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Female genital mutilation: multiple-case studies of communication strategies against a taboo practice

Kyung Sun Lee
Iowa State University

Female genital mutilation:

Multiple-case studies of communication strategies against a taboo practice

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Kyung Sun Lee

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Program of Study Committee:
Eric Abbott (Major Professor)
Daniela V. Dimitrova
Robert Mazur

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ABBREVIATIONS

BAFROW The Foundation for Research on Women's Health, Productivity and the Environment

CEDPA Center for Development and Population Activities

EuroNet-FGM European Network for the Prevention of Female Genital Mutilation

FGM Female Genital Mutilation

FORWARD Foundation for Women's Health Research and Development

GTZ Deutsche Gesellschaft für Technische Zusammenarbeit

IAC Inter-African Committee

IEC Information, Education, and Communication

ICRH International Center for Reproductive Health

MYWO Maendeleo Ya Wanawake Organization

NGO Non Government Organization

NORAD Norwegian Agency for Development Cooperation

PATH Program for Appropriate Technology in Health

PRB Population Reference Bureau

SDC Swiss Agency for Development and Cooperation

UN United Nations

UNESCO United Nations Educational, Scientific, Cultural Organization

UNFPA United Nations Population Fund

UNICEF United Nations Children's Fund

USAID United States Agency for International Development

WHO World Health Organization

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I dedicate this thesis to those groups and individuals relentlessly working to eliminate FGM. It is my sincere hope that through them, this thesis will in any way assist the lives of the women in FGM-practicing communities.

ABSTRACT

This thesis examined female genital mutilation (FGM) in Africa and the global movement to eliminate the practice. Despite three decades of concerted efforts, behavior change of FGM-practicing population has been small. This thesis outlined international actions and how they influenced activities at the national and the local level.

A textual analysis of secondary sources revealed that the international community, guided by concerned UN organizations and large donor groups, define FGM as a violation of human rights and set a uniform goal to completely eliminate all forms of FGM. By coordinating actions not only at the international but also at the local level, any alternative being raised by cultural relativists is strictly ruled out.

However, an in-depth analysis of strategies implemented at the local level found that less attention has been focused on the effectiveness of messages that are being introduced to FGM-practicing communities. In particular, the case studies found that introducing the concept of human rights, in most cases, failed to succeed. The human rights argument did not correspond to the local reasons for practicing FGM. The case studies showed that the abstractness of the concept needs to be tailored to the realities and experiences of the FGM-practicing communities. A large majority of communication strategies and theories followed the traditions of the dominant paradigm. However, upon implementation, many lacked community-driven behavior change. Implementation of theories and strategies that take a participatory approach are suggested in order to evoke community-based and community-led solutions to FGM. Finally, this thesis suggests a decentralized model of behavior communication that permits greater flexibility of approaches to anti-FGM communication.

CHAPTER ONE: OVERVIEW

1.1 Introduction

Since first rising to the limelight in 1979[1], the global movement to eliminate female genital mutilation (FGM) today has reached the point of increased success in raising awareness about the issue but less so in behavioral change. A prominent example of increased salience of the issue is the pledge by governments to eliminate of all forms of FGM by the year 2010 and commemorating every February 6 as the International Day of Zero Tolerance to FGM. Such international development has sprouted widespread commitment to the issue, as can be witnessed through a survey conducted by World Health Organization (WHO), which indicated that 46 percent of the organizations cited international pressure as the reason for initiating FGM programs (WHO, 1999).

The concerted efforts have brought about promising results, such as community-wide abandonments of FGM and adoption of an alternative rite of passage without circumcising girls. Nonetheless, behavior change has been small and slow; the Demographic and Health Surveys show little decline in the prevalence of FGM (Yoder & Khan, 2008; Yoder, Abderrahim, & Zhuzhuni, 2004). In fact, over the last two to three decades, the total number of circumcised women has not been curbed (No Peace without Justice & Bonino, 2005).

According to the announcement made by the Program for Appropriate Technology for Health (1998) on the status of the FGM programs, “little attention had been given to the status of FGM programming, the types of behaviour change strategies being implemented,

[1] In Khartoum, Sudan, the World Health Organization held the first international conference on FGM.

their successes and failures, what lessons have been learned, and what support strategies are required if the elimination goal is to be achieved" (as cited in Skaine, 2005, p. 198). World Health Organization (WHO) also lists scientific-based program monitoring and evaluation, among others, as suggested agendas for future research (1998, p. 48). A critical reflection of intervention approaches to behavior change is needed at this point in order to impel the anti-FGM movement to a wider scope of behavior change.

1.2 Female Genital Mutilation: Health Consequences & Explanation of Persistence

Female genital mutilation is the collective term given to several different practices that involve the cutting of female genitals. A more embracing definition adopted by WHO includes "all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 2008, p. 4).

The surgical process of FGM is categorized into three types, according to the degree of invasiveness of the procedure to the female genital organs. The mildest form is referred to as *sunna*, meaning 'tradition' in Arabic (Mackie, 1996, p. 1002). This process involves "partial or total removal of the clitoris and/or the prepuce" (WHO, 2008, p. 4). The second type of operation, called excision, consists of "partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora" (WHO, 2008, p. 4). This form is said to have been invented by Sudanese midwives when the British colonizers outlawed infibulation in 1946 (Sarkis, 2003, para. 5). The most extreme form, or infibulation, involves "narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the

clitoris" (WHO, 2008, p. 4). The WHO has recently revised its grouping of FGM procedures by adding a fourth type, which refers to "all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization" (WHO, 2008, p. 4).

In many countries of Africa as well as in pockets of Southern Asia and the Middle East, this practice is a deeply ingrained social ritual, marking the status and readiness for marriage among girls and women. Its severe psychological and physical health threats have been widely documented by scholars and anti-FGM advocates. A study conducted in Sierra Leone found that 83 percent of all females undergoing circumcision are likely to suffer certain conditions that require medical attention at some time during their life (Koso-Thomas, 1987, p. 29). The reported health threats are not only immediate but also continuous, ranging from hemorrhage, urine retention, and possible HIV infection from repetitive use of surgical tools to maternal death and maternal morbidity, permanent damage to reproductive organs, and painful sexual intercourse. Psychologically, some women have been found to lose trust and confidence in caregivers, or suffer from depression and lack of sexual pleasure (FORWARD, 2002; WHO, 2008).

For any outside observer, what is probably the greatest paradox of FGM is that "parents and other family members are perpetuating a tradition that they know can bring harm, both physical and psychological, to their daughters" (UNICEF Innocenti Research Center, 2005, p. 11). FGM is a multifaceted practice that encompasses the overall social structure and the worldview of the practicing groups. The social mechanisms that work to maintain the practice are also deeply ingrained, so that breaking away from them would uproot the status quo of the society. In order to gauge the multiple facets of the practice, it is

necessary to draw a "mental map" from the perspective of the locals and perceive how particular ideas are woven among one another to firmly root FGM as a justified practice. Unlike common perception, "[t]he matter is not as simple as men oppressing women" (Lundquist, 2004).

At the core of the beliefs surrounding FGM is 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" (WHO, 1999, p.5). This quote expresses the multifaceted nature of the practice and its overarching power to shape the life of a female constituent in the practicing community. The statement also portrays one of the local myths surrounding female sexuality that justify the reason for removing the clitoris. The common beliefs are that an uncut clitoris will continue to grow, that it will poison the male penis and the baby upon contact, and that the clitoris equals the male penis and therefore, cutting it rids the masculinity to complete the feminine identity. However, in a culture where virginity is the utmost value in a bride, female circumcision symbolizes not only purification[2] but a high bride price. Marriage to a husband who is wealthy enough to pay a high dowry means economic and social security for the woman.

Nonetheless, FGM has surprisingly less to do with the patriarchal male-female relationship than the interests among women to maintain the practice. In addition to securing marriage prospects, FGM is an initiation process into womanhood through which the girl becomes accepted into the women's sphere. According to Robertson (1996), FGM was

[2] The Arabic term for FGM, *tahur*, translates to "purification" (Boyle, 2002, p. 24) and in other cultures, as "scraping the girls clean" (Lightfoot-Klein, 1989, p. 48).

traditionally a way to uphold the seniority structure and ensure continuance of gerontocratic women's groups.

This phenomenon indicates that older women are the most influential decision makers in having young girls circumcised. Previous researchers have identified paternal grandmothers and aunts who decide whether and when the girl would be circumcised (Skaine, 2005; Shell-Duncan & Hernlund, 2006). Interestingly, in cases of inter-ethnic marriages where an uncircumcised woman marries a husband who is already wedded to circumcised co-wives, the bride is said to be taken by the wives to be circumcised (Films Media Group, 1998; Shell-Duncan & Hernlund, 2006). The co-wives of the husband are also identified as powerful decision-makers.

Therefore, the psychological suffering seems to be as painful, if not greater, for those women who refuse to undergo circumcision. FGM is identified as a step towards consolidation of social identity, and refusing to do so will ostracize the woman from the community. Women who aren't cut are associated with invective terms and referred to as someone who is *immature*, *uncivilized*, and *unclean* (Shell-Duncan & Hernlund, 2006). In some societies, they are banned from participating in public events. Among the Masaai in Tanzania, an uncircumcised woman is never referred to as a mother, even if she has children, and in other ethnic groups, they are barred from important communal activities, including funerals (Boyle, 2002). Such strict enforcement mechanisms ensure adherence to the practice.

Religious prescription is another powerful enforcement mechanism. Many Muslims in FGM practicing communities steadfastly believe that the Koran requires both girls and

boys to be circumcised for spiritual purification (Teferra, 2004). Abiding by religious obligations is therefore another reason why the practice continues.

Taking into consideration the reasons for persistence of FGM and the worldview of practicing cultures is the first step toward behavior change interventions. Knowing that escaping from circumcision results in hardships that are stronger than the physical pain from the operation, for example, allows for a context-specific intervention that targets not only the girls who are prone to circumcision but intergenerational constituents of the community.

1.3 Overview of the Study

This study is organized as follows. First, a brief history of the anti-FGM movement will trace the evolution of the FGM discourse from a scientific health risk discourse to that of a violation of human rights. A closer look into an international non-government organization, Inter-African Committee, will shed light on how the issue has been shaped and addressed by a mainstream organization committed to eradicating FGM. The theoretical framework for this research follows, which covers the dominant paradigm and participatory approaches to strategic communication for behavior change.

The ensuing chapter will be dedicated to a comparative analysis of intervention approaches. Four multiple-case studies will investigate community-based strategies to eliminate the practice. This study takes an inductive approach by analyzing published material and working papers that report on anti-FGM interventions. This approach seems appropriate for the purpose of this study as it allows an in-depth examination into the unique characteristics of FGM and the context in which it is practiced. It will also enable a close examination of challenges and limitations facing the anti-FGM communication strategies.

By assessing the types of behavior change communication strategies that are being proposed or implemented, I hope to shed insight on the current limitations which the communication component of the transnational movement faces and recommend possible alternatives to further progress toward changing the behavior of those undergoing the practice of FGM.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL BACKGROUND

This chapter provides an overall history and context in which current anti-FGM principles and strategies have developed. It begins by introducing the distinct characteristics of FGM communication that separate the topic from related international health and/or human rights issues. Next, the chapter outlines the historical development and evolution of discourse surrounding anti-FGM communication. The subsequent overview of two paradigms of development communication and transnational advocacy networks, the Inter-African Committee in particular, sets the base for anti-FGM communication strategies to be discussed in Chapter four.

2.1 Distinctiveness of FGM Communication

Many behavior change strategies implemented in anti-FGM campaigns are adapted from the preceding campaigns against proscribed behaviors. However, familiarity with the factors that distinguish FGM from other health and reproductive practices, such as abortion, HIV/AIDS, and family planning, provides a clearer perspective of how to tailor the communication approach according to unique facets of the topic under scrutiny. The characteristics listed below are not mutually exclusive from other campaigned-against practices; most factors overlap at one point or another. For example, both FGM and family planning are considered "taboo" topics of communication. This allows adoption of models that have been modified to fit the "taboo" quality of family planning. Therefore, clear knowledge of a particular practice creates an opportunity for communication specialists and

researchers to look into campaigns designed to cater to similar characteristics within a range of practices rather than blindly adopting a complete model.

Taboo Communication

Anti-FGM communication falls under the range of a "highly taboo topic of communication." Specifically, taboo communication is referred to as the "category of message transfer in which the messages are perceived as extremely private and personal in nature because they deal with proscribed behavior" (Rogers, 1973, p. 62). The strong social norm associated with the practice makes it almost forbidden to speak of anything contrary to absolute adherence. Concerted efforts over the last decade by advocacy groups have opened up community-wide discussions and have rendered the issue easier to approach. Nonetheless, the privacy and sensitivity of the issue necessitates that the communications specialist gain the acceptance and trust of community members before addressing any FGM-related topic.

Collective Nature of Decision-Making

Planning a communication strategy to tackle FGM should take into consideration its collective nature of decision-making. For most cases, the decision to undergo FGM is not an individual choice. The decision-making power of the girls is minimal in an extended family, where the paternal grandmother is the gatekeeper to maintain peace and tradition within a family. Furthermore, as the average age of girls undergoing the operation has decreased substantially in some countries, they are less capable of expressing their opinions and rely on representation by the adults of the family (Yoder, Abderrahim, & Zhuzhumi, 2004). Studies have identified the principal decision-maker as the paternal grandmother or aunt (Skaine, 2006; Hernlund & Shell-Duncan, 2007). Another power of decision-making lies in the co-wives of the husband. If a bride who is wedded to an ethnic group that practices FGM, the

co-wives or female relatives of the husband are reported to arrange for the wife to be circumcised (Hernlund & Shell-Duncan, 2007; Hernlund, 2003). The third influential group of decision-makers involves peers, when a girl from a non-circumcising family spontaneously joins her friend for circumcision. Shell-Duncan and Hernlund's project (2006) in The Gambia found circumcised women among the Wolof, an ethnic group that does not practice FGM. Their research identified that some Wolof girls who intermixed with other ethnic groups that practice FGM participated in female circumcision, even without parental consent. Although the percentage of spontaneous involvement has continuously decreased in part due to anti-FGM advocacy efforts, traces of circumcised women are still found among the Wolof.

Multiple Stakeholders Involved

Multiple interest groups are involved in maintaining the custom. While the elder women serve as the gatekeepers of tradition to ensure that their progeny adhere to tradition, family members of the girls also support the practice to maintain the family honor and high bride price upon marriage. Religious leaders advocate the practice on religious grounds that FGM is a form of spiritual purification. For the village leaders, FGM establishes the power relationship among women and is a mark that grants political rights for women to participate in communal events and decision-making process. For the circumcisers, FGM is a profitable source of income. During a circumcising season in Uganda, a circumciser would surgically operate on up to 800 girls. For every girl, the circumciser receives 10,000 Shillings, equivalent to 6.11 US dollars (Lirri, 2008). In a country whose per capita income is an estimated $300 (World Bank, 2008), female circumcision serves as a highly lucrative

occupation, which even comes with other perquisites, such as beer, goats, chicken, and in some villages, prestige and fame (Lirri, 2008).

Socially Mandated

FGM is a practice that has been internalized by both men and women of practicing regions for thousands of years. It constitutes part of a ritualized rite of passage that marks the entrance into womanhood. A circumcised woman is accepted into the community as a mature, respected member, and not adhering to the practice often leaves the woman socially excluded by other women. It is a mark that shapes the individual as well as the group female identity and defines gender roles.

Not easily Observed

What is probably the greatest challenge for an anti-FGM project coordinator is that the results are never visible. Because physical examination is widely perceived to be unethical for research purposes, the inability to find tangible evidence jeopardizes the validity and reliability of statistical figures. Methodologies used in field research have also been questioned. In fact, a longitudinal study on the status of FGM in Ghana conducted by a self-reporting method has resulted in inconsistencies in prevalence figures (Jackson et al., 2003).

Practice Perpetuated by Women

Although anti-FGM advocates frequently center on male control of female sexuality as a major factor of persistence, FGM is a practice that is largely situated in the women's sphere and remains a female ceremony. In fact, for most practicing groups, men have very little role in the ritual and in many cases, do not prefer a circumcised bride (Films Media Group, 1998; Carr, 1997). A survey even found that higher proportions of men favor

abandonment of FGM than women in numerous African countries (Yoder, Abderrahim, & Zhuzhuni, 2004, p. 44). It is the women who organize and regulate the ceremonies, and it establishes their social positions. According to Robertson (1996), historically, FGM was a way to effectively structure the age-grade system established upon initiation and strengthen gerontocratic women's organizations. It also solidified friendship as women survived the ordeal together. Today, women demand FGM as it remains one of the few social spheres over which women have any control. Therefore, discourse that continuously blames men and denies the agency of women may be counterproductive.

Problem Defined by Western Feminists

As a transnational social movement, the anti-FGM movement is characterized by having its problem definition originate from the outside and flow inwards, mainly by Western feminists. As a problem defined from the outside, framing the issue to catch the attention of international supporters has been the central mission for the activists. The following section closely examines how Western feminists, after decades of advocacy, were able to bring this issue into public light.

2.2 International Advocacy: Evolution of anti-FGM Discourse

Although the FGM controversy was recorded as early as the early 1900s (Keck and Sikkink, 1998; Prazak, 2007; Robertson, 1996), awareness of the practice outside the affected regions was limited to some medical experts and anthropologists (Keck and Sikkink, 1998). Since then, the nature of the debate inherent in female genital mutilation has evolved parallel with changing international norms and perceived legitimacy of the political discourse. Thus, for activists involved, timeliness has always been a crucial factor that determined whether the

message will rise to the public agenda or die out in the debate. Choosing a timely moment to "'frame' issues to make them comprehensible to target audiences … and to 'fit' with favorable institutional venues" largely determines the success of their efforts (Keck & Sikkink, 1998, p. 3).

Early attempts to address FGM as a "tool of patriarchy and a symbol of women's subordination" by Western feminists lacked such timeliness. It aroused conflicts with both African feminists and international organizations. The human rights violations inherent in FGM were first brought to the attention of the world community by the UN in 1958 in the context of the Universal Declaration of Human Rights formulated three years before. However, it was opposed by international organizations that refused to address human rights and gender relations issues, which were considered to be domestic matters. Addressing the issue without explicit invitation by the concerned government would impinge on the sovereignty of the nation. Despite the UN's urge to investigate the prevalence and health threats of the practice, WHO refused to study FGM claiming it was "social and cultural rather than medical" in nature (UN Yearbook, 1959, 205). At the same time, heated conflict continued between feminists from the two regions. The African counterparts strongly protested against the imperialistic perspective of the Western feminists toward African women as lacking in autonomy. Nahid Toubia, a Sudanese surgeon and anti-FGM activist commented,

> Over the last decade the … West has acted as though they have suddenly discovered a dangerous epidemic which they then sensationalized in international women's forums creating a backlash of over-sensitivity in the concerned communities. They have portrayed it as irrefutable evidence of the barbarism and vulgarity of underdeveloped countries… [and] the primitiveness of Arabs, Muslims, and Africans all in one blow (1988, p. 101).

Thus, despite numerous campaigns waged by a network of women's and human rights organizations, including renaming the problem from female circumcision to a more dramatic term of "female genital mutilation" by Fran Hosken, an outspoken feminist and founder of Women's International Network, the discourse failed to score high on the public agenda.

Instead, a 'safer' scientific health discourse was adopted at a WHO seminar on traditional practices affecting the health of women and children, held in Khartoum in 1979. As a result of this event, the issue of female genital mutilation conveniently found its place under the label of "practices affecting the health of women and children" alongside the birth control movement. The medical frame, which appeared more apolitical and neutral than the human rights frame, looked at FGM as a source of multiple health risks. Most importantly, "health rhetoric permitted a compromise between rights and sovereignty" (Boyle, 2002, p. 48). Thus, message and intervention strategies opposing FGM throughout the 1980s up to 1990 were dominated by the health risk frame.

The high rate of medicalization of FGM in many countries mirrors this initial discourse surrounding FGM. In Egypt, whereas 79 percent of mothers are circumcised by trained medical personnel, 94 percent of daughters are circumcised through medical procedures (UNICEF, 2005). The medical discourse treated FGM as an isolated problem and was not successful in rooting out the practice or tackling the perceptions underlying the practice.

The transition of anti-FGM discourse, from medical-scientific to human rights and gender equality, coincided with an increase in international attention to women's issues. The increase in nations supporting resolutions such as those put forward by the Convention on the

Elimination of All Forms of Discrimination Against Women (CEDAW) is an example. Whereas only 22 countries ratified the resolution in 1981, the number grew to 170 countries by 2002 (UNICEF Innocenti Research Center, 2005). CEDAW advises action against "cultural practices in the context of unequal gender relations" (UNICEF Innocenti Research Center, 2005, p. 15). Another instrument that provided a foundation for the human rights discourse is the 1989 Convention on the Rights of the Child (CRC), which "makes references to 'harmful traditional practices' in the context of the child's right to the highest attainable standard of health" (UNICEF Innocenti Research Center, 2005, p. 15). The issue has gained further salience through mass media coverage. In 1994, CNN broadcast footage of the circumcision of a 10-year-old Egyptian girl by a village practitioner. This program, which drew international attention to the operation, led to a $500 million lawsuit brought against CNN for allegedly damaging Egypt's reputation (Boyle, 2002). Although the court denied the lawsuit, the coverage and ensuing events led to heightened awareness and debate on FGM.

Although numerous events led up to the transformation of the discourse surrounding FGM, the milestone to the violation of human rights discourse took place in 1995 when the joint statement of WHO, UNICEF, UNFPA, and UNDP labeled the medical basis for anti-FGM policies a "mistake" (Boyle, 2002, p. 55). With the dissemination of apology statements for the treatment of FGM as a medical issue, international organizations started to address violence within the private sphere as a public issue (Boyle, 2002). Movement actors strategically framed FGM as a form of violence against women, grouping FGM with other forms of violence against women, such as battering and rape. While state involvement with problems within the private sphere (such as family violence) was once avoided, both

government and non-government organizations started to mobilize toward human rights protection. Today, problems associated with the practice of FGM have been defined from various perspectives. Dorkenoo (1994) classifies FGM as a violation of the rights of women, the rights of children, the rights to good health, and the rights to development.

2.3 Two Paradigms of anti-FGM Communication

This study examines an issue that crosses many areas within the development communication agenda. Its means to achieve the end differ according to the organization committed to the issue. Therefore, in order to better understand the strategies implemented by the organizations in action, a brief explanation of the two veins in development communication follows.

The definition of development communication widely varies according to its approach and objective, but it can be summarized as "strategic application of communication technologies and processes to promote social change" (Wilkins, 2000, p. 197), with the ultimate goal to "raise the quality of life of populations, including [to] increase income and well-being, eradicate social injustice, promote land reform and freedom of speech, and establish community centers for leisure and entertainment" (Melkote, 1991, p. 229).

Development studies originated from the Post-World War II efforts to assist less-developed countries or the previously colonized to perform on par with the developed North. The communication component in development efforts has been traditionally overshadowed by other counterparts – economic, agricultural and sociological – attributed in part to the absence of a communication requirement in donor agencies that frequently shape the development projects (Agunga, 1997). Despite the difficulty in incorporating communication

theories to development efforts, two branches of communication frameworks have emerged to encompass the field: the dominant paradigm and the participatory approach.

The Dominant Paradigm: Informing and Persuading toward Development

At the center of the dominant paradigm's philosophy was that the problem of development in the developing countries was due to lack of information. Equating development with the national per capita income, it believed that transmission of information from those who have achieved rapid economic growth downward to those who have not would lead to adoption of "modern" ideas and values by the less developed countries. For early development researchers, notably Lerner (1958) and Schramm (1964), media technology was a promising means to achieve this goal through transmission of pro-modernization information in the media. This, in turn, would foster vicarious learning that would eventually be emulated by the receivers.

Although only a certain degree of correlation was demonstrated between media exposure and economic development (Rogers, 1976), the effectiveness of using mass media as a tool to bring about development was largely assumed as can be witnessed by the statistics of UNESCO (United Nations Educational, Scientific and Cultural Organization), which set mass media penetration as an indicator of modern attitudes (Waisbord, 2000). In his seminal article, *The Passing of the Dominant Paradigm*, Rogers concluded that top-down, one-way linear form of communication was "indirect and contributory, rather than direct and powerful" to fostering development (Rogers, 1976, p. 135)

The diffusion of innovations is perhaps one of the most influential theories of the dominant paradigm and is also widely supported by anti-FGM communication specialists.

According to its leading proponent, Everett Rogers, "Diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system" (2003, p. 5). The diffusion model was formulated under the premise of the dominant paradigm that lack of information or knowledge is at the root of underdevelopment for Southern countries (Waisbord, 2000). Therefore, the role of communication was both transfer of information and persuasion, and exposure to mass media was a factor that could, through vicarious learning experience, bring about modernization (Lerner, 1958).

Diffusion researchers proposed five stages in individual experiences in the adoption of innovations process: awareness-knowledge, persuasion, decision, implementation, and confirmation (Rogers, 2003, p. 161). While the media can raise awareness and knowledge, the diffusion researchers concluded that interpersonal communication is what encourages the decision to adopt a new behavior (Rogers, 2003). The diffusion model also segments its audience into five groups, according to their inclination to adopt an innovation and the characteristics of each group. The *innovators* are the venturesome group that introduces an innovation. Rogers claimed that opinion leaders, who are located in the center of a network and therefore hold the influence to disseminate an innovation in a community, are a part of the *early adopter* category (Rogers, 2003). The opinion leaders encourage further spread of an innovation to the eager *early majority* and the skeptic *late majority*. The last category is comprised of *laggards*, staunch traditionalists and the group which the diffusion wave may never reach.

Numerous mainstream advocates of FGM eradication have encouraged the application of the diffusion model (UNICEF, 2007; WHO, 1999). Based on the diffusion process of interactive innovations, they argued that reaching the critical mass or the “social

threshold in the diffusion process" is necessary for the idea of FGM abandonment to take off on its own. In essence, the traditional norm guiding FGM cannot be broken until a critical number of the community population decides to stop the practice (UNICEF, 2007; TOSTAN, 1999).

An important discovery of the diffusion research was that change was not motivated by economics, but rather by communication and culture (Waisbord, 2001). This finding led to increased integration of literacy programs and health issues in development programs. Health and human rights education was also conducted by anti-FGM organizations teaching various stakeholders about the health implications of FGM and its violation of human rights. The instructions were based on findings from diffusion research that transmission of knowledge results in changes in attitude, which is eventually reflected through behavior change. However, two decades of efforts have found that increases in awareness do not necessarily lead to attitude change (Hernlund & Shell-Duncan, 2007). While evaluation studies showed a sharp increase in awareness of the harmful effects of FGM, its prevalence has not waned much over the last two decades (WHO, 1999). Such evidence has led many evaluation studies to conclude that participatory methods that involve the whole community are needed to bring about behavioral change (Leye, Bauwens, & Bjälkander, 2005; NGO Networks for Health, 2000; WHO, 1999).

Participatory Communication: A More Effective Model?

There has not been a unified definition of the term participatory communication nor an established model, frequently resulting in a "conceptual fuzziness" of the concept that is so widely applied in intervention programs today (Huesca, 2000, p. 75). Despite the lack of

uniform definition, participatory communication has found its identity through a number of common characteristics and a set of norms guiding the approach.

First, participatory communication engages in a horizontal form of communication. It perceives people as dynamic actors who are actively engaged in social change. Therefore, the project planner approaches the site not with solutions but with questions. The role of the outside person upon arriving at the community is not to instruct or persuade, but to provide the people with the means to think about their present situation and how to go about their future. Community-wide dialogues are held to identify needs and how to go about addressing those needs.

Participatory communication values traditional modes of communication that focus on interpersonal communication. Supporting this standpoint are studies that found marginal and illiterate groups in developing countries prefer to communicate face-to-face rather than through mass media or one-way forms of communication (Okunna, 1995). Many FGM abandonment projects therefore prefer to utilize interactive, locally-available forms of communication.

However, designing and disseminating messages with the input of the local population takes considerably longer than testing a pre-constructed strategy. Because learning to be sensitive to the cultural environment, opening a community-wide dialogue, and coming up with a locally devised strategic solution is not a quick process, most participatory communication projects require a long-term commitment. Some require multiple returns to the site that last for years.

Despite the long, arduous process, participatory projects frequently result in creation of a sense of ownership by the beneficiaries of the problem-solving process and results. This

quality is indispensable, particularly after the project planners have withdrawn from the community. Rather than becoming dependent on the outside for any problems that arise, community members are able to take it on with their own hands. This process, also labeled critical thinking, is what is ultimately installed into the minds of the beneficiaries. Thus, according to Calvelo, an ideal expert in participatory approach is someone who follows these stages, from "indispensable, necessary, useful, and once the initial goals are achieved superfluous" (as cited in Dagron, 2001).

Because of the emphasis on local participation in all stages of project implementation and using locally available means of communication, participatory communication is commonly labeled as a "bottom-up" approach. Ultimately, it serves to strengthen the democratic process of decision making and installs cultural pride and self-esteem in the community by attending to the voices of the individuals (Dagron, 2001). It also ensures sustainability unlike other costly top-down approaches that fail to continue after the project planners withdraw from the site.

However, there are many difficulties that challenge the procession of participatory communication projects according to the characteristics listed above. The first challenge is following the requirements and time frame set by donor agencies. Most donor agencies expect a proposal of strategies to be implemented upon entering the site as well as a specific time frame. However, participatory projects tend to take longer, and it is costly to train local moderators, such as peer educators and facilitators.

Moreover, there is no established model of participatory communication, and the resulting lack of replicability of projects complicates the implementation process. For example, out of the 50 case studies conducted by Dagron (2001) on participatory

communication programs that "made waves," none were quite the same. His study shows that there is not, or rather, cannot be one unified formula or blueprint of the participatory method, making the implementation process more difficult.

Others have also warned against a number of mistakes committed by the project planners in executing a participatory communication project. First is the naive treatment of the community as a homogenous entity devoid of any complexities surrounding any social structure (Dagron, 2001; Mohan & Stokke, 2000). Researchers emphasize the need for project planners to demystify the idealized vision of a community that is firmly united by its history or culture. Any community is a composite of divergent interests, complex power relations, and different socioeconomic status. Mohan and Stokke (2000) focus attention on situations in which neglect of power disparities have resulted in exclusion of the lower economic groups of people and decision makers in favor of the elites.

The process of community dialogue that seeks to enhance the democratic process may be just as disruptive to community traditions for those with different definitions of "democracy." Members who have traditionally not been involved in decision making may not be interested to do so. Commentators argue that participatory communication may seem just as foreign as the diffusion model and may be perceived to be pushing for pre-set goals and actions (Waisbord, 2000). In such situations, participation may run the risk of becoming an end rather than the means to bringing about change.

2.4 Transnational Advocacy Networks

Transnational advocacy networks refer to "forms of organization[s] characterized by voluntary, reciprocal, and horizontal patterns of communication and exchange" (Keck &

Sikkink, 1998, p. 8) who "work internationally on an issue … bound together by shared values, a common discourse, and dense exchanges of information and services" (Keck & Sikkink, 1998, p. 2). Keck and Sikkink (1998) explain how transnational advocacy networks operate and the conditions under which they have influence. According to the authors, the uniqueness of a transnational network can be found in advocacy – to promote causes, principled ideas, and norms. Most constituents of the anti-FGM movement are neither those who are directly affected nor those who feel grievances about the current situation. Instead, they are categorized into conscience adherents (McCarthy & Zald, 1997), or outsiders who are sympathetic to the cause. Therefore, transnational networks are said to be not "easily linked to a rationalist understanding of their 'interests'" (Keck and Sikkink, 1998, p. 9).

Transnational advocacy networks seek to gain influence by incorporating a number of tactics in their advocacy efforts. Keck and Sikkink (1998) categorize them into four typologies: information politics, symbolic politics, leverage politics, and accountability politics. *Information politics* refers to the power to rapidly gather and disseminate information. Information spread by advocacy networks is characterized in a number of ways. First, they provide alternate sources of information originating from other than that of the institutionalized structures. The information quotes sources that might not easily be heard and often includes dramatic human stories with testimonies made by various people. Drama and credibility of the information are essential components of the tactic to influence the public and policymakers (Keck & Sikkink, 1998, p. 19). Advocacy networks investigate hard facts and strategically use them to create issues by using language that is very dramatic and eye-catching, or the so-called "human rights methodology."

Another way that advocacy networks attract the attention of the international community is through *symbolic politics*, or the process of creating and providing persuasive interpretations for powerful symbolic events. The symbolic event can be a particular incident, a pseudo-event, or a dramatic footage. One example is CNN's live footage of the 10-year-old Egyptian girl being circumcised by a village excisor. Activists found the right timing[3] and the right medium to maximize international attention. By framing an issue in a particular light, it passes on a uniform message and guide for action to the broad public. The main goal of this tactic is to create awareness and expand the constituencies of the network (Keck & Sikkink, 1998).

Upon gaining public attention through information and symbolic politics, activists seek to influence policy change through a tactic known as *leverage politics*. Activists term their efforts to impose influence toward the political officials *leverage*, in other words, weak groups gaining influence over far more powerful institutions (Keck & Sikkink, 1998). This is achieved through the ability of an organization to call on support from a stronger organization within the network and also the ability to affect the media. The live footage of FGM in Cairo was a direct, coercive measure by activists to urge the government to live up to its policies. The coverage undermined the legitimacy of and embarrassed the government, which would not have been possible without collaboration with the media.

Accountability politics is used to hold powerful actors to their previously stated policies or principles. This is a tactic to prevent governments from showing discrepancy between policies and actions. Accountability politics is a strategy that should be at the core of

[3] Just one year after the coverage, WHO, UNICEF, UNFPA, and UNDP issued their official statement against FGM, and the UN awarded the Inter-African Committee with a population award for its efforts to eradicate FGM (Boyle, 2002).

interest for anti-FGM advocacy networks, with 29 African countries legally banning FGM but with no comprehensive implementation of the law that trickles down to the local level.

Inter-African Committee on Traditional Practices: Organizational Tactics

The discussion of the transnational advocacy network and its various tactics to gain public and policy influence focuses attention on an anti-FGM organization's efforts to initiate actions and shape the issue as a central player in the anti-FGM advocacy network.

The Inter-African Committee (IAC) is an international non-government organization with member organizations in 28 African countries, 8 affiliates in Europe, Japan, and New Zealand ('Inter-African Committee,' 2008). Established in 1984, it was one of the first organizations to address harmful traditional practices, mainly FGM, as a violation of human rights and gender equality. IAC uses many tactics to construct the issue, change behavior, and influence policy.

The organization produces bimonthly newsletters that include activities carried out by member committees, successful projects, conferences and symposiums convened by IAC, political achievements, and appeals to partners and governments. The activity reports and newsletters function to collect and disseminate information that would otherwise remain scattered throughout various regions. Furthermore, they are a way of keeping contact and mobilizing information with likeminded counterparts near and abroad, counterparts whom the organization frequently depends on for funding. The research committee set up by IAC is a strategic resource to establish the credibility of information gathered by the group, and to gain leverage/influence by acting as a central think tank within the network in providing viable communication strategies toward elimination of FGM.

The newsletters are also used as a form of symbolic politics, as a medium to dramatically situate FGM as a harmful traditional practice that is a form of violence against women and a human rights violation. Editorials protest against a "diluted" terminology of the practice, stating that it "does not reflect the accurate extent of harm and mutilation caused by all types of the traditional practice…" (IAC, 2005). Another notable example of symbolic politics is the declaration of February 6 of each year as an International Day of Zero Tolerance to FGM. This day is celebrated by all national committees and has spread in significance for organizations dedicated to eradicating FGM around the world. Embedding a symbolic meaning to a certain day adds importance to the initiative and at the same time, increases its chance to catch media attention.

IAC plays a bridging role that ties the grassroots and national NGOs and international organizations together by passing on information of their activities to individuals from a higher level of organization. For smaller national committees, the organization acts as a proctor by monitoring and evaluating the activities of the committees. Each committee is classified into hierarchical groups according to its level of performance. It is anticipated that the funds are allocated proportionate to the level of performance. To maintain constant involvement of stronger organizations, IAC works with the Special Rapporteur on harmful traditional practices, who passes on activity reports and concerns to the UN. By doing so, the IAC is able to constantly keep the issue on the international agenda.

IAC is just one of 90 local and international NGOs committed to eradication of FGM. As the issue has continued to develop in importance among the human rights activists, a variety of strategic approaches to addressing the problem have been implemented. Previous

discussions have explored the characteristics of anti-FGM communication, the history of FGM, and FGM as a transnational movement.

2.5 Research Questions

Considering the above theoretical framework and literature review, this study aims to answer the following research questions:

RQ1: Who are the stakeholders involved in anti-FGM communication?

RQ2: What are the guiding principles and goals of the organizations committed to eliminating FGM?

RQ3: What communication strategies are being implemented to eliminate the practice of FGM?

CHAPTER THREE: METHODOLOGY

In order to address the research questions, multiple-case studies and textual analysis of secondary sources will be conducted. The material to be analyzed in the study was collected through Popline, an online database on reproductive health. Other standard databases and websites of individual FGM movement organizations were also consulted. A comprehensive search yielded empirical and theoretical journal articles, books, book chapters, theses, and dissertations. The search also yielded compilations of publications from advocacy groups such as newsletters, project proposals, activity reports, and declarations for action.

3.1 Exploration of anti-FGM Stakeholders and Communication Strategies

The first objective of this study is to explore the stakeholders of the anti-FGM movement and the discourse which has framed the movement. To accomplish this objective, the first section of chapter four will analyze secondary sources of information. The roles of various stakeholders in shaping and framing the anti-FGM movement will be investigated. Sources include relevant books, book chapters, journal articles, policy reviews, and international treaties and conventions. The second objective is to critically analyze up-to-date communication initiatives in eliminating FGM. Again, a textual analysis of secondary sources will be conducted. The analysis is based on a selection of documents that discuss communication strategies to eliminate the practice of FGM. The materials include but are not limited to journal articles, project proposals, evaluation reports, review papers, and organization newsletters. Each document was carefully examined for any mention of communication strategies proposed or used to bring about FGM behavior change. All

strategies were included, those frequently sponsored by large umbrella groups as well as the outlying approaches and strategies that have not been implemented. Including such scattered ideas that diverge from the dominant approach will create a far more comprehensive blueprint of current strategic approaches to anti-FGM movement.

For all three research questions, multiple sources of evidence will be collected and reviewed to achieve triangulation. For example, referring to a journal article using participant observation, interview data with project participants and/or implementers, project reports from different implementation sites, and media coverage provide a wealth of information that allows cross-confirmation of evidence. Using multiple sources is important in investigating different strategies, as project reports written for donor agencies would presumably tend to cover mostly positive information and outcomes. Therefore, anthropological papers written by researchers through a participant observation method, or assessment reports documented by a third party will be consulted to balance possible bias. Furthermore, using multiple sources allows the researcher to discover a range of outcomes of a strategy that is implemented in different sites. This allows for a generalization or alternatively, cautionary points to prevent over-generalization of a particular strategy.

3.2 Theoretical Approaches to anti-FGM Communication: Strategy Variables

Each strategy identified in the sources was categorized into a matrix of theoretical approaches to anti-FGM communication. The variables were created in order to provide a general understanding of the philosophical and practical origination of particular strategies, the endorsing groups, on-site implementation, and outcomes. The variables are listed as

follows: 1) theory 2) philosophical underpinning 3) target level 4) proponents 5) donor agency 6) implementation 7) empirical evidence.

1) *Theory* refers to "sets of concepts and propositions that articulate relations among variables to explain and predict situations and results" (Waisbord, 2000, p. 1). Tracing the theory of a strategy provides an understanding of why the strategy was proposed or chosen for practical implementation and its expectation of the outcome. A theory explains the cause and nature of the problem, as well as provides guidelines for intervention. The strategies are categorized into one of two theoretical models: the dominant paradigm and the participatory approach. A strategy is placed in the dominant paradigm category if it is a one-way, top-down form of communication, centers on transmission of information, and adopts concepts and models that outline individual behavior change in the pattern of knowledge-attitude-practice. Strategies that use communication instruments to spur interpersonal discussion and eventually persuade its audience to implement behavior change are also classified in this category. Strategies categorized in the participatory model are characterized by maximizing input of local resources, including viewpoints and decisive power of the people into the project. It emphasizes discussion among participants and the process rather than outcome of the anti-FGM project. It utilizes community-based forms of communication venues, such as songs, theater, drama, and other activities that require participation of members.

2) *Philosophical underpinning* is a description of the theoretical approach and the premise under which the strategy was developed. It traces a strategy back to how it originated and explores some previous areas to which it has been applied.

3) *Target level* is the level of audience a particular strategy targets. Identifying a strategy's target level of audience indicates who the strategy perceives as the key actor

instrumental to bringing about change. The target levels are classified into individual, group, and community. Individual refers to girls expected to undergo circumcision. Group focuses on specific groups or stakeholders of FGM within the community. Examples include traditional circumcisers, village leaders, and religious leaders. Finally, community targets a comprehensive mixture of all stakeholders within the FGM-practicing community.

4) *Proponents* refer to the organization that adopts the campaign strategy. It also includes researchers who propose a certain anti-FGM communication strategy, although it may not yet be empirically tested.

5) *Donor agency* refers to the sponsor of the particular project in which the strategy was used. For anti-FGM campaigns, the donor agencies mostly comprise bilateral and multilateral organizations, including USAID, UNFPA, and UNICEF that finance and/or partner with local organizations to implement anti-FGM campaigns in practicing communities. The roles and perspectives of the donor agencies are highly influential in that most non-government international and local organizations are small in size and funding, and therefore rely on donors.

6) *Implementation* assesses how a programmatic activity is installed in a specific setting. One of the greatest challenges faced by the anti-FGM movement is the discrepancy between international discourse and the extension of its principles down to the local people. This category examines if and how an abstract idea is brought down to the level of a local setting and creatively applied to adapt to the local setting.

7) *Empirical evidence* refers to what happens when a strategy is implemented at the local level. This research will observe the process of evaluation, including how outcomes were measured.

Drawing a big picture of the communication strategies and descriptive accounts of their theoretical approach and empirical evidence will increase the validity of the in-depth multiple-case studies.

3.3 Multiple-Case Study: 'Target Level' Based anti-FGM Intervention Strategies

The overview of the strategies and their theoretical roots will be followed by a variable-oriented case study on anti-FGM intervention projects. A popular definition of a case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2003, p. 13). A case study approach seems appropriate as anti-FGM communication research is a study about a culturally-bound contemporary phenomenon that emphasizes knowledge of the cultural and historical context of FGM.

The unit of analysis or the "case" of this study is the anti-FGM communication strategy. The case study focuses on strategies that target the community as the main level of audience. The target level was chosen according to the recommendations made by numerous project reports and evaluation papers that emphasize the importance of involving all stakeholders within the community into the program (Joyce, 2006; NGO Networks for Health, 2000; WHO, 1999). This helps to not only persuade the immediate decision makers to abandon FGM but also to create a supportive environment for ending the practice. It raises the question, "How do community-centered strategies influence the anti-FGM communication intervention?"

The multiple-case studies integrate a number of validity and reliability tests during data collection and research design. Yin (2003) provides three tests that are applicable to this

research: construct validity, external validity, and reliability. As the internal validity test only applies to causal case studies, it was not considered for the purpose of the current case studies.

Construct validity is particularly challenging as the case study method is commonly perceived to be subjective in nature. First, as previously noted, multiple sources of evidence are collected and reviewed to compare and confirm the evidence. Yin also suggests maintaining a chain of evidence that allows the readers to trace from the initial case study questions, evidentiary material, and the case study report (2003). Therefore, in addition to the in-text citations, a case-study protocol will be devised to provide a procedural link that allows the readers to easily trace the steps and raw evidence of the case studies. The protocol will include case-study questions, the list of documents referred to for each case study, and the matrix of theoretical approaches to anti-FGM communication.

External validity, according to Yin (2003), is "knowing whether a study's findings are generalizable beyond the immediate case study" (p. 37). This research uses a multiple-case study design to examine the strengths and challenges of community-based strategies. Each strategy was selected for the relatively high degree of reported successes and promising results in involving the community and changing behaviors. Although four is far from exhaustive, they will be used to investigate the general factors that account for the strengths and weaknesses of the current community-based programs. Each case study followed by the case study questions to ensure a scientific process in design and to develop cross-case implications and conclusions. The case study protocol, in turn, maximizes *reliability* by allowing any researcher to replicate the research and arrive at closely resembling findings and conclusions.

CHAPTER FOUR: RESULTS

4.1. The Network of "Umbrella Stakeholders"

This section delineates how the current stakeholder groups emerged as the driving force to anti-FGM mobilization. The term 'umbrella stakeholders' refers to the group of organizations spearheading the movement that is the mastermind behind the goal and objectives guiding anti-FGM programs. This group seeks to coordinate actions of the organizations working on FGM that are scattered geographically, which is in part achieved by providing technical and financial resources to the smaller groups. Although the discussion does not provide an exhaustive list of umbrella stakeholders, it outlines some of the most prominent. The objective is to explain how complete eradication of FGM has become a uniform goal of the international community and how the human rights discourse came to dominate the philosophical approach underlying the movement.

International Mobilization against FGM: The Beginning

Although the violation of human rights inherent in the practice of FGM was initially raised by Western feminists, their provocative discourse was largely dismissed by the international community at the time and rebuked by African feminists (Boyle, 2002). The anti-FGM movement that eventually sprouted a groundswell of participating governments and NGOs nearly two decades later was directed and formulated largely under the leadership of the UN organizations.

When the FGM issue was first raised in the 1950s, the sociopolitical atmosphere of the time that granted full rights to state sovereignty prevented the issue from being adopted by international government organizations (IGOs). This especially applied to the UN, whose

structure was intimately linked to the sovereign nation state system. Even as the wave of interest in women's rights as human rights during the 1980s prompted IGOs to take concrete action, they were cautious to address a problem that was a local phenomenon and embedded with a high degree of cultural sensitivity. Upon addressing the issue to the public, it used a soft-spoken, culturally sensitive approach. For example, while NGOs insisted on using the more provocative term female genital mutilation, multilateral and bilateral organizations referred to the practice as female genital cutting, which sounded "less pejorative" and was "better received by communities that practice the procedure" (Boyle, 2002, p. 60).

The initial bifurcation in the approach of the two groups was somewhat reduced as they collaborated increasingly with one another to legitimize the movement and create supportive publicity. At the same time, heightened public support for issues related to violence against women set the stage for international mobilization. The narrowing of the gap was, however, largely directed under the leadership of UN organizations participating in the mobilization against FGM.

The Coming of the Umbrella Stakeholders

Since the early 1950s, FGM as a harmful traditional practice has been on the agenda of the UN and its agencies, in particular, the WHO. The main task of concerned UN organizations was to set up coordinated action in the African and the Eastern Mediterranean countries. For this purpose, the UN created organizations that would serve to link the international organizations with the FGM-practicing countries. The 1979 seminar on harmful traditional practices convened by the WHO was the first international conference on FGM. It was a milestone for international mobilization against FGM in that it set "the pace and

direction for international and national plans of action" (Convention on the Elimination of all Forms of Discrimination against Women, 1979, para. 98). Specifically, it recommended a total eradication of the practice, meaning that alternative strategies, such as medicalization or safer methods of practice were no longer accepted. Also among its appeals was a call for creation of an inter-African committee to address traditional practices affecting the health of women and children (Convention on the Elimination of all Forms of Discrimination against Women, 1979, para. 98).

The NGO Working Group on Female Circumcision (later renamed NGO Working Group on Traditional Practices Affecting the Health of Women and Children, hereafter called the NGO Working Group) was established in 1977 under the auspices of the Commission on Human Rights (Smith, 1995). Composed of experts designated by concerned NGOs and UN agencies, its main role was to coordinate the actions of NGOs working toward eradication of FGM. In 1984, the NGO Working Group organized a seminar in Dakar in collaboration with the WHO, United Nations Children's Fund (UNICEF), and United Nations Population Fund (UNFPA). The seminar led to a unanimous decision to work toward eradication of FGM and other harmful traditional practices. Following the seminar, the IAC was launched to implement the recommendations. Its main role was "to act as a bridge between the groups working among people and those providing support for their activities" (WHO, 1998, p. 60).

The NGO Working Group and IAC have subsequently led the creation of 28 national committees in Africa that comprise the chapters of IAC. The committees work mostly autonomously at the grassroots level, and today, most national-level programs are executed by the national committees. The IAC became the first international NGO based in Africa to challenge the age-old tradition and to collect African perspectives and opinions, which was

perceived to be much needed in a movement that was defined and initiated in the West. However, it must be noted that although the IAC pioneered the creation of the African NGO network to address FGM, the impetus for change was fueled from the outside by the UN agencies for the purpose of transferring their ideas into the areas where FGM is prevalent.

Meanwhile, in Western Europe awareness and actions against FGM were fueled presumably for two reasons. First, the geographical proximity to Africa and its post-colonial relationship made it a more familiar issue, but more importantly, the growing witnesses of FGM being practiced within European borders due to increased immigration carried the issue to the EU agenda. Although it is beyond the scope of this thesis to address anti-FGM activities in Europe, some organizations that have extended their intervention efforts to African countries will be mentioned.

A number of European-based international NGOs have been actively involved in lobbying for prohibitive legislation and campaigns in the continent as well as addressing the needs and risks of the women undergoing circumcision. An example is Foundation for Women's Health Research and Development (FORWARD), which was one of the first organizations to be established in response to the growing number of circumcised women in the UK ('FORWARD,' 2008, para. 3). It established an unprecedented specialized clinic for African women with gynecological complications. Internationally, the organization funds activities in eight African countries and maintains close relations with the IAC (Smith, 1995, p. 83).

Many European government organizations have also taken concrete measures against FGM. Since 1999, the German development agency, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), has been operating a supra-regional project, "Ending Female

Genital Mutilation" (GTZ, 2007a, p. 1). This project aims to support local NGOs in FGM-practicing countries in developing, implementing, and evaluating intervention approaches (Bodiang, 2001). The agency supports activities in Kenya, Burkina Faso, Guinea, Senegal, Mali, the Central African Republic, and Mauritania (U.S. Department of State, 2001). In addition, the Norwegian Government launched an International Action Plan for Combating FGM in 2003 and since then, has increased its allocations to NGOs and international organizations (Bentzen & Talle, 2007). The Swiss Agency for Development and Cooperation (SDC) is another bilateral organization that is committed to anti-FGM action as a promotion of human rights and empowerment of women. Like the two previously discussed agencies, it funds IAC in production of educational material and implementation of anti-FGM projects (Bodiang, 2001). The increase in overseas funding has subsequently led to closer collaboration among European and African organizations.

NGOs and IGOs: A Story of a Symbiosis

The UN agencies and the IAC were integral to creation of an international consensus in goal and approach toward eradication of FGM. The relationship between the two is a synergistic one in nature. By extending its 'antenna' to the national and local organizations, the IAC engaged in leverage politics by allowing the smaller and weaker groups to exert influence over more powerful organizations. For example, the regional seminars organized by the IAC and co-sponsored by the WHO provided a forum to share and exchange strategic ideas, project outcomes, and challenges among national chapters, government organizations, UN agencies, and NGOs (IAC Newsletter, 2005). In addition, the Special Rapporteur designated by the Sub-Commission on Prevention of Discrimination and Protection of

Minorities regularly visited and arranged seminars with concerned groups to consolidate the developments and achievements of the projects. The product, “A Study on Traditional Practices Affecting the Health of Women and Children” completed in 1989 eventually led to the adoption of the Plan of Action for the Elimination of Harmful Traditional practices Affecting the Health of Women and Children (Smith, 1995). The IAC and the Special Rapporteur function as tools of leverage politics for smaller and hierarchically lower organizations to gain influence over those more powerful. Such vertical interaction among the hierarchically-organized network also created legitimacy of the UN organizations as working on behalf of “the people,” or the grassroots organizations directly representing the local people (Boyle, 2002, p. 63).

In turn, the UN employed symbolic politics to enhance the legitimacy and public support of IAC’s work. The 1995 Population Award granted to the IAC is a symbolic event that elevated the awardee amidst the anti-FGM umbrella stakeholders. In 1998, the UN General Assembly gave official recognition to the IAC and its activities in “the context of traditional and customary practices affecting the health of women and children” (UN General Assembly, 1998, p. 11).

As the IAC continuously succeeded in establishing national chapters and gained international recognition, it sought to create a consensus among the network groups in the approach to challenge FGM. At the 1990 seminar in Ethiopia, it proposed to change the terminology from “female circumcision” to “female genital mutilation.” The term argued for recognition of the violence against women inherent in removing a healthy tissue for non-therapeutic reasons. The proposal was endorsed by the United Nations Center on Human Rights, which urged that the terminology be used in the future. The WHO later adopted this

terminology and in its most recent statement, displayed agreement with the IAC's stance by declaring FGM a "violation of a person's right to the highest attainable standard of health" as it "interferes with healthy genital tissue in the absence of medical necessity and can lead to severe consequences for a woman's physical and mental health" (WHO, 2008, p. 9).

IAC's efforts to unify the approach to eliminating FGM among network groups was further reflected in the Common Agenda for Action adopted at the 2003 International Conference on Zero Tolerance to FGM. The agenda set a goal of complete eradication of FGM through collaboration with "relevant government departments, WHO, UN agencies and others to adopt an integrated approach to FGM elimination" by the year 2010 (IAC, 2003a, p. 9). The purpose of the document was to enable joint action from top-to-bottom and vice versa. Such networking has led to a uniform philosophical approach and goal-setting among stakeholder organizations and governments.

The consensus in the strategic design is further witnessed in the two documents published by the IAC and the UN General Assembly. The "Use of Indicators in the Campaign against FGM" (2003b) was devised by IAC's Scientific Committee to provide a comprehensive guideline for systematic designing and monitoring of anti-FGM projects. The Strategic Objectives section of the publications and the strategic recommendations outlined in the Resolution on Traditional Practices Affecting the Health of Women and Girls (UN General Assembly, 2002, p. 4-5) adopted by the General Assembly bear close resemblance in their recommendations for strategic implementation. The two publications appeal for scientifically rigorous campaign designs, advocacy at a national level, increased training capacities of health personnel, and a holistic approach involving community. For example, both emphasize the importance of community-based campaigns to promote community-wide

development. The 12th recommendation of the General Assembly urges committed organizations,

> To continue to take specific measures to increase the capacity of communities, including immigrant and refugee communities, in which female genital mutilation is practiced, to engage in activities aimed at preventing and eliminating such practices; (p. 4)

Similarly, the 9th and 10th strategic objectives of IAC's document state,

> Integrated Approach involving all stakeholders to address FGM within the ambit of gender and development.
> Mass mobilization towards consensus building to abandon FGM (p. 14).

The only divergence between the two is that the General Assembly resolution positively relates abandonment of FGM to economic independence which in turn leads to increasing decisive power. The resolution states,

> To take all necessary measures to empower women and strengthen their economic independence and protect and promote the full enjoyment of all human rights and fundamental freedoms in order to allow women and girls to better protect themselves from, inter alia, traditional or customary practices affecting the health of women and girls (p. 4).

In contrast, the IAC seems to narrow the target of economic empowerment strategy to traditional circumcisers, as the objective specifically provides for, "Social and economic reorientation of circumcisers and rites of passage initiators" (p. 14). Nonetheless, numerous campaigns see empowerment of women as their principal intervention strategy (WHO, 1999; Muteshi & Sass, 2005; Feldman-Jacobs & Ryniak, 2006).

Creation of Common Approach and Goal: The Current Picture

The three international conferences dedicated to women's issues were instrumental to the development of anti-FGM mobilization for two reasons. First, they aided in creation of an

international consensus on the philosophical approach and goals of the anti FGM-movement. The 1993 World Conference on Human Rights in Vienna declared FGM to be a human rights violation. The following year, the International Conference on Population and Development condemned the practice of FGM and urged the governments and NGOs to work toward eradication of FGM. The succeeding conference in Beijing two years later for the first time globally acknowledged reproductive and sexual rights of women as human rights (IAC, 2003a). The three conferences identified FGM as a violation of the human rights of women and set a goal of complete abolition of FGM. As a result, alternative viewpoints and approaches that had created intense debates decades ago subsequently were marginalized from the mainstream movement.

The second outcome of the international conferences was a sharp growth in organizations committed to FGM. A survey conducted by Population Reference Bureau in 2001 found that most NGOs addressing FGM were created within the preceding three years (Creel et al., 2001). Interestingly, another survey conducted by WHO (1999) found that 46 percent of participating NGOs cited international pressure as the motivation for developing FGM programs. Therefore, it seems safe to state that the participating NGOs were initiated as a result of the growing salience of the FGM issue on the international agenda. They consequently adopted the goal and philosophical approach as declared in the conferences. However, the survey conducted by PRB found that the majority of the organizations lacked expertise in advocacy and campaign implementation as recommended by WHO (1999), which also identified a greater need for technical assistance in capacity building, material development, and program monitoring and evaluation. The increased demand for outside

assistance heightened interest in donor opportunities as well as professional expertise to guide scientifically rigorous intervention programs.

According to WHO (1999), 42 percent of the anti-FGM organizations rely on UN agencies, namely WHO and UNICEF for financial and technical support (WHO, 1999, p. 12). However, in response to the rapidly growing demand in funding and technical assistance, the large donor agencies collaborated to establish the Donors Working Group in 2001. The group is composed of WHO, the World Bank, US Agency for International Devleopment (USAID), UNICEF, and GTZ, among others.

The main objectives of the Donors Working Group were to share strategies on FGM/C, document best practices, and establish an overall framework for collaboration to create a common agenda (No Peace Without Justice & Bonino, 2005). The consensus of the group is that FGM should be addressed as both a health and human rights issue. Their ultimate goal is to stop the practice in countries where FGM occurs. The influence of the donor agencies in shaping the funded projects has been widely documented (Wilkins, 2000; Waisbord, 2000). Considering that 84 percent of organizations working on FGM are international and national NGOs (WHO, 1999, p. 9) and that most of these groups rely on outside funding, it may be concluded that the role of the donor agencies is substantial in shaping and monitoring the enactment of the human rights approach in the FGM elimination programs.

While financial support by donor agencies played a large part in reinforcing the human rights perspective and complete eradication of FGM among participating organizations, the close resemblance in strategic approaches seems to be influenced by the sharing of professional expertise in developing strategic intervention programs. Individuals

that have taken leadership roles in anti-FGM action are commonly involved in designing and evaluating remedies to the problem in multiple institutions. One such individual is Efua Dorkenoo, who is a human rights activist and a health specialist from Ghana. Since founding FORWARD in the UK in 1983, she has also served as an expert on FGM in WHO from 1995 to 2001 (Equal Opportunities Committee, 2004). Another example is Olayinka Koso-Thomas, who is a medical specialist and an anti-FGM strategist in Sierra Leone. She also has been appointed as a member of the scientific committee of IAC. The tight networking among the specialists has resulted in strategic similarity in intervention projects.

To sum up, the UN-led action sprouted widespread philosophical opposition to FGM, and the creation of donor organizations in response to the growing commitment to the issue led to reinforcement of the goal and philosophical approach to the issue. The international treaties and resolutions served as legal instruments that required conformity from party nations. National compliance with the international norm is further monitored by UN or UN-influenced mechanisms, such as IAC and the Special Rapporteur on Violence against Women and the Special Rapporteur on Harmful Traditional Practices that hold the mandate to seek and to receive information from governments and NGOs regarding relevant topics of action. As a result of constant advocacy and surveillance, 13 African countries now legally prohibit the practice of FGM and adopt some penal code for those who conduct the practice. Critical voices have attributed such legal enactments to pressures from foreign aid that require evidence of concrete action against FGM (Hernlund & Shell-Duncan, 2007). Notwithstanding, the anti-FGM legislations have become useful tools for local NGOs working to end the practice on grounds where it is practiced.

4.2 The Human Rights Controversy: Outlying Voices

The firm grounding of FGM as a violation of human rights that contravenes international human rights treaties and conventions has, however, earned strong criticism from a camp of legal and human rights scholars. Based on a number of claims, they have challenged the application of the human rights argument to FGM.

Human Rights: Arguments from Cultural Relativists

According to the umbrella stakeholders, FGM is designated as a harmful traditional practice that goes against three primary protections: the right to health, the rights of the child, and the right to bodily and sexual integrity (Mhordha, 2007). The cultural relativists, however, question "How can a group of states demand that another group of states outlaw a traditional practice that is both historically based and claimed as vital to group integrity?" (Breitung, 1996, p. 2). The commentators rebut the human rights argument by pointing out the "human rights violations" apparent in Western practices that are largely overlooked and by reconceptualizing human rights.

The right to health approach has been the most frequently used and perhaps the easiest one to integrate into messages, as it is objective in nature and does not challenge the belief structure of the practicing communities. However, commentators note that the health rights argument may very well induce a backfire that attacks practices in Western countries that are potentially life-threatening but nonetheless conducted for aesthetic reasons. The most commonly cited is a type of plastic surgery popularly referred to as "designer vaginas," which women undergo although it is not socially necessary (Hernlund & Shell-Duncan, 2007).

Violation of the rights of a child is another justification of FGM elimination made by advocates of children's rights, in particular, UNICEF (UNICEF Innocenti Research Center, 2005). However, in a society where FGM is the norm, girls who do not undergo the practice are the exception and consequently face the risk of being outcast from the community as well as losing prospects for marriage. Therefore, cultural relativists claim that parents committing their children to FGM are not abusive or harmful to a child's well-being. According to Breitung (1996), in a society where uncircumcised girls are ridiculed as dirty and unmarriageable, circumcising girls is what protects children's rights.

The third realm of rights breached by FGM is the right of bodily and sexual integrity. Referring back to the genital modification surgery, Wilson (2002) comments that both cases seek to control female sexuality by either enhancing or minimizing the sexual drive. Therefore, whereas in the West, women find low sexual desire to debilitate the male-female relationship, African societies seek to diminish the sexual desires of a woman (Wilson, 2002). Boyle states,

> In both cases, women's sex drive is something that "needs" to be fixed. In both cases, men are the presumptive beneficiaries of the intervention. In both cases, women are made to feel ashamed and uncomfortable with their sexuality (Boyle, 2002, p. x).

The numerous loose ends in anti-FGM principles led commentators such as Grande to assert, "Such attitudes [that fail to acknowledge violations from Western context] highlighted in the debate over FGC, constitute a powerful example of a double standard that affects much of the internationally dominant human rights discourse" (Grande, 2004, p. 1, as cited in Mhordha, p. 16).

Universality of Human Rights

In addition to the above arguments, the critics of anti-FGM principles contested the validity of human rights as a "natural law" or a universal concept. Ibhawoh (2004) contends that human rights are not static or universal and that they need to be recognized as distinct cultural constructs. Specifically, "…the modern concept of human rights stems from the contemporary articulation of legal entitlement, which individuals hold in relation to the state" (Ibhawoh, 2004, p. 23). The perception of the individual as an autonomous unit, therefore, is the premise of the philosophy.

Is the notion then applicable to the African context, where societies were operated in a "communal social structure?" In Africa, Ibhawoh explains that "rights were assigned on the basis of communal membership, family, status, or achievements" (2004, p. 24). In consideration of the collective nature of the social structure, the commentators argue that enforcing a Western concept whose philosophical basis is the exact opposite of the African-context is unfeasible (Ibhawoh, 2004; Howard, 1990). In the African context, FGM was a mark that entitled a woman to her rights by granting community membership, status, and decision-making power. Grenbaum adds that FGM is a prerequisite for marriage and reproduction, and therefore, performing FGM confers the right to bear children for the local culture (2001). The proponents of cultural relativism attribute the human rights discourse as to the reason for difficulty in intercultural communication. Their arguments lead to the conclusion that lack of success in the intervention programs is due to their disregard for the local conceptualization of rights, which are fundamentally divergent from the Western notion of human rights.

The need to respect the culture as well as to minimize the health risks has created a new paradigm in the field of public health, referred to as harm-reduction strategy. According to Shell-Duncan (2001), the harm-reduction strategy is an "approach that seeks to minimize the health hazards arising from a variety of behaviors by encouraging safer alternatives, including, but not limited to, abstinence" (p. 1014). Some examples of the strategy used in public health campaigns are "responsible drinking" through designated driver or free taxi service, reduction of cancer risks through alternative sources of nicotine, such as patch and chewing gum, and school-based condom distribution (Shell-Duncan, 2001). In this respect, medicalization is proposed as a harm-reduction strategy to maintain the symbolic meaning of FGM while minimizing the health costs.

An example of a harm-reduction strategy that seeks to maintain the symbolic aspect of FGM while discarding of its adverse health effects is one proposed by Groh (1999). He recognizes that traditional requirements of the ritual must be met in order for a campaign to be realistically successful. Acknowledging that there must be some kind of a cutting with blood, he proposes a variant form of FGM that is minimally invasive and does not involve harming of the genital organs (1999). However, this strategy has not been implemented, most likely because the method is still included in type four of the FGM as classified by WHO, which states, "All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization" (WHO, 2008, p. 4). Indeed, it has faced strong opposition from non-governmental organizations and GTZ (Baumgarten & Gahn, 2002, as cited in Leye et al., 2006).

Such harm-reduction strategies were suggested in order to prevent illegal FGM performed in secrecy, frequently under unsanitary conditions. These strategies target the

staunch resistors of FGM elimination efforts, as stated by Abdulcadir, Somali gynaecologist in Italy who suggested a *sunna*, or a mild version of the circumcision at the hospital by using an anesthetic cream and performing a slight cut in the clitoris. “We consulted with the women attending our meetings and with the leaders of 10 local communities of immigrants from Africa, who have a strong influence, and they agreed this could be a last resort option for the women who [were not prepared] to abandon the practice" (Turone, 2004, p. 247). This strategy was also met by strong attacks from NGOs in Italy and condemned by European NGOs at an international conference in Florence in 2004 (Leye et al., 2006).

Granted there are no health threats and no ‘mutilation’ of tissue, such strategies that seek to maintain the symbolic act of cutting still face an insurmountable challenge, as the umbrella stakeholders believe that the medicalization or a less severe performance would counteract efforts to eliminate FGM. Therefore, despite the widespread criticism of human rights arguments surrounding FGM as an ‘arrogant gaze’ or ‘visceral reactions, not informed knowledge,’ current strategies are all implemented with the goal to eliminate all forms of FGM, notwithstanding their means.

4.3. Communication Strategies: Efforts to Eliminate a Taboo Practice

This section collected and analyzed different communication strategies proposed and/or implemented to eliminate FGM. All strategies integrate the “FGM as a violation of human rights” message with the health and religious-based argument. They have been categorized according to two conceptual models: the dominant paradigm and participatory approach. The strategies that carry forward the premises of the dominant paradigm seek to achieve social change by evoking knowledge, attitude, and behavior change. These strategies have an

established intervention formula that is adapted by the intervention community. Strategies falling under the participatory approach, on the other hand, not only target but involve community members in planning, implementing, and evaluating social change. These strategies are inductive in nature and do not have a blueprint solution to incorporate into the community.

This section will explore the two categories of strategies. The four in-depth multiple case studies will focus on anti-FGM projects that targeted the general community to bring about an enabling environment for abandonment of FGM.

4.3.1 Complete Eradication of FGM: Strategies Following the Dominant Paradigm

Knowledge, Attitude, Practice Model

The information, education, and communication (IEC) strategy was originally developed to tackle public health problems in the US, such as high-fat diets, smoking, and substance abuse during the 1970s and 1980s and was subsequently adopted by health-related development interventions in developing countries (Waisbord, 2000).

In the area of FGM, the strategy was considered a promising tool to break the taboo surrounding FGM and open discussions among the practicing community members. The IEC strategy focused on promoting, informing, motivating, and teaching about the adverse health effects of FGM through sensitization activities, such as incorporation of FGM-related information into school curricula and outreach activities at churches and mosques. Many of these programs utilized some form of mass media, such as posters, radio and television programs, films, and newspaper advertisements.

Whereas most IEC strategies in the past were mass produced and targeted anyone, recent methods have emphasized multi-channel and multi-level implementation (Feldman-Jacobs & Ryniak, 2006). One example is the 'Ndukaku' or 'health is better than wealth' initiative in Nigeria (Center for Communication Programs, 2005). While the community-level mobilization activity was participatory in nature, the locality and state-level activities used awareness-raising sessions and media advocacy to change behavior. At the local level, a documentary, Uncut--Playing with Life, was aired at community gatherings, and advocacy visits to traditional leaders were made. At the state level, the National Association of Women Journalists in Nigeria used regular newspaper columns, radio call-in shows and public forums to encourage the abandonment of FGM (Center for Communication Programs, 2005).

The National Committee to Fight Against the Practice of Excision in Burkina Faso is also actively involved in creating and disseminating IEC materials. The committee coordinates all actions of local groups in Burkina Faso that work to end FGM (WHO, 1999). In particular, it has developed a saturation strategy, which seeks to disseminate information and awareness sessions from the canton (a regional unit following the province) down to the family level through the words of traditional leaders (WHO, 1999). It starts with a small number of provincial leaders conducting one-day information and awareness sessions for a larger number of canton leaders, who then conduct the same sessions with the village leaders. The pattern follows in a pyramid form to the family level, and the results are reported back up the path. This strategy has also been implemented to outreach FGM-practicing population through voices of religious groups, youth, and the police (WHO, 1999).

The National Committee has also set up an SOS Hotline and used the media to run the SOS Excision public service announcements and anti-FGM songs with support from

UNICEF and RAINBO. The messages mostly describe the health threat of FGM or describe the consequences of breaching the law. Visual images are sensational, with a naked girl covering her genitals and refusing to be circumcised, for example.

Figure 1. IEC posters produced by the national committee of Burkina Faso. From *Media/Materials Clearinghouse.*

The mass mobilization strategies have led to increased awareness and some attitudinal change. However, studies have shown that this has not been sufficient for behavior change. Because such communication methods are one-way, they have been found to influence awareness, but are less effective in bringing about behavior change (WHO, 1999). Numerous IEC materials depict FGM as a harmful practice. However, demanding that people stop circumcising may be perceived as a threat to the survival of the local custom. In fact, Shell-Duncan and Hernlund (2006) found that although most rural FGM-practicing groups were fully aware of the campaigns and their messages, the majority did not intend to stop practicing female circumcision.

Another cautionary point is that the awareness-raising activities fail to provide a sense of protection for the girls and parents who wish to refuse FGM. The SOS Hotline has found that the callers frequently hang up the phone before giving complete information of where the circumcision has taken place and who was involved for fear of repercussions (WHO, 1999). Furthermore, IEC materials often lack a research base and are rarely pretested among the audience, which may possibly run the risk of an intended means becoming an end to itself.

In order to minimize the negative effects of IEC activities, the materials should be tailored to the local situation and beliefs. Local myths and misperceptions of FGM should be discussed and included in messages. More importantly, the audience should not only be told what to do, but how to go about making behavior changes. The education modules used by Tostan are a noteworthy example of equipping people with necessary skills to pursue behavior change.

Social Marketing Theory

Social marketing theory integrates the principles of advertising and theories of consumer behavior into strategic communication for social change. It grew out of the demand for marketing in the US to be "socially responsible" and work towards social good (Waisbord, 2000). Unlike education or propaganda, social marketing centers on changing the behavior by "fulfilling, rather than creat[ing], uncovered demand" (Waisbord, 2000, p.7). A common method to "fulfill" the "uncovered demand" in practicing FGM has been to provide livelihood skills training for girls and women, including circumcisers. The approach is based on the assumption that economic empowerment of women would grant greater autonomy and

decision-making power. The conversion strategy for circumcisers largely implemented by the IAC (IAC Newsletter, 2006) equips circumcisers who have pledged to abandon their occupation with microcredit to start an income-generating activity. Evaluations of this strategy have thus far shown low levels of effectiveness (GTZ, 2001; Toubia & Sharief, 2003) First, success in curbing the supply-side does not necessarily discourage the demand to circumcise. Second, there is a limit to designating circumcisers as the main social target group or promoting circumcisers as change agents. In most communities, they do not command an influential position in a community, and studies have shown a tendency for the former circumcisers to revert back to their more lucrative occupation (GTZ, 2001; Muteshi & Sass, 2005).

The livelihood program for girls and women in an FGM-practicing group was part of the Navrongo FGM experiment to compare the impact of livelihood training to FGM education. The participants received training in domestic chores, such as preparation of local dishes, weaving of mats and baskets. Livelihood programs included acquiring book keeping and managerial skills, identification of income-generating activities, and learning marketing skills. The traditional housekeeping and income-generating lessons were meant to replace what the girls would learn during the seclusion period following their circumcision (Feldman-Jacobs & Ryniak, 2006). The experimental study found that provision of the livelihoods program did impact the rate of FGM among the community girls, but was weaker in effect than receiving FGM education. An interesting result was that a combination of both strategies resulted in a “statistically significant” reduction in the risk of undergoing circumcision (Feldman-Jacobs & Ryniak, 2006, p. 15).

Trans-theoretical Model of Behavior Change

The trans-theoretical model of behavior change was developed by Prochaska and Di Clemente (1986) to explain the psychological and behavioral processes individuals experience in stages leading to rejection or adoption of behaviors. It originally developed as a result of a study on smoking cessation, from which the researchers found a common sequence of change in the smokers' efforts to change their behavior. This combined model of behavioral change is the product of a number of cognitive and behaviorist theories. The model was applied in numerous fields within public health, including substance abuse, dietary change, exercise promotion, and safe sex (Prochaska and Di Clemente, 1992). It was subsequently introduced in the area of anti-FGM communication by Izett and Toubia (1999) and empirically tested by Shell-Duncan and Hernlund (2006). The trans-theoretical model consists of five stages, which individuals often relapse and recycle through, as well as dimensions of "supportive environments" that foster behavior change.

The stages follow the sequence of precontemplation, contemplation, preparation, action, and maintenance, with possible relapses within the process. In the *precontemplation* stage, the individual is conditioned by pre-existing knowledge and beliefs, and there is no intention to change a particular behavior. *Contemplation* is the second stage where the individual becomes aware of a problem and considers the possibility of taking action to address the problem. A multiplicity of triggering events may lead to this stage, from an extreme form of death in the family from FGM to the cumulative effect of a number of several factors. Direct experience, such as witnessing the pains the daughter suffers after circumcision and exposure to new information about FGM may be two factors that trigger contemplation. Societal changes, such as immigration or a war that grants women greater

independence is a factor that is much stronger in influence than any intervention programs (Izett & Toubia, 1999). However, Izett and Toubia (1999) caution that feelings such as confusion, fear, and guilt of going against one's tradition may relapse into strong resistance. By the third stage, *preparation*, the individual experiences changes in attitude. He/she displays some behavior that reflects intention to change. Possible threats may be pressure from the individual's social network to forego her decision. The fourth stage, or *action*, involves modification of one's behavior in order to follow through with the decision to change. This stage may be implemented by participating in an alternative ritual ceremony or making a public pledge not to circumcise. The final stage, *maintenance*, is where stabilization of behavior occurs and individuals sustain the behavior change without turning back to his/her former behaviors. For all stages above, a supportive social environment is a crucial factor to maintaining one's decision not to circumcise (Prochaska & Di Clemente, 1992). For anti-FGM projects, the supportive atmosphere should ideally extend to neighboring communities where inter-ethnic marriages take place.

Prochaska and Di Clemente (1992, as cited in "Travelsmart," 2008) categorize the enabling environment into five dimensions: legal, resource, social, cultural, ethical, and spiritual features. *Legal features* consist of legislative instruments that have the power to enforce adherence to the law. Despite the lack of enforcing mechanisms of anti-FGM legislation, evidence of "reluctant abandoners" to FGM has been found among those who were motivated by fear of being punished (Shell-Duncan & Hernlund, 2006). *Political features* refer to the system of governance that either restricts or supports access to information and social action. *Resource features* include resources that are required to achieve the change of behavior. These range from availability of material resources to

acquiring knowledge and skills that foster a community-wide readiness for change. Livelihood training is an example of providing the resources for the women to attain greater decisive power and autonomy. *Social features* refer to the social structure and power relations within a community that prescribes expectations according to gender, class, and position. *Cultural features* are the norms and beliefs that guide action. Recognizing that the choice to be circumcised is not an individual decision led some anti-FGM programs to seek to change the community-wide norm associated with FGM to encourage abandonment of the practice. *Ethical and spiritual features* are also influential to many FGM-practicing Muslim groups who believe that female circumcision is prescribed by the Koran. For example, some communities are accepting of a milder form of FGM but insist on its maintenance as the "failure to circumcise either girls or boys is considered haram (sinful) in the community's understanding of Koranic teaching" (Teferra, 2004). Changing the religious perception underlying FGM is another strategy undertaken by numerous anti-FGM campaigns.

In adapting the trans-theoretical model, a number of differences should be acknowledged between the previously applied areas of public health and FGM. Whereas smoking, substance abuse, and unprotected sex are proscribed behaviors, FGM for the practicing groups is a social norm that shapes female identity and gender roles. In addition, the choice to be circumcised is much less an individual decision compared to choosing to smoke or drink. Despite the differences, the theory is a promising tool for anti-FGM intervention programs for a number of reasons. First, the model provides a useful means to find out about the enabling and hindering factors to the FGM abandonment process for individuals. The application of the model seems particularly advantageous in identifying the factors that motivate the readiness for change. Its principles may be applied not only to

observe the girls at risk but also the network of social groups that hold the decisive power to circumcise the girls. The model provides a scientific basis to tailor the intervention tactics and messages according to the stage of change the individual or the group is experiencing.

The trans-theoretical model has not yet been extensively tested in anti-FGM intervention projects. However, Shell-Duncan and Hernlund (2006) conducted a qualitative study to categorize community members in Senegal and Gambia into certain stages according to their readiness to change. The study in turn devised a set of modified stages of behavior change that is customized to better fit the anti-FGM communication, consisting of non-contemplation, contemplation, reluctant practitioner, reluctant abandoner, and willing abandoner (p. 66).

Convention Theory: A Rapid and Collective Abandonment

The convention theory was originally developed by Schelling (1960) and applied to anti-FGM campaign by Mackie, who claimed that FGM can be eliminated in one generation through organized diffusion (1996). The theoretical elements of this approach have been supported by UNICEF and USAID, both donor agencies to Tostan, a Senegalese NGO whose implementation of the community-based development closely reflects the theory (UNICEF, 2007; Kasdon, 2005).

Schelling's self-enforcing social convention theory uses game theory to explain that apparently harmful social conventions are maintained due to interdependent expectations of the group members (Mackie, 1996). This concept is close in nature to FGM in that despite the extensive intervention campaigns, families continue to practice to ensure the marriageability of the daughter. One family cannot give up the practice while the other still

maintains it for fear of jeopardizing the marriageability of the daughter. Therefore, the solution is to coordinate the abandonment throughout the intra-marrying communities as a whole (Mackie, 1996).

In line with such logic, the social convention theory proposes that if an initial core of families decides to abandon FGM, this group would then attempt to recruit other families within the intra-marrying communities to abandon circumcision. By doing so, it increases the choices of those who are marriageable within the non-cutting group. The knowledge and actions of these non-cutting families would spread to other families through the social network, which would eventually lead to a coordinated abandonment (Mackie, 1996). Therefore, the aim of the strategy is to create the initial core group that is opposed to FGM.

To support his hypothesis, Mackie uses the example of footbinding in China and the campaign to end the practice during the late 1890s and the early 1900s (Mackie, 1996). He points out that the underlying functions of the two seemingly distinct practices are in fact, quite similar. Like FGM, footbinding is believed to be traditionally sanctioned. It promotes chastity in a woman by limiting her mobility. The shape of the foot that resembled a “three inch golden lotus” symbolized beauty and womanliness (Xinhua, 1998). All these factors, in the end, led to better marriage prospects for a woman. This practice was outlawed by the Manchus in the 1600s, but the practice continued for another three centuries, until concerted efforts by the Anti-Footbinding Society in 1895 ended the practice within the next 50 years (Mackie, 1996). The footbinding abolition campaign entailed three steps. It propagandized the disadvantages of footbinding in Chinese cultural terms, conveyed international disapproval of the practice in a tactful manner, and promoted pledge associations, in which parents pledged not to have their daughters footbound or to allow their sons to marry a bound

women (Mackie, 1996). Consequently, by 1908, Chinese general opinion was opposed to footbinding (Mackie, 1996).

According to Mackie, "Footbinding and FGC are each a special kind of convention such that either nearly everyone does it or no one does it, so that when it ends it must end quickly" (Feldman-Jacobs & Ryniak, 2006, p. 34), and organized diffusion is the strategy proposed to bring about the rapid collective abandonment. The strategy is akin to Roger's theorization of diffusion of interactive innovations and the "S curve" of innovation adoption (2003). According to organized diffusion, the decision to abandon the practice must be enforced by a critical mass of the "initial core," meaning that the number should be large enough to become self-sustaining. The initial core will be established by an education campaign that explains the physiological facts surrounding FGM and advantages of natural genitals and the disadvantages of circumcision (Mackie, 1996). The second stage is to convey international opinion on the negative health consequences of FGM in a tactful manner. Finally, a public recognition should take place to reinforce the conviction of those who decided to abandon FGM by displaying others who are also willing to do the same. The initial core should eventually be able to grow to a "tipping point," where the pattern becomes irreversible and leads to a natural change in the social convention (Mackie, 1996).

The following two case studies will examine how education and awareness creating activities were used to eventually change the behavior of FGM-practicing communities. They will also examine how targeting the whole community worked to strengthen the impact of the program. The alternative rites of ceremony follows the premise of awareness-attitude- and behavior change stages by using sensitization activities, Family Life Education, and the alternative rites of passage ceremony. And Tostan's community development program uses

education modules, community mobilization, and public declaration to coordinate a critical mass to lead community-wide abandonment of FGM.

4.3.2 Alternative Rite of Passage: "Circumcision through Words"

Background: Alternative Rites of Passage in Kenya

The alternative rites of passage referred to as "Ntanira na Mugambo" or "cutting through words" was first implemented in August 1996 in Tharaka district of Kenya. It was a strategy pioneered by a US nonprofit, Program for Appropriate Technology in Health (PATH) in collaboration with the Kenyan national women's group, Maendeleo Ya Wanawake Organization (MYWO). PATH provided technical assistance, including the educational curricula and manual to train peer educators and girls, while MYWO worked with network groups of women expanding across the country (Chege, Askew, & Liku, 2001).

Anti-FGM intervention in this region is not a new phenomenon. The Protestant missionaries have attempted to stop the practice since the early 1900s through legislative measures by the colonial government. However, the coercive intervention only fueled rebellion among the people of Meru, and even saw adolescent girls attempting to circumcise each other. FGM, which was seen as a symbol of ethnic identity and colonial defiance, spiked in numbers (Thomas, 2000).

Today, efforts to eradicate FGM are reflected in Kenya's National Plan of Action for the Elimination of Female Circumcision, and in 2001, the Ministry of Health banned FGM operations in health facilities (US Department of State, 2003). However, in consideration of the history of conflict and resistance surrounding the practice, Kenya's anti-FGM intervention programs called for a culturally sensitive approach that is respectful of the tradition. In this context, the alternative rites of passage strategy was born. The development

of the strategy was preceded by two years of preliminary qualitative research that assessed the nature and the extent of the practice in four districts of Kenya. The group discussions that involved women's groups found that the population felt very strongly about the importance of the ritual surrounding FGM (Chege, Askew & Liku, 2001). From this information, PATH proposed the idea of an "alternative rites" at a national MYWO seminar in 1995. This strategy would seek to change the behavior of people by replacing the act of cutting with an alternative activity while replicating all other activities of the rite. The purpose of this strategy was to preserve the original meaning and intention of the ritual while discarding the harmful aspect of it. The alternative rites would not interfere with the original purpose and function of the ritual, keeping the essence of the practice alive. Because of this attractive alternative that respects local tradition and is culturally sensitive in approach, the alternative rite has been reported to be possibly the most successful strategy towards more collective elimination of the practice (Joyce, 2006; WHO, 1999; Chelala, 1998) and has also been implemented in The Gambia and Uganda (Muteshi & Sass, 2005).

Theoretical Approach of the Alternative Rites Strategy

The alternative rites of passage strategy closely reflects the trans-theoretical model of behavior change. This strategy attempts to guide the audience from knowledge, attitude, to behavior change by hosting three levels of activities – community sensitization, Family Life Education, and the Coming of Age Day. The community sensitization was in part achieved through years of community outreach and mobilization activities executed by MWYO. The meetings and discussions sought to familiarize the community members with new concepts and information about human rights, gender roles, and health implications of FGM. Although

the training manual created by PATH reportedly places FGM in a human rights framework, the extent to which the emphasis is placed on human rights by the MWYO trainers and peer educators at the community level seems unclear (Chege, Askew, & Liku, 2001). Peer educators, mostly comprised of mothers, were responsible for community outreach to convince the members to have their daughters participate in the program. The first stage sought to activate contemplation, during which participants become aware of the health problems associated with FGM, misconceptions surrounding the practice, and female empowerment.

Following the preparation step, the project sought to reinforce awareness and create a positive attitude toward abandonment of FGM through three to five days of seclusion for the alternative coming of age candidates (WHO, 1999). This stage was participatory and interactive in that the girls not only received "words of wisdom" from selected parents but also created songs, dances, and dramas about FGM that would be performed on the day of the ceremony.

The public ceremony encouraged the candidates and the parents to move to the action stage. On this day, through their performances, the girls declare not to undergo circumcision, and parents promised to maintain the decision not to circumcise their daughters. The ceremony was also witnessed by religious, government, and community leaders.

Target Audience

The success of the alternative rites strategy can largely be attributed to the comprehensive nature that incorporated diverse stakeholders surrounding the practice. The project was designed to create a supportive social environment of the decision to abandon the

practice. It involved mothers who acted as peer educators. In the Gambia, it also involved a large number of religious leaders who endorsed the alternative coming-of-age ritual. In addition, district-level chiefs, village heads, and local government officials attended a workshop to plan implementation of the curriculum. Former circumcisers were trained as facilitators of the new rites of passage curriculum (Muteshi & Sass, 2005).

The program integrated suggestions of various stakeholders, including mothers, girls, community leaders, and fathers on how to implement the programs, what topics to include in the lessons taught during the week of seclusion, and what gifts to give during the ceremony. For example, mothers decided that the daughters should have one week of instruction, guidance, and counseling during which they would receive both modern life skills and traditional wisdom (Chege, Askew, & Liku, 2001).

Implementation

Twenty families participated in the initial program. The alternative rites of passage ritual closely follows the traditional version and is composed of three phases: community sensitization, seclusion of the girls, and community celebration. Table 1 outlines how each phase may correspond to the stages of change for individuals. The first stage, community sensitization, aimed to raise awareness of community members about human rights, gender roles, and health implications of FGM. Selected women acted as peer educators, which expanded to youth and men in subsequent projects. As the condition to participate in the program was to have the approval of both parents, the role of peer educators was instrumental to reach out to other women and husbands. Women's rights topics appeared in

the curriculum, including rights to equal education opportunities, rights to sexual enjoyment, and how FGM limits these rights (Muteshi & Sass, 2005).

Table 1. Implementation of the trans-theoretical model of behavior change

Stages of Change	**Implementation**
Pre-contemplation	*Beliefs and attitudes before intervention* -FGM prepares girls for pains upon giving birth -it is a mark of ethnic identity -it is a prerequisite for marriage
Contemplation	*Community Sensitization* -public and group meetings -workshops: talks by leaders, documentary -peer educators reach out to convince girls and parents to participate in the program
Preparation	*Family Life Education* -lessons on traditional and modern life skills -discussions, creation of songs, dances, and drama *Advocacy* -religious leader workshops
Action	*Coming of Age Ceremony* -performance by the candidates of initiation -gift giving and celebration -public declaration of parents
Maintenance	*Securing an enabling social environment* -community-wide sensitization of the harmful effects, misconceptions, and violations of women's rights of FGM -involvement of multiple stakeholders in devising program format and educational content -endorsement made by religious and village leaders

The second phase carried out a week of seclusion, which emulated the traditional healing period after circumcision. The week's program consisted of Family Life Education for the girls in a hotel, community hall, or a school. It included decision-making, hygiene, personal relationships, reproductive anatomy, sexually transmitted infections and prevention,

and myths about FGM, among others (Muteshi & Sass, 2005, p. 27). The seclusion period also dedicated time for girls to discuss traditional wisdom with their grandmothers and aunts and to prepare dramas and songs promoting the abandonment of FGM for the celebration.

The period of seclusion was followed by a Coming of Age ceremony officially recognizing girls into womanhood. This phase consisted of feasting, gift giving, and presentation of certificates as an alternative to circumcision of girls. The ceremony was witnessed by community members as well as religious and local leaders and government officials. This phase also involved public declaration of the parents not to circumcise their daughters in the future.

Although the activities can be described as corresponding to each stage of the Trans-Theoretical Model of Behavior Change, it is important to note that one activity may very well function as different stages of change according to the level of readiness of the individual. For example, the alternative ritual may function as a maintenance stage for the parents of the initiates, but for a non-participant of the program, the same activity may serve to be a preparation stage that triggers thoughts about sufferings experienced in the name of tradition.

Emprical Evidence

The first alternative rite ceremony was covered extensively by the press, raising awareness of the approach. However, despite the widespread acclaim, resistance from local population has been displayed in a number of ways that challenges the development of the strategy.

Among the Kurian community in Kenya, the alternative rites of passage program took place during the traditional genital cutting season in late November. Approximately 3,500

boys and girls would be participating in a ritual that would initiate each participant into adulthood. However, that year, 289 additional girls were prepared to undergo an alternative rite of passage. While others underwent genital cutting, the 289 girls participated in a week-long series of workshops that educated girls on topics such as FGM, empowerment, reproductive system, peer pressure, legal rights, and gender. All of the girls completed the process and received certificates (Prazak, 2007 p. 24). Nonetheless, the alternative ritual took a surprising turn when all but 80 of the girls were pressured or forced to undergo circumcision on their way home in adherence to the cultural norm that allowed the participants to return home only after the surgical operation (Prazak, 2007).

In Tharaka and Kisii districts of Kenya, groups that were opposed to the program spread malicious rumors, stating that the alternative rites program "forces girls to drink blood under oath, inject contraceptives into the girls' clitorises, go against cultural and traditional practices and pollute the community with foreign ideas…" (WHO, 1999, p. 109). Such rumors that invoke negative repercussions required execution of more awareness campaigns, discussions, and testimonies from former participants.

Among the Maasai, parents responded to the aggressive campaigns by lowering the age of circumcision by an estimated 4 years (Nzwili, 2003). Prazak also finds that the rate of FGM among the Kuria group increased as the age of circumcision for both sexes declined (2007). Lowering the age of girls would mean less decisive power on the part of the girls, and in turn, less chances of opposition. Younger girls are also said to be more tolerant of the pain from the operation making the surgical process easier for the adults to control.

In comparison to other groups in Kenya, there were a higher number of Abagusii who wanted the practice of FGM to continue. The reason for the adamant adherence to the

practice can be found in the reason for performing FGM. Rather than being an initiation and celebration into womanhood, FGM for the Abagusii serves as a cultural definition of being a female Abagusii. The practice, therefore, is a symbol of pride and maintenance of the minority group.

Alternative Rites of Passage: Few Words of Critique

A close examination of the project reports, research and assessment papers found a number of challenges faced by the strategy. First, although the projects described that the parents were fully involved in deciding whether or not to have the daughters participate in the alternative ritual, the extent of their involvement seems questionable. An assessment of an alternative rites program in Narok, Kenya, found that the parents were not fully informed of the purpose and the process of alternative ritual, and at times, the daughters themselves did not fully understand the objectives of the Family Life Education. The lack of full involvement of the parents may have fostered coercing or pressuring the daughters to undergo circumcision following the alternative rites ceremony.

Studies caution that alternative rites of passage may not be successful in ending the customary practice if the particular group does not execute the ritual as a public event (GTZ, 2001; Chege, Askew, & Liku, 2001; WHO, 1999). The Maasai, for example, mostly perform the procedure at their homes and it is often immediately followed by marriage. Attempting to change the nature of the practice by introducing a ceremonial ritual may not find a high level of success (Chege, Askew, & Liku, 2001).

Ultimately, the reason for some discouraging results seems to point to the program's inability to capture the intention and purpose of the ritual. The structure of the program is

soundly designed to emulate that of the traditional FGM ritual in the way the phases are organized. However, the intention and purpose of the activities are fundamentally divergent from those embedded in the customary ritual. The initiation for the practicing community symbolizes restoration and continuance of the cultural group (Prazak, 2007). The process is an implicit learning experience for the initiates who are introduced to collective living and learn to endure hardships among the company of one another. By being allowed to socially associate in a free manner among genders, the boys and girls become social equivalents, during which they learn about male-female relationships (Prazak, 2007).

The genital cutting is carried out simultaneously to serve the purpose of learning about collective living and gender relationships. It is an experience that prepares both sexes for communal living and social interaction. However, in an alternative ritual setting, girls are singled out to learn about concepts, such as human rights, that are unfamiliar to the culture. These alternative rituals, therefore, fail to meet not only the purpose for the girls but also for the boys.

4.3.3 Tostan and the Village Empowerment Program

Background: "Breakthrough" in Senegal

Tostan, which means "breakthrough" in Wolof language, is perhaps the most widely accredited by the international community for its success in FGM abandonment (Mdhordha, 2007; Joyce, 2006; Feldman-Jacobs & Ryniak, 2006). The Basic Education Program, a non-formal education method developed by the organization can be traced back to a center created for Senegalese children in 1976 by the founder of Tostan, Molly Melching (Feldman-Jacobs & Ryniak, 2006). The center promoted entertainment-education for children through

radio programs that included messages of health and the environment into songs, stories, games and plays. It also had various activities, such as theater, puppetry, and games. This experience later developed into the Basic Education Program over a 15 year period with the support of UNICEF. The programs are largely financed by USAID and by GTZ (Diop et al., 2003).

An estimated 28 percent of women in Senegal are circumcised (US Department of State, 2003), but the rate varies widely by region. In the region of Kolda, for example, 94 percent of women have undergone FGM. The government has set up countermeasures by banning the practice in 1999 with up to five years of imprisonment for breaching the law and developed an action plan with the aim to eliminate FGM by 2015 (US Department of State, 2003). Among the NGOs concerned with FGM, Tostan is probably the most active in the field (GTZ, 2007c).

Tostan's program is not just a project to end FGM; it is a holistic community development program. It emphasizes community ownership by helping the community to achieve their goals rather than to target a single development issue (Feldman-Jacobs & Ryniak, 2006). Therefore, topics about FGM are not introduced until module 7 or two years following the education program. Other topics include literacy, math, health, sanitation, women and children's rights. This case study will concentrate on a number of educational modules that specifically concern FGM and topics related to the practice.

Target Audience

The project works mainly to empower the women through education, as they are the main caregivers of the household. The classes are composed of an adult class and adolescent

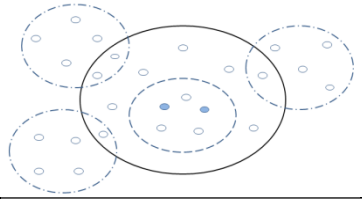
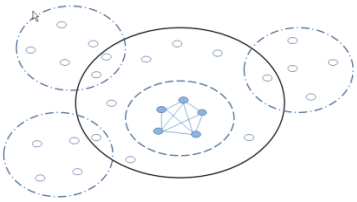
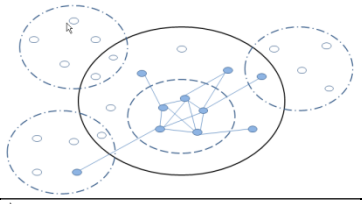
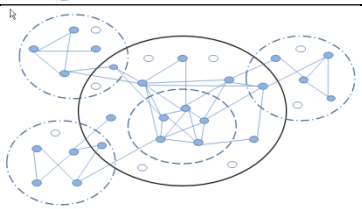
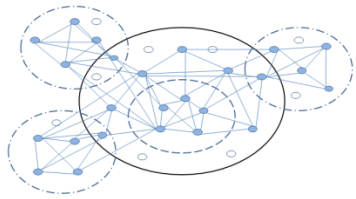
class for females. However, following the results of several studies conducted in Burkina Faso that showed the importance of the role of men in the decision-making process, the Basic Education Programs in Burkina Faso and Guinea included a separate men's class (Diop, Badge, Ouoba, & Melching, 2003). Although the program starts with a small number of participants, it eventually grows to involve the whole community during the adopt-a-learner, community mobilization, and public declaration stages.

Organized Diffusion Model: Implementation through Three Stages

Tostan's education program typically runs two classes of 25 female students in each community, divided according to the age of the person. There are eight modules in total that last an estimated 30 months. Following the objective of the program, to "promote self-development through the use of adapted educational materials" (Tostan, 1999, p. 16), the topics are all directly related to improving the daily activities of the local women. Table 2 summarizes the process of diffusion for the participants of the education program. As the participants progress through the sequence of stages, they start to recruit others and promote their decision to abandon FGM. The 'organized diffusion' column sketches out how the initial group is organized to eventually reach a broad range of social networks across intra-marrying communities.

Modules one through six taught technical information that set the base for making decisions and finding solutions to problems confronting the community, such as deteriorating health, hygiene, the environment and rural migration (Tostan, 1999). These modules were comprised of principles and how-to knowledge. *Principles knowledge* refers to functioning principles underlying how an innovation works (Rogers, 2003).

Table 2. Organized diffusion to abandon FGM: Reaching the tipping point

Diffusion of Innovation			Organized Diffusion
Knowledge	Awareness	existence of FGM	
	How-to	leadership skills, decision-making	
	Principles	germ theory	
Persuasion		-application of knowledge to daily life -reinforcement: games, theater, discussion	
Decision		-adopt-a-learner strategy -social mobilization activities	
Implementation		public declaration	
Confirmation		-disappearance of circumcision ceremony	

For example, the learning about transmission of germs topic in module two assisted participants to learn that infection from circumcision was related to causes other than "bad spirits." During class, the facilitator sprayed perfume into the water and asked the class participants to smell it. The participants realized that although the water looks clear, there may be something in there that is not visible to the naked eye. Through the activity, the

women were able to understand that although blades used to circumcise girls may look clean, there are germs that can infect the person who comes into contact (Tostan, 1999).

How-to knowledge contains information that is necessary in order to properly use an innovation (Rogers, 2003). During the Basic Education Program, the women learned about leadership skills in making and defending important decisions. This training was later reflected when they decided to abandon FGM and defended their decision to the public. The sessions dealing with FGM followed many other topics which prepared the participants to be able to take action upon gaining awareness knowledge about FGM. Information on FGM was not introduced until modules seven and eight. The areas of reproductive system, sexuality, menopause, and human rights education helped women make informed decision on whether to continue or abandon FGM.

After each lesson, the participants were encouraged to "adopt a learner," such as a husband, friend, or a relative, and share the newly acquired knowledge with others. This was the first step to taking the discussions outside of the classroom setting. The organized diffusion strategy was implemented by Tostan as a way to disseminate the lessons of the educational program across and outside the community and lead to a collective abandonment of FGM. Here, the decision to adopt an innovation may be portrayed by participants taking concrete action: recruiting others, defending their decision, and promoting others to abandon FGM. Dissemination of their ideas would not only increase marriage choice for the non-circumcising group but enable a community wide abandonment.

Another way to encourage organized diffusion was through social mobilization activities. Community-wide activities were conducted to reinforce the Basic Education Program outside of class and foster interpersonal communication, which is according to

diffusion research, instrumental to inducing persuasion and decision to adopt an innovation (Rogers, 2003). Traditional musicians, singers, poets, and actors were invited to make performances and hold discussions on the controversial messages relayed to the audience. In addition, local religious leaders who supported education for development organized meetings that were greeted particularly with great enthusiasm by the community members (Tostan, 1999).

Public Declaration

The objective of public declaration is not to create complete abandonment within the community, but to reach a critical mass of the population who are abandoning and encouraging others to do the same. According to Melching, founder of Tostan, "If 40 percent in the community do abandon after the Public Declaration, that may constitute enough people to influence others and lead to a tipping point where all will abandon" (Feldman-Jacobs & Ryniak, 2006, p. 34). Mackie asserts that public declaration plays the key role for FGM abandonment campaigns, as invisibility of the practice keeps people unsure of whether others are undergoing circumcision. It is a way to ensure that abandoning FGM is a collective effort (Mackie, 1996).

Public declaration may also act as group pressure to conform to collective voice. After observing a considerable number of community members declaring abandonment of FGM, he/she may feel obliged to do the same. Alternatively, a person who may have been unsure may decide to follow along with the crowd. In this case, the stages would take the knowledge, decision, and persuasion route rather than the theorized knowledge, persuasion, and decision. This phenomenon is reflective of the cognitive-dissonance theory, which states

that when there is a discrepancy between attitude and behavior, attitude will most likely change to accommodate the action, thereby reducing the psychological discomfort (Griffin, 1997).

Communication Method

Tostan's program emphasized the use of multiple channels of communication in its activities. In order to familiarize the participants with new concepts, drawings and flipcharts were included in the lessons to supplement verbal explanations. The theater presentation on FGM incorporated the setting, songs, and even crying as it actually happens in the community. The realistic examples of their daily lives further increased familiarity and the willingness of the women to engage in critical thought-evoking discussions. The participants then identified examples that were pertinent to the topic by referring to similar situations in their daily lives through stories, drama, poems, songs, and interviews. Superstitions and traditional beliefs surrounding the subject were also openly discussed (Tostan, 1999), and different opinions and questions were shared. By this time, the participants were literate, and they continued to become familiar with topics by reading books or writing articles, stories, and songs. The variety of activities was helpful to form an attitude toward FGM. The community mobilization activities also integrated traditional forms of expression, such as poems and songs of well-known artists to provoke critical thinking.

Implementation and Empirical Evidence

An evaluation conducted by the Population Council in 2006 found that among the 2,657 villages that publicly declared to abandon FGM, the rates declined by 60 percent (UN Integrated Regional Information Networks, 2007). Yet, the practice is far from complete

elimination; in many of the villages that have publicly pledged not to circumcise, some people are still undergoing the practice, even those who have declared to abandon (UN Integrated Regional Information Networks, 2007).

Overall, the results of evaluation studies found that unlike other anti-FGM intervention programs, the support toward FGM for both the experimental village and the neighboring villages decreased after the duration of the program. The results supported the effectiveness of the organized diffusion strategy and the "trickle-across effect" (Gryboski, Yinger, Dios, Worley, & Fikree, 2006), which aimed to spread the idea to stop FGM across intra-marrying communities and eventually lead to collective abandonment. A study conducted in the Kolda region found similar results. The level of awareness of human rights was assessed by asking questions that asked about various rights entitled to individuals – both men and women – to the intervention and the neighboring villages. The evaluation interview indicated that both groups improved in their awareness of five basic rights –to vote, health, education, drinking water and a clean environment (Diop et al., 2004). The awareness of women's rights was found to increase, according to two categories of indicators: schooling for girls and the role of women's unions to demand rights (Diop et al., 2004). In fact, Melching believed that human rights education was what ultimately led to the numerous community-wide abandonment of FGM. According to Melching, "Human rights education had a huge role to play in this process in order to make people aware and give them the tools they need to make decisions that I think they had wanted to make for a very long time [anyway]," (UN Integrated Regional Information Networks, 2007).

However, the study pointed to a difficulty in developing quantifiable indicators on attitude and application of human rights. It concluded that information from key informants

and observation in the villages showed a trend towards the creation of a healthy environment and a greater willingness to defend women's rights in the intervention area (Diop et al., 2004).

One of the important factors that was found to sway the community decision is the attitude of the village and religious leaders. Some leaders who perceived the program as coming to "fight against the traditional culture, which had come down from their forefathers, and even more to fight against the principles of Islam and the purification of the woman" (Diop et al., 2004, p. 8) closed down the education program and expelled the facilitator. The differences in willingness to abandon FGM among the two ethnic groups, Mandingo and Pulaar, was also largely due to the Pulaar religious leader who was not in favor of abandonment (Diop et al., 2004).

A major challenge faced by Tostan's program was that it frequently faced drop-out of participants largely due to lack of motivation to attend the education classes. In the Kolda region, only 64 percent of the women and 50 percent of men who had expressed initial interest actually participated in the Basic Education Program. Men who had dropped out stated that they had found no economic compensation in the classes (Diop et al., 2004). The program implementation in Burkina Faso faced the same difficulty. The lack of economic support mechanisms, such as microcredit project or income-generating skills were mentioned as the primary reason for lack of regular attendance (Diop et al., 2003).

For most of the regions where Tostan's activities are implemented, high poverty levels are common. In the Kolda region, 57 percent of households live below the poverty line, compared with 25 percent in urban areas (Diop et al., 2004). An inclusion of a livelihood training module in the Basic Education Program may therefore assist in economic

improvement of the concerned communities. It may also motivate participants to learn about other necessary knowledge that could be neglected due to irregular participation.

Nonetheless, Tostan has made major "breakthroughs" in FGM practicing communities in not only abandonment of FGM but also in promotion of health and hygiene, such as getting vaccination, washing hands, cleaning public areas, and preventing sexually transmitted diseases. The wide success of Tostan's community-based education program seems to be in large part from equipping participants with not just awareness knowledge but to how-to and principle knowledge of an innovative idea. For Tostan's education modules, the awareness knowledge of FGM, sexually transmitted diseases, and female sexuality came last. They were preceded by literacy programs, principles that discussed germs, explained how to prevent infection, problem solving, decision making, and leadership skills. Therefore, when the highly sensitive topics were introduced, they were able to critically make decisions on their own. Interestingly, Tostan's report states that it has found the "negative health consequences" and "the right to the highest standard of health" messages to be the most effective argument for discussions with men, women, and adolescents.

4.4 Complete Eradication of FGM: Participatory Strategies

The underlying philosophy of the participatory model lies in the "horizontal process of information exchange and interaction" that fosters social equity and empowers the participants with critical thinking and decision-making skills. Therefore, communication strategies stemming from the participatory model emphasize dialogue and provide participants with the opportunity to define a problem, plan, and implement possible solutions. Numerous assessment studies have emphasized the importance of incorporating a

participatory approach in anti-FGM intervention strategies (Gryboski et al., 2006; Leye, Bauwens, & Bjalkander, 2005; GTZ, 2001; NGO Networks for Health, 2000). Yet, comparatively fewer anti-FGM intervention projects have used the participatory approach in implementing their programs.

The lack of participatory programs may be due to the enormous challenge anti-FGM programs face in having the community members address the issue as a problem. The starting point of a participatory approach is that the community should identify its pressing needs, which in turn, are discussed and solutions are sought for. In most cases, however, the community members were reluctant, or even refused to speak about such a personal and sensitive topic as FGM. Out of all the projects that have been studied for this research, none was found where the community members challenged FGM as a pressing issue. All intervention programs to be examined were not truly participatory in that the implementers introduced FGM as a problematic practice. However, rather than instruct and persuade the communities, the programs sought to understand the community perspectives and find a solution within the boundaries of the communities.

Programs that take a participatory approach usually work with a group of selected community members to identify urgent health problems and explore possible solutions. The Community Action Cycle model used in the hamlet-level (the lowest regional unit) of the Ndukaku initiative recruited a group that represented the men, women, and youth of the community. They identified the most pressing health issues, which the facilitators used as an entry point to critically discuss traditional practices, household decision-making, and status of women (Center for Communication Programs, 2005). Then the facilitators provided the group with guidance as they developed action plans to eliminate FGM. The group was also

trained with advocacy skills to speak with traditional leaders and ruling councils about the social and health complications of FGM (Center for Communication Programs, 2005). The intergenerational dialogue project takes a similar format. Group members are chosen according to their status and influence in the community, and these members are encouraged to reflect on their worldviews and the social norms that guide their actions through a variety of locally available means of communication.

The positive deviance model also takes a participatory approach. It first enters the community with a question rather than a formula to apply into the setting. Whereas the idea of an alternative rite of passage was pre-constructed by an outside group and subsequently elaborated by community members, the positive deviance model involves community individuals from the start by raising a question. Second, it takes an assets-based approach, meaning that it looks for resources that already exist within the community for solutions, rather than importing outside resources into the community, which is frequently met with local resistance. In other words, it looks for best practices within the local setting rather than bringing in an existing one from outside. Therefore, the solution is derived from the local people, which imbue a sense of ownership of the derived solution.

Observational Learning: Vicarious Learning through Role Models

The essence of the positive deviance model strongly resembles Bandura's theories of observational learning (1977). Based on the grounds that direct self-reinforcement cannot account for all types of behavioral learning, Bandura claimed that learning is mostly done by observing and modeling others. According to Bandura, "Most human behavior is learned observationally through modeling: from observing others one forms an idea of how new

behaviors are performed, and on later occasions this coded information serves as a guide for action" (1977, p. 22). This type of learning through vicarious experience has been used to explain a wide array of behaviors, including aggression, drug abuse, and eating disorders.

Bandura identified three different types of learning: A *live model*, where individuals personally demonstrate a behavior. Community events that stage women who are not circumcised in a favorable light have been found to have positive impact. One such event is a public wedding ceremony organized by Kembatta Mentii Gezzima, an NGO based in Ethiopia (Teferra, 2004). The organization works with women who refuse to undergo FGM or men who refuse to marry a circumcised woman. During the wedding, the bride wore a placard stating contentment of not being circumcised and the groom affirming that he was happy with his bride (Teferra, 2004). Being a true community event, the strong imagery fosters the vicarious learning process. V*erbal instructional model* involves descriptions and explanations of a particular behavior, and *symbolic model* refers to a display of behavior through mass media. Learning may take place through all three types of experience, but successful learning occurs through a sequence of four steps: attention, retention, reproduction, and motivation (Bandura, 1962).

First, successful learning requires attention from the observer. Here, similarity, status, competence, and attractiveness are all conducive factors to catching the observer's attention. *Retention* refers to the ability to store information. Strong imagery and language are said to affect the level of retention. *Reproduction* is the actual performance of the behavior by the observer. In order for continuous reproduction of the behavior to be possible, one has to be motivated to replicate the behavior. *Motivation* occurs through reinforcement, such as a sign of approval and praise verbally or by receiving an award.

It seems noteworthy to mention that observational learning theory may pertain to both the dominant paradigm and the participatory approach according to how it is applied. For example, a media program that uses a fictional character who refuses to undergo FGM would be categorized under entertainment education. For the positive deviance approach and the public wedding ceremony in Ethiopia, observational learning theory is seen as participatory partly because the role models are found within the community. Focusing on similar and familiar events, characters, and messages among the elements of the observational learning theory strengthened vicarious reinforcement and facilitated the observers to emulate the desired behavior.

Symbolic Interactionism: Negotiating Social Reality from the Inside

Symbolic interactionism is a sociological theory that seeks to explain the process of interaction among human beings in construction of meaning and social reality. The theory was coined and developed by Herbert Blumer (1969), who points out three basic premises of social interactionism.

1. "Human beings act toward things on the basis of the meanings they ascribe to those things."
2. "The meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society."
3. "These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he/she encounters." (Blumer, 1966, p. 2)

Blumer refers to the reality that people, as active and creative social participants shape through interaction as *social reality* (Blumer, 1969). He states that social reality is created by using language to embed meanings into symbols that would otherwise be futile. The notion of social reality and creation of symbolic objects through interaction among its

social constituents are theoretical principles that can easily be applied into the practice of FGM among many ethnic and religious groups. An approach from the perspective of symbolic interactionism suggests that rather than impose outside beliefs onto the groups, the role of the researcher should be try to understand FGM as a symbolic object and its historically established, profound meaning created by the constituents. According to Blumer,

> "The contention that people act on the basis of the meaning of their objects has profound methodological implications. It signifies immediately that if the scholar wishes to understand the action of the people, it is necessary to see their objects as they see them… simply put, people act toward things on the basis of the meaning that these things have for them, not on the basis of the meaning that these things have for the outside scholar" (1966, p. 50-51).

Until now, most intervention projects have failed to observe FGM as a social symbol. Considering only the physical act of FGM centered around the act of scarring has led to sensitization programs with the greatest interest in transmitting the "objective reality" that is "independent of the social definition" (Charon, 2001, p. 43). Most sensitization activities have taken place through education by instructing the concerned population about the health consequences and human rights violation inherent in FGM. Such projects hardly question how practicing FGM is able to satisfy the worldview of the social constituents. They also fail to observe how interaction among the social players has come to shape the meaning of the practice.

The intergenerational dialogue is a model that has been created in reflection of social interactionism. According to symbolic interactionism, just as social reality is constructed through interaction among its constituents, social change is also brought about through the interaction process and interpretation of each others' actions. Charon (2001) presents a diagram that reflects this idea.

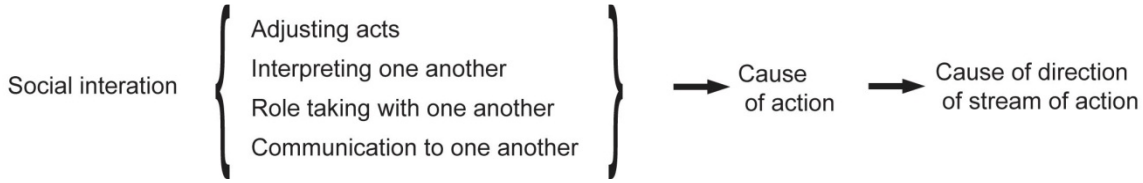


Figure 2. Social interaction in the process of change in behavioral action. From *Symbolic Interactionism: An Introduction, an Interpretation, an Integration,* by J. M. Charon, 2001, p. 146.

The diagram shows that the way people behave constantly changes through communication that enables interpretation of one other. One way of going about this is by taking the perspective of someone else and observing how others define the situation (Charon, 2001). An effective communication and cooperation needs to start from knowing how others define what meanings are embedded into the symbolic object under consideration.

This diagram is what the intergenerational model follows in its intervention process. Rather than to instruct and persuade the community members to change their behaviors, the model fosters interaction among generation groups within the community. The program then pursues social change stemming from the perceived needs that arise from the interactions. The assumption of the model is that whereas interaction shapes social reality, problems within social reality may remain unaddressed for a variety of reasons: they may be taken for granted, people may not believe they can be improved, or some may just avoid addressing the perceived problem to others. Therefore, the program works to "create(s) a secure framework for identifying suppressed conflicts and dilemmas, discussing them and finding solutions that everyone can accept" (GTZ, 2007a). The generation groups are defined to play central roles in cultural maintenance and change.

The intergenerational dialogue enables different generations to reflect on and share their respective worldviews and expectations of one another. By doing so, the generation constituents are encouraged to take the role of the others and imagine how the other generation views the community (GTZ, 2007a). This activity is the stepping stone to defining problems in the community and negotiating how and under what conditions to bring about certain societal changes. It also dismantles the stereotypes or prejudices that each group may have held of one another.

The following two case studies will examine how the social learning theory and symbolic interactionism were implemented in an anti-FGM intervention setting.

4.4.1 Positive Deviance Model

The premise of positive deviance is that there exist an individual or a group in every community whose "uncommon practices/behaviors" led to the discovery of better solutions to a problem than the neighbors who have access to the same resources (Masterson & Swanson, 2000). The objective of the positive deviance model is to "identify the specific practice that, in spite of harsh conditions (e.g., poverty), allowed one group (i.e. the positive deviants) to have better outcomes than the majority" (Lapping et al., 2002, p. 129).

The positive deviance model was developed by Jerry and Monique Sternin in 1991 in search for a model to help remedy the widespread malnutrition in Vietnamese communities. Popular approaches to alleviating poverty consisted of mass donations of supplemental food, diffusion of innovative ideas or products, or application of the systems theory that was used to identify the factors responsible for malnutrition. The systems theory method successfully derived a blueprint of various levels of deficiencies, such as the low level of education,

health care, unhygienic conditions, birth control, and the low status of women. However, this holistic approach that addressed all the deficiencies was not only costly and intrusive, but was also unsustainable after the intervention project withdrew. From such observation, Sternin and Sternin attempted an unprecedented model called "Positive Deviance" (Pascale, Millemann, and Gioja, 2000, p. 176).

Since the first implementation of the model in 1991 until 1999, more than 250 communities in Vietnam restored the health of an estimated 50,000 malnourished children. Moreover, it is reported that the younger siblings of these children are enjoying the same improved nutritional condition (Waugh, 2004). The positive deviance model has been applied in various settings since then, including the World Bank education project in Argentina to prevent early education drop outs, HIV/AIDS risk reduction program, girl trafficking in Indonesia, promotion of handwashing in US hospitals, and even in international corporate business settings (McCloud, Aly, & Goltz, 2003; Pascale, Millemann, & Gioja, 2000)

The anti-FGM positive deviance program was first implemented in 1995 by the International Center for Research on Women and The Center for Development and Population Activities. The program was a part of the Promotion of Women in Development project funded by USAID. Four local NGOs were involved in the project that was selected for their diversity in location of operation – rural versus urban – and Christian and Muslim religious affiliation. The project team trained them to develop participatory skills and to identify the positive deviants.

Background: Positive Deviance Program in Egypt

FGM in Egypt dates far back into the ancient times, possibly to the point of origination during the Pharoanic era (Mackie, 1996). The tradition still remains strong as is evidenced by the 97 percent circumcision rate among ever-married females (El-Zanaty, Hussein, Shawky, Way, & Kishor, 1996). The statistical analysis revealed that FGM was almost universal among girls aged 8 to 13. The people demonstrate strong resistance to campaigns installed throughout the country. When the government ordered a health facility to be shut down after death of a girl during circumcision at the center, it instigated outrage and mass protest demanding re-opening of the clinic (Slackman, 2007). As a result of the death of the girl, the government strengthened its law banning FGM and adding that even in situations of illness, female circumcision is no longer permissible (Reuters, 2007).

The positive deviance project was developed in response to the results of a survey conducted by Demographic and Health Surveys, which revealed that FGM was almost universal among girls aged 8 to 13. The experimental phase from 1997 to 1998 involved 4 communities, which expanded to 16 in 1999 and 2000 for the second phase. Since then, the project has involved 24 communities in Egypt (CORE Group, 2004). There are four goals guiding the project. The first is to increase community awareness of FGM, not through sensitization activities but through interaction with the positive deviant individuals. Second is to support leaders to break the silence surrounding FGM and the third goal is to increase community-generated advocacy efforts. The fourth goal is to monitor “at risk” girls.

Implementation of the Positive Deviance Model: The Four D's

The positive deviance model consists of four steps: Define, determine, discover, and design. The *define* stage was implemented through a two-day workshop during which the organizations examined the problem and learned about the positive deviance approach. The *determine* stage entails identifying those individuals who are exhibiting the desired behavior, notwithstanding the means. In Egypt, an estimated 300,000 women between the ages of 8 to 13 who weren't circumcised would qualify as positive deviants. However, positive deviants cover both men and women. The men included doctors who refused to circumcise girls, husbands who willingly married uncircumcised women or did not require them to be cut after discovering, fathers who kept their daughters from being circumcised, religious leaders who advocate abandonment of FGM, and journalists who actively seek to report intervention efforts to FGM. The female positive deviants were mothers and grandmothers who refrained from circumcising the daughter or granddaughters, *Dayas* – or traditional circumcisers who gave up their occupation, young girls and older sisters of the girls who were able to convince her family not to circumcise, and female teachers who advocated abandonment of FGM to their students (Masterson & Swanson, 2000).

The actual identification of the positive deviants was conducted through informal conversations with community members and through a snowballing method that asked each positive deviant for knowledge of any other uncircumcised women.

During the *discover* stage, the project team analyzed the solutions that positive deviants found which prevented them from practicing circumcision. Any actions that were "true but useless" or not easily accessible were discarded. For example, being influenced by family members who have immigrated abroad is not a common phenomenon for the local

population and therefore was dismissed. Another unfeasible instance would be a family from a high socioeconomic status that is knowledgeable and supportive of the international norm on human rights and chooses not to circumcise the daughter.

The solutions were collected through interviews with positive deviants, which questioned the specific factors and the turning point that enabled the individuals to take a different action. It also asked for specific words or messages the individuals used to convince the decision makers. Proposed strategies for community-based action regarding FGM were also identified. Finally, the interviewer asked if the positive deviant individual would be willing to serve as an advocate or a peer educator (Masterson & Swanson, 2000; Muteshi & Sass, 2005).

From the interview, the project planners identified some common determinants that triggered deviance from FGM, including a deep sense of betrayal and loss of trust in the parents, and negative physical and psychological impact from practice. Another conducive factor was an external validation of personal conviction from medical, religious leaders and teachers (CORE Group, 2004).

The results of the interviews were subsequently applied into the *design* stage, or creating intervention activities. The organizations implemented awareness-raising campaigns to groups that were influential to FGM decision-making, communication materials, including posters, newspaper advertisements, pamphlets, dramas, and puppet shows all used the words and messages of the positive deviants. Testimonial sessions were also held where the positive deviants shared their experiences and ideas with the community.

According to the social learning theory, observation of people who are “just like me” is an important characteristic – similarity – that catches the attention of the observer. It is a

"social proof" that there are people similar to the observer who have abandoned circumcision and are being supported by others of their actions. Therefore, the testimonials serve as a direct response to demands by older women such as, "Show me an uncircumcised woman who is virtuous. Then I will consider not circumcising my daughter!" (CORE Group, 2004, p. 14).

Target level of Audience

While the positive deviance program involved community-wide mobilization, the main target of the program was the girls who were at risk of being circumcised and their family members. The community group tracked the girls that had not yet been circumcised through community networks, and made regular visits to the girls and their families. A girl was placed in a high-risk category if, for example, her older siblings were all circumcised or if the mother was strongly in favor of circumcision. The tracking system identified the individuals interviewed, the number of visits, and the attitude of the interviewee of FGM after the meeting (McCloud, Aly, & Goltz, 2003, p. 5).

Empirical Evidence and Evaluation

The home visits to at-risk girls found that 73 percent of the families declared they would not circumcise their daughters. The indicator for an at-risk girl to be labeled as "saved" is if the girl is married without being circumcised (McCloud, Aly, & Goltz, 2003). The indicator, however seems questionable in reference to a number of studies that found numerous instances of circumcision after marriage (Hernlund & Shell-Duncan 2007; Films Media Group, 1998). The bride was mostly pressured to undergo circumcision by the husband's co-wives or the mother-in-law.

Evaluation of the programs has found that even within the same region, the intention to change differed. This was in part attributed to the growing instances of migration from more conservative areas. In addition, higher success rates were identified for Christian than Muslim communities, most likely due to the ingrained belief that the practice is prescribed by the Koran (McCloud, Aly, & Goltz, 2003).

The community workers were instrumental to the success of the positive deviance program. Being part of the community network, they were the ones able to identify the positive deviants, which CEDPA project implementers pointed out as being the most difficult part of the project. In addition, the community workers also identified the "at-risk" girls by determining whether the mother was circumcised, whether she was strongly in favor of circumcision, and whether the older sisters were circumcised. Incorporating community members into the planning stage was highly advantageous to learning about the unique situations of the community.

An unanticipated result was a strengthened relationship between the community and the NGOs. The partner organizations affirmed that the Positive Deviance Inquiry provided an opportunity for community leaders and staff to design development strategies as equal partners (Masterson & Swanson, 2000). Furthermore, the level of trust between the organization and the community was found to influence the community inclination to change. Therefore, the length of time that the local organization has been operating in the region is also an important indicator (McCloud, Aly, & Goltz, 2003).

4.4.2 Intergenerational Dialogue

Introduction

The generational dialogue project was initially formulated in response to the discrepancy between awareness and behavior. Although many families were aware of the health complications and other harmful effects of FGM, most daughters were still undergoing the practice. In fact, it was even reported that the leading members organizing anti-FGM projects had their daughters circumcised (Roenne, 2005). The contradictory evidence led to a new principle, "listen and inquire: don't preach!" which focused its attention on listening and facilitating discussions rather than instructing and teaching. The generational dialogue model sought to understand how different generations and sexes in a community perceived their world; their values, concerns, and aspirations. Then the program provided a space for the groups to share and listen to each others' stories, fostering negotiation based on a stronger understanding of one another.

Background: Guinea

FGM has been a longstanding tradition in Guinea, which is widely practiced notwithstanding the ethnic group or religion of the woman. The 1999 Demographic and Health Survey points to a nearly universal 98.6 percent prevalence rate (Yoder, Camara, & Soumaoro, 1999). Guinea passed a law in 2000 that protects women and men against torture and all cruel treatment affecting the body and the reproductive organs (US Department of State, 2001). However, the government has yet to enforce its law in any way. Although practice of certain types of genital mutilation for men and women has been outlawed by the government since 1965 and carries a life sentence upon breaching the law, there have been

no convictions to date (GTZ, 2007b). The only reported changes are that there is an increase in the age that girls undergo circumcision and that it is increasingly being performed by health professionals (GTZ, 2007b).

Target Group

The local NGO partners selected the target groups and their representatives, consisting of no more than 15 per generation and gender group. The initial participants were selected on the basis of their influence, interpersonal skills, and respect received by others, which all contributed to the multiplier effect of the dialogue approach. Among the members were religious leaders, who were always included in order to stimulate discussions in the Muslim communities. The target group expanded to the community in the community dialogue phase as the workshop participants brought intergenerational dialogue out to the local population.

Project Implementation: The Workshop

The discussions were designed to conform to the local tradition and to accommodate elements for connection between the older and younger generations. The objective of the workshop was not only to have the two generations identify with each other, but to learn things about each other that may never have taken place had it not been for the workshop (Finke, 2006). During the curiosity exercise, each generation came up with a list of questions that they have always wondered about but never dared to ask. Then the two generations came together to share the questions and answers.

The workshop also sought to empower each generation with the sense of being heard and taken seriously, as well as being respected and appreciated. The power and

powerlessness exercise encouraged each group to discuss the skills and strengths of the other group (Roenne, 2005). The groups also exchanged questions and answers regarding their respective domains of power and powerless. The discussion was a way to become aware of and to break the stereotypes and prejudices each generation held of one another.

Utilization of Traditional Forms of Communication

The main facilitative element of the workshop seems to be a bottom-up communication method. The communication tools were highly effective in an area where 85 percent of women and 62 percent of men are illiterate (Committee on the Elimination of Discrimination against Women, 2001). All discussions were held in the local language for the elders who were not familiar with any other. The discussions also emulated the social and moral education of the young generation that take place through the use of proverbs, folk songs, and dances by having local instruments available in the rooms (Roenne, 2005). Interacting through music and dance became customary. Every day, the women and girls began their dialogues by singing together. For the men, religion played an important role in uniting them together. The two groups referred to religious proverbs, metaphors, verses, and prayers to make their views more comprehensible or more acceptable to the other generation. The first activity of the workshop utilized this traditional mode of communication by pairing a young person with an older person to introduce each other and to speak about a proverb that they consider relevant to the workshop (Finke, 2006).

Tools and gadgets that are a part of everyday lives of the local population were utilized to share the life paths and worldviews of the older and younger generations. The elements ranged from necklaces, bows, and arrows to condoms, cell phones, or a photo of a modern wedding (Roenne, 2005). These objects were arranged in a path to signify the stages

in their lives. Although the objects themselves are meaningless, embedded into them were the social norms and morals that guide the temporal structure of the older and younger generation. For example, in Labe and Faranah, the different types of arms represented different stages in a man's life. The boys picked up slings, for young men, bows and arrows, and rifles for adults. Being able to use a gun and hunt meant a young man was ready for fatherhood (Roenne, 2005).

Community Dialogue

Two months after the workshop, the generation dialogue was taken outside to the community. The workshop participants initiated intergenerational dialogues with other community members, starting with families and friends. The objectives of this phase were "to involve ever more members of the community in generation dialogues, to adapt the dialogue to the realities of a community, and to help the spirit of the dialogue to become a part of the everyday lives of all participants" (Roenne, 2005, p. 9). After a month of community-wide dialogue, a follow-up workshop was set up to exchange the experiences, listen to testimonies of members who have benefitted from the dialogues, and to plan new projects of a similar personality (Finke, 2006; Roenne, 2005).

The dialogues were conducive to creating a wider environment for change aspirations by the parents. In order to defend their decision to not circumcise the daughters, a training program for uncircumcised daughters was developed by a local partner organization (GTZ, 2005). The training program consisted of 20 uncircumcised girls between 8 and 13 to a four day peer educator program that taught the girls to share their knowledge and ideas with fellow peers (GTZ, 2005).

Evaluation of Impact: Action Research

The GTZ and the partner NGOs monitored the impact of the project through action research. Designing and conducting of research included the staff of the local NGOs in order to foster a better understanding of their communities. The first study compared the level of communication within the intervention and control families four months after the generation dialogue. The interviews found that a significantly higher number of participants replied that there was more communication and more mutual interest between the parents and children in families (GTZ, 2005). However, nearly half of the fathers stated that they have not discussed FGM with their daughters. This result showed that the objective of the generation dialogue, to open discussions about sensitive topics such as sexual morality and reproductive health, was somewhat limited.

The action research on training for uncircumcised girls took a positive deviance approach by asking the parents about motivations to not circumcise the daughters, reinforcing experiences, and any fears resulting from choosing not to circumcise the daughters. The study found that none of the girls who have participated in the training program or their sisters have been circumcised. The girls have experienced a heightened sense of self-esteem and empowerment, and have become role models within the community. Interestingly, the greatest fear of the parents was the idea that the concerned NGOs may fail to provide additional support to the daughters after the training (GTZ, 2005). The parents also suggested organizing a public “initiation event” to celebrate the initiation without circumcision with the community (GTZ, 2005).

The intergenerational dialogue has also been adapted in Kenya and Mali. However, no documentation describing or monitoring the projects is yet available by the project implementers.

Empirical Evidence and Evaluation

The dialogues included serious discussions about family, sexual and moral standards, and gender violence. The outcome of the dialogue didn't differ much among the three regions. All young women's groups brought up the double standards of elders' expectations to be virtuous but at the same time, to appeal to older men of wealth. All groups criticized the role of fathers and their lack of responsibility to the family. For example, the young men were opposed to polygamy because they suffered from lack of money and time devoted to them by the fathers. They stated, "We can do as we please and you're not in least bothered. If we go out at night, if we take drugs, you are not concerned. You criticize our mothers, but you do not talk to us" (Roenne, 2005, p. 16). The spokesperson for the young women's group even went on to state, "we don't even know what paternal love is" (Roenne, 2005, p. 14).

All three communities admitted to the limitation of circumcision in preparing girls for social and married life. The older men and women acknowledged that moral education would need to be supplemented through other forms of activities. However, they were against a radical abandonment and rather, suggested a "pretense" solution, such as a minimal incision or a visit to a health worker who would pretend to perform FGM and apply a plaster, that would be acceptable for the transition period.

While the intergenerational dialogues were found to solidify the relationship between older and younger women as well as older and younger men, the workshop did not address

the relationships between men and women. The first workshop in Conakry did not extend to inter-gender communication. In Faranah and Labe, all four groups came together to present what they hope to see and ways to strengthen the relationship from the other groups, but the discussion took place only once, on the last day of the workshop. The examination of the topics that were brought up included issues such as gender-based violence, the role of the father, and marriage, which require cross-gender discussions. For example, the women of Faranah and Labe wanted to be educated and trained in order to be free from dependence on the husband. At the same time, they were concerned of the difficulty in "finding men who will marry them and love them as educated and independent women" (Roenne, 2005, p. 12). However, men's generation dialogue also found that young men also hoped for a marriage based on mutual love with educated women who are able to contribute to the family income (Roenne, 2005). Whether such viewpoints were shared among young men and women are not mentioned in the project report.

Moreover, the impact assessment identified only 45 percent of men who admitted to speaking about FGM to their daughters. Although this percentage was higher than the 30 percent of non-participant males who have brought up the issue, the low percent implies a rather limited effect in cross-gender generation dialogues. According to the findings of the generation dialogue, this may be attributed to the distant relationship between fathers and daughters. Cross-gender generation discussions may help to narrow the gap between the two groups. The men may feel more encouraged to talk to their daughters about FGM if it is brought up as a topic in a cross-gender discussion.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

5.1 Discussion

The multiple-case studies examined four distinct efforts to mobilize communities toward FGM abandonment. The case studies sought for explanations and descriptions to operationalization of particular models, instruments and tactics used to implement strategies, and outcomes and evaluations of the projects. Although the case studies observed the overall process and results of the projects, Table 3 focuses attention on three main elements of comparison for the community-target level projects. The first column, *ideation*, asks who first raised FGM as a problem issue. The second column, *implementation*, observes from where the implementation models were derived and the extent to which they incorporated community input. The third column, *solution*, questions how solutions were derived.

For all four case studies, FGM was first challenged by intervention groups. This made it difficult for the projects to take off or to be participatory in design, as most villagers were reluctant to speak about the issue. None of the projects were truly participatory in nature, as the problem did not arise from within the communities but was introduced from the outside. The outside-driven aspect of the interventions made participation and involvement of community members a difficult process. However, the case studies also indicate that outside-driven problem statements do not necessarily lead to failure in behavior change.

The *implementation* column indicates that as the case studies progress, the implementation models become increasingly open for greater amount of input and participation by the community. Community education, as evidenced by Tostan, led to self-development or “development by the people.” However, the case study also found that community education requires long time of commitment from both the intervention group

and participants. A well-adapted method of learning is needed, which is tailored to fit the learning pattern of the participants. The established forms of sensitization through lecture and IEC materials seem limited in evoking behavior change. They may even lead to desensitization of the audience.

Table 3. Procedural pathway of the four community-based anti-FGM strategies

Case Study	Ideation	Implementation	Solution
Alternative Rites of Passage	introduced by outside	-step-by-step model created and brought in by outside agency - actualization of stages includes community input -strong community education	-introduced to the community by outside agency *"community follows"*
Village Empowerment Program	introduced by outside	-educational model created from past community development experiences -instructs and discusses topics adapted to the needs of the local women -strong community education	-abandonment decided by initial core *"an initial core leads"*
Positive Deviance	introduced by outside	-model asks questions -locally accessible, locally developed design and solutions -some community education	-found within community *"deviants build"*
Intergeneration Dialogue	introduced by outside	-model asks questions -exercises facilitate group discussions and sharing of viewpoints -no community education	-pretense solution negotiated among generation groups *"generation groups negotiate"*

The *solution* column observes how solutions were derived in each project. Other than the alternative rite of passage, all three projects had some form of community-driven decision-making. For the positive deviance strategy, the positive deviants sought out solutions to ending FGM. Here, it seems important to note that the influence and the position the deviants command in the community is key to the success of the program. Teachers,

religious leaders, village chiefs, and women who are respected by others are some examples of positive deviants who would be capable of leading community-based behavior change.

This chart, in essence, shows that the failure to change FGM behavior may largely be attributed to outsiders coming up with the solutions to stop FGM with little or no community input. The alternative rite of passage case study, for example, found that the decision-making to execute an alternative ceremony was pre-established by the intervention group, and the community mostly followed along with the program design. This program, despite its salience and acclaim, was met with some strong forms of resistance by communities. On the other hand, the reasons for wider success in behavior change of the latter three strategies may be that community-driven solution building created a sense of ownership and achievement by the community. For all three strategies, a common factor that facilitated community-led solution making was that the justification of the need to stop practicing FGM was well-understood by the community.

According to the chart, the strategy which should have had the greatest level of success is the intergeneration dialogue approach. This approach granted the greatest freedom of participation to the community members, and in consideration of generation gaps, power relationships, and the role of the elders in maintaining tradition, the strategy segmented its participants by generation to stimulate negotiated behavior change. Eventually, the dialogue was able to come to a community-based negotiation toward practicing FGM, which was to have a transition period by performing a minimally invasive operation. However, the dilemma of this solution seemed to be that it was not compatible with the organizational principle of GTZ, which saw any form of FGM as a violation of human rights. Hence, the negotiated solution was not an appropriate or a sufficient conclusion of the project.

The Current Picture of the anti-FGM Movement

The first part of Chapter four identified the root of the human rights philosophy of the international organizations. The case studies show that this framework clearly has come to shape the current anti-FGM programs. Seidman and Seidman's model of the legal system is used to describe the overarching framework of anti-FGM efforts (Seidman & Seidman, 1994).

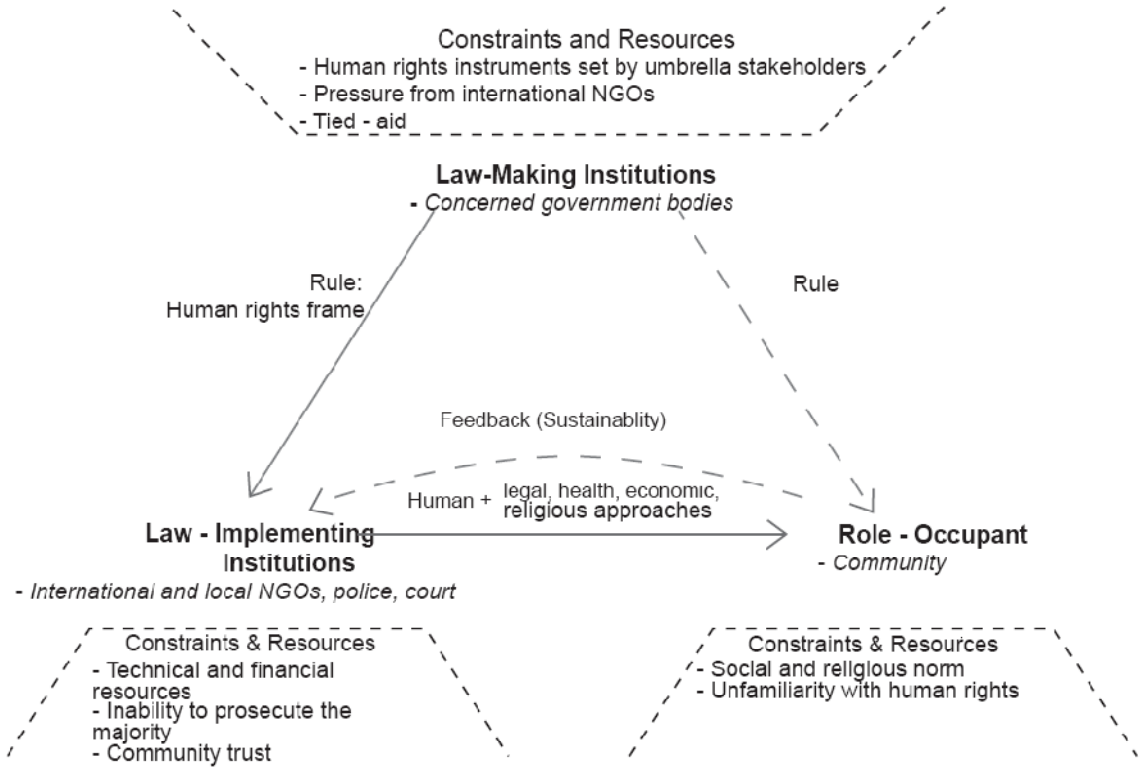


Figure 3. The model of anti-FGM movement. Adapted from "A Model of the Legal State," by A. Seidman and R. B. Seidman, 1994, *State and Law in the Development Process*, p. 118.

The original model intended to explain the legal system's interrelated mechanism of the law-making institutions, law implementing institution, sanctions, and feedback mechanisms. The model also showed that the choice of each involved party depended on

"how they choose within constantly changing arenas of choice" (Seidman & Seidman, 1994, p. 118). Although the model is based on a legal framework, a closer examination shows that it closely resembles the overall findings of this research.

Legal Enforcement

The law-making institutions of FGM, which refer to the concerned government bodies of FGM-practicing countries in Africa, are strongly influenced by international action. All four countries of the multiple-case studies – Kenya, Senegal, Egypt, and Guinea – issued laws that formally ban FGM of any form. Egypt, in particular, has even strengthened its law multiple times due to outside opposition and pressure. In 1994, the country issued a law banning FGM performed by anyone other than doctors in government hospitals. This policy was subsequently overturned following the women's rights and health advocates' criticism as government support of FGM (Shell-Duncan, 2001). Through in-depth media coverage of surgical performance and deaths arising from FGM, the FGM opponents pressured the government to issue a law in 2007 that banned everyone from performing any form of FGM. Tied-aid that requires a country to adopt a law before receiving any kind of aid is another factor that motivates countries to set official anti-FGM regulations.

However, enforcement from the police, prosecutors, and the court is rare. In most cases, the law fails to directly trickle down to the role-occupants or the FGM-practicing communities perhaps for two main reasons. First, the guiding law for the rural communities has been the long-established traditional norms, not government regulation. For the community, the traditional norms play a bigger influence than a national law. Second, enforcement is difficult when the majority is displaying a behavior that goes against the law.

In other words, “when a society is not homogenous and a subset of citizens supports a certain behavior, the simple act of criminalizing that behavior may not necessarily result in a reduction of its practice” (Wasunna, 2000, p. 109). Wasunna (2000) goes on to cite abortion as an example that continued to persist underground after the prohibition. For many of the FGM-practicing people, sanctions arising from failure to conform to FGM are perceived to be much greater than disobeying the national law.

Therefore, the government and international organizations have found law-implementing institutions other than social control forces, such as the police or the court, which has indeed been found to drive the practice underground or to the neighboring countries (Diaby-Pentzlin & Lisy, 2007). This process is also referred to as creating an enabling environment for change (UNICEF Innocenti Research Center, 2005). Institutions such as IAC’s National Committees and many countries’ ministries of health have been active in raising awareness and inducing attitude change. In consideration of the cultural sensitivity of the topic, international and local NGOs have partnered to approach FGM-practicing communities in a non-provocative, respectful manner. Nonetheless, a number of common constraints that may jeopardize the implementation process were found from the multiple-case studies.

Training Local NGOs: Those with “a True Stake”

Donor agencies, international NGOs, and national organizations are working increasingly in partnership with grassroots organizations. Analysis of the case studies have revealed that as the nature of the projects have become increasingly participatory, the role of the implementers has also been imperative to the success of the programs. In all case studies,

local staff served as facilitators and trainers of community members. Although project design and planning was executed by outside organizations, local groups were situated in the forefront to interact with community members.

Working with local groups offers numerous advantages. Outside interventions run a strong risk of being perceived as an imposition of external values. Even for national NGOs, working with the grassroots is an advantage because they are the most familiar with the local politics and conflicts and have established access to administrative officers. The local groups also maintain ongoing interactions with community members. These factors interact to speed up the intervention process by jumping through the "gaining the trust" stage, which can be tremendously time-consuming, if not impossible. For the alternative rites of passage model, the communities approached already-existing women's groups set up by MYWO. In executing the positive deviance model, the community-based FGM groups used local networks to identify the positive deviants and the "at risk" girls. The intergenerational dialogue strategy used local staff as facilitators in workshop discussions. All of the roles above were strong determinants of project outcomes.

Despite the advantages of working with local groups, the case studies found a number of challenges. First, better training the local groups in participatory methods and evaluation is needed. The case studies all implemented some type of training for the partner local groups to act as facilitators or instructors. However, there were instances of uncertainties in how activities were carried out by the trained facilitators. The assessment reports of the alternative rites of passage programs, for example, have been inconclusive on how much the idea of human rights violation was brought forth and communicated to the local population. Furthermore, despite the importance of the lessons taught in Family Life

Education, the mothers who acted as peer educators did not formulate a pre-set guideline or an outline of topics for discussions.

Furthermore, communicating about participation in the alternative rites ceremony seems to have caused misunderstandings that resulted in girls undergoing circumcision after the ceremony. Both girls and parents have admitted to being little informed about the program and its objectives even as they agreed to participate. A more effective implementation of the communication process seems needed. Perhaps a word-of-mouth method by asking already-committed parents to their daughters' participation in an alternative rites ceremony to visit other parents and speak about the process would have prevented the confusion. The government and the concerned ministries need to allocate their resources to equipping local NGOs with the much-needed skills in interviewing, monitoring, and evaluation necessary for a scientifically rigorous research. Workshops should explore cost-effective methods that can be applied in various development-related programs and do not require state-of-the-art mechanisms. A better training of local NGOs to implement, monitor, and evaluate projects is instrumental to ensure sustainability in the programs even after the larger donor groups have withdrawn from the site.

Human Rights Discourse: The Way to Go?

Despite the overarching norm of human rights that has guided anti-FGM projects until now, numerous field implementation experiences have recorded difficulties and uncertainties in introducing the concept to the local site. The assessment report of Kenya's alternative coming of age programs identified that sensitization activities largely focused on health-related messages, with only slight references to empowerment and human rights to

bodily integrity. This may be due to the same reason as Tostan, which found it "best to emphasize the negative health consequences and the right to the highest standard of health as the most effective arguments for discussion with the participants" (Tostan, 1999, p.90). The effectiveness of the human rights-based messages in alternative coming of age programs remains questionable, as none of the reasons stated as to why FGM should be discontinued by the community members included distinct human rights factors. Although one of the reasons included "limits education," this was preceded by "medical complications," "against religion," and "lost significance" as the top-most reason for wanting FGM to discontinue. The educational factor may in fact be the result of MYWO's strenuous campaigning through IEC materials that found that FGM hinders education opportunities for girls. Nonetheless, the reasons stated above might be used as sources to frame anti-FGM messages to encourage the rest of the community to abandon FGM. The loss of significance or the intention and meaning of the practice was a reason cited by the generation groups as well. Such messages may be easier for community members to adopt rather than abstract human rights ideas that may also be taken offensively.

The umbrella stakeholders have strictly established the fundamental framework of anti-FGM communication to be a violation of human rights. The limitation has been enforced through a vertical chain of communication. The vertical pattern, however, has witnessed difficulties in enabling the recommendation for a bottom-up approach from the same interest groups. This is evident in GTZ's intergenerational dialogue program. The group discussions resulted in a negotiated conclusion, where the elder group acknowledged that the practice has lost its original purpose and intention, but nonetheless recommended a "pretense solution," or a transitional measure that preserves the symbolic act of the practice should be maintained

for a period of time. However, because this solution would not be sufficient for the guiding norm of GTZ or the international community, the project continued to carry out programs that displayed direct efforts to stop FGM.

This research seems to suggest that human rights is a concept that is difficult both to transmit and for the participants to grasp unless accompanied by long-term commitment and education. Positive deviance, rather than adapting a human rights approach, focuses on discovering local motivations and methods to abandon FGM. Although a precise statistical result of overall program impact was not found, home visits made by positive deviants and the community program participants found that the number of families circumcising their daughters decreased significantly. The livelihoods program for community members is another possibility to lower the rate of FGM as shown by statistical findings that negatively correlate the rate of FGM with economic status. The economic assistance programs, if integrated into other strategies, may also act as a motivating factor to encourage participation.

Human Rights Strategy: An Impossible Task?

Analysis of various implementation strategies that seek to create awareness of human rights shows that insider-driven decision-making and action-taking are crucial factors to reaching the goal – abandonment of FGM. The first factor, insider-driven decision-making, refers to community's identification of FGM as a pressing need that needs to be addressed. However, none of the four case studies stated that the FGM issue was brought up by the community members. Tostan, which already had two years of basic education with the local women, was at first hesitant to include the topic in their Women's Health module. "The

hesitation was due to a cultural consideration: women had been reluctant to discuss FGC during the participatory research phase. Certain women expressed some hostility at the mere mention of the issue" (Tostan, 1999, p. 34).

In such a situation, Tostan integrated the topic into general community development programs. The human rights education was adapted to the context of the local environment and constantly encouraged the participants to identify with the topics by relating to their daily lives. In addition, the educational program included not only awareness knowledge, but principles and how-to knowledge, which encouraged critical thinking and autonomous decision making by the participants. The latter two types of knowledge equipped participants with objective information to form the basis for perceiving an issue as a possible problem, going about in finding solutions, and defending the decision.

Although the initial decision to pursue the issue as an intervention topic was not made by the community participants, the decision to stop FGM was made among participants of the educational class. The class-full of participants were able to grow into an initial core that spoke publicly against the practice, despite complaints from other sections of the community, mainly the men.

For all four case studies, religious and village leader endorsement to abandon FGM played a highly conducive role in solidifying the individual commitment to stop practicing FGM. One of the commonly found reasons for positive deviants abandoning FGM was leader support for ending FGM that strengthened their inner conviction. In addition, the opposition of the Imam to FGM empowered the women of the Tostan program with a powerful argument to convince their husbands and friends to abandon FGM. Tostan's program shows that long-term education with technical information that can change the community well-

being and human rights that is “translated to fit the realities” of the villages are necessary for a successful transmission of human rights messages. Most importantly, the decision to abandon FGM should come from the community members rather than from the outside organizations.

Bridging the Gulf in the anti-FGM Movement Model

The model of anti-FGM movement indicates some challenges in the current trickle-down pattern of communication. It shows that most attention is focused on coordinating goals and activities from the international level down to the grassroots.

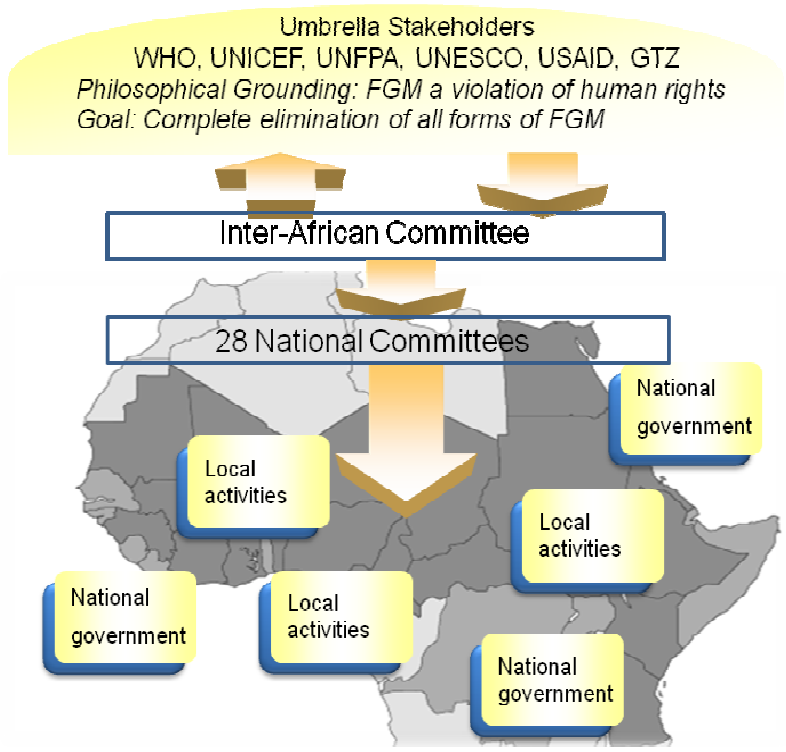


Figure 4. The pattern of anti-FGM communication

The assumption underlying the coordination efforts is that the unified discourse at the international level would trickle down to the role occupants. As such, most attention has been focused on lobbying and pressuring national institutions to adopt anti-FGM policies. Figure 4 outlines the pattern of communication that is predominantly human rights-based and flows downward from the international, national, to the local level.

At this point, it seems that a step away from the philosophical-based towards an implementation-based approach might strengthen the capacity of the law-implementing institutions to address the issue to the local communities.

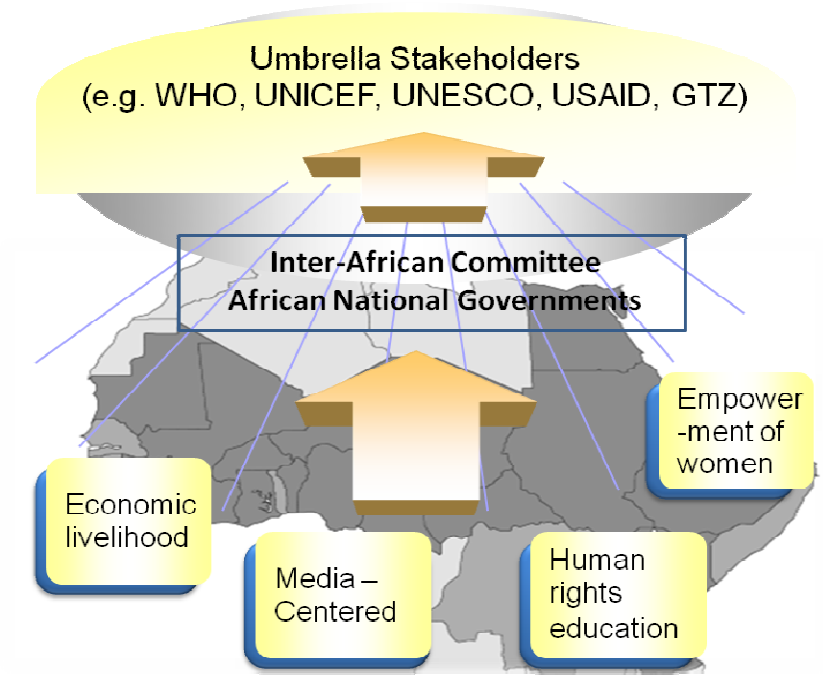


Figure 5. Decentralized model of the anti-FGM movement

The role of national governments would be to facilitate local implementation by allocating technical and financial resources to local organizations, and most importantly,

granting the freedom to seek creative means of working with the local communities. This idea is close in meaning to the concept of *decentralization*, which refers to devolution of authority and responsibility from the central government to local governments, the private sector, and/or the civil society. According to Figure 5, a decentralization of resources and responsibility to the local level would allow more diversified approaches to anti-FGM communication. Integrating the topic into already existing development programs, such as empowerment of women or economic livelihoods programs may be a way to facilitate implementation by hurdling the 'gaining the community trust' stage. The decentralized model seems advisable for behavior change communication targeting a highly cultural and context-specific issue such as FGM, as it allows for greater space to integrate ideas and input of the local community. This system would consequently assist in bridging the gap between the law-making institutions and the role occupants.

5.2 Limitations of the Study

This research faced a number of challenges and limitations. First, comparing different strategies and projects of a strategy conducted in different sites was a difficult task, as FGM is a very context-specific practice. Because each community insists different reasons for practicing FGM as well as diversified ways of performing the operation, one strategy that is effective in a community may not be as effective in another.

Second, the different amounts of data available for each strategy made it difficult to maintain an equal depth of analysis for each case study. Whereas more data and reports were available for the alternative coming of age and Tostan's community-based development

programs, considerably less has been found on positive deviance and intergenerational dialogue programs.

Third, this study relied on secondary sources for information. E-mail questions tended to cause delays and were very limited in exchanging questions and replies. In most situations, receiving replies from the participating organizations was rather difficult.

Furthermore, the research faced a challenge in not only the amount of data concerning anti-FGM strategies available to the public but also due to the language barrier in accessing some articles. Because numerous research papers and analyses were found in languages other than English, this research could not take advantage of the valuable resources and had to rely on sources written in English.

5.3 Suggestions for Future Research

This study was a comprehensive examination into the anti-FGM transnational movement. The in-depth case studies and analysis of secondary sources permitted a critical evaluation of the strategies and theories adapted from different disciplines. This is a method that would possibly benefit other international public health topics, such as HIV/AIDS, malaria, and sanitation issues. A diversification of such explorations would also enable better sharing of strategies that fit specific needs of a particular problem.

An overarching topic of this study was the use of human rights to address FGM. From the results of the study, a deeper examination into how programs introduce human rights messages into the sensitization or education sessions seems timely. An analysis of visual or textual material used to raise the awareness of and educate the participants may be a possible way to look into how human rights messages are relayed. This is not only limited to

the topic of FGM, but an array of development issues that are addressed under the framework of human rights.

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APPENDIX A: MULTIPLE-CASE STUDY QUESTIONS

Project Description
Describe the project.
Which group(s) was in charge of project operation?
Who was the donor group, and what types of resources did the donor group provide?

Theory and Strategy
Why was the particular theory chosen for the project? Why was it considered legitimate?
How as the abstract idea of the theory operationalized?
How is the strategy implemented?
What tools of communication did the project utilize?

Target Group
Who was the target group?
Why did the project target the particular group?

Project Outcome and Evaluation
What was the design for evaluating the project, and who is doing the evaluation?
What was the outcome of the project, and what outcomes have been identified to date?
Were there any indicators of behavior change?

Cross-project Comparison
Were there any differences in the outcome among different projects?
If so, what element in the project design seems to have brought about the difference?

APPENDIX B: LIST OF CASE STUDY REFERENCES

Case Study	Publication	Publishing Organization	Year of Publication
Alternative Rites of Passage	An assessment of alternative rites approach for encouraging abandonment of female genital mutilation in Kenya	Frontiers in Reproductive Health	September, 2001
	Rites of passage: Responses to female genital cutting in the Gambia	BAFROW	1999
	Community sensitization must precede alternative coming-of-age rite	Frontiers in Reproductive Health	May, 2002
	Medicalization of female genital cutting among the Abagusii in Nyanza province, Kenya	Frontiers in Reproductive Health	December, 2004
	Kenya: Report on female genital mutilation or female genital cutting	U.S. Department of State	June, 2001
	An alternative way to stop female genital mutilation	Lancet *(Medical Journal)*	July, 1998
	Grassroots in Kenya: Women, genital mutilation, and collective action: 1920-1990	Signs	1996
	Introducing alternative rites of passage	Africa Today	2007
	Are there stages of change in the practice of female genital cutting?: Qualitative research findings from Senegal and the Gambia	African Journal of Reproductive Health	2006
	New ritual replaces female genital mutilation	Women's e-News	April, 2003
Village Empowerment Program	Coordinated strategy to abandon female genital mutilation/cutting in one generation: A human rights-based approach to programming	UNICEF	June, 2007
	The TOSTAN program: Evaluation of a community based education program in Senegal	Population Council, GTZ, Tostan	August 2004
	Issue brief: Working to eradicate female genital mutilation/cutting	USAID	June, 2006
	Breakthrough in Senegal: Ending female genital cutting	Tostan	1999
	Replication of the Tostan program in Burkina Faso	Population Council, Mwangaza Action, Tostan	April, 2003
	Abandoning female genital mutilation: An in-depth look at promising practices	Population Reference Bureau	December, 2006
	Community-centered approaches to behavior and social change: Models and processes for health and development	NGO Networks for Health	2000

Case Study	Publication	Publishing Organization	Year of Publication
Village Empowerment Program (continued)	Evaluation of the long-term impact of the TOSTAN programme on the abandonment of FGM/C and early marriange: Results from a qualitative study in Senegal	Population Council	January, 2008
	A tradition no longer: Rethinking female circumcision in Africa	USAID	November 2005
	Senegal: FGM continues 10 years after villages claim to abandon it	IRIN News	August, 2007
Positive Deviance	Promoting FGM abandonment in Egypt: Introduction of positive deviance	CEDPA	N/A
	Positive deviance: An introduction to FGM eradication	CEDPA	N/A
	Female genital cutting: Breaking the silence, enabling change	CEDPA	2000
	Use of the PD approach in female genital cutting eradication in Egypt: Core group presentation	CORE Group	2004
	Positive deviance approach for behavior and social change	Tufts University	November, 2006
	Critical analysis of interventions against FGC in Egypt	Frontiers Project	2000
	Egypt demographic and health survey	National Population Council	1996
	The positive deviance approach: Challenges and opportunities for the future	Food and Nutrition Bulletin	2002
	Voices rise from Egypt to shield girls from an old tradition	New York Times	September, 2007
	World briefing Africa; Egypt: All female cutting banned	New York Times	June, 2007
Intergenerational dialogue	Addressing female genital mutilation: challenges and perspectives for health programs – part 1: Select approaches	GTZ	December, 2001
	Participatory impact monitoring through action research: Lessons from the generation dialogue and training for uncircumcised girls in Guinea	GTZ	2005
	Ending violence against women and girls – protecting human rights	GTZ	2005
	Female genital mutilation in Guinea	GTZ	2007
	Female genital cutting and the coming of age in Guinea	Macro International	1999
	Ending female genital mutilation	GTZ	2007

Case Study	Publication	Publishing Organization	Year of Publication
Intergenerational dialogue (continued)	German Technical Cooperation (GTZ) supra-regional project: Promotion of initiatives to end female genital mutilation (FGM)	African Journal of Reproductive Health	August, 2006
	Guinea: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)	U.S. Department of State	June, 2001

APPENDIX C: MATRIX OF THEORETICAL APPROACHES TO ANTI-FGM COMMUNICATION – DOMINANT PARADIGM MODELS

Theory	strategy	Target Level	Philosophical Underpinning	Proponents	Donor Agency	Implementation	Empirical Evidence
Knowledge, Attitude, Practice Model	Information, education, communication strategy	Community	-Behavior change follows the sequence of knowledge, attitude, and practice -Adapted from the public health campaigns in the US during the 1970s and 1980s	National Committees of the Inter-African Committee		-information–centered sensitization activities -use of mass media (e.g. posters, radio, television programs -SOS Hotline	Awareness has increased but not much impact on behavior change
Transtheoretical Model of behavior Change	Alternative rite of Passage	Individual & Community	-Developed from a study which found that smokers showed common sequences in efforts to quit -Integrates different behavior change theories in psychology	-MYWO -PATH -Action Aid Kenya -Pentecostal Fellowship of America -Cherish Others -Seventh-day Adventist Church -BAFROW -FORWARD	GTZ PATH USAID	1.Community sensitization 2. Family Life Education 3. Alternative ritual ceremony	-All but 80 out of 289 were forced by relatives or peer pressured to undergo circumcision upon returning from alternative ritual -Age of girls undergoing FGM decreased
Convention Theory	Village Empowerment Program	Community	-FGM is a self-enforcing social convention that needs to be collectively abandoned -When it has reached a tipping point, the abandonment process	Tostan	UNICEF USAID	1. Education workshops 2. community mobilization 3. Public declaration	-Decision to abandon led by a group of community women -Successful trickle-across effect to

Theory	strategy	Target Level	Philosophical Underpinning	Proponents	Donor Agency	Implementation	Empirical Evidence
			will be rapid and self-sustaining				neighboring villages -Increase in awareness of human rights
Social Marketing	Alternative livelihoods	Group (Women)	-Principles of advertising and consumer behavior adapted to behavior change communication -Economic livelihood provides greater autonomy and decision making power	Navrongo Health Research Center	ActionAid Ghana, Maata N Tudu Swiss Embassy Accra, USAID	Four cell design: groups receive either economic livelihood activities, FGM education activities, both, or none	-Both activities resulted in a decrease in FGM compared to the control group -Only the combined strategy was statistically significant in reduction of FGM
	Alternative income for circumcisers	Group (Cirumcisers)	-A decrease in the supply of circumcisers will create less demand for FGM -Providing former circumcisers with economic activity covers the demand to maintain their economic livelihood.	National Committees of the Inter African Committee		1.Identify and educate circumcisers of issues related to FGM 2.Train circumcisers as change agents to inform the community about the harmful effects of FGM 3.Provide resources for an alternative source of income	-The demand was not reduced -People sought other circumcisers in neighboring villages -Circumcisers are not influential enough to motivate community change

APPENDIX D: MATRIX OF THEORETICAL APPROACHES TO ANTI-FGM COMMUNICATION – PARTICIPATORY MODELS

Theory	strategy	Target Level	Philosophical Underpinning	Proponents	Donor Agency	Implementation	Empirical Evidence
Social learning theory	Positive Deviant Approach	Community	Solutions to problems exist within the community	-CEDPA -Caritas -Center for Egyptian Women's Legal Assistance -Coptic Organization for Services and Training (COST) -Manshiet Nasser	-USAID -CEPDA Washington	1.Orientation workshop for organizers 2.Identification of Positive deviants 3. Positive deviant interview 4.Community activities 5.Monitoring of "at risk" girls	-A higher level of success for Christian communities -73 percent of families declared not to circumcise the daughters -Strengthened relationship between the community and NGOs
Symbolic Interactionism	Intergeneration Dialogue	Community	FGM needs to be understood from the norms and the worldview guiding the community members' actions	GTZ	GTZ	1.Generation group Workshops 2.Community dialogue 3.Follow-up meeting 4.Training program for uncircumcised girls	-Negotiated conclusion for a minimally invasive form of FGM -None of the girls who participated in the training program circumcised