

Balancing on a knife's edge

An Analysis of Medicalized Circumcision in the Construction of Self in Kajiado, Kenya

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Masters Thesis submitted to the
Department of Social Anthropology

University of Oslo

July 2012

Abstract

The past couple of decades, medicalization of female and male circumcision has become more common in the district of Kajiado in Kenya. Medicalization implies that the procedure is performed by trained health personnel, who use modern equipment and medicine. This thesis analyses how the form, meaning, and legitimization of male and female circumcision among the Maasai in Kajiado District changes with medicalization. Furthermore, it explores which implication these changes have on experiences of body and self.

Medicalization of circumcision is seen as one element of a larger development. As with the rapid changes in the Maasai community, medicalization is filled with ambivalence. While it is seen as the best option for “the new times” it is concurrently considered to have made the Maasai bodies weaker than before. Based on four month of fieldwork I suggest that there is much to learn about social change in the Maasai community through exploring changing ideas about the body. An embodied perspective is also useful when studying how medicalization is differently inscribed, experienced and acted upon by the whole embodied person. In this thesis I am particularly interested in how medicalization is variously inscribed in the gendered person.

Acknowledgement

First and foremost, I must thank all my friends in the Kajiado District for letting me take part in their lives. This thesis could never have been written without their hospitality, kindness and patience. I hope this thesis will leave the reader with a sense of my informants' experiences, their challenges, hopes and aspirations.

I am indebted to my supervisor Aud Talle, who sadly passed away last year. Aud was a great inspiration and source of knowledge for my study of female circumcision among the Maasai. She was a great lecturer and person, and she always made room for students in her busy schedule. I must also thank my second advisor Rune Flikke for insightful and inspiring comments on the thesis. His lectures throughout the years helped me realize the importance of anthropology.

Furthermore, I wish to thank my friends Zlata and Ingrid for proof reading and commenting on the text. Your support was invaluable. Tina and Karianne; I truly enjoyed your company during field breaks in Nairobi.

Last, but not least, I must thank my family. Thank you for your encouragement and support throughout the years. Mom, for encouraging my interest in Social Anthropology and for always being there for me, Frøydis, for talking me through my first pathetic encounter with typhoid fever, and Dad, thanks for all that you taught me.

To all my friends in Kenya; I will see you again!

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Chapter 1

Introduction

Driving through the arid landscape of the Kajiado District for the first time I was chatting with my driver, a middle aged, white man, who worked at the hostel where I spent my first week in Kenya. As the Land Rover was passing numerous building sites and workers along the way, I told him about the purpose of my stay; to study the recent changes to female and male circumcision among the Maasai in the Kajiado District. He scoffed loudly and said; *“Female circumcision? It’s not that I am against female circumcision per se, but the way the Maasai do it...”* He let the sentence hang in the air, shook his head and said no more on the topic.

The incident reminded me of my first encounter with the discourse of female circumcision in relation to the Maasai community.¹ This encounter took place during a fieldtrip in Kenya in 2009, when I was working on my Bachelor on the international female circumcision discourse, as it was manifested in an international organization in Nairobi, Kenya. The organization was engaged in the struggle to end female circumcision. The organization’s aim was to decrease the prevalence of the practice within communities that presented high numbers of circumcision. One of the communities targeted was the Maasai population of the Kajiado District. One afternoon I was invited to join in a meeting between leaders of the different communities involved in the project. The project leaders had gathered in order to share experiences from working within the communities. As they exchanged experiences and narratives, one story in particular caught my attention. The story was told by the representative of the Kajiado District, about an old Maasai lady who believed that the clitoris of an uncut woman would grow long, *“to the knees”*, and distract the woman from her daily activities. Demonstratively the Kajiado representative rose from her chair and showed us, with large and exaggerated movements, how the old lady had demonstrated how one in such a

¹In this thesis, the term “discourse” refers to a certain way of speaking about and understanding the world, or a segment of it, as explained in Winter Jørgensen and Phillips (1999:9).

case would twirl the abnormal clitoris around a stick, securing it between ones legs. The story provoked laughter and cheerfulness amongst those present. I chuckled with the others, but felt somehow at unease, by the image presented of the old Maasai lady.

With this episode in mind I left Kenya with the impression that little or nothing had happened when it came to female circumcision amongst the Maasai. I was surprised when I later discovered, through the exploration of statistical data, that there had been a vast decline in the prevalence of female circumcision among the Maasai. From 1998 to 2009 the prevalence declined from almost 90 percent to 73 percent (Talle: 2010:149). The decline in circumcision rate is quite remarkable, considering that the ritual had been regarded mandatory a few years back. During my fieldwork among the Maasai in the Kajiado District I found that not only had the prevalence of female circumcision gone down, the performance of both female and male circumcision has changed considerably during the last decades.

In order to understand this development, it is necessary to consider historical, economic and cultural changes. In this thesis, I focus particularly on the changes that came in the wake of the medicalization of circumcision. Medicalization of circumcision implies that trained health personnel are involved in the procedure and that modern equipment and medicine is used when operating (Talle: 2010a). My main concern in this thesis will be to explore how medicalization has altered the form, legitimization, and meaning of female and male circumcision, and which implication these changes have on experiences of body and self among my informants in the Kajiado District of Kenya, specifically in the town of Loitek and rural Marok.

Although my main focus will be on female circumcision, I find it useful to compare female and male circumcision. Not only because they have been seen as complementary practices by the Maasai community, but because medicalization have some of the same implications for men and women.

Locating the problem

The story of the old Maasai lady represents a certain way of speaking about and understanding female circumcision. The reaction of the taxi driver gave the discourse an

ethnic dimension as he implied that it is not circumcision *per se*, but the way the Maasai do it which provokes him. In fact, both the staff of the organization that I worked with and the taxi driver are enmeshed in a local as well as a global understanding of the Maasai. To mention the Maasai is, to use anthropologist Dorothy L Hodgson's words, "*to invoke for most images of warriors, of men herding cattle, or proud patriarchs*". But the Maasai are also seen as culturally conservative and unwilling to change. They are perceived as representatives of the "*primitive*", "*prehistoric*", "*traditional Africa*" (Hodgson: 2001:2). The prevailing feeling among the organization's employees was that working with the Maasai was particularly challenging, due to their close tie with tradition. They were literally, to paraphrase one of the leaders of the project; "*Stuck in tradition*".

The narrative of the old Maasai lady can be viewed as representative of a century old portrayal of the backward, irrational other. When claiming that the Maasai were "*living the way our grandmother's lived*", the employees of the anti-circumcision organization were informed by an evolutionary narrative of "development", where development is supposed to happen in a linear line from traditional to modern (Ferguson: 2006:178). The phrase "*stuck in tradition*" legitimizes intervention, as it implies that these women are not able to escape the tentacle of their culture on their own. Female circumcision is a difficult terrain to explore, as colonialist, missionaries and anti-circumcision organizations have used it to justify the intervention by outsiders (Gruenbaum: 2001). When entering Kajiado I became part of a century long history of interaction between locals and missionaries, colonialists, and international agencies and organizations. When the colonialist and missionaries had their first encounter with the practice of female circumcision they were enraged and forbid the practice. Their intervention was, however, met with considerable resistance. Jomo Kenyatta, who was trained in anthropology and later became president of Kenya, defended the practice in his book "Facing Mount Kenya" first published in 1938. He claimed that the practice was an important marker of cultural identity and that a resistance towards it could only be interpreted as cultural imperialism (Gruenbaum: 2001:25). In some areas circumcision became a way of opposing the colonial power, the famous example being the Meru movement in which a number of young girls defied the ban on circumcision by circumcising themselves (Thomas: 2000:137). Still today, Kenyans will look to Meru as an example of failed intervention from the outside. A number of my informants were apprehensive to the international interest the topic has evoked, as they felt that the issue should be solved on a local level.

Nevertheless, the resistance towards outside intervention does not imply that female circumcision has not also been opposed from within. In fact the practice is widely condemned in the larger community in Kenya (Talle: 2010:39). Resistance against intervention should rather be seen as skepticism towards the strategies and methods used to attain the desirable goal, as these are characterized as “an imperial process whereby other people are appropriated and turned into objects, “exhibited, gazed at, and silenced” (Nnaemeka: 2005:29). In the words of Wandiba, a professor of anthropology, whom I met in Nairobi;

If you are an outsider, like you, and come with an NGO and you say you want to fight female circumcision, how will you do that actually, apart from sitting in Pan Africa hotel or Serena hotel and discussing it with members of an NGO? The problem with the NGO's is that they come and they want to impose their Western values and traditions. They come as people who know it all, they are not willing to learn, they are not willing to listen to locals and their point of view.

His words echoed that of other informants, feeling that outsiders would come, sit in fancy hotels and discuss what happened on the ground, without having an understanding of the ritual's cultural and social meaning. When discussing female circumcision I would often be confronted by my informants asking me what I truly felt about female circumcision. When asked I would repeatedly answer that I did not see it as my place to set out to stop female circumcision, adding that I believed change was only possible from within. Most of my informants would seem pleased with this answer, going on with the conversations. They were well aware of the image presented of them as “backwards” and “not prone to change”. The medicalized circumcision, however, represented fluidity in the ritual, which is in stark contrast to the image of them not being prone to change. My informants were not “stuck in tradition”, nor did they oppose change. As one of them said; “We want to change, but we need to do it our way. We don't want others to come and impose their ideas on us before we are ready”. When they decided to continue circumcising it was not an outcome of an irrational, backward culture, or ignorance of the negative consequences of female circumcise. My informants in Kajiado were well aware of the dangers and pain that followed from circumcision. Their decision to continue circumcising was a result of a careful impact assessment where the positive consequences outweighed the negative ones. Circumcision will not automatically wither away as soon as the “ignorant” societies practicing it have been taught the negative consequences of the practice. This belief has effectively ignored the complex working of a ritual such as female circumcision.

What should we call it?

Female circumcision is a challenging anthropological theme as it both demands and challenges the cultural relativist perspective. The practice forces observers, inside and outside academia to confront broader philosophical and ethical issues. As the anthropologist Gosselin notes, “the very decision to write (or not) about the topic has become a political statement, and so is one’s choice of tone and terminology” (Shell-Duncan and Hernlund: 2000: 2). Throughout this thesis I will use the term female circumcision, although I am aware of the implications of using the term. Critics have argued that the use of it de-emphasizes the severity of most forms of the procedure by comparing it to the removal of the foreskin of males. Another term frequently used by international organizations, activists and governments working against the practice is female genital mutilation (FGM) (Talle: 2010:73). Objections to this term have been raised on the note that it “implies intentional harm and is tantamount to an accusation of an evil intent” (Gruenbaum: 2001:3). The term is then “thought to imply excessive judgment by outsiders and insensitivity towards individuals who have undergone the procedure” (Eliah in Shell-Duncan and Hernlund: 2000:6). When I choose the term female circumcision it is because I render it as more in tune with the cosmology of those societies performing circumcision.

Female circumcision “includes a range of practices involving the complete or partial removal or alteration of the external genitalia for nonmedical reasons and appears in widely varied cultural contexts in Africa and other populations” (Shell Duncan and Hernlund: 2000:3). Although these practices constitute a continuum rather than discretely bounded categories, four major types are generally recognized. The least extensive type, and the only one which can be considered analogous to male circumcision, is known as *sunna* circumcision, which involves only the prepuce or hood of the clitoris. However, there have been made claims that no medical reports can document the existence of this practice. Instead, when *sunna* circumcision is reported, all or part of the clitoris have been removed (Shell Duncan and Hernlund: 2000:4). Some of my informants spoke of *sunna* circumcision as the removal of the “*tip of the clitoris*”. In these cases, I believe that they were actually talking about *clitoridectomy*, which includes the removal of all or parts of the clitoris. Traditionally the Maasai have been cutting with “*three cuts*”, which in the medical literature is referred to as *excision*, the partial or complete removal of the clitoris, along with part or all of the labia

minora (Talle: 2010a:52). The most severe type of circumcision is known as *infibulations* and involves the complete removal of the clitoris and *labia minora* as well as most of, or all of, the *labia majora*. The cut edges are stitched together so as to cover the urethra and vaginal opening, leaving only a minimal opening for the passage of urine and menstrual blood (Shell Duncan and Hernlund: 2000:4). Although only 10 percent of those circumcised have experienced this type of circumcision, this is the most widely known type globally. My informants in Kajiado would take great offence when people mistook their circumcision with infibulations, as this type is regarded as “*particularly bad*” as it implied “*cutting it all*”. In my material I will use emic categories of “*small cut*” or “*one cut*” when I speak of *clitoridectomy* and “*big cut*” or “*three cut*” when I speak of *excision*. These are the terms used by my informants.

When it comes to male circumcision the Maasai had a particular way of cutting which distinguish them from other tribes. When I mention the “*Maasai cut*” in this thesis, I am referring to the particular way of circumcising boys within the Maasai community. This involves the circumciser cutting a semicircular slit at the base of the foreskin, and subsequently threading the penis head through it. Then the circumciser removes all but the ventral seam of the foreskin. This *ndelesia* - a good inch-long flap of skin - is left to chase evil spirits out of a woman’s vagina during intercourse and to protect him against venereal diseases. Supposedly it also gives women added pleasure and so makes them prefer the *morans* to uncircumcised males.² The Maasai was proud of their circumcision and would often speak in derogatory terms of those tribes which practiced the “Swahili cut”. They would claim that the “Maasai cut” was more painful, thus requiring more endurance and strength than the “Swahili cut” which involved the complete removal of the foreskin.

Circumcision – an initiation into adulthood

Circumcision is a practice which has gone on for centuries. No one knows exactly when or where the practice has its origin, but both female and male circumcision was most likely performed in the ancient Egypt (Talle: 2010a:30). The origin of circumcision is probably found in a cultural and commercial center, and was spread through trade and contact to other

² <http://www.circlist.com/rites/maasai.html>

areas. Female circumcision is mainly based on the African continent along a North – South axis, meeting in Sudan (Talle: 2010a:33). A conventional idea is that the tradition spread from the Nile Valley, along trade routes (Johnsdotter: 2002:61). While some claim it was a practice which was meant to control female sexuality, others claim that it was a means of protecting young women from rape when they were alone in the households or out herding the animals (Johnsdotter: 2002:62). Male circumcision is a global phenomenon, as an estimated 30 - 34 percent of the male population in the world are said to be circumcised. While female circumcision is viewed as more of a cultural practice, male circumcision is normally connected to religious practice (Talle: 2010a).

Van Gennep argued in the Rite of Passage, that circumcision is one of many rituals marking a status passage – in the case of the Maasai- the passage from childhood to adulthood (Gennep: 1960). Circumcision is gendering the child, turning the boy into a man, and the girl into a woman. For Turner the initiation rituals signify death to the amorphous and indistinct state of childhood, so that the individual may be reborn into proper, gendered beings (Das: 1990:30). The function of circumcision is often seen as a way to prepare the man or woman for their preordained social roles within the society, the circumcision scar forever reminding them and others about their proper place (Leonard in Shell-Duncan and Hernlund: 2005:170). Among the Maasai, circumcision of men was meant to prepare them for the next stage within the age group system, while for women it was meant to prepare them for their future roles as wives and mothers. Female circumcision was believed to “open up” the fertility of a woman, making her ready for procreation. The painful initiation, as Clastres among others have pointed out, is a way of reassuring the society of the quality of the initiate (Talle: 2010a). For a Maasai, being able to stand the pain of circumcision was evidence to oneself and others that one was prepared to stand difficulties later in life. Life as a Maasai was known to be hard, with the threat of dangerous childbirth, hunting and droughts.

To be circumcised was a matter of “being or not being” a proper adult Maasai. Among my informants there circulated a narrative of an uncircumcised Maasai man, but even the thought of him was so incomprehensible that it was reckoned to be more of an urban legend. Uncircumcised women have gone from being outcasts to rather being seen as somewhat ambiguous beings. As their reproductive abilities have not been opened through circumcision, they represent an anomaly: they are neither children nor women. Their ambiguous status

prevents them from pursuing marriage and reproduction. Such an ambiguous status that was prescribed to uncircumcised women is not necessarily seen as a disadvantage. As Rita, one of the traditional women I interviewed said;

Let's say I had a daughter – and she was married immediately, she would have no possibility to continue her education. Circumcision leads to early marriage. If the girl is not circumcised she would still be seen as a child, and can therefore not be married off, so she can continue her education.

Not being circumcised can thus leave you with more alternatives. Although female circumcision represents a choice these days, it is not unproblematic. Girls are met with certain expectations from friends and family regarding circumcision. Nevertheless, in certain areas circumcised girls are met with a reversed stigmatization. Where uncircumcised girls used to be the outcasts, in some areas it is the circumcised girls that experience stigmatization for being different. This trend can be observed in mixed areas or schools, where girls from different tribes interact.

In the communities that perform both female and male circumcision, there is often a similar logic behind both forms of circumcision. An analysis of female circumcision, should therefore, where it is relevant, also take male circumcision into account (Talle: 2010a:39-40). For this reason, I have chosen to focus on the changes to both female and male circumcision, as they are seen as complementary practices among the Maasai. Furthermore, female and male circumcision was medicalized at approximately the same time. The implication of medicalization is similar for men and women in many ways, however there is an important gendered aspect to it, a point I will return to in chapter 3.

Analyzing circumcision

In the weeks prior to departure I felt an increasing distaste for my theme of study. I felt uncomfortable and unmotivated. The feeling returned to me on occasions throughout the fieldwork, but I was able to shake it off rather quickly. It took a while before I was able to let myself linger on the feeling, but when I finally did, I recognized it as a discomfort with the anthropological project. I did not understand the feeling properly until I was confronted by a former circumciser, who asked me what I was doing in the field. I had often been questioned

about what a young, Norwegian woman like me was doing studying circumcision in Kenya, but the confronting style of the circumciser made me realize something essential.

When I inquired the lady about her former occupation she threw a question back at me asking how this information would help me. In honesty I told her that the information would help me understand the practice better. “*And how will that help you?*” she asked again. Perplexed by her straightforwardness I answered that it would help me get a degree in anthropology. “*And how will that help me?*” the lady asked rhetorically before handing me a cup of tea. Her question was a relevant one as it pointed out an uncomfortable issue, that of different relations of power implied in the anthropological project. When I entered the field I did not enter a neutral space, but one which had been formed by years of contact with colonialists and missionaries. The way my informants interpreted me was likely to be affected by this long history of contact. While this outlook was numbing at first, the realization of it provided a useful starting point for an analysis of how my informants interpreted not only my presence, but that of anti-circumcision organizations, both national and international ones.

Female circumcision represented a difficult topic as its character as a barbaric and uncivilized practice has been used as a way of legitimizing intervention first by the colonial powers and the missionaries, then by international feminist organizations and anti-circumcision organizations (Shell Duncan and Hernlund: 2000). Although this stance may be effective when gathering financial support for work to combat circumcision, it is not necessarily the most fruitful stance to take when interacting with the Maasai. I am inspired by Aud Talle and her effort to create an understanding which exceeds the first cultural shock, a stance seeking dialogue instead of condemnation (Talle: 2010a). When my taxi driver effectively stopped our discussion about female circumcision, he was informed by a discourse rendering circumcision so terrible that it “defies comprehension and simply stops the mouth” (Kirby: 2005:81). It is, in Vicky Kirby’s term, unspeakable. Female circumcision is without a doubt a practice that involves a great deal of pain and suffering, a matter one should not take lightly when writing about the subject. But, it is imperative that the knowledge and understanding of female circumcision is grounded in people’s own concepts, cultural preferences and values (Talle: 2007:92). In this thesis I will try to write about the “unspeakable”, because I render it important to create a greater understanding of how the practice changes throughout time and space.

Theoretical framework

Circumcision was, until recently, a subject that anthropologist did not set out to analyze explicitly. It was too intimate, peripheral and difficult (Talle: 2001). The silence surrounding female circumcision is no a coincidence (Talle: 2007:91). The practice is not something informants would share, not because it is a source of secret knowledge, but because it is reckoned as one of those mundane events that one “just does”. Female circumcision could be located to what Pierre Bourdieu called the *habitus* of social life – actions inscribed in body practice and moral form, and which are reproduced without much further reflection (Talle: 2007:91). But as female circumcision has come under increased scrutiny by international media, feminist and human rights organization, health practitioners and legislators, the issue has also received more attention among anthropologists. Although the literature on female circumcision has grown large, few studies have examined medicalized female circumcision. Koso-Thomas suggest that the lack of such studies is connected to the view that female circumcision is so embedded in local structures of class, gender, politics, and economy that it remains impervious to change (Christoffersen – Deb: 2005:404). 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 medicalization of female circumcision challenges the static and ahistorical representation of the practice that prevails in the literature (Christoffersen – Deb: 2005:404). Medicalization is a part of greater social change in the Maasai community, a change which to a great extent has produced new ideas about the body and self. Inspired by Sandra Bamford’s (2007) approach to social change in the South Pacific, where she examines social change through the lens of changing ideas about the body, I explore how medicalization has influenced ideas of the body and self among the Maasai.

Further, I employ Steward and Strathern’s approach by viewing contemporary patterns of change in their complexities, including transnational flows of ideas and beliefs, localized versions of introduced ideas and beliefs, and locally generated new patterns of behavior and belief. Steward and Strathern applied an approach which combined the study of globalization –the realization of global influences in local context and the local transformations of such influences – and embodiment, how change is variously inscribed, experienced and acted upon

by the whole embodied person through time – in their analysis of change in the South – West Pacific (Bamford: 2007:xv-xvi). Their approach is useful also in the study of change among the Maasai. I suggest that medicalization has influenced the local context, by contributing to a general feel of loss and “weakening of the bodies”. Simultaneously, medicalization, with all its elements, is not uncritically employed, but is interpreted, resisted and accommodated according to local ideas and practices. Moreover, the way change, in this case medicalization of circumcision, is “inscribed, experienced and acted upon” is not gender neutral, but is informed by international and local understanding of male and female, which will be apparent in all of the chapters.

Embodiment is a concept I use frequently throughout this thesis, and it deserves elaboration. The body has risen in anthropological thought beginning as an implicit, taken for granted background feature of social life, to an explicit topic of ethnographic concern, thence a problem to be accounted for and finally an opportunity to rethink various aspects of culture and self (Csordas: 1999:172). The movement of the body to the center stage has led to an emergence of studies that claim that culture and self can be understood from the standpoint of embodiment as an existential condition in which the body is the subjective source or intersubjective ground of experience (Csordas: 1999:181). I will use an embodied perspective in this thesis because I render it useful for an analysis of change, as I believe embodied experience could be influential in changing the practice of female and male circumcision. Understanding the wider changes to the Maasai society through the body is a useful standpoint as the “understanding of culture should begin with an examination of the lived-in body, because one knows, feels, and thinks about the social world through the body” (Tapias: 2006).

In this thesis I discuss the medicalized circumcision from the perspective of the Maasai community in two locations in the Kajiado District of Kenya. When referring to the Maasai community I mean the milieu, social group and social environment people assert membership to in the face of opposing ideas and groups (Anderson: 1983). The community term is not unproblematic as it implies that the community is a bounded entity with the same ideas and values. In Kajiado there were fractions and contradictions, especially concerning the increasingly controversial issue of female circumcision. I present a fieldwork of great ambivalence, which supports the understanding of the community as an entity of fractions and

contradictions. I still chose to use the community term, however, as this is in line with the identification of my informants as Maasai. I will now proceed with giving a presentation of the two locations.

The place: Loitek

A one and a half hour drive, depending on traffic, from the vibrating pulse of the capital Nairobi, you will find the small town of Loitek. The main road dividing the town is heavily trafficked, as it connects Nairobi to the Tanzanian town Arusha. The town is located in the Kajiado District of Kenya, a district mainly populated by the Maasai tribe. Due to the rising costs of housing, the high population density, and the high crime rate in Nairobi, the district is experiencing an influx of people migrating from the big city. As you drive along the main road towards Loitek you pass hundreds of building projects on the way. Scattered on each side of the road you will also find the large flower plantations, which together with the building projects create work for hundreds of employees from all over Kenya. The high migration rate from other areas of Kenya makes Loitek a small, multiethnic society.

I arrived in Loitek in the beginning of February 2011 when the land was arid after a long dry spell. People would constantly be looking at the sky, sighing; *“soon, very soon, there will be rain again and you will see how green and beautiful our land is”*. The rainy season was supposed to start in March, but during my stay the rain was sparse, leaving the farmers and pastoralist in Kajiado in despair. The lack of rain was a constant source of worry and the drought was often subject of conversation. However, the Maasai are not unfamiliar with long periods of drought. Through history, several major droughts have made their livelihood difficult (Talle: 1988). As the Maasai have depended mostly on pastoralism, they have been particularly vulnerable to long droughts which leave their cattle without water and grazing opportunities. Fortunately, few in Loitek town, if any, depend solely on pastoralism for their income anymore. The majority find employment in kindergartens, schools, and banks or in the many shops in town. In addition, most families have a few cows or goats as a supplement to their main income.

The first month in the field I stayed at a motel along the main road. The motel, as I soon found out, has a quite dodgy reputation as a meeting place for men and women wanting to

“rent a room for an hour or two”. As I felt my position as a young, unmarried woman in her twenties already made me the subject of talks and rumors, I did not want to exacerbate the situation by staying at the motel. After searching for a new place to stay on my own for a while, I was given the phone number of a pub owner in town, Lucy, who apparently had all the right contacts. After an hour she had found me a place to stay, invited me for dinner and donated half of her kitchen supplies to me. I was happy to have found a place to stay, right next to the market place in the center of town. I had my own kitchen, bedroom and living room and shared a backyard with 5 other families. My new living situation gave me a closer connection to the field, as I was living among my informants, instead of separated from them. My apartment was located in the heart of Loitek. From here I had easy access to all the facilities in town. Just around the corner from my place one would find the main street, where I often met my informants for lunch at one of the many restaurants. The place always smelled of *nyama choma*, grilled meat, the specialty and pride of the Maasai, served with *chapati*, rice or French fries as a side dish. With the food you might enjoy a soda or a cup of tea, made by a half and half mixture of water and cow milk, and teaspoons of sugar. As a man you might enjoy a beer with your food, and then often the famous, Kenyan beer Tusker or an imported Heineken. As a woman you are not supposed to enjoy alcoholic beverages in public, but the rule is being challenged by young women who order the new brand on the market; Reeds, an alcoholic fruit cider. The cans have a delicate red and white label and can easily be mistaken for the non-alcoholic beverages which you can purchase at the supermarket. Tito, one of my informants in Loitek, giggled as she ordered the cider and told me that they easily fooled their fathers, who were not familiar with the new brands; “*The elders do not understand this new time. They are only able to recognize the green and brown beer bottles*”.

I spent my first week in Loitek with the NGO, Maa Partners Initiative (MAAP),³ an organization which was founded by “a group of concerned individuals, who had become concerned with the social, cultural and economic issues that were predisposing the Maasai community to high risk of HIV infection”.⁴ Lately, they have intensified their interventions to include a broad spectrum of development needs such as water supply, malaria control, Early Childhood Development and food security. I went to the office at opening hours in the

³Formerly known as Maa AIDS Awareness Programme

⁴<http://www.maapi.org/>

morning and back home the motel at closing hours in the late afternoon. A couple of times I would also go with them to the field, to get to know the wider community better. MAAP served as a good springboard to the rest of the Maasai community in Loitek, as the staff set me up with family and friends in the area. After the first week I decided it was time to “cut loose” from the organization, in fear of being too closely associated with their work by the Maasai. I would however keep in touch with the MAAP team throughout the whole field work, meeting them at weddings, church or *manyattas*.⁵

During my first week I also met with Leah, my interpreter in Loitek. As I speak neither Swahili, one of the official languages in Kenya, nor Maa, the language of the Maasai, I was dependent on using an interpreter for many of my interviews. In Loitek I normally managed on my own, as many people spoke English rather fluently. When interviewing older men and women however, I needed assistance. I was fortunate enough to get in touch with Leah and her family, which were well acquainted with Aud Talle, who had used both Leah’s mother, elder sister and Leah as interpreters and assistants during her many visits to Kajiado. Talle conducted research in the Kajiado district, mainly during the late 70s, early 80s, but with subsequent visits up to date. As Leah was familiar with anthropology and the way of an anthropologist, she made an excellent interpreter. Sometimes she knew what I was going to ask or in which direction the interview was going, almost before I was able to gather my own thoughts. As we worked together for a while and she got more familiar with my thesis, she would sometimes ask my permission to ask the informant this and that question. Although she was used to working with a more experienced anthropologist, she found joy and excitement in helping me in my work. She would be amused by the fact that I was not an experienced anthropologist, saying; “*You’re questions are easy, not like Aud’s. One time she asked me if I could ask the old mamas about love - Love*”, she could say and laugh of the memory. Other times she would tilt her head in bemusement over the answers we had collected, saying; “*I really didn’t know that*”.

Because Leah worked as a pre -school teacher I was only able to meet with her during weekends and school holidays. I would therefore do interviews and meet with English

⁵A Maasai settlement or compound, often temporary, established by a family or clan, or as an encampment of young warriors.

speaking informants during weekdays, usually after their work hours, and sometimes for lunch or coffee in the middle of the day. I spent the weekends with Leah and her family, doing interviews, learning to cook and going to church on Sundays.

The place: Marok

After staying in Loitek for a couple of months, the pub owner, Lucy, introduced me to her old friend, Jane. Jane was running an organization working to eradicate female circumcision in one of the more remote areas of Kajiado. Lucy insisted that I travel and stay with Jane at her home in Marok, for “*at least a week*”. I was not hard to persuade as I had been thinking about doing a comparative study for quite a while. I wanted to compare the development that had taken place in Loitek with another area of the Kajiado district. My interest in doing a comparative study on the medicalization of male and female circumcision had grown during the dialogues with my informants in Loitek. In practically every conversation I had on the topic of circumcision, change and modernity, the tale of “*the interior*” was raised. “*We used to circumcise at home, without anesthesia, but nowadays you will only find this in the interior*”. While the circumcision in Loitek took place at the hospital under “*settled conditions*”; “*It’s clean, it’s okay*”, the general impression was that in the interior one still used traditional women and men to carry out the circumcision that did not use anesthesia, sterile equipment, or medicine. “*The interior*” was a quite loosely defined concept, which I interpret to mean the rural areas. I was skeptical to the statements as I believed them to be an outcome of a discourse of modernization, where the changes in circumcision practices are legitimized and explained in terms of development, modernity and religious practice (Talle: 2010a). Within this discourse those practicing more modern forms of circumcision would accuse those in the more remote areas for being primitive and backwards in their way of circumcising (Talle: 2010a). When I spoke to Maasai women in Nairobi they would use the same discourse, only in opposition to the Maasai in Kajiado. Still, I was curious as to whether one would find as big a difference between the rural and urban areas as my informants in Loitek let me believe.

I met Jane at Lucy’s pub a rainy afternoon in March. She arrived with her driver and colleague in a Land Rover. Jane turned out to be an excellent driver, but as her pregnancy was coming to an end, she felt it necessary to have someone who could take over the wheel. As we

drove along the rough road from Loitek to Marok I quickly understood her reservations. The long, bumpy road in itself was enough to start a delivery. We followed the main road from Loitek towards Kajiado town and took off on a small dusty sideway. The road was rough and full of potholes from all the trucks that transport sand from the dried river banks in the area. The sand is driven to one of the many building projects along the main road between Nairobi and Arusha, where it is sold. Because of the poor roads, you depend on either a Land Rover or a motorcycle to get through the hilly landscape that surrounds Marok.

Jane lived permanently in one of the better areas on the outskirts of Nairobi. She was a Maasai, but originally from a different area of Maasai-land. She had met her husband Jackson years ago, when they were both students in Nairobi. Jackson was born in Marok. He was now working in the pharmaceutical industry and spent a good deal of his time travelling both domestically and abroad. The reason they built a house in Marok came partially from a wish that their children should be more attached to their fathers homestead, and partially from a need for a base for Jane's anti-circumcision project in the area. When Jane gathered men and women from the community for seminars and debates on the subject she would often gather them in the large garden that belonged to the house. Jane had cut down most of the growth, besides some huge trees that served as shelter from the sun. The house itself was designed by Jackson, inspired by his travels in the Swiss Alps. The house was round with a pointy roof and it was made of red bricks and white bricks which were collected from the river banks nearby. The inside of the house was inspired by the traditional room division of the Maasai huts. When you entered you would have the large common area to the left, where guests would be seated, and the kitchen to the right. Further down the hallway you would find the private bedrooms. The building gained a lot of attention from the local community, as it was dramatically different from other houses in the area, which were built in the traditional Maasai style, with sticks and cow dung. Her house, her way of living, and other small things like serving spaghetti with meals instead of the usual rice or chapatti, undoubtedly made her stand out from the local community. Yet she would often stress the importance of emphasizing one's identity as a Maasai when working with circumcision in the area. When we visited the *manyatta*, Jane would dress up in her traditional attire, to represent that she was "*one of them*". As she said it; "*When people see that you, as a member of the community, are working against the practice it is easier for others to distance themselves from circumcision*".

During my stay in Marok I lived in Jane's house with her and two interns from her organization, Joyce and Mary. Most of the time us women would be alone in the house. Jackson visited us when he had the time, during the weekends and on a couple of occasions he brought his youngest son with him. Their two sons usually stayed at their boarding school. Staying with the women gave me an intimate feeling of Marok. I woke up, had breakfast with them, and went to the field with Mary and Joyce. In the evenings when the generator was switched on for a couple of hours, we would sit down in front of the TV and watch the Mexican Soap Opera "*Soy tu Duena*", before we watched the news and discussed the national and international events. Moreover, I got an intimate feeling of the landscape. While in Loitek, I would often travel by *matatu*⁶, rarely taking any detours from the main roads. In Marok, on the other hand, I felt free to explore the landscape and the clusters of roads and paths that crisscrossed the area. In the morning I would go for a run, and I frequently changed my route. My informants boasted uninhibitedly of me if I was able to find my way back to a homestead after being there only once or twice before.

In Marok I would follow Joyce and Mary around. As they were quite new to their internship they moved around in the local community, establishing a closer contact with key persons such as teachers, doctors and chiefs. When it fit their schedule I would do interviews with teachers, employees at a rescue center nearby and women and men from various households in the area. The second time I visited Marok, Mary was busy with another job. Then Alice, the daughter of one of Jane's old friends, stepped in as an interpreter. She seemed happy to be kept occupied as she was at home waiting for a computer class to start over Easter.

The people in Marok rely on a mixture of subsistence farming and husbandry. The women often care for the animals, milk them and feed them. Young boys are often in charge of taking the cattle to graze. They take them from the compound in the morning and back home in the evening. Men make a living of selling cattle, keeping small businesses in town or by migrating to get work elsewhere. Although agriculture is seen as somewhat degrading work for a Maasai, many families would have both cattle and a garden with vegetables for subsistence or sales. Some of the women in Marok participate in small microcredit groups,

⁶Privately owned mini bus and an important mode of transport in Kenya

consisting only of women. Jane explained to me the importance of such groups as they let the women control some of the household income.

Methodological and ethical considerations

The fieldwork was carried out from January to May 2011. During my fieldwork I had one field break, which I spent in Nairobi and Mombasa, trying to rid my body of a cruel typhoid fever I contracted. However, I would on several occasions take a weekend in Nairobi, meeting up with two other students of anthropology.

The study of female circumcision may be both methodically and ethically challenging. Methodically it represents a challenge because you have to rely extensively on the oral representation of the practice. My material is mainly based on narrative representation of circumcision. It is difficult to know whether what is said about circumcision, actually corresponds to what is done, or whether the stories being told are an outcome of what the informants believe the anthropologist wants to hear. I will return to this in the last chapter. Nonetheless, I find the narratives to be an important source of information, because they can reveal much about changing feelings about bodies and self.

Data has been collected mainly through participant observation and semi – structured interviews. Participant observation gave me a more intimate relationship to places and people. I experienced that spending time with my informants, doing house chores, going to church or going dancing gave me access to information I would perhaps have missed out on otherwise. In the study of an intimate theme such as circumcision it was furthermore necessary to spend time building trust. The choice to do semi structured interviews was taken partly because I did not want to influence the direction of the interview too much, partly because my informants seemed more at ease with a less formal interview setting. Since I inquired about rather personal issues I preferred to let my informants go about in their own pace. I seldom used a recorder, as I noticed that it made some of my informants nervous as to what the data would be used for. I would carry my well – worn note book and write whenever I had the chance to. I tried to be as open as possible when it came to the objective of my study. Before doing an interview I would always present myself and my study in order to ensure that my informants understood the scope of the study. However, can we ever reach a truly informed consent?

Bourgois argues that the mere idea of participant/observation fieldwork counter the ideal of fully informed consent as the ethnographer is trained to “break the boundaries between outsider and insider”, encouraging people to forget that “you are constantly observing them” (Bourgois: 2012:327). When doing fieldwork boundaries between being an informant, interpreter or friend become blurred.

When doing fieldwork, the information available is affected by the interpersonal dynamics and interactions between researcher and insiders (Gartrell in Steward: 1998:30), which is inevitably affected by the age, gender and personality of the researcher. I therefore follow a reflexive trend in anthropology by writing my own embodiment into the thesis, focusing on my gendered embodiment (Csordas: 1999). From a phenomenological perspective the researcher’s body is understood as both an access and as a limitation to the acquisition of knowledge (Engelsrund: 2005). Being a woman in the field, or rather, to use Leah Hutchinson’s words; “an awkward cross between a woman and a girl” mostly proved advantageous (Hutchinson: 1996:46). As a young, unmarried European woman in the field I was able to ask stupid questions and was, most of the time, met with an indulgent patience, the one you would meet a young child with. But being a woman also presented me with some restrictions and challenges. I was for example not supposed to be out after dark. In the beginning I thought it was merely a safety issue, but after a while I understood that it was just as much an issue of presentation. “*It’s perfectly safe in Loitek, but it’s just not something you would like to do. A young and single woman should not be wandering about after dark. You don’t want to send out the wrong signal.*” Walking outside after dark did not present a threat to my safety, but a treat to my reputation as a respectful, young woman. Furthermore my presence as a young, unmarried woman would create a great deal of attention and curiosity from the opposite sex. As I walked through Loitek I was very visible to the gaze of young men and was frequently hollered at and approached. I was, however, not the only one attracting attention. Young women in Loitek would often be greeted in the same way. Naturally, my female informants, unlike me, had made an art of overlooking them. When some of them felt their boundaries violated they would not hesitate to let their feelings be heard. They shouted back, they humiliated the men through clever comments, and they always knew how far they could go. They knew how to play the game. As a newcomer to town I was not familiar with the games, with the codes and the slang. I could not seem to find the balance between being flirtatious and reserved. This probably contributed to creating a

strain on some of my relationships to my male informants. The tension was not necessarily anyone's fault, but an outcome of a situation where there is confusion around what is going on. For some of my male informants it might have been challenging to handle the idea of a young woman appearing, who suddenly wants to hang around and talk about quite personal issues. Even though I did my best to explain the nature of anthropology, it may have been difficult to interpret a new, unfamiliar situation with a quite assertive woman, who is not very well acquainted with the cultural codes. I remember the comments my female informants gave me as we strolled through the city "*You are looking them too long in the eyes*", "*Now you were too friendly*", "*Say no as if you mean it*". When my informant Tito introduced me to a male friend of hers, I tried leaning through imitation. I mimicked Tito's relaxed and easy going way of hanging out with him. We had lunch together, went for a swim and could have a beer in the afternoon. After a while I felt that our relationship went in the wrong direction. He would call to know my whereabouts, who I was with, and he wanted to visit me at home after dark. In the end, to my great regret, I felt it necessary to end the informant relation with him. It was not until later that I understood why Tito could act so aloof with him. Tito and he were part of the same clan, which practically made them brothers and sisters according to Maasai tradition. For Tito, dating him would be almost incestuous. That my approach towards her clan brother was interpreted in a different manner than Tito's did not come as a big surprise with the new information at hand. The balance between making oneself respected and being rude was difficult and may well have restrained my access to information from my young, male informants.

Choices I made during my fieldwork may have been both productive and inhibiting for the data I collected. Both in Loitek and Marok I was associated with NGO's working for the eradication of female circumcision. When in Marok I stayed with Jane, the leader of an anti-circumcision organization. People may therefore have been hesitant to reveal too much of their practices to me. My choice to stay with Jane in Marok was based on practical concerns, but also on an evaluation of her contact with the local community. Jane was very clear about the scope of her intervention. She wanted changes to happen through conviction, rather than force. I felt that the data I received in Marok was characterized by a great deal of reflexivity and honesty regarding a practice hotly debated in the area at the time of my fieldwork. Nevertheless the choice may have limited or influenced the type of information I gathered.

During my fieldwork I travelled between two places. Wolcott argues that when doing a multiple-site fieldwork you may risk forgoing the opportunity to produce well-contextualized qualitative study, ending up with an inadequate qualitative one (Steward: 1998:61). The holistic ideal of the ethnographer; that individuals can only be understood within the context of the whole, requires that one stay long periods in a location, in order to “develop a deeper understanding about local histories, relationships and culture” (Foster.et.al. in Steward: 1998:20). Undoubtedly my travelling between two different sites had implications for the closeness to my field. Still, I found it useful to have carried out a comparative study, because it gave me the chance to move beyond the simplified division between rural and urban, and traditional and modern Maasai.

Since the practice of female circumcision is illegal in Kenya the writing on the topic calls for cautions. I use pseudonyms in this thesis, both for the places I visited and the people I met. Some of my informants were more than happy to let me use their real names, but as the theme for my thesis concerns sensitive matters, I chose to use other names. My informants usually had two names, a Maasai name and a “Baptist” name. As most of them used their Baptist name when they were with me I have chosen to find pseudonyms that are similar in origin.

One of my concerns when writing about a topic so fraught with meaning was making the lives and experiences of my informants more exotic than they necessarily are. When looking through my note books as I was writing chapter two about medicalized circumcision, I realized something: My field notes from my visit to the traditional circumcisers in Marok were of more substance and detail than those from my visit to the doctor at the health clinic in Loitek. Was I in a process of ‘Othering’ the women I wrote about, focusing on the aspects of their lives which were most alien and exotic to me? Ethnographic writing has been criticized for its tendency to construct Otherness (Battagli: 1999:114). Throughout this thesis I will do my utmost to describe circumcision as closely to the experiences of my informants as possible.

Thesis Outline

Having outlined an approach for the analysis, I will give a short introduction to the chapters to come. In chapter two I present the medicalized circumcision as it has been carried out in

Loitek and how the medicalized circumcision has influenced the performance of circumcision in Marok. Here I focus on how medicalization has influenced ideas about a weakening of both individual bodies and the social body. I further focus on the way my informants have recreated the ritual as one of modernity. Chapter three focuses on an interrelated theme, namely how changes in society associated with modernity, and the rise of “new diseases” such as HIV/AIDS have created a new legitimate ground for circumcision, as it is now seen as a healthy response to the “new times”. Here, there is a clear gendered aspect, as female circumcision is rendered as a harmful, traditional practice by the international community, while male circumcision is regarded as a modern and healthy practice which is said to prevent the spread of HIV/AIDS. I also present a counter-narrative to the dominant discourse of female circumcision as an impediment to health and sexuality. In chapter four I explore the effect medicalization, and particularly the use of anesthesia, has on the meaning of circumcision. Furthermore, I explore the effect the use of anesthesia, and the subsequent “*disappearance of pain*”, has on notions of belonging among the young Maasai in Kajiado and how the use of anesthesia can change relations between the individual and the community. In the last chapter I attempt to understand how all the changes to the Maasai society, and especially the medicalization of female circumcision, contribute to changing notions of the body and self. In this last chapter I focus solely on women, since they have experienced a particular strain on their image of body and self because of the international discourse on female circumcision, which renders their bodies as mutilated.

Chapter Two

Changing realities - experiences with medicalized circumcision

It's clean – it's okay

Seenoy

The way people engage with wider so-called global processes of change, or modernity, has gained a lot of attention from anthropologists over recent decades (Geissler and Prince: 2010:5). In this chapter I explore how my informants in the Kajiado District engage with medicalization of male and female circumcision, and how medicalization is connected to wider processes of change. Medicalization of circumcision represents, I believe, one element in a larger picture of change. Medicalization is a relatively new phenomenon in Kajiado, as medicalized circumcision has only gone on for a couple of decades.

The experience with and understanding of the practice is varied. While some would be looking back with nostalgia on times when circumcision “*used to matter*”, others would claim that for the “*new, modern times*” medicalized circumcision was the only right way. In this chapter I wish to include different experiences with and understandings of the practice, because they are invaluable when attempting to understand how my informants interpret the changes to Maasai society, land and bodies.

Although most of my informants saw medicalization of both female and male circumcision as a positive transformation, there was a certain degree of ambivalence connected to the change, exemplified in the following stories of Leah and Daniel, two of my informants in Loitek. Their stories illustrate not only how the medicalized circumcision was typically performed in Loitek, but also how they, and the community surrounding them, interpret the medicalized practice. Their stories create an important background for the rest of the analysis, as they shed light on some of the wider changes to the Maasai community.

Before proceeding it is necessary to dwell upon the concept of modernity, as I will be using it throughout the chapter.

Creating modern bodies

Modernity, as argued by Comaroff and Comaroff, and others, is not one thing, but many. It is a metaphor for some new or emerging “here and now” materialities, meanings and cultural styles, seen in relation to the notion of some past state of things (1993:xiii). I shun away from the term in my analysis for a while. This was partly because of modernity’s elusive nature, as neither this nor that and partly because of my uneasiness with the concept, since it has often been used in order to create distance between “them” as traditional and “us” as modern. Yet, I have come to deem the term useful as it represents a “[...] central element in people’s understanding of self, as something that is both an expression of accumulated experience and influencing people’s actions” (Kolshus: 2005:38, my translation). Modernity is thus what the anthropologist calls a “native category”, a category shared by an enormous population of natives (Ferguson: 2006:177). Although the term as an analytical tool, might be both vague and confusing, it remains the center of a powerful “discourse of identity” (Pratt in Ferguson: 2006:177).⁷

My approach throughout this thesis will be inspired by Comaroff and Comaroff and their understanding of African and other modernities as co-evolved, thus implying multiple, coexisting modernities. This approach is not necessarily unproblematic. When suggesting that medicalized circumcision should be seen as within modernity, and not outside it, I contradict the understanding many of my informants had about circumcision as a harmful practice which belongs to the past, not the present, and definitely not to the future. Still, I render it important to present all these different understanding of circumcision in order to understand how the practice changes, and how it loses and gains new meaning. The many different understandings of medicalized circumcision may seem contradictory, but in reality they represent the great fluidity and ambivalence which characterize the field of circumcision.

⁷ When I use the term modernity, I use it as an analytical tool and not as an understanding of a linear process. I also use it as an emic understanding of development and what characterizes “the new times”.

Leah's circumcision story

One Sunday towards the end of my stay in Loitek I was going to church with my interpreter, Leah. Leah was walking in front of me with little Trevor tied closely to her back in a *lesho*.⁸ An umbrella was protecting them from the scorching sun, but the heat still caused tiny drops of sweat to drip down Trevor's forehead. He was often with us when we entered the field; either sleeping on Leah's back or playing at our feet as we did interviews. Trevor was the second child of Leah and Simon. The couple married a few years back, shortly after Leah finished her education to become a pre-school teacher. They met while Leah was still in high school. In fear that Leah would be forced to end their relationship they had kept it a secret. Her mother, Seenoy, had warned her against being with boys, as she feared that Leah would get pregnant and kicked out of boarding school. Leah feared that if their relationship was discovered, her family would start the process of finding her another, more suitable husband. As Leah's eldest sisters had been married off some years earlier, her fear was not unwarranted. By the time their relationship was detected, Leah was already with child. So, Seenoy agreed to take care of her new grandchild, while Leah finished her education. Although Leah's actions were not popular, she received her blessings to marry Simon after she completed her education.

Leah was born in 1986 as the eight child of ten, by her mother Seenoy and father Tipanko. She grew up in a time of considerable change in the Maasai society. The changes in female circumcision and other bodily practices could be exemplified by comparing the stories of Leah and her elder sisters. "*Times are changing*", she said. "*While my elder sister and brothers had their front teeth pulled out, my mother did not want the same for me and my younger sister*". During the past couple of decades, body practices such as the pulling of teeth, expanding earlobes, scarring, and tattooing, had vanished. When asked why they could leave such practices, while continuing the circumcision, she told me that circumcision was something else; "*a necessity*", while the other practices had been, "*just for decorations*". This could serve as an example on how social change was expressed on the human body (Strathern: 2007:240). Bodily markers became signs of one's social status if one wanted to associate with "the modern life" one left certain bodily practices. When walking passed a man

⁸A shawl

with long, extended earlobes, Maina whispered to me; “*See that man? He has never gone to school. You can tell by the length of his earlobes*”.

This morning, on our way to church, she would for the first time tell me about her own circumcision;

I was taken to the hospital at the age of 16, in the company of my aunt and little brother. I had just finished form 1, so I was a bit older than the average age for girls. That's because I had to wait for my little brother to come of age, so that we could go to the hospital together. I remember that my school ended on a Thursday and that I was taken the next day, on a Friday. We left after dark so that no one would see. I was circumcised that very night, while my brother was circumcised in the morning. Circumcision was not my wish, but I had to respect the wishes of my father. He was a very strict man.

Her story was typical of other circumcision stories I had heard in the area, where a girl would be taken to hospital with a brother as to not raise suspicion among family and neighbors that might oppose the practice. If the family was confronted with taking a girl to the hospital they could say that she was only accompanying her brother to his circumcision. Female circumcision would be celebrated by throwing a small, private party at the girl's home, often masked as the celebration of a brother's circumcision, or a festive occasion such as Christmas or New Years. The secrecy was a necessity, as both the parents of the girl and health personnel risked being prosecuted for having the girl circumcised. Female circumcision was made illegal in 2001 through the adoption of the Children's Act, a piece of legislation condemning the practice on minors (UNHCR).⁹ Despite the ban, medicalized female circumcision seemed to have gained ground, not only in the Kajiado District, but in the whole of Kenya. The 1998 Demographic Health Survey (DHS)¹⁰ indicates that up to 38 percent of married women in the age group 15 – 49 underwent a form of female circumcision, of which one third of these women reported being cut by a health care worker, either at a health care station, or at home (Christoffersen – Deb: 2005:403). The survey clearly shows that the younger the women were, the more likely that they would be circumcised by an educated circumciser, indicating that the practice is being taken over by educated personnel. While the mothers in the survey would be circumcised traditionally, their daughters would be

⁹ <http://www.unhcr.org/refworld/docid/47975f332.html>

¹⁰ <http://www.measuredhs.com/pubs/pdf/fr229/fr229.pdf>

circumcised by medical personnel. This is quite a dramatic change during a short period of time (Talle: 2001:67).

Because of the Children's Act, families could not openly take their girls to the hospital or a clinic. It would be necessary for the girl's guardian, often an aunt or another female relative, to make arrangements with the doctor beforehand. Leah told me that before she was sent to the hospital, her aunt had made inquiries to a doctor in the area. *"That is how we do it. Before circumcision, the guardian will go to the hospital and inquire about circumcision. When you reach an agreement, you will take the girl"*. The guardian would carefully ask whether the doctor could perform the procedure. Most often rumors had already circulated, indicating who would be willing to circumcise. Private clinics performing the procedure would often be well known among local users (Talle: 2001:67).

Medicalization was said to have started in the late 1980's, early 1990's, in Loitek, and had steadily become more widespread despite the ban from 2001. Leah recalled;

I believe medicalization started in 1987. I know that was the year, because it was the year my older sister was circumcised and she was the last one in my family to be circumcised at home, the traditional way. Nowadays most girls are sent to the hospital or they will have the doctor come to their home.

It was not uncommon for health personnel to make home visits, performing the procedure there with medical equipment. Leah told me that the doctors would; *"take their "mkunga"¹¹ kit, with all the necessary equipment. They carry the anesthesia, the needle, spirits and gloves, and then for each girl they use different razorblades"*. In Loitek it was more common to take girls to the hospital for circumcision due to the availability of health services, while visits from the doctor were more common in the rural areas.

While telling her story, Leah revealed that when she had been taken to hospital, the doctor had only cut *"the tip of her clitoris"*. When talking to Leah's mother one afternoon, I asked her whether she believed that the doctors would take less flesh than the traditional ladies.

¹¹ Midwife

Seenoy did not believe that it was the medicalization alone that had made people prone to cut less.

The doctors will do as the guardian asks. If the parents want a big cut, the guardian will ask for that. If the parents want a small cut, the guardian will ask for that. The doctor will do as the parents want. Of course the doctor might urge them to cut less, but it is not for the doctor to decide.

It was a shared feeling that going to the hospital gave the guardian, and thereby also the mother, a greater freedom of choice when it came to the amount of flesh being cut. While it had always been common for mothers or other female relatives to consult the circumciser on the extent of the cut before circumcision, the privacy of the hospital made it easier to resist the comments from eager spectators. Several of my informants told me about the traditional way of circumcising, where circumcision used to take place in the girl's homestead, and where women would gather around the circumciser in order to make sure that she would do a "*proper Maasai circumcision*". If the circumciser cut too little, she would be confronted by the other women, encouraging her to take more. In the privacy of the hospital, girl's guardian has the final say about the extent of the cut. Leah had a "*small cut*" because her aunt and guardian had asked for it, in accordance with the wish of Leah's mother. Her father, although in favor of "*the traditional cut*" would never know that she only had a "*small cut*". A doctor Leah talked to told her that nowadays, a mother could come in and urge the doctor to take as little flesh as possible, even though her husband might have been in favor of the traditional cut. "*He will never know, so I just cut a little bit*".

Seenoy believed that the reason more and more people nowadays asked for a smaller cut, was because the younger generation did not want to stop the practice entirely, but rather carry it out in a more modern way. "*The small cut*" constitutes a compromise for the younger generation. They want to respect the "*ways of their mothers and grandmothers*", but in safer and less harmful ways. Other informants claim that the change is an outcome of a more practical concern, namely that it was desirable for the girls to heal before the holiday ended. Like Leah, most girls are circumcised during the long Christmas or Easter holidays, thus the small cut would be more practical for them. Irrespective of the reason for the change, the general sentiment among some of my informants is that medicalization implies the beginning

of the end of the practice. Like Mary said it; “*People will not stop circumcising immediately. It takes time, so in the meantime it is better to do it in this modernized form*”.

While the medicalized female circumcision is associated with a transition to a less extensive cut, male circumcision has not gone through the same transition. At the hospital men would still have the traditional Maasai cut. Daniel, with his 25 years, was one of my male informants young enough to have had his circumcision done in the hospital.

Daniel’s circumcision story

In the third week of my fieldwork, I was introduced to Daniel through my friend Tito from the Maasai community center in Loitek. I felt that the gendered composition of informants was quite biased, so I had asked her to set me up with some of her male friends. Daniel and I met for lunch at the motel where I spend my first month. He was an easy-going person, and the following weeks we would spend some time together, meeting up for tea, lunch or a swim. Daniel had been raised by his grandparents, just outside Loitek. When his parents died in a car crash some years ago, they had left him a plot of land and he subsisted for a while on the money he got from dividing and selling the land. Even though he realized that his land would not last forever and did not provide him with a safe future, he saw it as a good income along the way, while he built a career for himself. At the time when I met him, he was involved in one of the many building projects in the area, trying to save up some money so that he could continue his college education in Nairobi. But since he was providing for his younger sister’s school fees as well, he did not deem it likely that he would go back to school in the nearest future.

One afternoon when we were having tea in the motel where I stayed, Daniel told me about his own circumcision. Daniel was circumcised at the age of twelve together with another boy his age. They had been picked up by a truck early in the morning, and were driven to the health clinic in Loitek with their guardians. At the clinic, a local doctor circumcised them the traditional Maasai way. The day of circumcision they had not prepared in any particular way. They had dressed up in black *chukas*, not because it was tradition, as Daniel emphasized, but because the light fabric would not put pressure on the wound. The hair on their heads had already been shaved off the day before, as a symbol of their new ritual status, as they were

“leaving their childhood behind”. When they had finished the liminal period of healing, they were supposed to shave again, as they entered a new status as adults.

In addition to shaving, another ritual was also widely implemented; namely the blessing of cold water. Before boys and girls were circumcised, a *sufuria*¹² of water would be placed on top of the house during the night, often with a piece of metal, like an axe or knife, in order to make the water extra cold. On the morning an already circumcised boy or girl from the same age group would pour the water over the initiate, the boy or girl about to enter the adult sphere. The water functioned as a blessing, *“cleansing the initiate of all the past sins”*, but it also had a more practical function of *“numbing the area before cutting”*. Some of my informants said that even though the boy or girl was taken to the hospital it was good to keep the blessing, as the cold water *“make the blood slower”*, and thus *“prevent excessive bleeding”*. The shaving and blessing of cold water are rituals that have been preserved, but whom none saw as rituals, but merely as *“something we just do”*.

After circumcision the boys rested for a couple of days, before they started “wandering about”, meeting with other age mates, going from homestead to homestead. The wandering about signaled to the rest of the community that they now took part of the same age group, while it also strengthened the solidarity within the group. When the wound had healed completely, the family would have a small celebration. Not like the ones they used to have with wine, slaughtering and dances, but a small gathering of friends and family. My informants explained the move towards smaller celebrations in terms of the individualization of circumcision with medicalization, but also in terms of an economic decline in the Maasai community; *“Now that boys are going to hospital we don’t have the large common celebrations like before. With this economy no one can afford to throw such a big party alone. So we just gather some close friends and family”*.

An ambivalent practice

Daniel was circumcised during the Easter holiday and had returned to school after the healing process was over. He had not participated in any rituals surrounding the circumcision and the

¹² A pan.

subsequent initiation to the age grade system¹³, as these were seen as highly time consuming. Young people who went to school or had jobs in town no longer felt that they had the time to spare. As a result many of my young informants, Daniel included, were not particularly aware of the symbolic importance of their circumcision; namely the advancement in the age grade system. It was said that the young Maasai's of today, did not even know the name of their age group. Daniel could name his age group, but when he wanted to spell it for me, he had to call an age mate in order to get it right. When I asked Daniel about his knowledge about the age group system, he hesitated for a while before stating;

Life has changed. For now, many of us go to school and we don't know about the age group. Cause when you go to school you will leave the traditional way, so when someone comes and ask you what your age group is, you don't know because you already live in town, and in town there are no age groups.

Several of my informants ascribed the lack of knowledge about the age grade system to the medicalization of circumcision. Daniel explained;

Previously boys used to be circumcised together, maybe 10 – 15 boys at the same time. Then they would automatically know which age group they belonged to as the age group is consisting of boys being circumcised together.

The direct consequence of a more individualized circumcision was a lack of knowledge about the meaning of circumcision and the incorporation into the age grade system, which again, as the elders claimed, resulted in a lack of respect among young boys. A teacher I talked to complained that nowadays boys did not know what the circumcision implied. “*They get the respect that follows from circumcision. They are greeted by the hands instead of their head, but they do not honor this respect, by acting accordingly*”. Maina, one of the employees at MAAP gave me an example of the lack of respect these young, newly circumcised boys show;

They no longer have respect for the teachers. They are rude and difficult. I read in the newspaper the other day that a teacher denied two 12 years old boys access to class because they had just been

¹³The age grade system used to be what “structured” and encompassed Maasai society (Spencer: 1993:140). It comprises hierarchically structure age groups. The boys who are circumcised together takes part of the same age group.

circumcised. The teacher was reprimanded, but I understand him. Now that they are circumcised they think they can do what they want. It's just too young, you know.

Maina was of the impression that boys these days were too young to realize the responsibility that followed circumcision. Earlier boys were circumcised when they were ready, it was said. While individual maturity was still regarded as important, the circumcision age seemed to be more standardized these days; *“boys will be circumcised after class 8”*. *“The lack of respect”* might be interpreted as a kind of social disorder resulting from a breakdown of community control by the elders. The same trend was found among the Duna in Papua New Guinea, where a signal of disorder was found in *“young boys growing up too fast”* and by implication not proper or fully (Steward and Strathern: 2007:xi). As medicalization was individualized and standardized, the elder generation had little influence over a ritual which once confirmed a young man's place within the age grade system. The elder generation used to be in control of the rituals connected to circumcision, but as these rituals were no longer of the same importance they had lost a considerable amount of power.

While Daniel ascribed the lack of knowledge and interest in the age group system as an outcome of a more *“enlightened and educated”* youth, the elders saw it as a sign of a cultural degradation of the Maasai. The elder generation of Maasai in Marok and Loitek were troubled about the development in the Kajiado District. Many expressed concern that their culture was dying. Both the lifestyle of the young, as well as, the lack of interest in the cultural heritage and the recent business of *“selling of the forefathers land”* was a concern. The business of selling land was regarded as a modern tragedy by the elders who claimed that the young generation wasted their land, selling it for a song. *“They sell their land, and instead of building something for themselves, they waste their money on short time pleasures like beer, cars and women”*, was an often heard comment. All the youth cared about, it was said, was easy access to *“icons of modern wealth”* (Setel: 1999:8) such as cars, houses and phones. The selling of land was seen as a degradation of the livelihood and culture of the Maasai. Daniel, who subsisted on dividing and selling his land, saw the development as a natural response to new times. For him it was not about *“leaving his roots behind”*, but about trying to live a better life. With the dim prospect of global warming many young Maasai emphasized the importance of finding different sources of income than herding cattle. Daniel explained;

People are moving forward, people are getting employed, and people are getting their own work, so we are trying to leave that life [pastoralism]. Those days we used to keep herds of cattle, a thousand, two thousand, but for now the climate are changing, rainfalls are getting less, so now when you keep the cattle, if you have more than a thousand, they die, and you are just left with nothing.

Ideas of “diminishment, decline and decay” are, as Strong emphasize, not symmetrically distributed between categories of person and will often seem to contradict themselves (Strong: 2007:108). The younger generation regarded the older generation’s way of living as out of tune with the changing realities brought upon them by global forces, while the elder generation regarded the lifestyle of the young as out of tune with the traditional Maasai way of living. When speaking of the past, my elder informants would turn to nostalgia, idealizing “*the way things used to be*”. They would tell me stories of large herds of cattle, of big ceremonies and great warriors. At the same time they realized the advantage of “*moving forward*”. “*Previously we used to be so backwards. We used to keep thousands of cattle and then when the drought came they just died, and we had to start all over again*”. Hodgson found among Maasai in Tanzania that elders would speak of themselves as stupid for having clung to a masculine mode which embraced pastoralism and rejected education, farming and involvement with the state (Hodgson: 2001:253). A strong sense of ambivalence towards the changes to Maasai society was revealed in conversations with my older informants. The same sort of ambivalence was also found among my younger informants, who revealed a fear of “losing their culture”. An informant of mine in his early 30s stated that he regretted his lack of interest in the rituals surrounding circumcision and the advancement within the age group system, as he did not feel as connected to his culture and his age mates as he should. He felt a sense of loss, as he realized that he did “*not have a strong sense of belonging to his own culture*”.

The ambivalence to the changes in the wider society was also felt in relation to the medicalization of circumcision. According to Bauman, ambivalence is characterized as a disorder caused by the possibility of assigning an object or an event to more than one category (2001:1). Medicalized circumcision was such an ambivalent project, as it was both strengthening and weakening the bodies of the Maasai. On one hand bodies were seen as less vulnerable to diseases and infections, and hence stronger, but on the other hand they were regarded as weaker and not “*strong as they used to be*”.

The ambivalence felt in connection to both changes in land and bodies was also identified by Jerry Jacka during his fieldwork among the Ipili in Papua New Guinea. He identified a close relationship between the imagined degradation of land, society and bodies. Contrary to what Foucault described as modernity's increasing control and discipline over "docile bodies", the weakness his informants ascribe to their skin, is a different trajectory of modernity in which they sense a decreasing control and discipline of their bodies (Jacka: 2007:62), a point I will return to in chapter three.

So far I have presented examples of two medicalized circumcisions carried out in the hospital. My informants in Loitek emphasized the medicalized procedure of circumcising would be common in the urban areas. They claimed that if I wanted to learn about the "traditional" circumcision I should go to the interior, where they would still "*perform the procedure like our forefathers did it*". In the following I will present the story of two traditional circumcisers in order to see how they too incorporated elements of the medicalized practice in their way of circumcising.

Changes in Marok

One afternoon, one of my interpreters in Marok, Alice, asked me whether I would like to interview one of the traditional circumcisers in the area. The circumciser, Beatrice, turned out to be a friend of her mother and had recently participated in a seminar organized by Jane and her organization. The seminars had been targeting circumcisers, religious leaders, chiefs and others who were regarded as having a special influence on the prevalence of female circumcision. Apparently Beatrice had stopped circumcising shortly after the seminar and I was eager to learn more about her experience¹⁴.

The next day, as the morning mist dissolved, we set out for her home. The walk took us all morning as we had to stop in various homesteads along the route, presenting ourselves and passing our regards from Alice's mother. We arrived in the circumcisers homestead as the sun had reached its highest point in the sky. Beatrice was expecting us, sitting outside with a

¹⁴The decision to stop circumcising seemed to have come simultaneously as Jane started her work in the area. Although she claimed that circumcision was a part of her, she used present tense when describing the procedure, and so will I.

number of her grandchildren and female friends. While one of the kids fetched a *calabash*¹⁵ with milk and started preparing tea for us we went on with the usual polite remarks. As I presented myself and my project she looked at me with a curious and cheerful glare. She found it amusing that I came all the way from Europe to inquire about circumcision, but was not alien to the interest *mzungu*'s had towards the practice as she had been trained in Jane's organization, an organization that deals with a number of international donors. After I had stated my purpose; to learn more about the practice in order to, hopefully, create a greater understanding of it, she seemed at ease, and as the tea was served she started telling us about her life as a midwife and circumciser.

Beatrice began circumcising some ten years ago, after working as a midwife for some time. It was not uncommon for circumcisers to simultaneously work as midwives or to start out as one (Talle: 2010a). Her career as a midwife was more of a coincidence than a deliberate choice. She had happened to be alone in her homestead with a nine month pregnant woman when the woman had gone into labor. Beatrice was forced to help her deliver and started "out of necessity". From that day on she used to be called upon when women needed her help delivering. For her, the transition from midwife to circumciser was a natural one as they "*both go for the same*". Before starting as a circumciser she had not received any special training, other than observing "*the mamas*" practicing circumcision. The need for special training was not something my informants emphasized. Leah explained to me; "*It will come automatic too you, as they themselves have already gone through the operation*". According to my informants you would have an embodied knowledge of how to carry out the practice once circumcised yourself.

As a circumciser, Beatrice had a particular way of performing the procedure. She used to place the girl just inside the door of the house, in order to ensure a secluded space with enough light to perform the task. When the girl's legs were secured by some helpers, she would grab hold of the clitoris with her fingernails and cut it all the way around. She would stop cutting when "*a special kind of white flesh reveals itself*". It was important to cut the whole of the clitoris, she said, as the clitoris might grow back otherwise. Removal of the clitoris was an essential part of the practice as the old saying was that the clitoris might harm

¹⁵ Bottle gourd

the baby at birth. *For the perfect lady...*” she continued, “...*you should only cut the clitoris. Those circumcisers that are not experts would take more*”. When Beatrice had finished circumcising and cleansed the wound she would help the girl to her feet and when she rose “*she would be a woman*”. The transition from girl to woman would be noticed almost immediately as her way of “*walking, sitting and moving*” would change. “*Once she is circumcised she is a woman, and she will behave accordingly*”, Beatrice said.

Apart from the transition in form, both Beatrice and the other circumciser I talked to in Marok, Rita, had incorporated other elements associated with the medicalized practice. When asked about which items Beatrice would use during the procedure she told me that she used paraffin, razorblade, gloves and antibiotics. Paraffin was spread on the wound after circumcision in order to speed up the healing.¹⁶“*Previously we would only use milk to cleanse the wound, but nowadays we use the paraffin*”. The razor blade was the same, but Beatrice stressed that these days they would always use a different razor blade for each woman, because of “*the new diseases*”.

The rise of the new diseases was a narrative repeated frequently by my informants when explaining why the medicalized circumcision was the preferred style nowadays. Educational campaigns on HIV/AIDS have been identified as an important factor contributing to the rise of medicalization of circumcision. These campaigns have highlighted the risk of transmitting HIV and other infections through sharing a knife or non-sterilized blade (Njue and Askew: 2004:11). Beatrice could with ambiguous feelings tell me a story she had heard in one of Jane’s seminars, which had been “*eye opening*” for her;

The way we used to do it was not good. I went to a seminar organized by Jane’s organization. There we heard the story of a young girl who was infected by a serious illness by the circumciser. The young girl later died. I felt so ashamed, thinking that I could have done the same to the girls I circumcised. I would then have blood on my hands.

Such narratives as the one above have made circumcisers and families of the girls more aware of the infection risk in the aftermath of circumcision, which had implications for the routines around circumcision. Health personnel have registered an increased interest for tetanus toxoid

¹⁶Paraffin was in general not used in the hospital, but was associated with the medicalized practice.

injections to use after circumcision, even when the circumcision has been done outside the hospital (Njue and Askew: 2004:8). This demonstrates an increasing concern with the safety of the procedure, as families seek various ways to reduce the likelihood of adverse health outcomes while still retaining the practice (Njue and Askew: 2004:8).

Beatrice and Rita stressed that the most important thing for them was the safety of the girl and her future children. To ensure that safety they claimed that for the time being, it was better that the procedure was done by a trained doctor. As Beatrice said it;

It is better to take the girl to the hospital. The doctor will concentrate on the girl's health, giving her injections to protect her from germs. Otherwise she would struggle a lot. I prefer the doctor. He is better compared to us [the traditional circumcisers].

Their way of talking might have been influenced by ideas about health and expertise, advocated at the anti-circumcision seminars. Both Rita and Beatrice referred to themselves as “*experts*” within their fields, who performed the procedure with “*expertise*”. As Beatrice said it; “*If you can't cut it with only one cut, or maybe two, then you lack expertise*”. I suggest that their acclaimed expertise was an outcome, not only of their long experience, but of their utilization of elements associated with the medicalized circumcision, and the fact that they “*did not cut much*”. Although they saw themselves as experts, they still regarded it better that the doctor performed the procedure nowadays. Medicalization theory argues that the acceptance of a multi-causal model of health and illness by the medical profession has resulted in an increased medical expansion into numerous areas of life that were previously outside medicine's sphere of influence (Zola 1977; Strong 1979) and that medicine's claim to expertise is bound up with its rise to professional status (Morris: 1991:7). Rita and Beatrice's idea that circumcision would be better executed by a doctor, although they used the same equipment, might have been informed by this medical expansion.

Changes in the form of circumcision

In both Loitek and Marok it seemed to be increasingly common to ask for only “one cut”. The transition from circumcising the clitoris and *minor labia* to only cutting the clitoris is a quite recent development in those areas. Talle has described how the Maasai used to be proud of

asking for the “big cut” (Talle: 2010a) or what the circumcisers referred to as “three cuts”. The change in form is associated with the medicalization of circumcision. Where medicalization is widespread, the form of the circumcision is in general less extensive (Talle: 2010a: 69). It has been argued that when medical personnel take on the practice of circumcision, the physical cut is smaller and the ensuing pain significantly less severe than that experienced by their mothers and grandmothers (Christoffersen-Deb: 2005:410). The consequences of the medicalized procedure are believed to be less harmful than the consequences that the traditional practice may have. Beatrice welcomed the change in form, as she as a midwife was aware of the dangers related to circumcision. She could tell me that if a woman had three cuts it was in her experience more likely that she would have difficulties in labor; “*When women with a big cut gives birth it can lead to wounds and clotting of blood, then I can say that most women will experience problems in relation to her circumcision*”. As she would only cut the clitoris, she reduced the area of scar tissue, thereby leading to a safer birth.¹⁷

Beatrice stated that her way of cutting was a milder and modernized form of circumcision. Yet, she held forth that there was an important difference between her way of cutting the clitoris and the “*Swahili cut*”, where only “*the tip of the clitoris was cut*”. If you did not cut “*until the white flesh beneath revealed itself*”, you might as well leave the practice, according to her, as there was a good chance the clitoris might grow back. She maintained that she did not cut much, only what was necessary. According to Rita however, Beatrice’s way of circumcising involved too much flesh being cut. Rita claimed that the professional circumciser would only need one cut to make a “*perfect lady*”. In order to reach the “*white flesh underneath*” you would need at least 3 or 4 cuts, she argued. In that case you would have cut “*too deep*” and could not be considered a professional; “*If you can’t cut it with only one cut, or maybe two, then you lack expertise*”. The two circumcisers were therefore not in agreement on how much flesh it was necessary to remove.

¹⁷The medical complications of female circumcision in relation to birth are disputed. The World Health Organization, for instance, states that there should be no reason for obstructed labor, as a result of female circumcision (Johnsdotter: 2007:124). Oberstmeyer suggest that the reason the harmful effect of female circumcision are uncritically circulated have to do with political, economic and ethical factors (Johnsdotter: 2007:123).

While both of the circumcisers claimed that the “*Swahili cut*”, where you cut only part of the clitoris, was not the original way of circumcising, they were unaware, or effectively ignored that their way of cutting only the clitoris, was not regarded as the original Maasai cut either, as they only cut the clitoris and not the *minor labia*. Other Maasai, whom I talked to, claimed that only cutting the clitoris was not an original cut, and could be compared with the Swahili cut. This ambiguity towards how much flesh it was necessary to remove, was revealed in many conversations with informants. While Leah felt that her circumcision where only “*the tip of the clitoris*” was taken was a valid one, Beatrice’s claim indicated that she might as well have left it. This uncertainty towards what constituted the original and valid cut has also been found in other areas of Kenya. Among the Abugusii in the Western part of Kenya, circumcision was almost universal a few years back. Like the Maasai, they have experienced an increase in the number of medicalized circumcisions performed (Njue and Askew: 2004). Njue and Askew suggest that the medicalization leads to a confusion as to what is allowed and not, something that in the long run, might lead to a decrease in the circumcision rate. While the shape of and style of the procedure used to be shared, there is no longer one, unambiguous cut which consolidates your place as a proper Maasai. I will return to this point in chapter 4.

Reworking the practice of circumcision

The transition in form was explained as a modernization of the practice, where a once traditional practice had been transformed to a practice of modernity. The change of form may have been influenced by the anti-circumcision work in the area. Jane’s anti-circumcision organization had started their work in the area four years ago. Yet, the campaigning against female circumcision had gone on for years prior to that, as messages were circulated in health care centers and in schools. While many of the national campaigns during the 70s and 80s employed a health-based approach which emphasized the serious medical consequences of circumcision, the campaigns today are characterized by a rights-based approach (Talle: 2010a:79). However, the rights- based approach, which focuses more on women’s right to sexuality, is not the preferred approach in Marok, a point I will return to in the next chapter. Jane told me that her organization applies the health-based approach, especially mother-child health, as the Maasai in the area seem more responsive to this type of argument. The health-based approach is effective among many, especially the educated. But instead of stopping to

circumcise, they would have the procedure done under medically safe conditions, thus leading to an increase in the medicalized practice. The campaigns have thus had unintended consequences (Talle: 2010a:79), as the goal was total eradication of the practice.

As midwives and circumcisers Rita and Beatrice were well aware of the dangers of circumcision in relation to birth. Whereas they both emphasized the importance of cutting the clitoris, they left the *minor labia* intact. Cutting the *minor labia* would lead to more scar tissue, which could make labor harder, they explained. In addition, the *minor labia* were believed to have an important function as a barrier, so that no dirt would enter the body.

The way the traditional circumcisers talked of circumcision was strikingly similar, and seemed to borrow elements from a medicalized discourse. The practice was referred to as an operation or as a procedure, rather than a ritual or a practice; the different anatomical parts were referred to as part of a functionalistic whole “*the minor labia is like the eyelashes to the eyes or the lips to the mouth, it protects dirtiness from entering into the body*”. This way of expressing oneself was familiar to me since I had encountered it in seminars arranged by other anti-circumcision organizations in Kenya. Rita and Beatrice used many of the same expressions in their description of the procedure, and I believe they were influenced by the discourse used in anti-circumcision material.

As Crewe and Harrison find, people will internalize, and selectively use, particular forms of the discourse of modernity (2002: 133). In my view, Rita and Beatrice’s statements illustrate their reinterpretation of circumcision as a healthy practice, not a mutilation. By using elements of the medical discourse on health, mixed with their own long experience as midwives and circumcisers, they had been able to recreate the practice as a modern and healthy one. They did not necessarily incorporate all the elements of the medicalized circumcision; only those elements that they felt were in accordance with their own experiences. As midwives they had experienced complications during labor due to scar tissue resulting from extensive cuts. The transition from “*three cuts*” to “*one cut*” was therefore seen as unproblematic, because, in their opinion, it led to safer child births. However, Rita and Beatrice were not comfortable with all the elements used in the medicalized procedure. Neither of them used anesthesia during circumcision, because they regarded it as unnecessary. Rita explained; “*Nowadays we cut so little. I have heard that the pain when injecting the anesthesia is just as bad as the pain of the cut*”. Beatrice told me that she heard the use of

anesthesia would make the clitoris soft and more difficult to cut. They were also reluctant to use gloves. Rita told me that although she always used antibiotics and new razorblades for each woman; “*for the safety of the girl*” she did not use gloves, as she felt it hindered her work. Beatrice stated that although she would use gloves “*for hygienic reason*”, she was not entirely comfortable with them. She complained that the gloves made her hand slip and could at worse create more damage than good.

Multiple modernities

The way people in the Kajiado district mixed elements which are associated with the more “traditional” way of circumcising, with more “modern” ways, challenged simple models that assume an evolutionary, linear change from tradition to modernity (Hirsch in Bamford: 2007:8). The traditional circumcisers would include elements from the medicalized procedure such as the use of gloves or antibiotics, while “traditional” rituals like the “blessing of cold water” or “the shaving of the hair” would be included in the medicalized procedure in hospital. The continuation of circumcision should therefore be seen, not so much as “being stuck in the past”, but as attempts to reconfigure the procedure in changing times. Here I lean on Arce and Long, as they claim that ideas and practices of modernity are themselves appropriated and re-embedded in locally situated practices, thus accelerating the fragmentation and dispersal of modernity into constantly proliferating modernities. These ‘multiple’ modernities (Comaroff and Comaroff 1993:1) generate powerful counter tendencies to what is conceived of as Western modernization, exhibiting so-called ‘distorted’ or ‘divergent’ patterns of development, and re-assembling what is often naively designated as ‘tradition’ (Arce and Long: 2000:1). Modernity is in fact “reworked from within” by local actors who appropriate the symbols, practices and trappings associated with it, thus combining ‘modern’ with so-called ‘traditional’ features, sometimes in grotesque hybrid form (Arce and Long: 2000:2). I suggest that medicalization of circumcision is seen as an example of such a “grotesque, hybrid form”, as it mixes elements of a traditional practice with the assumed neutrality and rationality of Western biomedicine. Medicalization becomes a dangerous anomaly between traditional and modern practices and I believe it is this nature that makes medicalization of circumcision such a difficult and controversial issue. With the medicalized circumcision, one becomes inscribed in the discourse of medicine. The traditional circumcisers identify themselves as modern actors, because they meet the recommendations

of the government and health care organizations, not by stopping to circumcise, which is the objective of the anti circumcision movement, but by modifying the procedure and making it “more safe”.

While some might see medicalized circumcision as a “grotesque, hybrid form”, I suggest, based on my informants’ experiences, that circumcision should be seen as a practice within modernity and not outside it.

Summary

In this chapter I have focused on different manifestations of the medicalized circumcision. Medicalization has altered the way circumcision is performed, not only in the urban areas of Kajiado, as my informants from Loitek assumed, but also in the more rural areas. In this chapter I have shown how my informants would mix elements of the “traditional” practice with the “modern” medicalized practice, thus creating a hybrid which was in accordance to their understanding and experience. My informants used elements that they ascribed to modernity in order to recreate the practice of circumcision within new realities, placing both the practice and hence themselves as within the realms of modernity. Their understanding of modernity might be different than the Eurocentric post-World War II notion of modernity, where one imagined a linear development from traditional to modern societies, and more in line with the attempt of anthropologist in “reinventing” the term modernity. Although modernization theory has been deemed as flawed a long time ago, Arce and Long (2000) suggest that one should, instead of emphasizing either “the end” or “incompleteness” of modernity focus more on the way modernity is reworked from within. Although female circumcision is often regarded as a “barbaric” and “backwards” practice” belonging to the past, I argue for the practice as one within modernity, simply because it is one of these here and now materialities (Comaroff and Comaroff: 1993).

Modernity, here represented by the medicalization of circumcision, is fraught with ambivalence. While some saw medicalization a healthy response to “the new modern times” others regarded it as a sign of a more individualistic and weakened society. A weakening of the structures which used to bind the Maasai together; such as the solidarity bond between age mates, strengthened through the elaborate rituals surrounding circumcision or the feeling of a

shared pain led to a perceived feeling of weakening bodies as well. Here it becomes evident how changing bodily modifications becomes a sign of a greater change in society. I will continue this discussion in the next chapter.

Chapter 3

The construction of modern and healthy bodies

Now that I'm not circumcised, will I lose control of my body?

Rita

Medicalization of circumcision, although perceived as an ambivalent practice as seen in the last chapter, is after all viewed as “*the best option for these new times*”. The new times are characterized by a change in livelihoods and social relations, but also by the appearance of “*new diseases*”, in particular *biita*, AIDS. The narrative of the new diseases must be seen in a wider perspective of social change, where urbanization and modernization are important factors. History has shown that with rapid changes in society, there is an increased need to control the individual bodies, and then especially female bodies. The rapid changes to the Maasai society might have led to a perceived feeling of uncontrollable and weakening bodies, which made them more vulnerable to diseases.

In this chapter I will look closer at how my informants in Kajiado responded to the discourse of the new diseases, how it was applied and resisted, and how the threat of diseases became important legitimizing factors in the medicalization of male and female circumcision. It becomes clear that the way circumcision was “inscribed, experienced and acted upon” is clearly gendered, a point I will start the discussion with (Bamford: 2007:xv-xvi).

Healthy and unhealthy bodies

While female and male circumcision used to be seen as complementary practices by the Maasai community, the way my informants’ spoke of the practices at the time I entered Kajiado was irrefutably different. This manner of speaking corresponds with an international discourse which deems female circumcision as an “*unhealthy and harmful traditional practice*” which destroys a woman’s physical and sexual health. While male circumcision is

spoken of as a “*modern and healthy choice, which may protect the man from sexually transmitted infections*”. This is reflected in the political rhetoric, where male “circumcision” is contrasted with female “mutilation” (Talle: 2010:42). The international stance on male circumcision can be summarized in the recommendation made by the World Health Organization (WHO) in 2007; “*male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence*” (WHO: 2012). Although the recommendation has received a fair amount of criticism¹⁸, it quickly gained ground locally. When I asked my informants in Kajiado why they circumcised boys I would often receive the answer that it was tradition, and they would follow up the answer with the statement; “*besides, it is good to circumcise men as it will protect us from sexually transmitted diseases such as AIDS*”. In Kajiado, male circumcision was spoken of as an effective means of protecting oneself from HIV/AIDS. As a result, medical personnel in Kajiado experienced increasing numbers of people wanting their sons circumcised, even amongst ethnic groups that traditionally did not perform circumcision. A doctor I talked to at the public hospital in Loitek could tell me that even Luos¹⁹ would come in for male circumcision.

Male circumcision was seen as necessary if one wanted to produce a healthy and modern body. It was regarded as “*the right thing to do*”, and those who failed to produce a circumcised body, were seen as “*backwards*” and as an obstacle to development. I became acutely aware of this distinction one afternoon when I was invited to watch a prayer rally for one of the accused in the International Criminal Court trial²⁰, who had recently returned from The Hague. Watching the prayer rally in the backyard of Lucy’s pub, I noticed the manner in which the speakers talked about the prime minister of Kenya. The Prime Minister, Raila Odinga, was considered to have betrayed the prosecuted and was thus referred to in unfavorable terms. Amongst the harsh words used, were “half caste” and “half breed”. His opponents were accusing him of not being a man, of being weak and cowardly. I immediately

¹⁸The international effort to stop female circumcision has led to an increasing critique of male circumcision as well. The basis for the critique is that male circumcision, as female, first and foremost is a cultural practice, anchored in a particular time (Talle: 2010a:43-44).

¹⁹The Luo are an ethnic group in Kenya. They have not had a tradition for male circumcision.

²⁰Four leading Kenyans have been ordered to stand trial at the International Criminal Court accused of planning the deadly wave of violence that followed the 2007 presidential election.

interpreted the language as “trash talk”, where the opponent is degraded to “half man – half animal” or where the heritage of the opponent is questioned. But when I some weeks later confronted a Luo friend of mine with the incidents at the Prayer Rally, he interpreted them in the light of Odinga’s identity as an uncircumcised Luo man. He told me that Odinga, throughout his career as a politician, had experienced vast amounts of trash talk based on his failure to produce a circumcised body. As he was not circumcised, political opponents did not deem him worthy of political duties, because he could not possess any of the characteristics associated with a circumcised man; bravery, masculinity and power. “*Who wants an uncircumcised man as a president?*” his opponents rhetorically asked. It seemed this rhetoric was strengthened with the recommendation from the WHO.

The new discourse, where the circumcised man constitutes a healthy and modern body represents a dramatic change from the way my informants described “*the old way of circumcising*”;

10-15 boys would line up together and have their prepuce cut by a traditional circumciser using the same knife. It was like a breeding ground for diseases as the circumciser did not sterilize the knife between each boy.

While male circumcision is presented as a rational and logic choice based on a neutral medical knowledge, the continuation of the practice deserves more attention. The change illustrates how male and female circumcision are ancient practices which we have taken with us to the present, and given different meanings according to changing material, geopolitical and historical circumstances (Talle: 2010a:44). The legitimization of male circumcision based on the function it is supposed to serve has changed throughout the years. The function of male circumcision has not only changed within the Maasai community, but internationally as well. From being a procedure that was said to counter masturbation and incurable diseases such as epilepsy, to being a hygienic practice and finally today, being a practice that may counter diseases such as HIV/AIDS (Talle: 2010a:40-42). For the Maasai, circumcision used to be an initiation into a shared community, a way of proving to oneself and the rest of the community that you were worthy of membership in that community. While it used to be the pain of circumcision that proved one’s character, it was the cut itself that proved one’s moral character within the medicalization discourse.

While medicalized male circumcision has gained considerable support by an international community, medicalized female circumcision has raised considerable controversy. On one hand, a medical argument forms the foundation of most anti-circumcision campaigns, by emphasizing that female circumcision exposes women to unnecessary and often severe risks. On the other hand, any efforts to minimize the health risks through medical interventions are strongly opposed by anti-circumcision advocates, based on the belief that medicalization counteracts attempts to eliminate the practice (Shell-Duncan, Obiera and Muruli: 2001). Medicalized female circumcision thus becomes both a health improving tactic at the same time as it come to represent a legitimization of the practice which was the threat to the body in the first place.

The WHO states that “female genital mutilation is universally unacceptable because it is an infringement on the physical and psychosexual integrity on women and girls and is a form of violence against them” (Bell: 2005:6). Implicit within the WHO position is the assumption that female sexuality is destroyed by circumcision. Among the Maasai however, circumcision was not viewed in relation to sexuality and chastity, but rather, to reproduction. Several of my informants would therefore counter the claim of circumcision involving sexual mutilation, a point I will return to.

Clearly, male and female circumcision are regarded as very different practices, and perhaps rightfully so. Yet, there is a paradox in the way female and male circumcision is presented. While some of my informants argue that female circumcision should be abandoned because it is a harmful traditional practice, many of them also described male circumcision as more painful and complicated than female circumcision. The complexity of the male circumcision made some of my informants’ claim that male circumcision was more pertinent to transfer to the hospital, than female circumcision. This brings me to the next section about the different implementation of medicalization of male and female circumcision.

The gendered implementation of medicalization

While it is practically universal now for boys to be circumcised at the hospital or by a doctor, female circumcision has not been medicalized to the same extent or at the same speed. The different implementation of male and female circumcision can be seen in connection to the

resistance to the practice in the international community, and the ban from 2001. However, male circumcision might also have been more easily transferable to the setting of the hospital, because of a believed qualitative difference between men and women, where the identity of women is associated with the essential stuff of the body and nature and man's identity is located in their transcendence, and aligned with mind and culture (Howson: 2005:67).

This difference could be detected in the narratives my informants told about male and female circumcision. Typical for the presentation of female circumcision was a wall painting I took notice of in one of the anti-circumcision organizations I visited in Kajiado. The picture displayed a young girl being held down by three elderly women, her face resembling the famous painting "Scream" by Edward Munch. The image of the girl child with her legs spread on a cow skin outside her mother's hut reproduces the image of girls being connected to nature. It is literary "blood, sweat and tears", the stuff of nature. Male circumcision, on the other hand, was often associated with the white and sterile hospital, with modern technology and medicine. Even when "*the old way of doing it*" was described by my informants it was an image of peace and order, where the boy was standing firmly with his arms crossed above his chest, his face cut out in stone. It was an image of the boy, beating the primal experience of pain. His ability to master pain was seen as an achievement, as the male circumcision was regarded as more painful and complicated than the female circumcision. When describing male circumcision, my informants emphasized that it was more extensive and painful than female circumcision. It was often estimated that while the circumcision scar of the women takes one week to heal, men's circumcision scar takes five to six weeks. It was also claimed that male circumcision was more painful, because it "*needed to be decorated*". Beatrice explained;

The male circumcision is made to be round, while the females circumcision is just flat. The male circumcision is decorated. It takes skills to decorate the male circumcision. For the girls you just cut it.

The male circumcision is more like a piece of art, which needs to be carved, stretched and decorated while the female circumcision is "*just something we do*" and "*practically the same as delivering babies*". In opposition to the female circumcision where one simply just cuts a bit, the male circumcision demanded more expertise and knowledge to execute. The male circumcision is thus more of a cultural construct, as it was "decorated" by human hands, while

female circumcision was associated with the functions of the female body, and thus to nature. While a woman's body is about reproduction, the male body in contrast, lacks a natural creative function, so the male Maasai must (or have the opportunity to) assert their creativity externally, "artificially", through the medium of technology and symbols (Ortner drawing on de Beauvoir: 1976). Male circumcision - although "carved in flesh" - is an important symbol of the Maasai community, a "distinctive mark" which distinguishes them from other tribes. The mark is so important that even though male circumcision is now transferred to the arena of the hospital, the Maasai cut is upheld. The doctor I talked to at the public hospital in Loitek told me that their doctors were trained in the particular Maasai cut.

Because male circumcision is associated with "*expert knowledge*" while female circumcision is seen as an embodied knowledge, something "*one just does*", taking boys to hospital might have been seen as more "natural". This decision could also be seen in connection to the status male circumcision has attained by the international community, as a method of preventing HIV/AIDS. Male circumcision had thus been enmeshed in an international discourse of the practice which deemed it healthy and modern. However the continuation of the particular, painful circumcision of the Maasai men could not be explained solely based on its health promoting function. The decision to continue performing the Maasai cut at the hospital, although it was regarded as more dangerous and complicated than female circumcision, which in turn was normally performed with a smaller cut at the hospital, shows that practices and discourses of public health are not necessarily value free or neutral, but rather highly political and socially contextual (Lupton: 1995:2). Therefore, the different ways of talking about male and female circumcision must be understood, not based on the natural attributes and the effects of the practices, but based on historically and culturally specific ideas of the human body (Bell: 2005). I suggest that the different images presented of boys and girls might partly be an outcome of the inclination to perceive women as closer to nature, and men as closer to culture (Ortner: 1972). However, I also believe that the different status of female and male circumcision is related to different cultural and historical ideas about sexuality, which I will expand on in the rest of the chapter.

The constructed nature of sex

The previous section clarifies the constructed nature of not only gender, but sex. Although male and female circumcision used to be complementary practices, performed to gender the boys and girls into proper men and women, there is a clear gendered aspect to the medicalization of female and male circumcision. The feminist philosopher Judith Butler, among others, has challenged the biological – non-cultural – foundation of the category sex which is usually taken for granted. She argues that the distinction between gender and sex is deceptive: the category sex is also socially and culturally constituted. There is no sex prior to discourse; sex itself is a gendered category. It cannot be seen as “a politically neutral surface on which cultures acts” (Butler in Johnsdotter: 2002:79). The different implementation of male and female circumcision indicates that the body was already gendered, filled with historically and culturally specific ideas. As bodies are always a historical and cultural construct, the implementation of medicalization will thus be differently “inscribed, experienced and acted upon”.

The constructed nature of gender and sex becomes clear in the history of the clitoris. Among the Maasai the clitoris was regarded as a harmful and dirty part of the girl. The clitoris needed to be removed in order to open the fertility of the girl, making her ready for procreation. It was of utmost importance that the clitoris was removed before childbirth as it was said that it might harm, even kill the baby at birth. Marilyn Strathern has argued that at birth the child will be composed of both male and female parts, in gender term it is androgynous (Strathern: 1993). In circumcising communities the clitoris has often been associated to masculinity, while the foreskin of men has been associated with femininity. The clitoris is thus necessary to cut in order to gender the girl.

In Western society the clitoris plays a different role, as the locus of female sexuality. However, it has not held this position for long. Until the 1970's the clitoris had a marginal status in the West even being left out of anatomy textbooks altogether (Moore and Clarke in Bell: 2005:10). This status could be explained by the idea, maintained for example by Freud and his pupils, that the erogenous zone is confined to the clitoris in the child and the young girl, while sensitivity in the adult women is and should be vaginal (Shell-Duncan and Hernlund: 2001:22). However, in the 1970's the clitoris reemerged as a powerful symbol of

women's liberation and rights, with the Hite Report. The Hite Report indicated that almost all women achieve orgasm through clitoral, as opposed to vaginal stimulation (Bell: 2005:10). The cutting of the clitoris thus came to represent a patriarchal oppression of women. The Hite Report was followed by other publications such as the Myth of the Vaginal Orgasm, where the author Alice Koedt accused women who claim the capacity for vaginal orgasms of ignorance and false consciousness (Bell: 2005:10). The rise of the clitoris spurred the interest of anti-circumcision work, as circumcision was seen as "amputation of sexual desire". Several anthropologists have commented on this claim, leaving room for alternative voices. Fuambi Ahmadu, for instance, attested to the claim that ideas about sexual pleasure must be seen as culturally constructed and historically situated (Shell Duncan and Hernlund: 2001:22). As a woman born and raised in America, she said after voluntarily going through the Kono initiation ritual, which included excision;

My research and experience contradicts received knowledge regarding the supposedly negative impact of removing the clitoris on women's sexuality. Much of this taken-for-granted information may come from popular misconceptions about the biological significance of the clitoris as the source of female orgasm" (Ahmadu in Johnsdotter: 2002:56).

The history of the clitoris illustrates that ideas of sex and gender are not neutral, but historically and culturally constructed.²¹ The way changing circumstances came to affect my informants' notion of their bodies and sexuality is illustrated in the following example.

Changing notions of sexuality "in the time of HIV/AIDS"

Some days after we had visited Beatrice me and Alice set out to visit Rita, another female circumciser in the area. While walking through the arid and hilly landscape of Marok I enjoyed Alice's company and her stories from the area. This morning Alice told me about her grandmother, Charity's, opinion of Alice's final thesis in her "Early childhood development" class. Alice had written a paper about the relation between female circumcision, early marriage and the drop-out rate for Maasai girls in school. While Alice claimed that there was a direct link between the three, Charity and her peers had a different explanation for the high

²¹ Although many societies that circumcise women may be aware of the importance of the clitoris as an area that increases sexual pleasure, female circumcision may not be rationalized as suppressing women's sexuality (Korieh: 2005:113).

drop-out rate; namely the increasing number of uncircumcised girls. When girls were not circumcised, she said, they would not be able to “*sit still in school*”. They would be at unease, running after boys instead of concentrating in school, like they should be. I found Alice’s story fascinating because it revealed a change in the way female circumcision is legitimized. Previously, circumcision among the Maasai was not related to chastity, but rather to reproduction and marriage (Talle: 2010a). Among the Maasai, being a virgin at marriage was not a valued idea, quite the contrary. Should a Maasai girl turn out to be a virgin at the time of her marriage, she risked being sent back to her father with the message that “*she has no door*” and should therefore be opened before she was returned. Virginity in the technical sense was neither socially nor culturally valued (Talle: 2010a). A similar lack of appreciation of virginity has been reported from other pastoral societies, for example by Evans Pritchard’s work with the Nuer. On the whole, it is not uncommon in many African societies for unmarried girls to lead a rather free sexual life. It is only when women are able to bear children that their sexuality becomes subject to social control, because at that stage decisions have to be made concerning the fate of their progeny (Talle: 1988:110). Charity’s claim that young, uncircumcised girls would be “running after boys” therefore represented a new way of talking about circumcision.

Still wondering about Alice’s story, we arrived at the circumcisers homestead. We were led into Rita’s house by her daughter in law. Coming into the Maasai hut from the sun, would always leave you blind for a couple of seconds before the eyes got used to the dark. As my eyes adjusted, I could glimpse Rita’s features, where she was sitting next to the fire with her grandson on her lap, preparing tea for us. I could never really get used to the darkness inside the Maasai houses, always tripping on something when I entered. My clumsiness, it seemed, was often appreciated as it disarmed the awkward situation of having a stranger asking you all sorts of questions in your home. After Rita had told us her story; how she had started as a circumciser and how she used to perform the procedure, we began talking about the anti-circumcision work being done in the area. Rita felt that the government’s work could be counter-productive to the challenges of “the new time”. Although Rita, to a certain degree, agreed with the government’s concern about the health risk of female circumcision, she did not agree with the focus of their campaigns. She explained to me that even though you had to respect the constitution, she felt that it overstressed the sexual rights of a woman, at the expense of the right of the child. “*The government is saying that one no longer feels sexual*

pleasure when circumcised, but they are not focusing so much on what they should focus on, namely the child's health". She continued;

The government focuses on the sexual feelings, but then I have some questions. Now the government wants us to have these feelings in the time of HIV/AIDS, so then I won't be able to control myself, how will that make sense actually? Now that I'm not circumcised, will I lose control of my body? Finding pleasure will lead us running around. The government is focusing too much on the reaction part, leaving the health behind.

Surprised that also she linked circumcision to sexuality, I asked her whether she considered circumcision as a means of decreasing a woman's sexual desire. Rita shook her head replying that sexuality did not have anything to do with circumcision, but that it was biologically determined;

Ones individual character might have some saying, but it is biologically determined. Sexuality is inherited and flows from one body to the other through the blood. In some families you will find that the urge is stronger, hormones to hormones. Even environmental factors, like the warmer climate, might have some saying. Some people have that problems, they are not at peace. Circumcision will not have any saying for your sexual urge.

She further claimed that some tribes would feel more than others; *"you find in some tribes [those who do not circumcise – my comment], when you just hold the lady, she loses her senses"*. She stretched out, placed her hand on my knee and added *"for example it would be enough to just touch her knee and she would lose control"*.

I was puzzled by the inconsistencies in Rita's answer. On one hand she asked herself if women would lose control of their bodies if they were not circumcised, but on the other hand, she claimed that circumcision did not affect sexuality. While we wandered home that evening I wanted Alice's opinion on what we had just heard. Alice thought about it for a second before she stated that she shared Rita's ideas. She believed that sexuality would either be located in the blood; through your genes, or in the head. As she explained to me; *"If, for example, your father is very active in that area, if he has kind of a – what can I call it – disorder [excessive sexual drive – my interpretation] and you get most of your genes from your father, you will feel the same urge"*. Sexuality might therefore be inherited through your blood. Alice

continued by stating that she did not believe sexuality is located in your sexual organs, but in the brain. To underline her point she gave me another example.

If I'm with a boy and I'm not really into him, I will not feel anything, but if I like him and am interested in him I will feel. So sexuality is in the head. My teacher also told me that if a man approaches you and then you see him, your brain sends signals to your genitals and then you feel.

Her logic was in line with Johnsdotter's emphasis on the importance of emotional cognitive processes in understanding sexuality, as located in the brain as well as in the various erogenous parts of the body (2002:54). Rosie and Tito, two informants from Loitek shared Alice's ideas of sexuality as located in the head. They were not circumcised themselves, so their opinions were based on them observing circumcised friends;

You know, nowadays boys prefer uncircumcised women, cause they say circumcised women have less feelings in that area. I do not believe that. It's all in the mind. I see my girlfriends, walking with their boyfriends, smiling and holding hands. They seem to be happy; they are still with their boyfriends.

Tito and Rosie saw the healthy relationships of their friends as an indicator that they also had a healthy sexual life and hence healthy sexual organs, countering the Western discourse about mutilated and destroyed African women. As Rosie said about the commonly used mutilation term;

Mutilation is a big word, because it implies that something is broken. My girlfriends are not broken. They know their body and they know best what they are and what they are not.

At the same time they were quite aware of the international discourse on female circumcision and how it was beginning to change attitudes towards female circumcision. "*Some of my boyfriends say they don't want a circumcised girlfriend because she has no feelings. She will be harder to please*". A similar reasoning was found by boys who felt that having an uncircumcised woman was more challenging, because she was more likely to run around with other boys. "*You are damned if you do, damned if you don't*", a friend told me about the dilemma.

Counter narratives

As I pointed out in the beginning of this chapter, it seems as if the way my informants think and talk about female and male circumcision is influenced by the international discourse on the practices. Within the dominant, international discourse, female sexuality is said to be impaired by circumcision. Yet, the dominant discourse will always be contested (Jørgensen og Phillips: 1999). The way Alice and Rita spoke of sexuality in relation to female circumcision might present a form of counter narrative, where the international discourse on female circumcision as sexually mutilating is challenged.

As mentioned, circumcision is connected to reproduction in the Maasai community, rather than sexuality. The right-based approach, which focused on women's right to sexuality, does therefore not have resonance with Alice and Rita, who view sexuality as genetically determined, as it "*flows through the blood*", rather than being located in the genitals. Hence, the health based approach, has more resonance with Rita and Beatrice, since they, as midwives and circumcisers, have experienced difficult deliveries, because of "*big circumcisions*". They believed that they met the recommendations of the government by minimizing the "*flesh taken*" to the clitoris, and not cutting the *minor labia*. By cutting only the clitoris they had modified the practice and made it more suitable for the "*new times*", without losing the important function of the practice, namely opening a girl's fertility by removing the dangerous and polluting clitoris. As the clitoris was said to be harmful to the infant, removing it was considered to be in accordance with the recommendations of the government and anti-circumcision organizations. As explained in the last chapter, the *minor labia* was believed to serve an important function; by preventing dirtiness from entering the body.

This opens for an interpretation of the female circumcised body as a modern and healthy body, in opposition to the mutilated and unhealthy body represented by the international community. Their interpretation of the international discourse shows how individuals draw upon medical discourse (language and practical) to articulate and frame their experience and in turn are able to engage in a dialogue with medicine as knowledgeable practitioners of 'health' (Howson: 2005:24). Through drawing on a medical discourse Rita managed to

recreate circumcision as a moral and healthy choice. The uncircumcised body, on the other hand, came to represent something dangerous and uncontrollable.

Beatrice and Rita's choice to only cut the clitoris could be seen an example of how development policies and practices interact with and reconfigure local ideas in important, although, in unintended and unexpected ways (Hodgson: 2001:10). Beatrice and Rita had responded to the health risk approach of the campaigns, although not in the manner intended by the anti-circumcision organizations. Based on their experience as midwives and circumcisers, they challenged "expert knowledge" by devising "counter narratives" about the role the clitoris played with regards to sexuality (Arce and Long: 2000). However, there was a degree of ambiguity connected to the role of the clitoris. While the clitoris was said to be disconnected from sexuality, both Charity and Rita were apprehensive of the discontinuation of female circumcision, as it might result in girls "*losing control of their bodies*". Before discussing the obvious paradox here, it will be necessary to explore the assumption of increasingly uncontrollable female bodies. The feeling of uncontrollable bodies might be seen in connection with the rapid changes in the Maasai community. These changes, often seen in light of dichotomies like urban-rural, tradition-modernity, past-present, made the Maasai bodies more vulnerable to diseases. In the following sub-chapter I will demonstrate how certain spaces and people are considered more vulnerable than others.

Uncontrollable bodies

For the Maasai, AIDS, which comes from the outside and brings death and misfortune, becomes imaginable within a larger discursive context of modern living and urban sociality. Within this discourse "Maasai culture" as represented by the Maasai themselves and others, both facilitates and prevents the transmission of HIV, simultaneously (Talle: 2010b: 148). One of the aspects which was seen as facilitating transmission, was the increasing migration from rural to urban areas, because of work or school. During the Victorian Era, disease was said to be located in geographical places, some places being conducive to good health, while others were embedded in disease (Flikke: 2001:17). The urban areas, Loitek and Nairobi, represented places embedded in disease, in the narratives of my informants.

When Jane and I had a short stop at my place in Loitek on our way from Marok to Nairobi, she expressed relief that my time in Loitek was limited; *“I am glad you are not staying there for long now. That place is so immoral. Men come to have sex with prostitutes and then go home to their wives and infect them with diseases like HIV”*. The idea of the urban areas like Loitek as disease-ridden might as well be an outcome of what these towns represented, namely large changes to the Maasai community. They were both towns where the Maasai no longer depended on pastoralism, but on wage work or agriculture, where the Maasai no longer *“showed respect”* or lived by the age system. The changes that the Maasai community was going through were often associated with modernity. Modernization creates a paradox, on the one hand institutions associated with modernity, such as the schools and hospitals, were seen as limiting the threat of diseases. On the other hand, changes associated with modernity, such as the work migration, were seen as increasing vulnerability to infection. By and large, modernity is often accompanied by a sense that bodies are increasingly out of control (Bamford: 2007).

I believe that the Maasai, due to their nomadic lifestyle, have been perceived as a population at risk, and subsequently in need of being controlled. Since colonial times, the nomadic aspect of pastoralism, has challenged metropolitan ideas of civilization and order, with its constant, seemingly incoherent movements of people and livestock, pastoralist have bewildered and frustrated colonial administrators, and thwarted their attempts at control (Hodgson: 2001:52). Anthropologist Sharon Stephens, drawing on Mary Douglas, notes how migrants in general are considered to be people out of place (Stephens, in May: 2003:8). Rural migrants in general and Maasai migrants in particular are seen as aliens, deviant and outsiders ‘doubly damned’: as conservative minorities who refuse to become ‘modern,’ and as ‘out of place’ strangers in the city (Omari and Shaidi, in May: 2003:8), (May: 2003:8).

Because of their particular lifestyle the Maasai were thought of as being at a particular risk of diseases (Armstrong in Flikke: 2001:17). It was often implied that it was only a matter of time before the disease would explode throughout Maasai land, despite the relatively low prevalence of HIV infections (Talle: 2010b). The Maasai community is therefore subjected to a number of campaigns on HIV/AIDS, which might have contributed to the feeling of being at risk (Talle: 2010b).

Just as the Maasai community might be regarded as particularly at risk because of their “lifestyle” as nomads and migrants, segments within the community may be regarded as more uncontrollable than others. Female sexuality has historically been seen as more dangerous and uncontrollable than men’s. Suzanne and James Hatty argued that the discourse of disease, which followed the epidemic spread of syphilis in Florence in the late 1490’s, changed the way earlier codes of the body were shaped in the arts. The naked sensual body disappeared, gender relations were sharpened and female sensuality became dangerous. “The sexual love, venus, and its related love potion, venenum was turned into venom. Sin was thereby linked with bodily disorder and women became dangerous spreaders of disease” (Flikke: 2001:150). In times of uncertainty, history has shown how female bodies would often be subjected to increased control. Since women’s bodies are often made metonymic of larger social bodies, such as family, nation – state or even of religious tradition itself, especially if the integrity or tradition of these social bodies are threatened, sexuality and women’s sexuality most of all, is therefore considered to be important to protect and control (Ellingson and Green: 2002:4). Even though my informants recognize that also men are spreaders of disease; “...*the man will have lovers in town and go home to his wife and spread the disease*”, it was seen as more pertinent to control female sexuality.

The idea that the Maasai community was particularly threatened by disease might also be connected to the stereotypical image of the Maasai. Coast suggests that the image of the Maasai as disease ridden might be based on the European fascination of the Maasai norm of sexual access by a husband’s age mates to his wives, since such references appear frequently in colonial records (Coast in May: 2003:8). Several authors have suggested that measures to counter the spread of HIV/AIDS are highly influenced by stereotypical ideas about an African sexuality (Arnfred: 2004).

That female and male bodies and sexualities are culturally and historically constructed is clear. The different ideas of female and male bodies and sexuality have implications for the implementation and legitimization of medicalization of circumcision. Ideas of bodies and sexuality might be altered with changes in society. The feeling of uncontrolled bodies may be seen in connection to bigger changes in the Maasai community. One of these changes was that of global warming, which both Beatrice and Alice mentioned as an explanation to the

increased sexual desire in women. I will now return to the paradox of sexuality in relation to female circumcision.

The influence of global processes

Although both Alice and Beatrice agreed that sexuality was not located in the genitals, but in the blood and brain, there was a sense of uncertainty on the matter, exemplified in Rita's question; *Now that I'm not circumcised, will I lose control of my body*? Her question might be interpreted as resistance to the rights-based approach to female circumcision, fronted by the government, but I believe there was more to it than that. While the two different ways of talking about circumcision in relation to sexuality might seem contradictory at first, they might not be. As seen in the last section, forces connected to modernity might give an impression that the individual bodies were "*out of control*". Setel found, in his study among the Chagga in Kilimanjaro, that his informants visualized a growth in *tamaa*, desire, leading to an "*excessive sexual desire*"; "*The birth and growth of tamaa, an emotion with a history, contained within it a layered set of implicit statements about personal disposition and changes wrought by population dynamics and modernity*" (Setel: 1999:59). A person's *tamaa* was seen as a mixture of personal disposition and outside forces. Rita and Alice seemed to have the same understanding of sexuality, as it could both be an outcome of personal dispositions and outside forces. Setel identified forces associated to modernity, such as the urbanization and migration as influential to the growth of *tamaa* (Setel: 1999:59). As mentioned earlier forces associated to modernity might give an impression of "*bodies out of control*". I will here focus my attention on one force in particular, that of global warming. Global warming not only had an important influence on individual bodies, but the social body as well. Both Alice and Beatrice suggested that there was a connection between global warming and "*bodies out of control*". They suggested that the warmer weather could make the blood warmer, and as sexuality was located in the blood, this could lead to "*excessive desire*".

The link between sexuality and climate is not a new one; in fact it dates back to the Victorian Era. The hot, moist African climate of decay was metaphorically linked to the black bodies whose natural state was to blossom early and quickly decay. The metaphorical link between the two was described in an essay by Sigmund Freud where he claimed that the lack of knowledge about female sexuality, was linked to the lack of knowledge of "the dark

continent” (Flikke: 2001:45). Female, black bodies were objects of great scientific curiosity, and as they were studied, they came to represent the inverted image of the European male ‘self’. The medical theory thereby provided a hypothesis that stimulated the confusion of outside with inside; the hot moist continent with the equally hot and moist black body and, finally, condensed the black body to disease, decay, and moral corruption (Flikke: 2001:45).

Global warming was a force which affected my informants deeply, and was said to be one of the main factors which made pastoralism impossible, as the droughts made it difficult to keep “*thousands of cattle*”. Global warming therefore came to affect not only the livelihood of the Maasai, but the individual bodies as well by making them “*hotter*”. Global warming thus came to have a grave effect on both the social body and the individual bodies, posing a threat to the Maasai society on many levels. Droughts, although also a recurrent part of the past, were always interpreted within the discourse of global warming. Global warming might have, and rightfully so, left my informants feeling like bystanders to an external force, which they could do little about. The narrative of global warming and its impact on sexual desire might have been a way of taking control of a development which is out of their hands. The narrative of global warming and warmer bodies could be a way of handling unanticipated change and demonstrate a creative act of agency to cope with history as the Maasai themselves present it (Steward and Strathern: 2001:xvii). The spread of new diseases, instead of being seen within a myriad of complex reasons, had a straightforward explanation, within this narrative, explaining the excessive sexual desire in terms of global warming. If the problem was excessive sexual desire, then it could be solved through circumcision of girls. Studies in other areas of East Africa have found that modernizing forces might induce the incentive to circumcise women. Among the ethnic group Meru in Northern Tanzania, Talle found a revitalization of clitoridectomy as a tradition, in reaction to the current modernization, economic decline and political instability in the area (Talle: 2010c:44). The Meru believed that the moral decline connected to these developments could be stagnated by circumcision.

The two opposing ideas about the connection between circumcision and sexuality did not necessarily compose a paradox if one considers the narrative of global warming. As global warming affected the bodies, an abundance of desire was created, leading the young girls to “*run around*” and “*not being able to concentrate in school*”. The excessive sexual desire could be controlled by circumcising the girls.

Circumcision – an outcome of modernity or tradition?

When Alice spoke of her grandmother and her friends and their belief that the high drop-out rate in schools was linked to a decreasing number of circumcised girls, they might have been brushed aside as conservative, old ladies, trying to hinder progress and modernity. But the picture is not necessarily so clear when considering that in the end, their interest is having the girls circumcised in hospital. Alice's grandmothers shared the same fear as Alice, namely that the girls would drop out of school. They just had different explanations to why this happened. The elders, I suggest, were not rejecting modernity, by supporting a "traditional" practice such as circumcision, but promoting modernity in their ways. They supported the girls going to hospital for circumcision in order to finish school, the hospital and school being two institutions associated with modernity in Kajiado District. Circumcision was only a means for giving young girls more alternatives than they used to have. To stop circumcising may have represented being a part of "the modern world", but it still served as counterproductive to what was associated with modernity: to pursue education, have fewer babies and to have healthy bodies. Circumcision was considered to be a means to prevent early marriages, early pregnancies and diseases. It thus provided the girls with healthy and moral bodies.

Rita regarded circumcision as a sound response to the new challenges of the new times, be it the threat of external forces such as the HIV epidemic or global warming. Her argument that circumcision might be a way of controlling bodies in "*the time of HIV/AIDS*" revealed that circumcision was seen as a response on contemporary challenges. According to Comaroff, modernity is a metaphor for new and emerging 'here-and-now' materialities, meanings and cultural styles seen in relation to some past state of thing. The new way of doing circumcision was in Rita's view, in accordance with the challenges of "the new time" and in accordance with the recommendation from the government concerning health. But instead of stopping to cut, as was the intention of the anti circumcision organizations and the government, they chose a different strategy that was more according to the challenges of the new times. They chose female circumcision as a way of curbing the excessive sexual desire, and in this way promoting modern and healthy bodies. In this way the female circumcisers takes part of a struggle over meaning as to what constitutes a modern, healthy body. While the anti circumcision organization will resist the idea of modern, circumcised bodies, my informants interpret their circumcision in new, unforeseen ways. As Escobar recognizes, development "is

always mediated, reshaped, and even resisted at local levels when policies are translated into practices” (Escobar in Hodgson: 9:2001).

Summary

In this chapter I have explored the way medicalization has been variously inscribed in male and female bodies. The gendered implementation of circumcision is, I suggest, partly an outcome of gendered ideas about the body, health and sexuality. Medicalization does not take place in a vacuum, but are informed by a shifting knowledge of the body. Moreover, it is not neutral and a-historical, but continuously formed and adapted to local cultural and social conditions.

The cultural and historical construction of the body and sexuality is evident in the way people talked about circumcision. While the clitoris is regarded as an essential part of female pleasure in the Western world, it was seen as superficial, “*without value*” by Rita and other informants. Among my informants’ two seemingly contradictory narratives about sexuality circulated. One claimed that sexuality and circumcision was unrelated, the other claimed that circumcision was impairing for sexuality. As seen in this chapter these discourses might not be contradictory if we take into consideration the way my informants interpreted the effect of external forces working on their bodies. Global warming, migration and urbanization was said to make the bodies of the Maasai, and then the female bodies in particular, increasingly more uncontrollable. This development demanded counter efforts. Male circumcision was continued as a way of countering the spread of diseases like HIV/AIDS and enmeshed the male body into a world of modernity. Female circumcision, on the other hand, has been condemned as a harmful and unhealthy practice by the international society. My informants in Kajiado have created a counter narrative to this dominant belief, as they continue circumcision, and argue that this is as a way of curbing an excessive sexual desire. Female circumcision could thus be interpreted as a modern and healthy practice. Circumcision, both male and female, must be seen as a dynamic process, rather than a static one, responding to changes in society.

In the next chapter I will present another aspect of medicalization, namely the use of anesthesia and its implication for the meaning of circumcision.

Chapter 4

The disappearance of pain

Previously we had to feel the pain of the knife in order to become a real Maasai.

You don't have to feel pain in order to sit in an office.

Moses

“Pain occurring in other people’s bodies flickers before the mind, then disappears” (Scarry: 1985:4). Pain as the quote suggest is an elusive feeling, difficult to grasp for the anthropologist. Yet, I will try to convey the experience of pain my informants described in this chapter, because it has been so important to the “unmaking and making” of persons within the Maasai community. The opening quote by Moses suggests that rituals will alter their meaning as society changes. With medicalization, the “*pain of the knife*” has vanished, which led many of my informants to claim that the meaning of circumcision has evaporated with it. As Seenoy said it; “*Circumcision used to be an initiation ritual, now it is merely an operation*”. In this chapter I discuss the implications of a “painless” circumcision for the function and meaning of circumcision among the Maasai in Kajiado District. In order to do so, an insight into the cosmology of pain within the Maasai society is in order. This chapter considers which function the pain fulfilled among the Maasai previously, as well as what effect the use of anesthesia has on relations between generations, and between the individual and society. I begin this chapter with the stories of two of my interpreters in Macuru; Mary and Joyce, because they were defining for my understanding of how pain works.

“Maybe it would have been better if I’d felt the pain”

One afternoon Joyce, Mary and I were on our way back from a fieldtrip to one of the schools nearby. On this particular day, students from all over Marok had gathered for a football and volleyball championship at one of the high schools in the area. For Mary and Joyce it was

important to participate in such events as they wanted to make their faces known to students and teachers from Marok. *“If you want to work with female circumcision it is important to gain trust. This way we will show the community that we are a part of it”*. With their white and red caps with anti circumcision slogans they had been watching the games eagerly, shouting and cheering with the other students.

Joyce and Mary were both locals, but had been schooled in different areas of the larger district; Kajiado. Coming straight out of school they had just been engaged as interns in Jane’s anti-circumcision organization. At the time I arrived in Marok they were still getting to know their way around, introducing themselves and their message at schools, health centers and churches in the area. Joyce was the younger sister of Jason, Jane’s husband. She was educated in social work. She was the middle child in a family of five children, with three brothers and one younger sister. Mary was the middle child and the only girl in a family of five children. Mary’s grandmother had only born one child and she was determined that that child, Mary’s mother, should have an education. Her family had not been happy about her decision as they felt it was a waste of time and money, to educate a girl. It was not a matter of course that Mary’s father received an education either, since he was born with a handicap. But he had been adopted by a missionary family who provided him with an education. Since education had not been much valued at the time her father grew up, it had merely been seen as a bit odd that someone would pay for a handicapped boy to go to school, but his family did not have any contradictions to him going to school. Mary’s parents had met in school and fallen in love. *“I am lucky to have grown up in a family who value education. My uncles were not really happy about me going to school, but my parents had made up their minds “*.

As the championship winners loudly announced their victory the three of us began our walk back home. The white and red caps which had consolidated their place in Jane’s organization were now providing shade from the setting sun in the horizon. Ducking from the prickly branches and bushes on each side of the narrow path we talked about the evolution of circumcision in the area. *“So how did your family react to your anti-circumcision work?”* I asked Mary who was walking in front of me. *“I have to be honest with you”* she answered me, *“my family has not yet stopped circumcising girls. Unfortunately I did not get away from FGM”*. As the sky turned red she told me how she had been taken to hospital nearly a decade ago.

I was 16 at the time I was circumcised. I had then been waiting for my brother to come of age so that we could go together to the hospital. Circumcision had just been made illegal when I was circumcised and my family felt it was better that we went together so that no one would suspect anything. We were followed by my mother and grandmother. As boys are supposed to be circumcised by men and girls by women, we were taken to different wards in the hospital. But the woman who was supposed to circumcise me never showed up. We waited and waited, but in the end my mother asked me whether it was okay for me to be circumcised by a man. I just wanted to get it over with so I agreed that the male doctor could circumcise me as well. I had to promise never to tell anyone about it, especially not my father and I haven't.

From the beginning Mary's father had been skeptical to her being circumcised in the hospital. Her father had wanted her to be circumcised traditionally, but her mother had decided against it. Since it was usually the women who had the final saying about how their daughter's circumcision should be carried out, her father had caved. Mary's mother regretted the choice she made for Mary. She said that if she had known what she knew today about female circumcision she would never had let her gone through with it. Mary on her part did not seem to be resentful of her mother's choice.

I did not feel any pain during circumcision, so mine was not as bad as others. Besides, the circumciser only took a small portion of flesh. The traditional circumciser will cut the minor labia or cut until they hit the bone. In hospital they will only cut the tip of the clitoris.

Even though she had not felt any pain during the cut, I did not get the impression that her circumcision had been entirely painless. Still walking in front of me her final words on the subject were, "*Maybe it would have been better if I'd felt the pain*".

Throughout my conversation with Mary, Joyce had remained silent, walking behind me. At that point, I was discouraged by her silence and did not ask her about her family's stance towards her job in Jane's organization. I only took it for granted that she had not been circumcised as she often talked warmly about how her mother had turned against circumcision, participating in a solemn ceremony denouncing the practice. It was not until the end of my stay in Marok that I learned about her circumcision. While Jane and I were sitting in the garden outside her house, overlooking Mary and Joyce doing some chores, Jane suddenly turned around to tell me that Joyce had a "*very bad circumcision*". "*She was very young at the time of circumcision and she bled a lot. She never speaks about her circumcision*

with anyone and you shouldn't ask her either. It is too painful for her to talk about". Joyce and I spoke freely about any other subject, including circumcision, but she never spoke of her own circumcision.

The incidents with my interpreters continued to puzzle me during my stay in Marok. Their stories, as it turned out, would create an important backdrop for my understanding of the recent changes to female circumcision among the Maasai in the Kajiado District of Kenya.

Understanding pain

To describe pain is no straightforward task. The sensation of pain may not necessarily be amenable to translation into language in general and analytical languages in particular. Therefore there may be a profound disjunction between experience and its cognitive apprehension by self and others (Scarry: 1985). "Whatever pain achieves, it achieves in part through its unsharability, and it ensures this unsharability through its resistance to language (Scarry: 1985:4). Elaine Scarry turns to Virginia Woolf, who wrote about pain;

English, which can express the thoughts of Hamlet and the tragedy of Lear has no words for the shiver of the headache... the merest schoolgirl when she falls in love has Shakespeare and Keats to speak her mind for her, but let a sufferer try to describe the pain in his head to a doctor and language at once runs dry (Scarry: 1985:4).

As pain passes most of its time in utter, inhumane silence, writers who describe something so inherently resistant to language must inevitably shape and possibly falsify the experience they describe (Morris: 1991:3). When writing about Joyce and Mary's stories of pain, I run the risk of misinterpreting them. As Geertz states, whatever sense we have of someone else's inner life, we gain it through their expressions and not through a magical intrusion of their consciousness. My interpretation of their stories of pain will therefore merely be a "matter of scratching surfaces" (Geertz: 1983:373), the life of pain found in "fragmentary episodes and in scattered moments" (Morris: 1991:3) rather than in a straightforward text.

Mary's ambivalence towards her circumcision and Joyce's silence seemed to be important, but I had difficulties understanding them at first. Mary's wondering had no resonance with me

since I felt that the choice between having a painless circumcision and a painful one was obvious. Joyce's silence on the other hand made me wonder whether she did not trust me with her story. Joyce had on several occasions underlined how her mother had turned her back on circumcision. It seemed to be important to her, this importance stretched far beyond my initial suspicions that she was protecting her mother.

My failure to interpret Mary's ambivalence or Joyce's silence might be an outcome of the unsharability of pain, but it might also have been an outcome of my limited knowledge of the function pain played in Maasai community. I have been raised with a biomedical understanding of pain, where pain is something to be avoided, thus the meaning of pain eluded me. Morris claims that an understanding of pain requires many kinds of knowledge, but the knowledge we most consistently ignore or dismiss concerns the bond linking pain with meaning (Morris: 1991:18). With the introduction of biomedicine in the late nineteenth century, pain became regarded as "simply the stimulation of specific nerve pathways" and lost its meaning. "Our pain is now officially emptied of meaning (...) buzzing mindlessly along the nerves (Morris: 1991:4). What happens then when the culture of biomedicine, with its denial of the meaning of pain, meets the Maasai culture where pain had a vast meaning in the creation of persons? Before expanding on this, an insight into the meaning of pain among the Maasai community is in order. I have already noted that pain played an important part in the circumcision ritual, and I will expand on this, employing Veena Das and her two theories of pain.

The anthropology of pain

Throughout her extensive work on pain Veena Das has articulated two different ways of looking at this sensation, as these have been formulated within classical sociological traditions. According to the first formulation, pain is the medium through which society establishes ownership over individuals. According to the second, pain is the medium available to an individual, through which a historical wrong done to a person can be represented, taking sometimes the form of describing individual symptoms and at other times the form of memory inscribed on the body (Das: 1995:176). Implicit in this distinction is the question of whether pain can be seen as providing the possibility of a new relationship, the beginning of a language game rather than its end, or whether it destroys the sense of community with the

Other by destroying the capacity to communicate (Das: 1995:176). Throughout this chapter I let myself be inspired by the first theory; pain as the beginning of a language game.

The functions of pain

Pain, as Das notes, is an important medium through which society establishes ownership over the individual body. Here she turns to Clastres and Durkheim. Pierre Clastres argued that in primitive societies, torture was the essence of the initiation rituals. Through these painful initiation rituals, which were part of the normal cycle of rituals, young men did not only prove their capacity for physical resistance, but ensured the society of their quality (Das: 1995:178). Among the Maasai, the initiation rituals proved as a test of the courage and strength of the initiates. During circumcision a boy was not supposed to “*move an eyelid*”; those who did were subjected to ridicule and shaming. Girls were not exposed to the same treatment, although they should preferably remain silent during the procedure. Managing the pain of circumcision was an important indication that you would be able to withstand painful experiences and difficulties as an adult Maasai and that you were a person on whom others could depend (Talle: 2010).

An important function of the circumcision ritual was thus to demonstrate your individual worth for yourself and your community. But the most important *function* of the ritual, and this Clastres emphasized, was how the tribe used the suffering to teach the individual something essential (Clastres: 1987:183). After the painful rituals are completed and all suffering has been forgotten, there remains a surplus in the body, in the form of a scar left on the body. Through the initiation ritual, society imprints a mark on the individual, a sign of their membership in the group. The mark becomes an obstacle to forgetting – the body thus becomes memory (Das: 1995:179). The pain of circumcision creates belonging – when you are inflicted and suffer through the pain, you are “one of us, and you will never forget it” (Clastres: 1987:184), for what is remembered in the body is well remembered (Scarry: 1985:152). The social body is then inscribed in the body of the individual.

Pain is here the medium through which memory is created, an account also found in Durkheim’s work on how the person comes to be defined through totemic beliefs. The totem is, as he argues, “not only placed upon the walls of their houses, the sides of their canoes,

their arms, their utensils and their tombs; they are also found in the bodies of men". The totem of the tribe is thus inscribed in the body (Durkheim in Das: 1995:179). The best way of proving to one self and to others that one is a member of a certain group is to place a distinctive mark on the body, for the objective of such a mark is not to represent or to bring to mind a certain object, but to bear witness to the fact that a certain number of individuals participate in the same moral life (Durkheim in Das: 1995:180).

Thus, there are two obvious functions of the painful initiation as the inscription of marks on the body: measuring personal endurance, and giving notice of membership (Clastres: 1987:185). But what happens then when the initiates are injected with anesthesia before the ritual? Will the ritual be emptied of its meaning? In the following analysis I will explore the implication the use of anesthesia has on these two functions, beginning with the implication it has on ideas of personal endurance and strength.

“A useless practice”

Several of my elder informants stated that the medicalized circumcision was a useless practice in the absence of pain. Because the boys no longer felt the pain they did not grow up properly. James, a middle aged teacher claimed that; *“Nowadays they don't even feel the pain which used to make us men”*. Circumcision has lost its transformative powers, as illustrated by Seenoy's claim; *“Previously circumcision used to be a rite of passage, now it is merely an operation”*. The transition to a painless medicalized circumcision had implications for how the elders interpreted various episodes and developments within the Maasai community. Some would for instance interpret the increasing number of divorces as an outcome of the painless circumcision. Leah explained;

They [the elder generation] believe that those who have not experienced the pain of the cut, are not prepared for the hardships of adult life. Women become intolerable to pain. That's why they will be the first to file for divorce. She will not be prepared to stand difficulties in her home, so she will run away.

A similar argument was used about men who had difficulties in providing for their families by keeping a job. Because they had never felt *“the pain of the knife”* they were not prepared for difficulties that would come with the responsibilities of adult life. The elder generation's

claim about a “painless” circumcision was resisted by the younger generation. This shows that the experience of pain are not timeless, but changing, the product of specific periods and particular cultures (Morris: 1991:4). While the elder generation emphasized the “*the pain of the cut*”, my younger informants would highlight the long period of healing as the worst pain. As Maina said it; “*For girls it takes only a week before they have healed completely. Us guys, it can take 4 – 5, maybe even 6 weeks before we have healed completely. Because we have a big cut, this period is very painful*”. Another informant explicitly compared the pain of the knife with the healing period;

The elders will say that it was the pain of the knife that was worst. It's not the cut in itself that was painful, because that only took some few seconds, it was the healing period that was the worst, and we still feel that.

The same reasoning was used when it came to female circumcision. Although girls had their circumcision done with anesthesia, the element of pain was still present. Rita had for instance heard that the pain of the injection was as painful, if not even more so, than the pain of the cut. Furthermore she emphasized that the effect of the anesthesia would not last the entire week it took to heal.

That circumcision is still reckoned to be an ordeal is illustrated by the stories my younger informants could tell me, often jokingly, about “*going to the hospital*”. Mary told me about the time her younger brother was supposed to be circumcised. He had just finished class 8 and was scheduled to go to the hospital for circumcision, when he had changed his mind. Fearful of the experience, he had pleaded with his parents to let him wait another year. But after a few weeks in boarding school, bullied by other circumcised boys, he had changed his mind and had had the procedure done. Maina, one of the employees at MAAP, would tell stories about boys being afraid, shaking of fear even as they went to the hospital. Like he said it; “*You still need to present yourself as a man, controlling your fear*”. Mary and Maina viewed these stories as a confirmation of the physical endurance circumcision still entailed, while James, the elderly teacher, would see them as examples of the cowardice of the young generation.

Through reinterpreting the experience of pain, the youth were able to recreate the practice, as within the realms of pain. Even though they did not feel “*the pain of the knife*”, they insisted

on having a pain, stating that “*we still feel the pain necessary to be adults*”. Nevertheless, the elder generation of Maasai remained in doubt about the younger generations medicalized pain, even denying its existence; “*the youth today does not longer feel the pain of circumcision*”.

The doubt felt in the elder generation brings me to Wittgenstein and his private language argument. Wittgenstein regarded pain as an example of a private object and asked if it was possible to speak of a private language to describe such objects. We may, according to Wittgenstein, distinguish two aspects of pain, its communicability and its inalienability (Das: 1990:27). When speaking of the communicability of pain, we ask whether it is possible to communicate one’s experience of pain to another person. The second question, about the inalienability of pain is to ask what it means to ‘have’ a pain. The difference between the two might be seen as a question of having certainty versus having doubt. While for the person in pain, “having a pain” may come to be thought of as the most vibrant example of what it means to “have certainty”; pain for the other person might be so elusive that “hearing about pain” is the same as “having doubt” (Scarry: 1985:4).

The elders clearly had doubt when it came to the pain felt by the younger generation. In the following I suggest that the doubt felt by the elder generation might jeopardize the integration of the younger generation into a community of shared pain.

Circumcision and belonging

In the previous section I wrote about how the experience of pain was a way of proving oneself as a worthy member of society, and how the elders regarded the medicalized circumcision as a useless practice once the element of pain was gone. In the following I will turn to the second function of pain as defined by Clastres, namely that of giving notice of membership in the society.

Durkheim claimed that membership of a certain group is best proven by placing a *distinctive* mark on the body of the initiate, the totem of the tribe. I have here emphasized the word *distinctive*, because the particular “Maasai cut” was crucial for my informant’s identity. When I asked Daniel what would have happen if he had chosen a Swahili cut, instead of a Maasai

cut, he looked at me in disbelief; “*But Elanor, then I would not have been a Maasai*”. Bodily decoration, and here the particular Maasai cut, is a means through which social self-identities are constructed and expressed (Strathern and Strathern: 1971). My informant’s were proud of the “Maasai cut” as it was regarded as more painful and beautiful than the “Swahili cut”.

While it was unheard of to change the particular male cut, it had become increasingly more common to ask for a “*small cut*” among women. Asking for “*the big cut*” was connected to the traditional life as a Maasai, asking for “*the small cut*” connects the individual to development and the modern lifestyle (Talle: 2010:70). The difference between male and female circumcision might be related to the status of women, symbolized as less than fully social beings. Women have often been excluded from the rituals of collective life (Strathern: 1993:41). Inscribing society into their bodies might not have been as important. This could also be seen in connection to the Maasai community as a patriarchal one. The collective body of the tribe or clan is then ideally a body of brothers (Strong: 2001:118). Keeping the distinctive “Maasai cut” for men might have been seen as important in times of change. The Maasai community was viewed as disintegrating because members of the community were leaving behind the traditional Maasai way of life. The body differentiates very efficiently both between social groups and within social groups, and as Mary Douglas has pointed out, threats to social boundaries between groups and between individuals can produce increased concern with the boundaries of the body (Ardner: 1987:113).

But a distinctive mark was not enough to note membership. Clastres emphasized the element of pain in creating belonging. The circumcision mark becomes a hindrance from forgetting your membership in the group, the body itself the memory of the pain inflicted on it. The Maasai then became part of the same community through the painful initiation, the mark of the Maasai society imprinted on their bodies. But with medicalization the embodied experience of pain was no longer shared. Women, not only had different experiences of pain, but different bodily marks. The Maasai community had thus gone from sharing the same pain and bodily modification, to a diversified experience of pain and diversified bodily markers. The way my informants differentiated between “modern” and “traditional” Maasai, in accordance to – among other things – their particular circumcision, might indicate that the community had already become more diversified. The medicalization and the disappearance of pain could then have an implication for the younger generation’s integration into a

community of shared pain. I believe that the medicalization represented a rupture in the continuity between generations, as the embodied experience of pain was now diversified. What were the implications of this rupture?

What is at stake?

Wikan (1990) has encouraged anthropologists to ask what is at stake for the people we study. What is at stake for the elder generation of women who denounced the pain of the younger? What is at stake for the younger generation who insisted on having *a* pain? Some of the elder women whom I talked to expressed an ambivalent, if not outright hostile position toward the medicalized circumcision because it did not involve the element of pain. Simultaneously Mary expressed ambivalence towards her medicalized circumcision because “*maybe it would have been better*” to have experienced the pain.

For the older generation what was at stake might have been a fear that the excruciating pain they felt during circumcision was now meaningless. With the introduction and implementation of a medicalized circumcision, pain was made unnecessary. What were the implications of this to those who had already experienced the pain. Did the medicalized procedure make their experience less meaningful? Aud Talle, among others, has done research among circumcised women in exile and their attitudes towards female circumcision. One of the women Talle interviewed, had at the age of seven insisted on being circumcised in her home country, withstanding the pain with great courage. After moving to London, surrounded by uncircumcised women, she felt that the pain she had experienced as a girl became meaningless. She claimed, without bitterness, that she had suffered “in vain” and that her daughter should not have to go through the ordeal (Talle: 2001). In London a sown woman represents a mutilated and incomplete woman. In the streets of London the Somali women are not “in the world” with a perfect body in the same way that they were in the savannah in Somalia. Now they are wondering the streets of London as mutilated souls in a mutilated body (Talle: 2007:103).

For the younger generation what was at stake was a feeling of belonging. When Mary expressed that it might have been better for her to have felt the pain of circumcision, there is a sense of loss in her statement. She seemed to believe that she had missed out on something

essential, an embodied experience which would have created a bond between their forefathers and themselves. And according to some of the elders, she has. As it was now, the youth would sacrifice a piece of their flesh, without the recognition from the entire community. I suggest that Mary's ambivalent feelings about her "painless" circumcision could come from being on the outside of a community of pain. Following Clastres the denial of the younger generation's pain could in fact imply that the younger generation did not enter the same community as the elder, as they did not have the same experience of pain.

Morris illustrates how pain engages us in a struggle of interpretation (Morris: 1991). He suggests that the experience of pain falls within a construction of opposite states so extreme that we seldom recognize their existence. "At one limit, we might imagine pain as filled with a total, conclusive, unambiguous meaning", much like pain has been understood among the Maasai, as necessary in order to make adult persons. At the opposite limit, instead of a meaning that wholly fills up pain, we should imagine a condition of complete and often desolate meaninglessness. The existence of pain, like Morris states, fluctuates between the extremes of absolute meaninglessness and full meaning (Morris: 1991). As an effect, a young woman might find her circumcision meaningless in one situation and meaningful in another. The changeable nature of pain "its power to take on new meaning or abruptly to lose, to regain, or to transform the meaning it temporally possesses" requires that we understand this feeling as engraved in a specific place and time" (Morris: 1991:37). When circumcised bodies move through space and time, they experience being subjected to a very different understanding of pain. They may experience being a whole, modern person in one specific time and place, while experiencing being a tortured, mutilated person in another. When biomedicine, with its denial of pain came to Marok I believed that the practice of circumcision became more ambivalent, as the women experienced their body as both complete and tortured, according to the setting they were in. The implication of such a dividable body image will be discussed in the next and final chapter.

When the younger generation insisted on the same pain it might have been because what was at stake was their proper place within the community. When stating that they are in pain – the claim must be met with either denial or acknowledgement - because "you are not free to believe or disbelieve me" – the future is at stake (Das: 2007:39). Through the work of Das and Wittgenstein I will explore the possibility that the younger generation might in deed take

part of the same community as the elders. Veena Das asks if one can claim to know the pain of the other and what it is like to relate to such pain. Das has used the writings of Wittgenstein in order to comprehend how one can allow such a pain to happen to oneself.

The communicability of pain

If we follow Wittgenstein's thinking, where pain could reside in another body, there might be a possibility to share this elusive sensation. Veena Das has through Wittgenstein shown how pain is in fact shared. She has used Wittgenstein and his scene from "The Blue and Brown Books" in a beautiful manner to illustrate how pain may reside in another body.

In order to see that it is conceivable that one person should have pain in another person's body, one must examine what sort of facts we all call criteria for pain being in a certain place... suppose I feel a pain which on the evidence of the pain alone, e.g. with closed eyes, I should call a pain in my left hand. Someone asks me to touch the painful spot with my right hand. I do so and looking around perceive that I am touching my neighbor's hand... This would be a pain felt in another's body (Das: 2007:39-40).

The sentence "I am in pain" becomes the channel through which an individual may move out of the "inexpressible privacy and suffocation" of pain (Das: 2007:40). The sentence does not mean that one is understood, but is the beginning of a language game, in which pain is not that inexpressibly other that resists language, but can in fact be shared, even if at a metaphysical level (Das: 2007:40).

Merely stating "I am in pain" does not make you understood (Wittgenstein in Das: 1995), but instead makes a claim on the other. When the youth insisted on their pain, telling stories of the painful healing process, they are asking for acknowledgment, which may be given or denied (Das: 2007:40). Stanley Cavell has developed the idea, noting that the utterance "I am in pain" is not simply a statement of a fact, but an acknowledgement of the fact (Cavell: 1996:93). The acknowledgement of pain might even be a way of handling that pain. The one who hears this utterance is thus forced to respond, either acknowledge it or deny it, because the future between them is at stake.

Das explores how the expression of pain is an invitation to share, a call for acknowledgement and recognition, and in this sense argues that pain cannot be a purely personal, subjective experience. She argues that there is no individual ownership of pain but that it can come to be collectively experienced, and she calls on Wittgenstein's reflections about the idea of feeling pain in another person's body to support her position. Veena Das challenges Scarry's claim that pain destroys one's capacity to communicate. Pain in this rendering is not that inexpressible something that destroys communication or marks an exit from one's existence in language.

That pain could reside in another's body was conceivable for my informants as the following example will show.

Pain felt in another body – the pain of the cow

One Saturday Joyce, Mary and I had been on our way to visit Joyce's mother, when I was asked whether I wanted to do an interview at one of the nearby homesteads consisting of several households; "*My mother won't be expecting us for some time, so we can do an interview before continuing*", Joyce told me before entering the gate. It did not take long before a number of women, a man and a flock of children had gathered under a large tree just outside of the *boma*. While the eldest children served tea we started inquiring about the recent changes to female and male circumcision in the area. When I asked the group how the use of anesthesia had affected the ritual, one of them told me that even though the doctor would use anesthesia, the initiate would still feel pain. There was a belief that the pain felt by the cattle, before they were released from the pen in the morning, was felt in the bodies of the initiates; "*They feel painful in their bodies because the cows are still inside. The cattle have been inside the pen all night and are longing to get out*". The cattle were not supposed to be released until the circumcision was over, so there was a strong incentive to have the procedure done quickly so that the cattle would not have to wait, extending both the pain of the cows and then concurrently the pain of the initiates. This particular pain was not only felt in the bodies of the initiates, but by the community at large, as it was indicated that especially "*those boys who are circumcised*" would feel the pain. This belief follows the claim made by Clastres that painful initiation is a way of strengthening the community. In the case of the Maasai, circumcision creates a strong bond between not only the individual bodies and the social

body, but between people and the cattle. In order for young boys to become good and responsible pastoralists it was important to feel connected to the cattle (Scheper-Hughes and Locke: 1987:7).

The narrative of the pain of the cows was widespread in Marok. The pain, although said to be felt at a higher level than the mere physical pain of the circumcision cut, was still felt as “*real, physical pain*”. Since the pain was more of a metaphysical experience the saying went that it would be felt even with the use of anesthesia. However, the people to whom I talked to were not entirely convinced; “*Maybe, you will not feel the pain of the cow as strong if you do it in the hospital*”. The sort of ambivalence could be caused by a fear that anesthesia would reduce the pain of circumcision and thus also the bond between the Maasai and their cattle. This narrative is interesting as it falls into a contemporary cultural transformation of the body, revealing an ambiguity in the boundaries of corporeality itself. The human body is not a bounded entity, leaving an opening for Wittgenstein and the conceivability of locating pain in another body (Csordas: 1999:180).

Here we have an example of how pain could reside in one body – the body of the cow, and at the same time be felt in another body. The narrative of the pain of the cows, illustrates in the same way as Wittgenstein’s movement in bodies that although I am the owner of my own pain, the pain does not necessarily always have to be located in my own body. It is conceivable that I can locate it in another body. Although feeling the pain of the other, might be more of a task for the imagination, than something that would happen in real life, as Cavell interprets it, you still need to let it happen to you (Cavell: 1996:97). The pain of the young generation might be just that, a task for the imagination. Yet to fully understand the pain of the younger generation it is necessary to listen to them, their embodied experiences of living in a circumcised body today, which will take me to the next chapter.

What are the implications of pain felt in another’s body? I suggest that the example of the cow shows that it is conceivable that pain is located in another body. That pain, instead of being a private object, demanding its own private language, opens for “a beginning of a language game”, where pain can be shared and communicated to the other. The pain of the younger generation could perhaps then be communicated and open for an understanding across

generations. If the pain could then be shared it is also possible that the elder and younger generation could take part of the same community of pain.

Summary

In the beginning of the chapter I asked myself what happened when the Maasai community with its experience of pain meets the culture of biomedicine through medicalization, a culture that sees pain as meaningless and something to be eradicated.

Pain, as we have seen throughout this chapter, has been deeply meaningful for the creation of persons among the Maasai community. Through the painful initiation ritual, society imprints a mark on the individual, a sign of their membership in the group. The excruciating pain ensures that they never forget their belonging. Here pain is a deeply social experience; those who suffer the same pain take part in the same community, a shared community of pain. When circumcision was medicalized it involved a diversified experience of pain. This has led to a struggle over meaning between the young generation and the elder generation, where the latter claim that the medicalized circumcision has no meaning. Seenoy claimed that circumcision has lost its social meaning as a rite of passage, because the “*pain of the knife*” is no longer felt in the bodies of the youth. The circumcision is now only an *operation*, her use of language establishing the transformation. But for my young informants circumcision is still meaningful even without the “*pain of the knife*” because the pain would be felt during the long healing period. This opens for Morris’ understanding of pain as stamped by a specific time and place, its changeable nature allowing it to “take on new meaning or abruptly to lose, or regain, or transform the meaning it temporally possesses (Morris: 1991:37).

The younger generation of Maasai have through reinterpreting the experience of pain, as something you feel after the cut instead of during, continued the practice within the cosmology of pain. They make a claim, insisting that they were “in pain”, asking for acknowledgement that may be given or denied. When a number of my elderly informants denied the young’s experience of pain, they were at the same moment, denying the young generation access to their moral community, the community of pain, access which the young generation saw as rightfully theirs as they *did* feel the pain. The denial created, I suggest, a rupture between the generations. Generational strains and conflicts have because of the

particular hierarchically organization of the Maasai community into age groups always been present. This conflict may not have been experienced as more dramatic than any other generational conflict. Nevertheless, I suggest that it led to a certain degree of ambivalence in relation to the medicalized circumcision, illustrated in Mary's question; "*maybe it would have been better if I'd felt the pain*". The rupture, I suggest, could be bridged if one takes into account Das and her theory of pain as the beginning of a language game, rather than its end. The example with the pain of the cow, where pain *is* felt in another body, could open for such an understanding.

Elaine Scarry emphasized the inalienability of pain, as a sensation difficult to express. I suggest that my interpreter's stories, the murmurs of pain, the ambivalence, the silence, the narratives they choose to tell, are all text. They say something important, not only about the recent changes in Kajiado, but how these changes came to influence the subjective experiences of pain. These subjective experiences may again be important to understand changing attitudes towards circumcision. How notions of the body and self changes with society is the focus of the final chapter.

Chapter 5

New discourses – changing notions of self

I feel shameful in my body.

Tina

Throughout this thesis I have presented how medicalization came to change the form, meaning and legitimization of medicalization, but also how medicalization came to change perception of body and self. In this chapter I will focus more explicitly on the way your circumcision came to play a toll on notions of body image. In this chapter I focus on the experiences of women. This is not to say that men were not struggling with conflicting ideals concerning circumcision and bodies. The conflict between having a medicalized circumcision versus a traditional one, could certainly have affected the self image of young men. My choice to focus on women solely in this chapter is linked to the intense work being done to eradicate circumcision all together, with an international discourse which deems the circumcised bodies to be mutilated and abject (Korieh: 2005:122).

The medically circumcised women have challenged the international discourse, by, in their minds, recreating the practice as modern and healthy. While I have presented the experiences of medically circumcised girls, I wish in this final chapter to include the story of three traditionally circumcised women; Alice, Sara and Tina, in order to better understand how conflicting discourses can come to influence the way you experience your body and how these women have chosen to deal with this bind. While the medically circumcised girls also have ambivalent feelings towards their own circumcision, the traditionally circumcised girls experience ambivalence towards not only their circumcision, but also to their own bodies.

In this chapter I question how the international discourse on female circumcision affects experiences of bodies and self among the young women of Kajiado. Their embodied

experiences of living in a circumcised body are found in the narratives they chose to tell. I believe that the narratives of these three traditionally circumcised women can create a better understanding of circumcision within a changing context.

Alice's story

The first story belongs to Alice, my third interpreter in Marok. On my second visit to Marok, Mary had been employed by another organization a couple of hours drive from Marok. Since Joyce had other chores to attend to, Jane introduced me to Alice, a neighbor's daughter. Alice, had just finished classes in early childhood development, and had returned home to await admission to a computer class. I met her a sunny afternoon in March over lunch at Jane's house. We sat down in the shade outside Jane's house, sharing a meal of spaghetti and meat. I immediately liked her as she came across as a mild and reflected young woman. The fact that she quickly recognized my dislike for the "*fatty, fatty meat*" that the Maasai were so proud to serve their guests, and would discretely push it onto her own plate, helped consolidate our friendship. There, in the shade of the acacia tree she told me her story. Her mother Agnes was the fifth wife of a man with whom she had two daughters with. The man, Alice's father, passed away 16 years ago. Alice and her little sister were too young for circumcision at the time of his death, so the decision fell on Agnes and the sisters' half brothers. As Alice's older sisters had all been circumcised, their half brothers had pushed for circumcision for their two younger sisters as well. But Agnes had fought for her daughters and decided that they should not have to go through the ordeal of circumcision. So Alice and her little sister were, to use Alice's own words, *saved*.

Over the next weeks I spent a lot of time with Alice. We were comfortable in each other's company and were able to discuss most matters. She would help me translate during interviews in the nearby homesteads, tell stories from the area and teach me how to make honey. When my stay in Marok was coming to an end I thanked Jane for introducing me to Alice. I told her that Alice had been of great help to me, especially since she was able to introduce me to two circumcisers that were friends of her mother. Jane told me that I had probably met the lady that circumcised Alice and her little sister. I was astonished. Alice had on several occasions repeated the story of how she and her little sister had been saved from circumcision. It turned out that both Alice and her little sister were circumcised at home. The

circumcision of her younger sister had been especially bad, as she had bled a lot. Jane did not seem surprised that Alice had told me a different story. “*She has to lie in order not to become bitter*”, she told me in a matter of fact manner.

As with Joyce, I wondered whether her story came from a wish to protect her mother. A desire to protect did however not explain that Alice’s story had come on her own initiative, with so much conviction and detail. She could have said nothing or just denied being circumcised and left it at that.

Sara’s story

I met Sara at a tea party at Jane’s house. Jane was having some of the women in the village over for tea. After giving birth, the custom was to invite the whole village over so that they could bring presents and bless the mother and child. Joyce and I accompanied Sara and her one year old daughter to the garden to get some fresh air, as the rest of the women finished their customary well-wishes and prayers for the baby. It did not take long before the conversation about the mother and child shifted to the recent efforts being done in the area to eradicate the practice of female circumcision. Sara told me that she had been circumcised last year at the age of 15. Since her parents had passed away, it was her older brothers who made the decision. Her brothers had regarded it as the most appropriate choice for her, since both of their wives were circumcised. Even though Sara felt the circumcision had been the right decision for her, she did not want to circumcise her daughter. After attending one of Jane’s seminars on the negative consequences of circumcision, she had come to the conclusion that the practice belonged to the past and was no longer necessary. Before heading back to the rest of the company I asked how she felt in her body, now that the practice was considered “*not necessary*”. She thought about it for a second before answering; “*I do not speak in the same manner as these women. I feel stupid when I open my mouth*”. Even though I had posed a very open question, her answer surprised me. Surrounded by women who spoke up against circumcision, she felt stupid in her own circumcised body.

Tina's story

A couple of days after my encounter with Sara, Alice and I paid a visit to one of her childhood friends; Tina. Tina lived nearby with her husband and two children. At the age of 15 she had been circumcised and subsequently married her childhood boyfriend from the same village. When she married she had quit school and shortly thereafter, she had her first baby. In mine and Alice's company she expressed regret for not having been able to finish her education, but said she had no other choice. When talking to Tina it became clear that she felt a great deal of ambivalence towards her own circumcision.

Like Sara, she felt it was the right decision for her, but when I asked her more about her own circumcision she was not comfortable with the topic. "*Even today*", she said, "*I will feel nauseous and dizzy when I see blood*". When the anti-circumcision organization had started working in the area she had felt uncomfortable in the presence of the uncircumcised women; "*I feel different than those uncircumcised. When I am around them I feel uneasy and with low self-esteem*". Because she had a traditional circumcision she stated that she felt shameful and guilty about her circumcision. She was determined not to circumcise her own children.

The role of narrative

While Sara and Tina could tell me about feelings of shame and guilt in relation to their circumcision and bodies, Alice chose to tell me an alternative story. The narratives these women told about their experiences relating to circumcision give an opportunity for understanding culture and self from the standpoint of the body. Not only do their narratives reveal a change in Marok, where you have uncircumcised women advocating against the practice, or where women have their circumcision done in the hospital, but their stories also reveal how they *feel* in relation to their bodies, in other words, the embodied experience of change. In order to better understand these narratives it will be necessary to dwell a bit on the role narratives play in the construction of self and worlds.

The relational aspect of narration

Narration will always be temporal and relational. A narrative is not simply that which is presented in a complete story. In order to constitute narrative, the story must be appropriated by a reader and audience (Good: 1994:143). The relational aspect of narration demands the listener or reader to evaluate his or her own position. My presence as a young, white woman from the West could be a factor when Alice chose to tell her story the way she did. Moreover the way I interpreted her story will be influenced by my own embodied vantage point. We understand the experience of others in some measure by the experiences provoked in us when we hear such stories, experiences which are affective, sensual and embodied (Good: 1994:140). My interpretation of Alice story of how she was “*saved from circumcision*” was influenced by Jane’s perception of what was happening on the ground in Marok; “*she has to lie in order not to become bitter*”. Jane interpreted her story as one grown out of an arising conflict between generations, as some girls were “spared” from the knife and some were not. The decision by Alice’s mother to circumcise her daughters traditionally was made within an environment where more and more girls were taken to hospital for a milder and “painless” circumcision. Jane implied that this fact was a painful one, which might destroy the relationship between mother and daughter, hence the lie. I initially interpreted Alice’s story as a lack of trust. This interpretation might be informed by my self-reflexive stance in relation to a direction within the social sciences which has been accused for “Othering” (Battaglia: 1999:114). Facts about the world are thus never stable, but through a wandering viewpoint they are dynamic and continuously altered in relation to the position of the interpreter (Iser: 1978). The way Jane and I interpreted Alice’s story might have been informed by our own preconceived ideas of circumcision as a mutilating practice. Instead of seeing Alice as an active agent, using discourse to strategically represent herself in a certain way in a certain social interaction (Jørgensen og Phillips: 2008:16), we interpreted her story as an attempt to handle the torture her mother had made her go through. Nevertheless, this interpretation could certainly be valid, taking Sara’s and Tina’s ambivalent feelings about their bodies into account. The way Alice decided to tell her story is interesting, and why, deserves a closer look.

Creation of self and worlds through narration

Narratives give the narrators an opportunity to create their selves and the world around them (Ricoeur in Good: 1994). They can also be used to give meaning to experience. By claiming that circumcision was the best option for themselves, Tina and Sara might give meaning to their experiences of circumcision, and to the choice made by their families. While the traditional circumcision made sense to them, they would in a changing environment not circumcise their daughters in the future. Narration, as Good emphasizes, not only reports and recounts experiences or events of the present, but projects our activities and experiences into the future, organizing our desires and strategies teleologically, directing them towards imagined ends or forms of experience which our lives or particular activities are intended to fulfill (Good: 1994:139). We are able to project our activities into the future, connecting past, present and future through narrative (Ricoeur in Good: 1994). When Alice chose to tell me her story the way she did, it might have been informed by her hopes and dreams for the future. As a student of Early Childhood Development, focusing on the rights of women and children, she might have felt that an uncircumcised body fitted better with her goals. This discursive representation might have been more in accordance with the image she had of herself.

Paul Valery has made a comment about the paradoxical nature of embodiment. He observed that the unease that confronts us in reconciling our sense of self with embodied existence lies in the contradiction between the stability that we feel about who we are, and the flux of that identity's incorporation:

We speak of [the body] to others as of a thing that belongs to us; but for us it is not entirely a thing; and it belongs to us a little less than we belong to it.... This thing that is so much mine and yet so mysteriously and sometimes – always in the end – our most redoubtable antagonist; is the most urgent, the most constant and the most variable thing imaginable: for it carries with it all constancy and all variation (Valery in Kirby: 1997:65).

Alice's sense of self might not have corresponded with her embodied existence, because she was confronted with a discourse that rendered her body mutilated and tortured. Distancing herself from her body might have been her way of taking control of the image she presented to me. In a world where the body becomes increasingly more important for self image the way one chose to stage oneself is important.

Alice's way of presenting herself may express her wish to modify those preconceived notions she believed that I saw her through. By changing my image of her, she may also change her own self-image. Goffman argues that persons are in the way of presenting themselves, guiding controlled impressions, not necessarily to deceive, but rather to sustain a reality, an event, a self. Structurally, the self is divided into two aspects, the performer who fabricates these impressions and the character who is the impression fabricated by an ongoing performance which entails them both (Young: 1997:34). Alice could be both. She was the proper circumcised woman, who met the requirements of a healthy body like it was understood by her mother and grandmother before her. While at the same time, she created herself as a character - a healthy, uncircumcised woman - to me. On ordinary occasions persons do not provide information to recipients so much as presents dramas to an audience. It is here that the theatrical metaphor for which Goffman is famous takes hold: talk about the self is not so far removed from enactment. We do not have behaviors and description of them but a modulation from embodied to disembodied performances. Storytelling is a special instance when the social construction of self in which "what the individual presents is not himself but a story containing a protagonist who may happen to be himself" (Young: 1997:34).

Narrating might be Alice's way of dealing with two very different discourses working upon her body. But it might also be her way of staging herself in front of me. Her staging was based on what she believed a young, white female from Norway, would regard as a healthy body. As seen earlier, Alice's narrative can be interpreted in multiple ways, one of these ways as a means to escaping the objectifying gaze of 'the Western eye' (Mohanty in Arnfred: 2006:8), represented by me.

The "Western gaze"

The international discourse of female circumcision has been criticized for essentializing women by defining them through their sexual parts. When Johnsdotter confronted a Somali informant with the stereotypical image of a Somali woman in Sweden, her informant could not understand why she had mentioned their state of being circumcised. Embarrassed she asked Johnsdotter; "*Do you think, when I talk to Swedes that they think of my sexual organs? I feel like walking genitals*". The discourse of female circumcision holds that a circumcised women's existence revolves around her state of being "mutilated"; she is "walking genitals".

As the definition of these women is genital, it follows that with a mutilated body you will have a mutilated soul. It might have been these images that Alice sought to escape. As she reconfigured herself as an uncircumcised woman, she avoided the “Western Gaze”.

Talle argues that the displacement of circumcised bodies in London is the displacement of bodies in pain. Traces of pain which have been inflicted on women’s bodies’ a long time ago, after circumcision and later at marriage and childbirth, surfaces through the gazes of others, on the streets, at health centers, and in the media. The public scrutiny and the global debate on circumcision are painful for exiled women. It intimidates them and draws boundaries between “healthy and unhealthy bodies” (Talle: 2001). Since the global discourse of female circumcision has become ever more present in Kajiado, I believe that the experiences of exiled Somali women in London could resonate in the experiences of my informants in Kajiado. As the international discourse of female circumcision reached the Kajiado district, it influenced the creation of self. My informants were aware of the way circumcision was regarded by outsiders, in particular the painful circumcision – as a barbaric act of torture. However, the “mutilated body” is not necessarily internalized, and a part of my informants self image. Subjectivity as a sense of self or self-identity is socially constructed through interactions with others. Subjectivity is fragmented, highly changeable and dependent on the context. There are numerous, often contradictory ways in which individuals fashion subjectivities (Lupton: 1994:7).

At the time when female circumcision was universal there might have been less ambivalent feelings towards the practice. Nowadays the young women, such as Joyce and Mary can view themselves in relation to other non-circumcised women. The circumcised body is the same, yet not, because it is depended on which environment it is in. It is therefore normal and abnormal, complete and destroyed. The ambiguous nature of the body could be exemplified by a question posed by the Norwegian anthropologist Johansen, by one of her Somali informants; “*Has my circumcision made me complete, or destroyed me?*”(Johansen: 2007:249). The meaning they attached to their circumcision is unraveling, both for them and for their mothers. “*If I had known what I know today I would never have let my daughters be circumcised*” was a phrase repeated amongst my informant. For Sara it felt right at the time, but it was a different matter for her daughter. Some of my informants said that they wanted to “*leave that life behind*”. But one cannot distinguish oneself from one’s body, leaving it

behind. Or can you? In a way one might say that that was exactly what Alice did when narrating her story when we were having lunch under the acacia tree.

Derrida's infamous phrase "*there is nothing outside of text*", creates anxiety because it suggests that there is no final limit to language (Kirby: 1997). If there is indeed nothing outside of text, then Alice is in a position of creating herself in a different form. Foucault was criticized for claiming that the body is only discourse, no materiality. Turner, on the other hand, emphasized the lived body. I am arguing for both in that I claim that Alice is able to create herself through discourse, while at the same time being revealed through her body. Even though Alice claims she is not circumcised, her way of "*walking, sitting and moving*" will tell a different story. Gestures and bodily habits come to belie what she puts in words (Jackson: 2012:238). The body is betraying her, telling its own story.

Summary

The women of Kajiado experienced two very different discourses working upon their bodies. Most of my informants had grown up within a discourse that rendered the circumcised body as healthy and responsible. With the introduction of the international discourse on female circumcision their bodies became symbols of their backwardness. However, the type of circumcision seemed to have a saying when it came to notions of body and self. When speaking with my informants I noticed a difference in the narration of circumcision, between those who had a medicalized circumcision and those who had a traditional one. While Leah and Mary spoke rather freely of their medicalized circumcision, Alice and Joyce chose not to tell me about their traditional circumcision and Sara and Tina revealed a great deal of ambivalence in connection with their traditionally circumcised bodies. I believe that the difference is to be found in the different local interpretations of female circumcision, where the medicalized circumcision represented a modern and healthy choice, while the traditional circumcision was seen as "backwards". Leah and Mary with their medicalized circumcision were thus inscribed with modernity, while Alice, Joyce, Tina and Sara were inscribed with tradition.

The narratives give an insight to the embodied experience my informants have of their particular form of circumcision. I believe these narratives serve as an important role when it comes to understanding how and why the practice of circumcision changes.

Conclusion

Medicalization, as seen throughout this thesis has contributed to changing the form, legitimization, and meaning of male and female circumcision. But more than that, I believe medicalization may have affected the way people came to regard their bodies, their experience of body and self. Whether you have a “small cut” or a “big cut”, a medicalized circumcision or a traditional one might have implication for whether your body is seen as strong or weak, as healthy or unhealthy, as traditional or modern. The type of cut becomes important in the construction of self.

Medicalization is seen as one element in a larger development. Like the rapid changes in the Maasai society, medicalization is fraught with ambivalence. While it is seen as the best options for these new times, it is concurrently considered to have made the bodies weaker than before. In this thesis I have used an embodied perspective, trying to understand changes in society through changing notions of the body. Bodily modifications could serve as an example of how changes in society were expressed in the human body. A weakening of the structures which used to bind the Maasai together; such as the solidarity bond between age mates, strengthened through the elaborate rituals surrounding circumcision or the feeling of a shared pain led to a perceived feeling of weakening bodies as well. The weakening physical bodies can thus be seen to mirror the weakening social body.

The way changes in society came to influence the way the Maasai regarded their bodies, could also be seen in the perception of more uncontrollable bodies (and then in particular the female bodies). With the narrative of the “*new diseases*” the Maasai population was thought of as at a particularly risk because of their lifestyle. While male circumcision is internationally recommended as a preventive measure against the spread of HIV/AIDS, female circumcision is seen as a dangerous and unhealthy practice which destroys the physical and sexual health of the girl. However my informants challenged the international discourse on female circumcision, by claiming that there was no link between circumcision and sexuality. Concurrently many of them did claim that circumcision was a way of “*curbing female sexuality*”. These two different ways of speaking about female circumcision first seemed as a contradiction. However they may be interpreted as a response to changes in the society,

changes which my informants could not do much about, such as global warming and the spread of the new diseases. Global warming was thought to make the bodies hotter than before, leaving them with an unnatural, “*excessive sexual desire*”. Female circumcision might be a way of curbing this excessive sexual desire, which again was a preventive measure for the spread of the new diseases as the girls would not “*run around with boys*”. Circumcision then became a sound strategy of handling a situation out of their control.

These examples show how people respond to external forces in ways that make sense to them. Medicalization with all its elements is not uncritically employed, but interpreted, resisted and accommodated according to local ideas and practices. The traditional circumcisers, for instance, would use those elements associated with the medicalized circumcision, which responded to their own experiences as midwives and circumcisers. While they had both experienced the dangers of excessive scar tissue during labor, they were comfortable with the transition to “*only one cut*”. They would however not apply the use of anesthesia as it did not correspond with their ideas of pain, gender and meaning.

The meaning and function of the ritual of circumcision has gone through a vast change, with the disappearance of pain. While some saw the “*painless*” circumcision as meaningless and a practice you might as well leave, other recreated the rituals within the realm of pain. The younger generation for instance claimed that it was not “*the pain of the knife*” which was the worst, but the pain of the healing period. In this way the transformative ritual was recreated and continued. Others again, claimed that these days, pain was no longer necessary to become a Maasai. As Moses sees it; “*You don’t have to feel pain in order to sit in an office*”. People will eventually abandon ceremonies that are unresponsive or unrelated to their lives (Kratz: 1994:25), and therefore a “*painless*” medicalized circumcision was a legitimate choice for some.

The ability to recreate the practice within new realities goes against the belief that with education, modernization and urbanization female circumcision will wither away. While some see the medicalized practice as one for the future; “*it’s clean – it’s okay*” others believed that medicalization was the beginning of the end. Whether medicalization opened for a continuation or an end to female circumcision is difficult to say, but I suggest that in order to assess change it is necessary to look to the embodied experiences of circumcised women. An

insight into the bodily experiences of living with a circumcised body makes it possible to better understand the informants' decisions to continue or stop the practice. Several of the women I talked to, and especially those who had a traditional circumcision, displayed a great deal of ambivalence not only to the practice, but to their circumcised bodies, claiming that they felt "shameful" in their bodies. The way Sara, Tina or Alice experienced their bodies, the way they *felt* about their bodies, constitutes an important incentive for them not to have their daughters circumcised in the same way. The great ambivalence felt towards the practice of female circumcision might be signaling that the end of the practice is near. As Talle has stated, it is in people's own knowledge and experience that we find the strongest arguments for the fight against female circumcision (Talle: 2003:127). Until we see the end of the practice, people will negotiate it, and find meaning to their own experiences.

Part of the task of anthropological writing is to retell stories in a fashion that will provoke a meaningful experiential response and understanding in the reader, even though our responses are themselves culturally embedded in quite a different structure of aesthetic or emotional response than that of the members of the society being described (Good: 1994:140). I therefore hope that my account of experiences and understanding of my informants is meaningful not only to the reader, but also to the people whose experiences I have tried to capture.

With this thesis, I am not trying to legitimize the practice of neither female nor male circumcision. Circumcision can be a painful and health impairing practice. However, I render it vital that one seeks to understand the practice and the changes to it through the experiences and perspective of the communities practicing circumcision. Rather than interpreting these people as victims of a false consciousness, it is important to listen to their own experiences and understandings in order to comprehend changes to the practice in this "new modern time".

Appendix

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Overview of informants

<i>Agnes</i>	Alice's mother. Had two daughters with her diseased husband.
<i>Alice</i>	My interpreter in Marok. 25 years old. Student of Early Childhood Development.
<i>Beatrice</i>	Traditional circumciser and midwife from Marok in her late 40s. stopped circumcising recently.
<i>Charity</i>	Alice's grandmother.
<i>Joyce</i>	My interpreter in Marok. 27 years old. Intern at Jane's organization.
<i>Mary</i>	My interpreter in Marok. 24 years old. Intern in Jane's organization.
<i>James</i>	From Loitek. 55 year old teacher.
<i>Jane</i>	Leader of an anti circumcision organization in Marok. Started working in Marok 4 years ago. Married to Jason. Three children.
<i>Daniel</i>	From Loitek. 26 years old. Student and construction worker.
<i>Moses</i>	From Loitek. 35 years old. Worked for an NGO.
<i>Rita</i>	Traditional circumciser and midwife from Marok in her 60s. Stopped circumcising recently.
<i>Rosie</i>	From Loitek. 27 years old. Worked for an NGO. Uncircumcised.

Sara Informant from Marok. 16 years old, unmarried with one child.

Seenoy Leah's mother. 10 children with her diseased husband Tipanko.

Leah Daughter of Seenoy. My interpreter in Loitek. 25 years old, married to Simon. Two children.

Tina Informant from Marok. 22 years old, married with two children.

Tito From Loitek. 26 years old. Worked at the Community Centre.
Uncircumcised