, the discussions are, in fact, initiated by the female partner. This is contrary to common belief that gender relations in patriarchal societies such as the Luo, are bias against women, especially with regard to sexuality. Also, there is evidence of cross-gender intergenerational communication regarding circumcision and sexuality. More young men hold discussions with or seek advice from their mothers before circumcision. This, too, is a shift from the traditional setup that only allowed discussion about sex and sexuality to occur between a child and his grandfather (or an elderly person with similar stature in society).

Conclusion and recommendations: Based on the finding that women play an important role in the decision-making process, I recommend that programs designed to implement male circumcision for HIV/AIDS prevention should involve women so as to strengthen acceptability and effectiveness of such programs.

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