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Female Genital Mutilation/Cutting among the Wardei of Kenya: Practice, Effects, and Prospects for Alternative Rites of Passage

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This study focuses on Female Genital Mutilation/Cutting (FGM/C) with the aim of establishing the rationale, outcomes, and challenges it presents to the girls and their families, and whether there is scope for developing alternative rites of passage. The study established that the major purpose of FGM/C among the Wardei was to control the initiates' sexuality before marriage. It poses serious risks to their health, including the possibility of bleeding to death. The practice affects Wardei girls' access to and participation in education as initiates normally take a long time to heal, and it also bestows on them a status superior to that of teachers who have not undergone circumcision. The study established that the Wardei community is willing to adapt or abandon their traditional practices as part of social change stemming from modernization and in response to international pressure. But eliminating FGM/C among the Wardei community would require comprehensive and sustained advocacy, sensitization, and public education by various groups, including religious and community leaders, government agencies, nongovernmental organizations, and community-based organizations. This intervention must target various groups—girls, boys, younger women, older women, and fathers—who have different perceptions of and interest in FGM/C.

Key words: female genital mutilation/cutting (FGM/C), rites of passage, Wardei (Kenya)

The Wardei of Tana River County in Kenya are Cushitic and closely related to the Somali. As do other Somali clans, the Wardei engage in nomadic pastoralism, and cattle, sheep, and goats are the main sources of their wealth (Fedders and Salvadori 1984). According to Kenya National Bureau of Statistics, about 77% of the population is below the poverty line, with a literacy rate of 40% and 30% for males and females, respectively (Republic of Kenya 2009). The Wardei community is rural and homogenous. They profess the Islamic faith, one of the predominant religions in the county and the coastal region as a whole.

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The Wardei practice FGM/C as well as boys' circumcision. Although FGM/C is common among the Wardei, educated or not, poor or rich, it is often hidden.¹ In this highly patriarchal society, most decisions are made by men. Women, however, decide when their daughters will be cut because it is their responsibility to prepare the girls for marriage. In any case, the men seem to be more vocal than women in their arguments against eliminating FGM/C. Nevertheless, there is insufficient knowledge about the practice in the Wenje Division of Kenya to design programs to challenge the practice. This study is intended to provide a detailed account of these practices in order to better inform policy, decision making, and advocacy work.

The circumcision of girls that is practiced by the Wardei, which involves the cutting of female genitalia generally referred to as infibulation, falls under Type III according to the classification used by WHO/UNICEF/UNFPA (1997).² The extent of genital tissue cutting generally increases from Types I to III. Severity and risk are closely related to the extent of the cutting, including both the amount and anatomical position of tissue that is cut. Type IV comprises a large variety of practices that do not involve removal of tissue from the genitals. Though limited research has been carried out on Type IV practices, they generally appear to be associated with less harm or risk than the other types (WHO/UNICEF/UNFPA 1997).

FGM/C is prevalent in 28 countries of sub-Saharan Africa, a few countries in the Middle East and Asia, among immigrant populations in industrialized countries as well as countries with descendants of slaves, such as Colombia. An estimated 100 to 140 million girls and women worldwide have undergone FGM/C, and at least three million girls are at risk of being subjected to the practice every year (Yoder, Abderahim, and Zhuzhuni 2004).

An estimated 32% of all women between the ages of 15 and 49 in more than half of Kenya's districts have undergone FGM/C. The 2003 Kenya Demographic Health Survey (Central Bureau of Statistics et al. 2004) recorded the following prevalence rates among various communities:

Kisii	96%
Maasai	93%
Kalenjin	48%
Taita/Taveta	62%
Meru	42%
Embu	44%
Kikuyu	34%
Kamba	27%
Miji Kenda/Swahili	12%
Somali (North Eastern Province)	97%

The Wardei belong to the Somali group and are known to engage in Type III (infibulation) (Asmani and Abdi 2008); the other communities practice other types of FGM/C.

THEORETICAL FRAMEWORK

The practice and abandonment of FGM/C by any community can be understood using a theory of social change. The theoretical framework of our study was adopted from UNICEF (2010), which applied social convention theory to explore the social dynamics of FGM/C in five African countries, Kenya included.

Social convention theory, adapted from Schelling's (1960) concept of self-enforcing social convention, has been used to explain why harmful social practices such as FGM/C continue to persist. The theory is based on the simple game-theoretic model originated by Mackie (1996, 2000) and refined by Mackie and LeJeune (2009). According to this model, when a social convention or a social norm is in place, decision-making is an interdependent process in which choices made by one family are affected by and affect the choices made by other families as a result of reciprocal expectations. The theory offers an explanation for daughters and their families continuing to choose FGM/C, and why it is so difficult for individual girls or families to abandon FGM/C on their own. The model posits that actions of individuals are interdependent, necessitating coordinated change among interconnected actors. This helps us to understand that FGM/C is maintained by interdependent expectations in the marriage market. Once this convention becomes widely expected of potential brides, the practice is locked in place: those who fail to comply also fail to marry and reproduce (Shell-Duncan et al. 2011).

The basic assumption regarding FGM/C is that parents want to do what is best for their children and will not hesitate to have their daughters cut as a way of preparing them for marriage. If this is not done, their daughters will be considered social outcasts. Accordingly, members of communities that practice FGM/C do not see the practice as dangerous or as a violation of the rights of the child but as a necessary step to raise and protect a girl and in many instances make her eligible for marriage. Where FGM/C is practiced, community leaders and members therefore argue that FGM/C is a social norm to which compliance is in the best interests of the community and its citizens.

Where the prevalence of FGM/C is high, no single family can choose to abandon the practice because that would affect their daughters' marriageability. This is described as an equilibrium state since no family has an incentive to deviate from the social expectation of cutting. Conversely, where a community chooses not to have their girls undergo the practice, FGM/C ceases to be a prerequisite for marriage. This also constitutes an equilibrium state since all families are acting in the same way and no one family has an incentive to cut its daughters. Although marriage is the main motivation for continuation of FGM/C in many cultures, it can also be associated with factors such as female initiation or religion. Consequently, a practice that started as a marriage convention may end up being enforced through a number of social, moral, or religious norms (Mackie 2000; Mackie and LeJeune 2009).

Abandoning a harmful practice such as FGM/C is only possible through a coordinated collective cessation within an intermarrying community. "Families will abandon FGM/C only when they believe that most or all others will make the same

choice at the same time” (UNICEF 2010:6). The process starts with a small core group, a critical mass, which conditionally resolves to abandon the practice and then recruits other members of the community to conditionally join in the effort until a sizeable group is willing to abandon the practice. This is only possible when a sufficient subset of the endogamous community publically and conditionally commits to discontinue the practice for a typical family to believe that the majority of families in the community expect most families *not* to cut; hence no family has a reason to go back to cutting.

Social convention theory incorporates specific strategies to be followed for coordinated rejection of the practice to succeed, as demonstrated in efforts that led to the ending of footbinding in China in one generation by those who spearheaded the reform. First, the population was taught that the rest of the world did not bind women’s feet, thus presenting them with an alternative. Second, the advantages of having “natural” feet and the disadvantages of having bound feet were explained. Finally, “natural foot societies” were formed in which members pledged not to allow their sons to marry women with bound feet and also not to bind their daughters’ feet. The strategy succeeded in changing the views of many Chinese and supports social convention theory’s hypothesis that coordination is important in ending such a practice.

A stable and coordinated abandonment within an interdependent community requires several steps. First, the majority of the community must be involved in discussion of the merits of continuing or abandoning a harmful practice. This is only possible when people have been made aware of the existence of an alternative, which must be more valued than the harmful practice. This is followed by a collective commitment by the majority of the endogamous community, which should be well publicized so each individual knows that most members have abandoned the practice and so that together they can monitor adherence to the change. This coordinated abandonment will effectively shift reciprocal expectations among community members from “most others will cut” to “most others will not cut.” And since the shift is to a more highly valued alternative, there will be little temptation to revert.

FGM/C is therefore not only a social convention, it is also a social norm—a rule of behavior that members of a community are expected to follow, with compliance being motivated by a set of rewards for adherence and sanctions for non-adherence. But norms can also be discontinued:

for abandonment to occur, it is essential that people are aware of and trust the intention of others to also abandon. Social expectations will change if people have a guarantee of the commitment of others to abandon. A moment of public affirmation of commitment to abandon the practice is therefore required so that each individual is assured that other community members are willing to end the practice (UNICEF 2010:9).

Using the social convention theory of change we report here on the social dynamics of FGM/C among the Wardei community in Tana River County, Kenya.

RESEARCH OBJECTIVES AND STUDY APPROACH

This study set out to document and understand the rite of FGM/C among the Wardei community in the Wenje Division of Kenya's coastal region. More specifically, it investigated the nature and purpose of FGM/C, perceptions of the community about the rite, and ways of designing alternative initiation practices for girls.

This study was exploratory, participatory, and descriptive, and because of the sensitivity and secretive nature of FGM/C, the study required the full cooperation and involvement of key informants, including girls who have been initiated, selected community and religious leaders, parents, and teachers. This qualitative study involved the use of in-depth interviews and focus group discussions that ensured participation of key community members in the design and data collection. The targeted communities were included in an ongoing advocacy project. Purposive sampling was employed to identify the focal areas for data collection and to identify respondents. It involved full participation of 22 key informants (7 girls and 5 boys, 2 women leaders, 3 Islamic leaders, and 5 community leaders: 2 chiefs and 3 headmen). During the data collection, invaluable support was provided by activists who were carrying out campaigns against FGM/C through ActionAid Kenya and government agencies. They also formed part of the sample for the study as key informants.

Apart from the literature review, primary data collection instruments included guides for interviews and focus group discussions (FGDs), which were held with community leaders and out-of-school girls 10 years of age and above. Ethical considerations were taken into account to prevent violation of the respondents' rights.

A research permit was obtained from the National Council for Science and Technology of the Ministry of Higher Education, Science, and Technology. This official document led to the research being welcomed and accepted by local leaders and community members. The research team sought respondents' consent, asking them if they would like to participate and also explaining the rationale behind the study. Since primary school pupils are minors, prior arrangements were made through the respective head teachers to obtain consent from the students' parents before they participated in the study.

Members of the community were aware of the researchers' association with ActionAid, which had been working in the community for some time. The community leaders were aware that FGM/C was illegal, but they argued that the practice is traditional/cultural and could not simply be discontinued by passing a law. "The community—the majority of whom are illiterate—are the custodian of this cultural/traditional practice and need to be targeted through public education and persuasion to stop the practice" (statement by a community leader). They were also aware that ActionAid's interventions were aimed at the discontinuance of FGM/C.

FINDINGS AND DISCUSSION

This section focuses on the nature and rationale of female genital mutilation or cutting, its effects on the girls' health and education, and the scope for alternative rites of passage.

Nature of Traditional FGM/C

The first objective of this study was to investigate the nature and purpose of FGM/C as practiced by the Wardei community in Kenya's Wenje Division. From discussions with key informants, we learned that the initiation of girls in the traditional Wardei community (unlike that of the boys) was quite elaborate and carried considerable significance not only to the initiates but to the community as a whole. Girls' circumcision (*bires*) traditionally involved the cutting of female genitalia generally referred to as infibulation (classified as Type III in WHO 2006a). This procedure involves narrowing of the vaginal orifice and creation of a vaginal seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris. (Subsequent problems with urination and menstruation are discussed below.)

Two types of FGM/C are performed by the Wardei community. Traditionally, the community practiced *sironiga* (infibulation), but currently they perform a simple cut of the female genitalia (*kisuna*). One key informant (a 67-year-old former circumciser) explained:

There are several kinds of cutting; the first one, which is very common, is called *kisuna*. This involves the cutting of the tip of the clitoris. However, it all depends on the circumciser, who decides the amount of flesh to be removed. The other procedure preferred by many elders is called *sironiga* (or *kifrauni*). This procedure is worse and it is actually being abandoned. It involves cutting the whole flesh in the birth canal and then stitching using a hard thread. The *awotta* (circumciser) measures the remaining hole by her finger. If it is still big, further stitching is done. This kind of circumcision is actually dangerous and sometimes is done as a punishment to women suspected of immorality, but in some villages it is the most preferred since it locks the girls completely.

As a social norm, the Wardei girls are expected by the community, including their parents, to undergo FGM/C when they reach adolescence. The onset of the menstrual cycle, and the maturation of the breasts and hips, indicated the girl had come of age and was ready for the cutting ritual. The practice generally targets girls who are 12 to 15 years of age. The exercise is largely the women's responsibility, but the fathers are always consulted and in most cases have the final say.

The girls' mothers start the process by informing the circumciser that their daughters are ready (typically the procedure is performed on several girls at the same time) and preparing a special place in the bush for the ceremony. The girls are then prepared by their mothers, who inform them about the importance of the procedure and encourage them to view it as a critical rite for transiting into women. Apart from

this, the mother provides a razor blade, thorns, and strips of cloth as well as a rope for use during the ceremony. In most cases, the ceremony is performed during the cold or rainy season not only to avoid excessive bleeding but also to ensure that there is plenty of food for the initiates to enable them to heal faster.

The traditional circumcision process is as follows: on the appointed date, girls aged ten and above are taken to the venue where they are cut with razor blades and then stitched together using thorns. Their legs are then tied together with ropes to ensure that the wounds in the genitals do not open up, thereby jeopardizing the healing process. Trained women called *awotta* (circumcisers) are charged with circumcising the girls. Because of their expertise, the circumcisers have come to be referred to as *fundis*, the Kiswahili equivalent for “artisans,” because the delicate operation demands precision. The experts are assisted by women who are in training. In the past, payment for the service was made in *bur’at* or *sirhin* (animal fat or ghee) or chickens, but nowadays one can pay as little as 100 Kenyan shillings (approximately \$1 US) based on the ability of the family to pay.

Traditionally the initiates are cared for by their mothers, the *awotta*, other women undergoing training as circumcisers, and elderly women. In addition to providing the initiates with food, they use traditional therapies (information based on a focus group discussion with women):

Treatment of the wound involves the use of special herbs, charcoal, and donkey waste. A hole is dug in the ground where these items are placed and burned as girls squat on it. The smoke is meant to dry the wound. This exercise is carried out for about seven days before the girls are washed and examined for signs of healing. Those found to be healing properly have their legs untied to start walking, but gently.

Each day, the initiates are usually carried to the bush before daybreak and back to their mothers’ houses late in the evening. Sometimes the women enlist help from men to provide security for the initiates. One 56-year-old woman stated:

This movement to and from the bush is done to ensure that the initiates are not disturbed by animals but at the same time they have to stay away from the men. If they have sex then the healing process gets disrupted.

The girls are examined frequently by the *awotta* and other experts to ensure proper healing, and any mistakes or problems are corrected immediately. For instance, those experiencing problems in healing go through a second circumcision procedure. One woman observed:

Although the repeat [second, third, and so on] processes are usually painful, almost all of us were willing to go through it again to satisfy ourselves that we are alright by the time we “graduated” [from the ritual].

Elaborate ceremonies, such as public celebrations with dancing and eating, are avoided because the practice is now outlawed in Kenya (as of 2011) and because of pressure from anti-FGM/C campaigners. The practice has by and large gone underground out of fear of prosecution by the state.

Rationale for Circumcision

From the discussions, it was clear that preserving girls' virginity (in Kiswahili, *bikira*) is the main reason to this day for the practice of FGM/C. Traditionally, the practice was meant to deter the girls from promiscuous behavior by inflicting as much pain as possible during sex. Virginity was so highly valued that the Wardei would go to any length to preserve it. After the clitoris and vaginal flesh was cut, the vaginal opening was stitched so girls would know that virginal penetration would result in considerable pain. The Wardei therefore use FGM/C (infibulation) to instill fear in the girls with regard to casual sex and its attendant consequences. A key female informant explained,

We circumcise our girls so that they have sexual restraint because of the pain that is inflicted on them. If the girls are not circumcised, they have not had any pain and they may end up having sexual intercourse with the boys and then end up with unwanted pregnancies, which are a big shame and a burden to the parents and the community.

These findings reaffirm those of other studies which indicate that African communities that practice FGM/C often believe that the procedure ensures and preserves a girl's or woman's virginity (Gruenbaum 2006; Talle 2007). FGM/C is also a social norm that is supported by certain beliefs: for example, that parents always wish the best for their children and would do anything to ensure a proper future for them. The belief that FGM/C ensures morality is another example of a mistaken assumption used by practicing communities to perpetuate FGM/C.

Interestingly, Wardei women also value FGM/C as an effective mechanism for instilling good moral behavior among their girls. Wardei women are the ones directly responsible for socializing the girls and consider this practice to be an effective mechanism for controlling their girls' sexual behavior. One woman likened girls' circumcision to a padlock by saying, "circumcision to the mother was like a house that she had locked and nobody could enter so easily."

The informants also invoke Islamic teachings, especially the *sunna*, to justify circumcision. Some of the community members professing the Islamic faith believe that only those girls who had gone through the cut should be allowed to pray or worship or even read the Quran, and also that it makes them clean before Allah. Religious beliefs have often been used to reinforce the practice of FGM/C (Abdi 2007; Clarence-Smith 2007; Johnson 2007). Although the practice can be found among Christians, Jews, and Muslims, none of the holy texts of any of these

religions prescribes FGM/C. Also, the practice antedates both Christianity and Islam (UNFPA 2006).

The role of national and local religious leaders in promoting or stopping FGM/C in the Wardei community varies. Those who support the practice either consider it a religious act or interpret efforts aimed at eliminating it as a threat to culture and religion. Other religious leaders oppose FGM/C and participate in efforts aimed at eliminating the practice. When religious leaders are ambiguous about the practice, they are often perceived as being in favor of FGM/C.

Similar views were expressed by some of the religious leaders in Wenje. For instance, a 63-year-old sheikh refuted the notion of FGM/C being a religious practice:

We circumcised our girls as a cultural demand. Some claim that they did it because of Islam, but that is not true. This was simply our tradition. What used to be culture has now been turned into a rule, a must for our people. Let me state that Islam does not allow tampering with one's body. I personally have been carrying out advocacy for the last two years but the people don't want to stop. I have told these *awotta* that spilling of blood is *haram* (illegal) . . . and it is not allowed in Islam.

The practice of FGM/C is also considered by the Wardei to increase social status and as a mark of adulthood that in most cases paves the way for marriage. A woman in a focus group stated,

In our community girls are circumcised as part of initiation into adulthood since without this, one cannot get married. And before a girl is circumcised she is considered immature for marriage, and of course no man will accept an uncircumcised girl for a wife.

The major expectation was for FGM/C to lead to marriage:

In the past there was a direct link between *bires* (FGM/C) and marriage. From the moment of circumcision onwards the girl knew that any man could come to seek her for engagement. While some girls had to wait long periods for engagement, others got engaged immediately after circumcision.

The focus on marriage of girls soon after circumcision emanated from the fear of early or unwanted pregnancies. To guard against this, parents and society as a whole ensured that the girl got a suitor soon after initiation. As expressed by a 65-year-old woman,

As soon as the circumcision ceremonies ended the initiate looked forward to marriage. The preparations for her wedding would have started by now be-

cause of the fear that some girls could “start trying out.” The society/parents expected the initiate to be ready for marriage and to be disciplined.

The idea among the Wardei of linking FGM/C with marriage is in agreement with the views of Dellenborg (2004), who points out that the practice was considered a necessary step in raising a girl properly and preparing her for adulthood and marriage. In some societies, the practice is embedded in coming-of-age rituals, sometimes for entry into women’s secret societies, which are considered necessary for girls to become responsible members of society (Behrendt 2005; Johnson 2007).

Among the Wardei, the practice is meant to secure a “positive” future for the girls, and no man would consider marrying a girl who is not circumcised. Accordingly, girls in most cases demand the procedure as a “marketing” strategy for marriage. The premium that the community puts on circumcision before marriage is demonstrated by the act of inspecting the bride before she is given away (before the wedding, to ensure that the girl’s virginity is intact). This is done by inserting a stick or a finger in the girl’s vagina. Accordingly, proof that the bride-to-be is a virgin is the happiest moment in the life of a parent, especially the mother, who would be relieved of undue pressure from the husband and the community at large.

The circumcision is accompanied by instructions from the *awotta*, the girl’s mother, and other elderly women during the seclusion period. The topics of these instructions include adult roles, how to relate to men, and how to dress—especially, how to dress modestly to cover their bodies:

The girls are advised by the parents, particularly the mothers, on how to conduct themselves now that they have become mature women. They are advised on how to live with their husbands and generally how to dress properly in public. They are also educated to be responsible, disciplined, and generally show respect to the elders. Such attributes are seen as early signs for girls who are growing up into disciplined wives in the future.

Instruction also touches on domestic responsibilities, such as decorating the house, milking, cooking, taking care of the homestead (*boma*), and other chores. In the past the teaching started in the bush when the girls were nearly healed and was continued at home, with emphasis being placed by their parents on practical aspects of life.

The teaching further emphasizes the preservation of the girls’ virginity, and in some cases threats are used as deterrence. For instance, girls are advised not to greet men or sleep on the same bed with boys. This is aimed at instilling fear; the girls are told that if they did that, they would automatically become pregnant. One woman in an FGD noted:

the curriculum among others exposed the girl to marriage issues such as the need to keep their virginity until marriage; they were instructed not to go

anywhere without seeking permission, not to talk to any man apart from her brothers, not to look at men directly in the eye, not to enter a man's house, including the brothers' house, and to respect the husband and in-laws once she got married.

Another (42-year-old) woman said that after circumcision the elderly women, including the grandmothers, train the girls on what behavior is expected of them after FGM/C. She noted,

we were told not to relate with boys sexually. In fact, we were told that playing with boys was a big sin that each one of us was expected to keep off. We were also told that after circumcision we must prepare ourselves to live as grownups, including getting ready for marriage. Our grandmothers always emphasized to us that we had to respect everyone in the community, especially the elders.

The above observations indicate that FGM/C is a manifestation of gender inequality that is deeply entrenched in the social, economic, and political structures of the societies that practice it. Like the dowry and child marriage, female genital mutilation represents society's control over women. Such practices have the effect of perpetuating normative gender roles that are unequal and harmful to women. For these reasons FGM/C is often upheld by local structures of power and authority, such as traditional leaders, religious leaders, circumcisers, elders, and even some medical personnel. In many societies, older women, who have themselves been circumcised, often become gatekeepers of the practice, seeing it as essential to the identity of women and girls. This is probably one reason why women, and often older women, are more likely to support the practice and tend to see efforts to combat the practice as an attack on their identity and culture (Draege 2007; Johnson 2007).

Community Perceptions on the Effects of Female Genital Mutilation/Cutting

The practice of FGM/C has been shown to violate a series of well-established human rights principles, norms, and standards, including the principles of equality and nondiscrimination on the basis of sex, the right to life (when the procedure results in death), and the right to freedom from torture or cruel, inhumane, or degrading treatment or punishment (UNFPA 2006). This section focuses on community perceptions of the effects of FGM/C on the initiates.

A number of studies have associated the practice of FGM/C with serious health problems. In most cases, girls who have undergone the practice experience pain and bleeding (Talle 2007). A study found that women who had undergone FGM/C are more likely to suffer from serious obstetric outcomes than those without the cut. Birthing complications experienced by women who had undergone FGM/C include caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient prenatal death at much higher rates

than among women who have not been cut. These risks are likely to be greater depending on the extent (type) of FGM/C (WHO 2006b).

In a number of instances, initiates in Wenje have lost their lives because of FGM/C. A 46-year-old male informant explained with bitterness that one of his daughters bled to death after circumcision:

I hate this practice of FGM/C because of a very bad experience that I went through. My own daughter aged 12 years, who was in class five, died from over bleeding after circumcision. . . . The reason why I get pained to this day is that nobody consulted me about her circumcision and I only learned about it a month later. I always get haunted by those painful memories whenever I talk about it. FGM/C is evil and the women should be well advised that this thing is not good.

Apart from problems that are directly associated with the procedure, the intervention itself is traumatic as girls are usually held down during the procedure to deter any movement or resistance. As mentioned earlier, those who are infibulated often have their legs bound together for several days or weeks thereafter.

An FGD with women younger than 30 years of age discredited the practice of FGM/C. The discussion outlined problems often faced by girls after the procedure when it comes to urination and menstruation. If the vaginal opening is fully closed, it becomes very painful to pass urine or menstrual blood, especially if blood clots form in the small opening after stitching. It makes the girls very uncomfortable. Such cases would be referred back to the circumciser for another round of circumcision to open it up slightly.

Apart from the pain associated with these experiences, the practice also leads to other challenges, as explained by a 22-year-old woman:

In my view, this practice of circumcising girls is not a good thing. My worry has come from my own experience when I got married. During my wedding everyone was very happy and celebratory except myself. I was really worried since some of my friends had warned me to eat well and prepare for the battle. During my first sexual intercourse with the father of my children [husband], the pain I experienced was unbearable. I screamed until some other people had to intervene to help me. The following day I had to go through the same experience and I tell you it was horrible, inflicting a wound on a fresh wound. I had to run back home to my parents for a while, but in the mean time I was pregnant. Before I could give birth to my first born daughter I had to be rushed to the hospital for an operation. This is an experience I would never wish my own daughter or sister to go through. In fact I wonder how girls from poor families survive.

Cases of failure by men to penetrate women during the first sexual intercourse after marriage are said to be quite common among the Wardei. In such instances, the newlywed woman is taken back to the awotta to have the genitalia opened, after which they are returned to their husbands with no allowance for healing. A 21-year-old woman explained that sexual intercourse in such circumstances can be a woman's worst nightmare:

The first problem that we as women go through is the pain that we experience during the first marital sex. The act of breaking virginity is a very painful and tedious process to the girls during marriage. Sexual penetration becomes a very stressful act that curtailed a girl's enjoyment during honeymoon. Instead of enjoying the wedding or honeymoon, one keeps remorseful, ever crying.

Problems associated with child delivery have presented serious challenges to the circumcised women in Wenje. It is not uncommon for pregnant women to have their genitals cut by traditional birth attendants at the time of delivery to open up the passage for the child. This can be a very painful procedure to which the men remain completely ignorant since girls are usually sent to their parents' home for delivery and only go back to their husbands once they have completely healed.

Sometimes, birth attendants are unable to help women deliver and the mothers must be admitted to hospitals to undergo surgery. According to a 29-year-old woman,

The biggest challenge then comes at childbirth. Child delivery becomes very painful and many women get admitted to the hospitals after the traditional birth attendants fail to help in delivery. The means of travelling to the hospital itself is not there, and you can imagine the time it takes with all the pain.

Apart from problems directly related to delivery, the long distances needed to travel, the poor transportation network, as well as the lack of health facilities complicate matters further. Although there are no official data at the local level, and our informants were not able to provide actual counts, they told us that many of the women who experience difficulty in childbirth actually die either at home or on the way to health facilities, and these deaths are not recorded in official statistics.

Although it is still a common practice, our informants are convinced that FGM/C has negatively impacted the educational aspirations of their girls. Data from the Ministry of Education indicates that Tana River County, the home of the Wardei, has below-average enrollment in primary and secondary education. For example, primary school net enrollment is only 63.3% (males = 66.8%, girls = 61.4%) compared with the national average of 84.6%.³ Local/community-level data are not available, but people we talked to associate the low participation of girls in schooling to FGM/C, as captured in the voices below:

Many girls get married immediately after the practice, thus drop out of school. For the few who remain in school, the pain and trauma associated with FGM/C affects their concentration in class and they end up not performing well in examinations, and in most cases end up dropping out of school. We do not have many educated women in our division because of this practice (said a 29-year-old female teacher).

Some of the girls take a longer time to heal and are forced to stay away from school, thereby missing classes, and eventually drop out completely. Other girls do not heal by the time schools open, leading to loss of learning time by two to three weeks, while other children find it difficult to concentrate in class (said a 32-year-old male teacher).

The informal education that the initiates receive and the perception that they are now “grownup women” is likely to divert their attention from educational activities and toward early marriages, thereby halting their academic careers. We heard that some girls would be rude to female teachers, especially those from other communities that do not practice FGM/C. Such girls believe that they are superior to the uncircumcised teachers. A male teacher put it candidly:

after circumcision, the girls are psychologically prepared to become adults and therefore fail to give much attention to classwork. They do not respect teachers, especially female ones from other communities, any more. Some have already been “given out” (engaged) to rich old men. This practice clearly impacts negatively on girls’ education among the Wardei in this division.

The practice is known to have a substantial psychological effect on the initiates. Most of the girls start thinking about marriage soon after circumcision, which in most cases leads to termination of their schooling. For example, one male teacher said, “Out of five circumcised girls, four end up marrying early with only one remaining in school.” It is therefore not surprising that no Wardei girl had completed secondary education between 2005 and 2009. A woman in a focus group captured this well when she said:

Last year [2009] only one girl went to secondary school. . . . Even today girls think they are grownups once they are circumcised and hence drop out of school . . . and therefore do not benefit from schooling and available job opportunities. That means they cannot get jobs so that they help the rest of us. This has led to perpetuation of poverty and the general underdevelopment of the whole Wardei community.

The teachers also explained that the effects of FGM/C are not only confined to the classroom but also interfere with extracurricular activities. Some of these

activities take place when girls are still nursing wounds that take time to heal, especially those from poorly performed procedures. As one of the female teachers pointed out, “in such instances our girls cannot participate in school games as they cannot spread their legs comfortably. They are always in fear or in pain and these impact on their performance.”

From the above discussion, it is clear that FGM/C results in serious challenges to the health of the girls, including the possibility of bleeding to death at the time of the operation. The procedure is very painful and traumatic. Complications during sexual intercourse are quite common among the Wardei, as well as during childbirth, which can also lead to death.

Prospects for Alternative Rites of Passage

This section focuses on the prospects for alternative rites of passage to replace FGM/C among the Wardei. As indicated above, FGM/C is regarded as a social norm and a process of “empowering” girls to attain adulthood. Abandoning this traditional practice altogether is a long process that requires multiple approaches, including sensitization, public education, and economic empowerment. The Wardei community—local leaders, parents, boys and girls—need to be persuaded, and even forced, to abandon the practice. Alternative ways and processes of “empowering” girls must be designed and implemented with participation by the community, as discussed in the section on our Theoretical Framework (and see UNICEF 2010:9).

“Champions” are needed among Wardei community to initiate and build consensus that FGM/C is an outdated tradition that should be abandoned. And some members of the community have started listening, which explains the presence of ActionAid in the community with their advocacy program promoting alternative rites of passage (see the report published by the Stop Violence against Girls in School Project 2011). Although the local government officials had started sensitizing the community about the negative effects of FGM/C, advocacy by ActionAid seems to have had a greater impact in creating dialogue with the community members.

Based on field experiences, abandoning FGM/C and adopting alternative ways of socializing teenage girls requires comprehensive interventions and social processes that can support successful behavioral change and address the core values and enforcement mechanisms that support the practice (UNICEF 2005, 2010; Yoder et al. 2004). Such change must come from and be owned by the Wardei people themselves, who stand to benefit from the process (UNICEF 2010). Our study has indicated that various groups among the Wardei—girls, young women, young men, and some older men/community leaders—support the abandonment of FGM/C because of its side effects on girls and women.

In this highly patriarchal society, targeting men as champions of social change is critical. A few local women leaders also felt that the practice should be abandoned. Engaging this group will be important in efforts aimed at ending FGM/C in Wenje. Also to be targeted are boys who are unwilling to marry girls who have not been cut. They are caught in “a belief trap” (Mackie 1996).

The key question is whether the Wardei are ready to embrace change, which in the final analysis will lead to abandoning the practice of FGM/C. Discussions with various community groups indicate that there is scope for modification of traditional initiation practices and embracing alternative rites of passage. The locals' perceptions and expectations are slowly, but surely, changing. All the schoolgirls with whom we spoke are opposed to these traditional practices. A 15-year-old girl summarized the "voices" of others in a focus group discussion with schoolgirls as follows: "circumcision of girls amongst the Wardei should be stopped because it is shameful to us and inhumane to the girls and breeds underdevelopment." One of the objectives of circumcising Wardei girls is to prepare them for marriage, which in most cases follows soon after. This has led to early marriages even for underage girls, forcing them to drop out of school, thus making them unable to compete for jobs or other opportunities associated with formal schooling.

Although the practice continues among the Wardei, some community members are beginning to reexamine their attitudes towards FGM/C. These changes have been occasioned by campaigns mounted by government agencies, community-based organizations (CBOs), and nongovernmental organizations (NGOs), such as ActionAid-Kenya; the realization by many people in the community that Islam does not sanction this practice, unlike what they were told in the past; and the expectation that girls should attend school, and that the education process should not be forfeited because of circumcision.

Another positive change is that some community members have shown their willingness to stop the practice altogether, as explained by a 67-year-old well-respected woman:

I personally was a circumciser, but I have my daughter who is 13 years old and I am wondering whether she should go through the cut. I would be very willing not to take her through the process if given alternatives. Personally as a circumciser, I have left that work, but if given alternative means of earning a living, I will leave the practice completely and join others to campaign against it.

A sheikh (a religious leader in one of the Wardei communities) captured the emerging mood in the community as follows:

As I speak to you now, I have three girls who have reached the age of initiation. But I have decided that they will not undergo FGM/C and I know that they will not fail to get married because what matters is the discipline of the girls and not whether they have been circumcised or not. My own view is that because FGM/C is a traditional activity, it will take time but will finally come to an end in the same way other cultures change. But it cannot die at once. If we use a lot of force, these people can even kill you. Some will even challenge

you by saying, what about your father, mother, and children that have done it in the past and continue to do it even now?

Some of the key factors that have led to changes in the community's perceptions have been stringent laws and regulations recently enacted, including the Children's Act of 2001, Kenya's Constitution (2010), the Prohibition of Female Genital Mutilation Act (2011), and the Basic Education Act (2013). The government also established the Anti-Female Genital Mutilation Board in 2013, headed by a former minister who has been in the forefront of fighting the practice.

Most religious leaders in the community are aware not only that FGM/C is illegal but that it is also *haram* (against Islamic teaching) as it is not prescribed by the Quran. That is why they do not support the continuation of the traditional mode of FGM/C and the accompanying rituals. They would prefer a modification of the practice in accordance with Islamic teaching, which requires a small amount of blood to be spilt by cutting a piece of the girls' genitals but does not involve stitching or tying of the initiates' legs with ropes to facilitate healing.

With aggressive and sustained public education and consciousness-raising, accompanied by enforcement of existing laws and policies, alternative rites of passage are steadily being embraced by the Wardei community. Since FGM/C is traditionally accompanied by a "coming of age," alternative rites-of-passage ceremonies that reinforce the traditional positive values but without circumcision have been pursued in other communities in Kenya, especially in the Eastern and Rift Valley regions. Such approaches have added new elements to the rituals, including education on human rights as well as sexual and reproductive health issues. Alternative rites have been found to be effective to the extent that they foster a process of social change by engaging the community at large, as well as the girls, in activities that lead to changing beliefs about circumcision (Chege et al. 2001; UNICEF 2010).

Maenedeleo Ya Wanawake (Women's Development) Organization with support from the Program for Appropriate Technology in Health, implemented an alternative rite-of-passage in five districts of Kenya beginning in 1996. The program involves the seclusion of young girls for three to five days for family life education. Some of the topics covered include interpersonal communication, harmful traditions, FGM/C, human anatomy, decision making, pregnancy and conception, courtship, dating and marriage, and empowerment of men and women. At the end of the seclusion a public "graduation" ceremony is held to mark their coming of age at which speeches are given and gifts are presented to the initiates (Chege et al. 2001).

CONCLUSIONS

This study focused on FGM/C with the aim of establishing its rationale, outcomes, and the challenges it presents to the girls and their families, and whether there is scope for developing alternative rites of passage that can empower girls and improve

their chances of continuing their education. The study established that the major purpose of FGM/C among the Wardei is to deter the initiates from engaging in casual sexual activities. The practice also opens the way to marriage. The research also established that FGM/C poses serious risks to the current and future health of the girls. The practice also leads to the girls attending school less often or dropping out to get married.

The Wardei community is willing to adapt or abandon their traditional practices as part of social changes stemming from modernization and from international commitments to human rights and gender equality. But eliminating FGM/C requires comprehensive and sustained advocacy, sensitization, and public education by various groups, including religious and community leaders, government agencies, NGOs, and CBOs. Such intervention must target various groups—girls, boys, younger women, older women, and fathers—who have different perceptions of and interest in FGM/C.

Even as alternative rites of passage are sought, members of the community should be helped to overcome certain long-held fears about abandoning the practice given its cultural importance. The proposed alternatives should build on some of the traditional practices that do not involve FGM/C. For example, ceremonies that used to prepare girls for adulthood could be revived to educate the youth about their future roles as responsible women. Girls' empowerment camps could be set up to educate them on various social issues, including aspects of reproductive health, and guidance and counseling with regard to proper moral conduct could enhance their learning. These activities should be accompanied by graduation ceremonies to symbolize the empowerment gained through these practices.

NOTES

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1. Wardei is a homogenous community, more than 95% rural. FGM/C is entrenched regardless of level of education and socioeconomic status. Men and women in the community regard it as a cultural/traditional practice that must be followed. It was not easy to establish whether the practice is common among the very few who are well-educated. During the project, community leaders indicated that FGM, like male circumcision, is practiced by all households. However, they indicated that the few rich, educated Wardeis living in urban centers might not say openly that they adhere to this practice.

2. FGM/C involves partial or total removal of external female genitalia or other injury to the female genital organs for nonmedical reasons. WHO (2008) has classified FGM/C into four types: Type I—Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Type II—Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III—Narrowing of the vaginal orifice and sealing it by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). Type IV—All other harmful procedures to the female genitalia for nonmedical purposes: for example, pricking, piercing, incising, scraping, and cauterization.

3. Republic of Kenya, Ministry of Education, Statistics and EMIS Section, 2008.

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