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Female genital cutting (FGC) is practiced in 28 African countries; infibulation is practiced in nine African countries. Six unsuccessful approaches to ending FGC are reviewed: cultural absolutism, cultural relativism, health education, feminism, human rights legislation, and psychosocial approaches. Two successful programs that have resulted in communities abandoning FGC, including Tostan in Senegal, are described. Successful programs are community-led, aim to change social norms in the whole community, and empower women. Governments and NGOs should use community-led programs based on participatory methods as recommended interventions in order to promote community-wide abandonment of FGC.

Key words: *female genital cutting, cultural relativism, health education, feminism, human rights legislation*

This paper will compare the characteristics of two successful programs to end female genital cutting (FGC) with six unsuccessful approaches to ending the practice. The purpose of the paper is to suggest that there are successful approaches to ending FGC, they are reproducible, and they should be employed as recommended interventions.

The World Health Organization defines three major types of FGC: clitoridectomy, excision, and infibulation. Clitoridectomy involves partial or total removal of the clitoris. Excision involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Infibulation involves excision of the labia minora and the labia majora, and stitching together the remaining tissue, leaving a seal over the vagina, with a posterior opening that

may be as small as a matchstick or as large as 3 cm. in diameter, for the passage of urine and menstrual fluids (World Health Organization [WHO], 2008). FGC may be done as early as infancy or as late as adolescence, depending on the culture.

Some type of FGC is practiced in 28 countries in Africa, as well as in parts of the Middle East, and among some groups in Asia (Asekun-Olarinmoye & Amusan, 2008; WHO, 2008; Yoder, Wang, & Johansen, 2013). This paper will focus on FGC in Africa. Although the worldwide prevalence of FGC is not known, Yoder et al. (2013) estimated that about 87 million women age 15 and above have been cut in 27 African countries and Yemen alone (p. 189). In some African countries, FGC is almost universal. For example, Yoder et al. (2013) reported the prevalence of FGC among women aged 15 and older as 98% in Somalia, 96% in Guinea, 93% in Djibouti, 91% in Egypt and Sierra Leone, 89% in Eritrea and Sudan, and 85% in Mali (p. 197). Infibulation is the major type of FGC practiced in Somalia, Djibouti, Eritrea, northern Ethiopia, and northern Sudan. It is also practiced in parts of Egypt, Gambia, Kenya, and Mali.

The practice of FGC in the Nile Valley and around the Red Sea is apparently of ancient origin. Female mummies from ancient Egypt show evidence of excision and infibulation, and in the fifth century B.C., the practice of FGC was reported by Herodotus (Caldwell, Orubuloy, & Caldwell, 2000). Thus, the practice of FGC in Africa predates both Christianity (which spread in North Africa after about 33 A. D.), and Islam, (which spread in North Africa after 632 A. D.) (Khaja, Barkdull, Augustine, & Cunningham, 2009). Although a significant percentage of participants believe that the practice of FGC is religiously based, religious scholars from both Christian and Islamic traditions report that there is no basis in either the Bible or the Qur'an for the practice.

Unsuccessful Approaches to Ending Female Genital Cutting

Outsiders from the global North have tried many approaches to end FGC, including "legislation, medicalisation (training health professionals to perform the procedure under sanitary conditions), religious condemnation, information, 'just-say-no' campaigns, educational efforts, and attempts

to institute alternative rituals"—all with little effect (Easton, Monkman, & Miles, 2003, p. 246). Six unsuccessful approaches will be discussed in this paper: cultural absolutism, cultural relativism, health education, feminism, human rights legislation, and psychosocial approaches. They will be contrasted with two programs that have successfully ended the practice of FGC in their communities.

Cultural Absolutism

Cultural absolutism describes an inability to be aware of a culture other than one's own, and a desire to impose one's culture on others. The essence of cultural absolutism is ethnocentrism—the attitude that the "natives" are "backwards"—all we need to do is tell them how much better our Northern culture is and they will recognize FGC as a "barbaric" practice and abandon it. One of the best known examples of this was the attempt to end FGC among the Kikuyu in Kenya (Caldwell et al., 2000). During the 1920s and 1930s, Protestant missionaries from Scotland mounted a major campaign against FGC. They declared that parents who "circumcised" their daughters would be banned from attending church and girls who underwent the procedure would be banned from attending school. This effort backfired so badly that historians believe it was one of the antecedents of the Mau Mau rebellions. Jomo Kenyatta, the founding father of Kenya, explicitly linked FGC to anti-colonial nationalism; the group circumcision ceremonies for girls became a symbol of the nationalist movement (Boyle, McMorris, & Gomez, 2002).

Cultural absolutism underlies many of the other unsuccessful approaches to ending FGC. Gruenbaum (2005) concluded that "Change strategies should be based not on the assumption that traditional beliefs are irrational and just need a good dose of public health education" (p. 435). Caldwell, Orubuloy and Caldwell (2000) concluded that one of the barriers to ending FGC is the sense in Africa that Northern demands for abandonment of FGC were "based on little more than foreign cultural aggression" (p. 238).

Cultural Relativism

The lack of success of religious condemnation led to a relatively quiescent period during the mid-20th century, when the

anthropological view of cultural relativism held sway. During the 1950s, the official view of the World Health Organization was that these "operations" on girls were "based on social and cultural backgrounds," and therefore WHO did not take a stand against them (cf. Boyle & Carbone-Lopez, 2006, p. 441; Caldwell et al., 2000, p. 240). Ethnographic work conducted in a number of societies showed that beliefs about FGC differed from culture to culture, and began to reveal the complexity and embeddedness of FGC. Ethnography continues to contribute to the discourse on FGC to the present day.

For example, among the Kikuyu in Kenya, FGC, usually clitoridectomy, is part of a group coming-of-age ceremony. Among the Kikuyu, membership in an age set is determined by communal circumcision ceremonies where a group of young women are initiated into womanhood. An uncircumcised girl would remain "a child forever" in the eyes of the tribe and could not marry (Caldwell et al., 2000, p. 245).

In Nigeria, the Yoruba believe that if an infant's head touches the tip of the mother's clitoris during birth, the child will die. Therefore, clitoridectomy must be performed in order for a daughter to be marriageable. If parents were to neglect circumcising their daughters, the daughters would be regarded as "abnormal or even monstrous," and the parents and their daughters would be social outcasts (Caldwell et al., 2000, p. 236, pp. 246-247).

A number of cultures in Northern and Eastern Africa have the belief that women are naturally promiscuous, and if left to their own devices will, like Eve, seduce men. Therefore, their sexuality must be controlled (Hassanin, Saleh, Bedaiwy, Peterson, & Bedaiwy, 2008; Manderson, 2004). For example, in Mali, people believe that

> a young woman's sexuality has to be controlled to ensure that she does not become over-sexed and lose her virginity, thereby disgracing her family and losing her chance for marriage. In fact, it is believed that because an "uncut" clitoris will become big, activities like riding a bike or a horse, or even wearing tight clothing will arouse an unexcised woman, who may then rape men. (WHO, 1999, p. 5)

Thus, FGC protects a young woman's virginity, family honor and the social order.

Ellen Gruenbaum has been doing ethnography on FGC in northern Sudan since the 1970s, when she first accompanied a midwife on her rounds. In Arab Sudan, "virgins are made, not born," through infibulation, which is called "purification" in the everyday language of villagers (Gruenbaum, 2006, p. 122). It is the responsibility of mothers to see that their daughters are infibulated. It is considered essential to remove the clitoris so that girls will be less "tempted" to behave promiscuously, and to create a physical barrier that makes sexual intercourse impossible. In addition, in this culture, an open vagina is considered to be loathsome and disgusting—dirty, hairy, smelly and unclean—the opposite of "pure." An open vagina is seen as physically repulsive; in contrast, the infibulated cover over the vagina, which is seen as "smooth," "clean," "neat," and "hygienic," makes a woman physically beautiful to her husband (Gruenbaum, 2005, p. 436).

Quotes from informants give a sense of the multiple meanings of infibulation. For example, an elderly woman said, "we do not want a girl who is easily used by every man, a girl with a big hole or opening" (Igras, Muteshi, Woldemariam, & Ali, 2004, p. 259). Another woman thought that the uninfibulated vagina would be "a large, gaping hole, capable of accommodating both penis and testicles" (Gruenbaum, 2006, p. 125). Another said, "We don't want the girl to be dirty, open, with smelly underwear" (Gruenbaum, 2006, pp. 131-132).

Finally, in Arab Sudan, husbands are said to prefer the small, tight opening of a virgin (Gruenbaum, 2005, p. 437). At marriage, a girl who has been infibulated must be "defibulated," or cut open, before first intercourse. Or, if the opening is large enough, sexual intercourse can take place after gradual dilatation, which may take months. It is assumed that sexual intercourse will be painful for the wife (Gruenbaum, 2006, p. 127). Traditionally, the midwife re-infibulates the woman after giving birth, so that she will be pleasing to her husband (Gruenbaum, 2006, p. 121).

Although a great deal has been learned about the cultural meanings of FGC from field work conducted by anthropologists, the perspective of cultural relativism informs, but does

not end, FGC. For example, in 1980, Dr. Mahnaz Afkhami, Executive Director of the Sisterhood is Global Institute, said,

> I have seen a lot more sensitivity from Northern feminists in the last few years, but … sometimes their attempts at cultural awareness and sensitivity can go too far, as we see among those Northern women who say that female circumcision is just another cultural practice. (Spadacini & Nichols, 1998, p. 45)

Health Education

Sometime during the late 1970s, the health education approach to ending FGC began. By 1982, the World Health Organization (WHO) had changed its position and adopted FGC as a major health concern (Easton et al., 2003, p. 446). In essence, the health education approach was overlaid on top of cultural relativism. The health education approach did not tell people that their culture was bad per se, or condemn FGC outright. It just informed them of the medical consequences of FGC. The assumption was that once people knew the facts, they would stop practicing FGC (Shell-Duncan, 2008).

Health education stressed the fact that because practitioners used unsterilized instruments such as "sharp stones, broken glass, scissors, or unsterilized razor blades, without anesthesia," to cut girls, the girls experienced pain, bleeding, and infection, and occasionally died (WHO, 1999, p. 37). For example, Spadacini and Nichols (1998) described an education program for secondary school students conducted in Ethiopia during the early 1990s, in which FGC was approached "from a reproductive health perspective, as this is the only way people in the field are likely to listen," according to Dr. Dahab Belay, a health consultant on the project (p. 47).

Educational programs on the negative medical consequences of FGC were tried in several African countries, including Egypt, Ethiopia, Kenya, Nigeria, and Sudan. The results were consistent and unexpected. Researchers discovered that conducting an educational program "focusing on the short-term risks of genital cutting, such as bleeding, infection and pain, has apparently had the unintended result of promoting the 'medicalization' of FGC, rather than its abandonment" (Sedgh, Jackson, & Ibrahim, 2005, p. 426). For example, in Sudan,

trained midwives "were by the end of the 1980s performing 36% of all female circumcisions [infibulations]" (Caldwell et al., 2000, p. 246). In Nigeria, "female circumcision has become the province of the trained nurse, working outside her normal hours, and, for many, has become an important supplementary source of income" (Caldwell et al., 2000, p. 246). In Egypt, it is estimated that about 58% of all female circumcisions are conducted by physicians and trained nurse-midwives (Boyle & Carbone-López, 2006, p. 454). Askew (2005) argued that since medicalization "provides a financial incentive for health providers to take up the practice," it is much more difficult to eliminate FGC where it has been medicalized (p. 469).

Obermeyer (1999) stated that while the problems of pain, bleeding and infection resulting from FGC have always been recognized, problems with labor and delivery were anecdotal and poorly documented. In a prospective study of more than 28,500 women giving birth in health care facilities in six African countries, the World Health Organization (2006) found that women who had undergone FGC had higher morbidity and mortality during childbirth than those who had not, and that the more extensive the FGC procedure, the higher the risk to both mother and infant. Women who had been infibulated had the highest risks. The study concluded that "deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death than deliveries to women who have not had FGM" (WHO, 2006, p. 1839). In addition, there is evidence that infibulations may affect primary fertility (Almroth et al., 2005).

Some argue that medicalization has resulted in "harm reduction"—surely FGC performed under sterile conditions with anesthesia is preferable to FGC performed with a shard of glass—and that medicalization has resulted in the substitution of "Sunna" circumcision (excision) for infibulation in some areas (Antonazzo, 2003, p. 475; Shell-Duncan, 2001). However, it is clear that health education alone does not result in the abandonment of FGC.

Feminism

Another approach to ending the practice of FGC was the feminist view that FGC was a "tool of patriarchy and a symbol of women's oppression" (Boyle & Carbone-López, 2006, p. 441). Fran Hosken is often credited with turning FGC into an international feminist issue. She published the first Hosken Report on FGC in 1979, and made FGC a feminist issue by featuring it prominently in the Women's International Network News (Gruenbaum, 2005; Johnsdotter, 2012; Manderson, 2004). Hosken is also credited with re-framing the term "female circumcision," which implied that FGC was analogous to male circumcision (which does not impair sexuality and has no long-term medical consequences), as "female genital mutilation" (FGM) (Johnsdotter, 2012; Obermeyer, 1999, p. 80).

While the feminist rhetoric of Hosken and others captured the attention of the global community, it was highly controversial (Boyle & Carbone-López, 2006, p. 442). African women rejected the feminist view (Antonazzo, 2003, p. 472). They considered the term, "female genital mutilation," to be offensive (Khaja et al., 2009; Manderson, 2004, p. 288). They pointed out that FGC is done by women (not men), for women, so that women can take their rightful place in society as wives and mothers. They flatly rejected the Northern view of women as sexual beings who were entitled to sexual choice and sexual pleasure. As Gruenbaum (2005) explained, women from cultures that practiced FGC valued "security, a husband's love, a stable marriage, and socially approved child-bearing over sexual orgasm" (p. 437). In 1980, African women boycotted a session featuring Hosken at an international women's conference, calling her perspective "racist," "ethnocentric," and "insensitive to African women" (Boyle & Carbone-López, 2006, p. 441).

Human Rights Legislation

Feminist advocacy against FGC, however, was not an isolated issue; it was part of a general feminist movement towards equal rights for women. During the 1970s, the argument that there was a relationship between gender equality and human rights gained ground (Boyle & Carbone-López, 2006, p. 442; Igras et al., 2004, p. 253). In 1979, the Convention for the Elimination of Discrimination Against Women (CEDAW),

which outlined a basic set of principles pertaining to gender and human rights, was adopted by the United Nations (Manderson, 2004, p. 285).

By the 1990s, the campaign against FGC was being framed as an issue of women's rights. A female child's right to be free of FGC, along with other kinds of violence against her person, was legally guaranteed in the United Nations Convention on the Rights of the Child (UN CRC), which came into force in 1990. In 1995, a Joint Statement of WHO, UNICEF, the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP) declared that framing FGC as a medical issue had been a 'mistake,' and asserted that women had a right to bodily integrity, which was interpreted as including the right to remain whole and unmutilated (Boyle & Carbone-López, 2006, p. 443). The Fourth World Conference on Women, held in Beijing in 1995, declared that women had the right to self-determination (to choose whether to have sex, marry, or have a child), and to be free from violence (including cultural practices such as female genital mutilation) (Manderson, 2004, p. 286). Thus, by 1995, female genital mutilation had been re-framed as a form of violence against women, like sexual assault and wife-beating. And in 1996, the U.S. passed legislation requiring countries to ban FGC in order to receive U.S. aid (Boyle et al., 2002). Ultimately, the women's human rights movement led to the adoption of the African Maputo Protocol on the Rights of Women in 2005 by the African Union.

The result of these international agreements was the passage of national legislation to ban FGC. Eventually, 27 of the 28 countries in Africa in which FGC is practiced ratified the UN Convention on the Rights of the Child (CRC) (Boyle et al., 2002, p. 6; Ngokwey, 2004, p. 186). Consequently, by the end of the 1990s, national legislation to ban FGC was put into place by all African countries except Somalia, which did not have a functional government. Ochaita and Espinoza (2001) point out that "the Convention [on the Rights of the Child] is not a mere declarative text, but rather a legally-binding instrument," that obligates all states that ratify the Convention to abide by its provisions (p. 330).

However, the approach of using legislation to end FGC has been largely unsuccessful. WHO (1999) concluded that,

despite bans on FGC at the national level, local practice of FGC remained largely unaffected. A large study in Egypt supported WHO's findings. Egypt already had a national law banning FGC, but in 2000, the law was strengthened so that health-care providers accused of performing FGC were penalized with three years of imprisonment, even if consent had been provided by parents (Hassanin et al., 2008). Hassanin et al. (2008) wanted to know if the new legislation had been effective in decreasing the incidence of FGC. Six years after the new law came into effect, they conducted a study of 3,730 girls attending middle schools in urban and rural Upper Egypt. They found that about 86% of girls aged 10-14 had been cut during the six years since the enforcement of the FGC ban began. They concluded that the new law had virtually no effect on the rates of FGC.

Devereux and Cook (2000) argued that anti-FGC legislation at the national level has not been very successful in eliminating FGC because such laws constitute another attempt to impose "fundamentally Northern concepts and programmes" on the global South (p. 64). They believe that anti-FGC legislation imposed at the national level will be unsuccessful as long as local institutions do not support it. Even in countries like Egypt, where national governments actually want to end the practice of FGC (as opposed to merely fulfilling the requirements for aid), North (1990) noted that "creating a system of effective enforcement … is a long, slow process that requires time to develop if it is to evolve—a condition markedly absent in the rapid transformation of Africa from tribal societies to market economies" (p. 60).

In addition, as with the health education approach, there were unexpected consequences to imposing national anti-FGC legislation (Kelleher & Franklin, 2008). At the local level, Antonazzo (2003, p. 474) found that when Senegal imposed anti-FGC legislation in 1999 in order to comply with U.S. aid requirements, criminalization seriously hampered Tostan's successful grassroots program to end FGC. Antonazzo (2003) concluded that:

> Making genital cutting illegal not only does not stop the practice, but it also turns everyday women and

> girls into criminals. It bars women with genital injuries from seeking life-saving help. Even worse, outright criminalization creates a backlash where even more girls than before are having their genitals cut at younger ages, and successful local efforts to end the practice are undermined and rendered temporarily ineffective. (pp. 476-477)

Shell-Duncan (2008) further argued that criminalization due to legislation takes away women's rights to make their own choices. Therefore, she concluded that "efforts to end FGC through a human rights framework" by legislating against it can be seen as being in opposition to the goal of women's empowerment (Shell-Duncan, 2008, p. 231).

Psychosocial Approach

Keleher and Franklin (2008) call the sixth of the unsuccessful approaches to ending FGC the "psychosocial" approach. The purpose of the psychosocial approach is to change attitudes towards FGC. For example, in 2000, CARE decided to reorient their FGC abandonment programs to a "rights-based" approach in order to "play a larger and more direct role in facilitating social change" (Igras et al., 2004, pp. 251, 256). They decided to move from defining FGC "solely as a traditional practice with serious reproductive health consequences," to defining FGC as "an issue of human rights and gender violence" (Igras et al., 2004, p. 253). CARE's goals included empowering women by expanding education to include social and rights messages (Igras et al., 2004).

To implement this new strategy, CARE developed a series of education and advocacy messages about the negative social and health consequences of FGC (Igras et al., 2004, p. 263). Then, they conducted a well-designed intervention using a quasi-experimental design with a treatment and a control group. The attitudes of Somali refugees (who practiced infibulation) in two refugee camps at Dadaab, Kenya were assessed before and after the intervention. Over an 18 month period, using advertising and mass communication campaigns, they presented FGC as a violation of women's human rights in the intervention refugee camp. No educational campaign was conducted in the other refugee camp.

As with other unsuccessful approaches, the results were unexpected. The project evaluators found that "significant changes over the baseline measure have occurred in knowledge of the harmful health, social, and psycho-sexual consequences of FGC" in the intervention camp (Igras et al., 2004, p. 264). However, they were surprised to find that "there was no significant increase in the number of people wanting to end the practice" in the intervention camp (Igras et al., 2004, p. 264). Indeed, the few families in the intervention camp that decided not to circumcise their daughters were subjected to severe social pressure. Igras et al. (2004) reported that:

> Other people in the project communities, the majority of whom wanted the practice to continue, started to exert social pressure and show their disapproval of families and individuals that wanted FGC to end. Several families moved from one refugee camp to another in an attempt to escape this social pressure. Families and girls who decided not to undergo female circumcision came to CARE and other agencies to ask for help and protection. (p. 264)

In other words, changing attitudes alone did not stop the practice of FGC. Those who tried to change their behavior as a result of their change in attitudes were subjected to severe social pressure.

The problem with the CARE approach is that while changing attitudes is necessary, it is not sufficient. Beliefs about FGC are socially constructed. They are culturally enacted by communities as a whole. Since they are culturally normative, they are enforced through social sanctions (cf. Imoh, 2012). Therefore, a focus on changing individual attitudes one person at a time will not achieve FGC abandonment. In order to stop the practice of FGC, the attitudes of the whole community need to change. What is needed is a successful model for sustainable change at the community level that can be reproduced.

Successful Programs to End FGC

Two programs have been successful in ending the practice of FGC: one from Ethiopia, and one from Senegal. I first encountered the Ethiopian program in 2008 in Muketuri, a rural

village in Amhara State, about 3 hours north of Addis Ababa. The story of this program is as follows.

In 1999, the German Foundation for World Population (DSW) funded the development of a course on Adolescent Sexual and Reproductive Health (ASRH) in Ethiopia. The program was written by an Ethiopian physician, and produced in Amharic and Oromo, the two most widely spoken languages in Ethiopia. The course included the usual components on sexual health, including prevention of HIV. It also included information on the consequences of three "harmful traditional practices" common in Ethiopia—FGC, bride abduction and early marriage. Then, the international NGO (DSW) turned the program over to an Ethiopian NGO, the Professional Alliance for Development in Ethiopia (PADET). PADET decided to start the program in Muketuri and hired a local young man to lead the program in 2000.

The program goal was to 'Save a Generation from AIDS.' The program design was to start an ASRH club in Muketuri, with a target audience of young adults from 13 to 29. In order to join the club, the young adults had to complete the ASRH course, be willing to lead community discussions and participate in other educational activities, and ultimately learn to teach the full course to others.

Initially, progress was slow. Condoms and other birth control methods were displayed during the course. Frank and open discussion of sexual matters was not customary in the community, especially for young women. Only a few young men attended the course. So, the program director met with community leaders, including village elders, the Muslim imam, the Ethiopian Orthodox priest, and parents, explaining the urgency of protecting the young from AIDS through education. Gradually, he made headway among community leaders and parents, who allowed their young people to attend.

Over time, the number of young people (including young women) in the community who completed the course increased. Graduates taught more sessions of the course and conducted educational activities, and an increasing percentage of community members were exposed to information on sexual and reproductive health issues. Club members built an ASRH community education center, which housed a health clinic with a full-time nurse, who is funded by the Ethiopian

health ministry, and participated in fund-raising projects for club activities. New ASRH clubs were started in several adjacent communities.

Although the primary goal of the program was reducing the incidence of HIV–AIDS, club members also participated in many discussions of FGC. Eventually a consensus was reached. In 2005, with support from many community members, including parents, religious leaders, and the women who had formerly been practitioners of FGC, the village elders decided to end FGC in Muketuri. (They also decided to ban bride abduction and the marriage of young women before age 18, other harmful traditional practices covered in the ASRH course.) Since then, several other villages in the area that have ASRH clubs have also decided to follow Muketuri's example and abandon FGC.

The second example of a successful program to end FGC is Tostan in Senegal. It is much larger than the program in Muketuri, and far better known, but in its beginnings it bears considerable similarity to the Ethiopian program. The word "tostan" is Wolof for 'breakthrough' or 'coming out of the egg.' The original program goal was to provide problem-solving skills to rural women in Malicounda-Bambara, an area where men worked as migratory labor in another country for most of the year. Initially, the Tostan program focused on literacy and teaching women the skills they needed to design their own projects as a means of addressing village needs. But then, Tostan added new modules on human rights and on women's health that included sessions on women's sexuality and FGC. Attendance at these sessions on women's health and women's human rights "broke all records, and lessons were disseminated by word of mouth around a much broader community" (Easton et al., 2003, p. 448). UNICEF provided funding for educational materials and most of the facilitator's salary, while the village provided food and housing for the facilitator and the remainder of the facilitator's salary (Easton et al., 2003, p. 446).

The outsiders who developed the original program thought that the women in the village would use their new collaboration and problem-solving skills to meet village needs by developing small livestock projects, well-baby clinics or improving village sanitation or the local water supply (Easton et al., 2003). However, when the women in Malicounda-Bambara

met to decide which village problem they wanted to address, the women chose something entirely unexpected.

They decided that their first priority was to end FGC once and for all. They discussed the issues with neighbors, local religious leaders and village elders. On 31 July 1997, the villagers of Malicounda-Bambara held a press conference in front of 20 Senegalese journalists and declared that they were renouncing the practice of FGC. The declaration was broadcast on national television and radio (Easton et al., 2003). Almost immediately, two nearby villages decided to join with Malicounda-Bambara and end FGC.

Soon thereafter, an imam from a neighboring community— who initially came to convince the women of Malicounda-Bambara that they were wrong, but eventually decided to support them after discussing FGC with the women in his own household—gave them some wise counsel. He advised the women to go to visit friends and relatives in nearby villages in the inter-marrying community, and said,

> Do not tell the villagers what to do, but rather what Malicounda-Bambara and Nguerigne-Bambara have done, and why. Then let them tell their own stories and make their own decisions. Avoid using graphic terms or demonstrations for taboo activities. Refer to FGC simply as 'the custom,' as everyone knows what is meant … Avoid condemning … practitioners … for practices they have been performing in good faith. (Easton et al., 2003, p. 449)

In less than a year, 13 inter-marrying villages around Malicounda-Bambara pledged not to cut their daughters. Since then, Tostan has offered the Community Empowerment Program to villages all over Senegal (Easton et al., 2003, p. 451). Not every village decides to end FGC. However, Tostan reports that since 1997, more than 5,500 villages in Senegal, and 1000 villages in neighboring Guinea, Burkina Faso, and other West African countries, have joined the women of Malicounda-Bambara in abandoning FGC (Tostan, n.d.). As in Muketuri, ending FGC was not one of Tostan's original program goals. Nevertheless, a social movement has begun in Senegal.

Characteristics of Successful Programs

Comparing two successful programs to end FGC with the six largely unsuccessful approaches suggests that successful programs have several factors in common. Most programs, including the unsuccessful approaches, convey information about the harmful effects of female genital cutting. However, in addition, the successful programs share three other factors. First, they are community led, not externally driven. Second, they focus on changing social norms at the community level, rather than changing attitudes at the individual or family level. Third, they empower women (cf. Rahlenbeck & Mekonnen, 2010; Shell-Duncan, 2008).

Community-led. The first characteristic of successful approaches to FGC abandonment is that they are community-led (Antonazzo, 2003, p. 475). Community-led change requires full participation, results in the community defining their own needs (Devereux & Cook, 2000), and requires that outsiders hand over control to members of the community (Chambers, 1997). The idea of full participation comes from a set of methods, originally called Participatory Rural Appraisal (PRA), designed to empower the poor and marginalized people of a community to define their own needs, and decide on their own priorities for community development (Kumar, 2002). The goal is for outsiders to 'hand over the stick,' not to the local elite, but to a local facilitator whose aim is to let the villagers, including women, the disabled, and the socially marginalized, make decisions for themselves (Kumar, 2002).

In order to succeed, PRA methods require that outsiders turn over control to the community. Chambers (1997) stated that relinquishing control to the community requires that outsiders step aside and trust communities to make their own decisions. Chambers (1997) described this as difficult, but possible:

> to put the last [the poor and marginalized] first is the easier half. Putting the first last is harder. For it means that those who are powerful have to step down, sit, listen, and learn from and empower those who are weak and last. (p. 2)

Trusting the community to make its own decisions is equally difficult for outside "experts," but it is the essence of

empowerment. Chambers stated that "much of the [participatory] rhetoric has been cosmetic and hypocritical as advocates and practitioners have failed to realize the need for personal and institutional change" (as cited in Kumar, 2002, p. 15). In both Muketuri and Malicounda-Bambara, facilitators who were members of the community presented educational information, including information on the harmful effects of FGC. At that point, they stepped back. Villagers could decide to discuss the new information with others, or let it drop. Whether the community decided to end FGC was truly left up to the community. In other words, outside NGOs turned over control to the community. These successful programs to end FGC were community-led, rather than imposed from the outside.

Community-level change. The second characteristic of successful approaches to FGC abandonment is that the goal is to change social norms at the community level, rather than to change attitudes at the individual level. The practice of FGC is driven by and enforced through social norms. As Keleher and Franklin (2008) stated, "FGM/C is a deeply entrenched social convention through which girls and their families acquire social status and respect. Failure to perform FGM/C may bring shame and exclusion" (p. 51). Therefore, change has to come one community at a time, not one individual at a time (cf. Antonazzo, 2003).

Mackie (1996) provided critical insight on this point. He showed that the practice of FGC serves the same social functions, and is enforced through the same social sanctions, as was foot binding in China. Like FGC, foot binding in China had been practiced for at least 1,000 years. Foot binding was said to enhance "womanliness," promote good health and fertility, and confer higher status. The tiny, 4 inch, bowed feet produced by foot binding were considered aestheticly pleasing and sexually desirable to a husband. At the same time, since women with bound feet could only hobble, bound feet were said to ensure chastity and fidelity. Mothers were responsible for producing the tiny feet so their daughters could marry well; it was unthinkable that a man would marry a woman with unbound feet (Mackie, 1996, pp. 1001-1002). The parallels with FGC are unmistakable.

Yet foot binding was eliminated in one generation in China (Mackie, 1996, p. 999). The critical innovation was pledge societies. If only one family failed to bind their daughter's feet, the

daughter would be unmarriageable, and the family would be social outcasts. So, the idea of pledge societies was introduced. When everyone in a marriage group pledged not to bind their daughter's feet, and not to marry their sons to girls with bound feet, the social sanctions were eliminated.

The problem that CARE experienced with their individually-based FGC abandonment program in Kenya was the issue of social sanctions. In the absence of change in the whole group, parents who decided not to have their daughter infibulated were violating such a strong social norm that they had to seek "protection" from CARE (Igras et al., 2005). Caldwell et al. (2000) observed the same issue in Nigeria.

> The real resistance now in Ekiti [a Yoruba area of Nigeria] to the abandonment of FGM, and probably elsewhere, is cultural in only a very specific sense, that of not behaving in the way most of the society does. Mothers are justifiably worried about their daughters being different, especially in such important matters as their 'femaleness,' being treated as different, feeling different, and being unmarriageable. (p. 251)

Thus, successful programs to end FGC seek change of social norms at the community level, within a marriage group (Antonazzo, 2003, p. 476). Since most African cultures are communally based, a community-based approach has the added advantage of being more culturally appropriate; members of the community will find such an approach more comfortable than an individually-oriented attitudinal approach.

Empowering women. The third characteristic of successful approaches to FGC abandonment is that they include female empowerment. The emphasis is on teaching women the skills they need to "improve their economic and social status, as well as their ability to participate in a process of community consensus around norms upholding the protection of the rights of women and children" (Shell-Duncan, 2008, p. 229). Both the PADET program in Muketuri, and Tostan, in Senegal, trained women to identify and resolve community issues, including, but not limited to, issues involving harmful traditional practices like FGC.

In summary, six approaches to ending FGC have been unsuccessful largely because they have failed to recognize the strength and power of gendered social norms. Like all social norms, the practice of FGC is a "collective cultural pattern with benefits and sanctions anchored in a broad system of social behaviour" (Easton et al., 2003, p. 453). Since FGC is a "collective cultural pattern," community-wide change must come from within, through literacy and empowerment of women influencing existing social institutions (Asekun-Olarinmoye & Amusan, 2008). However, despite the strength of social norms, culture is not static; it is dynamic. Beliefs about FGC are socially constructed and culturally enacted through daily life in communities. Therefore, Gruenbaum (2005) argued that change can and does occur, because "while cultural values are indeed powerful influences in structuring thought and action, human actors regularly critique their backgrounds, making choices that reinterpret their cultural and religious values" (p. 430).

Successful approaches to ending FGC will of necessity convey information about the harmful effects of FGC. However, in addition, in order to be effective, they must:

- Be community-led
- Change social norms at the community level
- Empower women

The two successful programs reviewed in this paper incorporate these characteristics. They respect local culture, employ participatory methods, and trust communities to determine for themselves whether and how they want to end FGC. As a result, both have been successful in ending FGC. These methods are reproducible and should be employed by international agencies and funders that are interested in ending FGC.

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