



FGM AND SOCIAL NORMS:

**A GUIDE TO DESIGNING CULTURALLY
SENSITIVE COMMUNITY PROGRAMMES**

June 2019

*Be grounded in your culture.
Preserve its positive traditional values
and let its abusive customs disappear.*

~ Amadou Hampâté Ba, Malian intellectual,
in *A Letter to the Youth* (1985)

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List of Abbreviations

ARP	alternative rite of passage
CtC	Change through Culture
FGC	female genital cutting
FGM	female genital mutilation
GHD	Girls' Holistic Development
GMP	Grandmother Project
IGF	intergenerational forum
NGO	non-governmental organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Introduction

Purpose of this Report

Over the past few decades, there has been enormous momentum within the international development community towards ending female genital mutilation (FGM). This has translated into a large number of laws, policies, campaigns and programmes at international, national and local levels, yet results remain mixed: while there is evidence that the most extreme types of FGM are slowly declining in prevalence,¹ the overall rate of decline of the practice does not always reflect the huge amounts of money, time and energy invested to date.

It is often felt by many FGM-practising communities that local priorities are ignored by visiting development ‘experts’ and that their cultures and traditions are framed as ‘problems’ to be ‘solved’. At the same time, for women and girls who are at risk or have experienced FGM and wish to end the practice, often the only solution perceived is to fight against their loved ones and risk losing their places in their communities. In contrast, the authors believe that there are alternative approaches that can encourage long-term shifts in social norms around FGM, which are both more sensitive and more effective.

28 Too Many, in commissioning this guide, felt that there was a growing consensus that the most effective approach to reducing FGM lies in culturally sensitive, community-based programmes that encourage social norms change. It was felt that anthropologists have a level of insightful evidence about the cultural contexts in which FGM is practised that is rarely available to policy makers, practitioners and campaigners, yet this information is important and necessary for designing effective norms-change programmes and should be shared more widely. For their part, the anthropologist who co-authored this guide agreed that much of the useful anthropological work on FGM to date has been published in academic journals and books that are not easily accessible to non-academics.

While this report is co-written by an anthropologist and cites anthropological literature, it should not be taken as representative of the views of all scholars working within this discipline. Discussions among anthropologists about the most appropriate role for them to take in FGM debates have been ongoing for decades, with large diversity in opinions and frequent disagreement. Some have preferred to remain silent on the issue, while others have chosen to document the reasons for people’s support of the practice and why campaigns often fail, but do not then prescribe specific actions. Some tend towards supporting abandonment efforts, while others advocate an end to procedures being performed on minors, but stop short of condemning the practice in the case of consenting adults.

Ellen Gruenbaum has written about possible roles for anthropologists in debates about FGM:

[T]he most useful role [for anthropologists] is to provide cultural perspectives on [FGM], offer a sophisticated analysis of why these practices continue, and describe the forces for change in various cultural contexts.²

This guide takes two positions in the midst of these debates. Firstly, it is addressed to an international audience and presents evidence on common assumptions about FGM, including often inaccurate and harmful discourses about the practice. Secondly, it draws on the (limited) available evidence to address the gap in the literature on how to design culturally-sensitive programmes to shift social norms around FGM in ways that address communities' needs and priorities and are accepted and supported by key actors who influence and support the practice.

The authors found that there was very little detailed analysis and evaluation, whether written by academics or development practitioners, on 'what works' when designing culturally sensitive, community-based programmes to shift social norms around FGM. Selected case studies and examples are given where available and appropriate, but, overall, this study calls for more research into what works, where and why.

Methodology

Given this gap in the literature, for the purposes of this guide, the authors have turned to Senegalese and American NGO Grandmother Project (*GMP*) and its Change Through Culture (*CtC*) methodology. *GMP*'s community-based social-norms-change programme in southern Senegal is grounded in a large amount of academic theory and three decades of practical experience, and has consistently received positive evaluations.

Beginning in 2005, founder Judi Aibel, who has a background in public health and anthropology, developed an original methodology for working with communities to promote change in social norms and practices relating to the wellbeing of women and children. That methodology has been refined through *GMP*'s Girls Holistic Development (*GHD*) programme, implemented in southern Senegal since 2008, which aims to catalyse a shift in norms surrounding FGM as well as early and forced marriage and premature school-leaving. *GMP* also refers to its methodology as the 'grandmother-inclusive approach'.

The *CtC* methodology is an innovative approach to promoting positive change in communities. *GMP* has found that, when programmes build on cultural realities, communities are more receptive, more engaged and more open to adopting new socio-cultural norms and practices that can improve the wellbeing of their women and children. The active involvement of culturally designated family and community authorities in health and development programmes contributes to more positive results. Much of the practical content of this guide therefore draws on the *CtC* methodology and previously published guides based on *GMP*'s approach. For further information see <https://www.28toomany.org/thematic/social-norms-and-fgm/>.

Who is this Guide For?

This guide is primarily for use by those responsible for planning and managing community-based, social-norms-change anti-FGM programmes in African contexts and for people who coordinate the assessments or evaluations of those programmes. The guide will also be of interest to researchers, government departments, policy makers and donors working to end FGM. The guide could also be used by members of practising communities to argue for more culturally

sensitive approaches to FGM that use their lived experiences, priorities and cultural resources as the starting point for processes of change.

Terms Used in the Guide

28 Too Many uses the term female genital mutilation (*FGM*) to align with terminology used by the World Health Organisation (the *WHO*), some UN agencies and the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (*IAC*). This is, therefore, the term used throughout this report. We acknowledge, however, that this term is contested, and many of the authors that we cite prefer alternatives including female genital cutting (*FGC*), female excision, or the hybrid label *FGM/C*. Section 5 of this report suggests some principles to be considered when deciding on which terms to use in programmes.

Limitations of the Guide

This document is intended to be a practical guide to designing community-based, social-norms-change anti-FGM programmes in the African context specifically. It focusses on the range of practices identified as FGM within the WHO's classification. It is, however, recognised that there are many other types of alterations to human genitalia, the risks of which should receive more international attention. They are not addressed in this report simply because of limitations of space.

Use of this Guide

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the authors, Dr Anneke Newman and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool and seek updates on work being undertaken in communities to shift social norms around FGM.

About the Authors

Dr Anneke Newman

Dr Anneke Newman is a British anthropologist. She first studied anthropology at Oxford, followed by a Masters in Gender and Development at the Institute for Development Studies in Brighton, UK. There she discovered participatory development, the idea that underprivileged and illiterate people have the capacity to analyse their situations and propose solutions, which are typically better-tailored to their circumstances than top-down projects conceived by outsider development ‘professionals’ or ‘experts’. During her PhD in Social Anthropology at the University of Sussex, she was introduced to the Grandmother Project – Change Through Culture and the grandmothers and communities of Kandia, southern Senegal. Now a researcher at the Université Libre de Bruxelles in Belgium, she continues to research and publish on gender and development and remains a firm supporter of culturally-affirmative, bottom-up participatory development.

28 Too Many

28 Too Many is an international research organisation created to end FGM in the 28 African countries where it is mainly practised and in other countries across the world where members of those communities have migrated. Founded by Dr Ann-Marie Wilson in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable influencers and in country anti-FGM campaigners and organisations to make sustainable change to end FGM. We are building a global information base, which includes detailed country profiles for each country practising FGM. Our objective is to encourage all those working in the anti-FGM sector to share knowledge, skills and resources. We also campaign and advocate internationally to bring change and support community programmes to end FGM.

Acknowledgements

Dr Anneke Newman and 28 Too Many are extremely grateful to all those who contributed their knowledge and experience to this report. Particular thanks are extended to Dr Judi Aibel of the Grandmother Project for sharing with us her work and the methodologies that have been successfully used in programmes focussed on FGM-practising communities in southern Senegal (for further information, see page 56).

28 Too Many carries out all its work as a result of donations and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations and individuals that have supported us so far on our journey and the donations that enabled this report to be produced.

For more information or to donate, please contact us at info@28toomany.org.



1. FGM as a Social Norm

There is an increasing consensus that FGM is often a social norm or ‘socially upheld behavioural rule’.³ This means that everyone does it, or people believe that everyone does it. Individuals practise it because they have never questioned behaving otherwise, they receive social benefits from conforming to the norm, or they fear social sanctions from others for deviating from the norm.⁴ Even when the adoption of FGM is recent, people can still be pushed to conform to another group’s social norms; for instance, in the case of vulnerable, internally displaced people in Sudan.⁵

*[In contexts where FGM/C is a social norm], families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.*⁶

There are many different understandings of what social norms are, but they tend to converge on the following elements:⁷

- Social expectations: a social norm is constructed by one’s beliefs about what others do and by one’s beliefs about what others think one should do.
- The relevant others are known as a reference group (and different norms may be relative to different reference groups); group members tend to hold the expectations of one another.
- A social norm is maintained by social influence: among enough members of the reference group, approval, including positive sanctions; disapproval, including negative sanctions; or by one’s belief in the legitimacy of others’ expectations.

FGM can be considered a social norm in a specific context if it meets the following conditions:⁸

- individuals are aware of the rule of behaviour regarding the cutting of girls and know that it applies to them; and
- individuals prefer to conform to this rule because (a) they expect that a sufficiently large segment of their social group will cut their daughters; and (b) they believe that a sufficiently large segment of their social group thinks that they ought to cut their daughters and may sanction them if they do not (which could include social exclusion, criticism, ridicule, stigma or the inability to find their daughters suitable marriage partners).

The social group or reference group are the people who matter to an individual with respect to FGM. It may include other members of one’s extended family or community; one’s ethnic group or people of the same faith if the practice is associated with ethnicity or religion; or other communities that one intermarries with.

Determining whether FGM is a social norm in a particular situation is important for designing programmes because, when it is, it is difficult for individuals or specific families to stop the practice on their own because of the social sanctions associated with deviating from the norm. Families will be encouraged to stop cutting their daughters if they are convinced that a

sufficiently large number of other families do not practise FGM, or are ready to abandon the practice.⁹

In addition to social norms, FGM-abandonment strategies need to take account of both moral norms and legal norms:¹⁰

- moral norms are motivated by an inner conviction of right and wrong (moral norms are much less conditional on what others do or think one should do than are social norms); and
- legal norms are institutional norms and commanded by the state; they are formal, often explicit and legitimately enforceable by coercion.

Insights from the Field of Community Development

From the 1960s, researchers and practitioners working in the field of community development have proven that many of the problems that affect the health and wellbeing of people in communities cannot be solved by one person or organisation using top-down measures or policies. Instead, broad community participation – if facilitated properly – is more effective in addressing community health problems.¹¹

Researchers in this field have developed and refined a number of sophisticated models and culturally sensitive tools, including participatory dialogue and education approaches, to empower communities to engage in collaborative problem-solving to improve collective health and wellbeing.¹²

To date there has been limited research on what types of FGM-abandonment programmes successfully work to shift social norms. Based on evaluations of FGM programmes that covered Burkina Faso, Egypt, Ethiopia, Kenya, Mali, Nigeria and Senegal,¹³ researchers found that, although there is a lack of quality evidence regarding the effectiveness of programmes to prevent FGM, ‘multifaceted community activities’ and ‘community empowerment through education’ approaches contributed to changing people’s beliefs about FGM. These shifts could in turn influence intentions and thus affect behaviour.¹⁴ Programmes should also work ‘with the naturally occurring units of solution in the communities, and carefully assess community structures and processes in advance of the program’. The authors write that ‘in order to be successful, the program chosen must be context specific.’¹⁵ In support of this point, the authors discovered that, although some programmes were tailored well to their initial context, they were much less successful once they were scaled up and applied to a different setting, because of differences in religion, gender relations and beliefs about FGM.¹⁶

Changing a practice that is deeply entrenched in the culture and social life of individuals will only be possible when an enabling environment for individual behaviour change has been created, which is likely best achieved through community-based programmes.¹⁷

These findings have been echoed elsewhere. A review of several accounts by anthropologists, development practitioners, public-health professionals and community groups, shows that successful programmes need to:¹⁸

- be context and culturally specific;
- be sensitive to people's views and beliefs and avoid being judgemental;
- use value-neutral language when referring to FGM;
- work with community structures and processes, and be culturally affirmative (using culture as a solution rather than framing it as the problem);
- start from solutions that naturally occur or are proposed by the community;
- work with a range of community members rather than a few specific individuals;
- collaborate with role models, authorities or 'community champions' to shift social norms;
- work towards people's own priorities and preoccupations;
- encourage open discussion of sensitive topics to bring taboos and painful experiences out into the open;
- build on diversity and ambivalence within the community, as many people may already oppose FGM even if they still practise it;
- create spaces for dialogue within peer groups and across different groups in society; and
- use education to challenge myths about FGM.

While helpful, we find that this list of bullet points regarding social-norms-change anti-FGM programmes is too vague to be operationalised easily. It is hoped that this publication will add operational depth to these findings.



2. The Relevance of Culture

What is Culture?

A lot of ambiguity surrounds terms like ‘culturally sensitive’¹⁹ and ‘culturally appropriate’²⁰ when used to describe FGM programmes. Such terms are frequently used, but what do they actually mean in practice? What do we mean by ‘culture’, anyway?

As many FGM interventions are funded, designed and implemented by ‘outsiders’ – i.e. individuals or organisations who are not members of practising communities – what does it take to develop sensitivity towards another culture? And how is this understanding supposed to be achieved and translated into practice in the limited timeframe of a development project?

Another challenge is how to replicate interventions as they go to scale, which entails adapting a model to a different cultural, social, economic or political context.

For anthropologists, culture is the full range of learned human-behaviour patterns. British anthropologist Edward Tylor* defined culture as ‘that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man [and woman] as a member of society.’ There seem to be a number of universal cultural traits regardless of where humans live in the world:

- communicating with a grammatically complex language;
- using age, gender, marriage and descent relationships to classify people;
- organising activities for the raising and teaching of children;
- having a sexual division of labour (e.g. men’s work versus women’s work);
- enforcing rules to regulate sexual behaviour;
- having a sense of morality, and distinguishing between good and bad behaviour;
- practising some sort of body ornamentation;
- making jokes and playing games;
- creating art, music and dance; and
- having some sort of leadership roles for the implementation of community decisions.

However, beyond these universals, learned behaviour differs enormously between humans and is constantly changing. Within a specific group, there is also a diversity of perspectives and practices and an ongoing debate about the best way of doing things.

* *The term was first used in this way by British anthropologist Edward B. Tylor in his book, Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Art, and Custom (London: J. Murray, 1871).*

The ‘Iceberg’ Model of Culture: the Apparent and the Hidden

American anthropologist Edward T. Hall coined the ‘iceberg’ analogy of culture.²¹ He suggested that, if the culture of a society was an iceberg, then some aspects are visible or apparent above the water, but the majority lies hidden beneath the surface. The external, and conscious, part of a culture is what we can observe and includes behaviours and some beliefs. This reflects the tip of the iceberg. The internal or deep part of culture lies below the surface, represented by the underside of the iceberg, and is often unconscious. It includes beliefs, values, assumptions and thought patterns that underpin behaviour.

Hall argues that the only way to learn the internal culture of another society is to actively participate in that culture over a long period of time. When one first encounters a new culture, only the most overt behaviours are immediately apparent. As one spends more time in that new culture, the underlying beliefs, values and thought patterns that dictate that behaviour are slowly revealed.

It is often difficult for an ‘outsider’ to fully understand the deeper, hidden aspects of a culture. It is therefore important that they collaborate closely with ‘insiders’ who are familiar with the local culture to ensure that this ‘internal’ knowledge of the deep culture in question is integrated into programme design.

Case Study: Infibulation in Rural Northern Sudan²²

Anthropologist Janice Boddy has undertaken research into FGM (particularly Type III, or infibulation) in rural northern Sudan since the 1970s. She has found that the explanation that infibulation increases women’s chastity and reduces their sexual pleasure was a result of the practice, rather than its purpose. Instead, its intent was to enable women to marry, bear children and achieve the social status of a valued adult by founding a new lineage.

Women also continued to support the practice because the removal of the external genitalia and sealing of the vagina were perceived as positive changes to their bodies, as they were related to a variety of wider customs and beliefs (deep culture) that stressed the symbolic value of ‘enclosedness’, cleanliness, roundness and purity. For instance, bodily orifices generally (including mouths, nostrils, etc.) were considered places where evil spirits could enter and were considered beautiful if they were small. Many illnesses were assumed to be the result of things ‘coming apart’ or ‘opening’ inappropriately. The organisation of the house and women’s place within it (a compound closed off by a wall or fence, kept clean at all times, referred to as a ‘belly’ and therefore explicitly associated with the womb) and preference for certain types of foods (including eggs, which are smooth, round and closed) also reflected these valued and deeply rooted cultural characteristics.

Women who had undergone infibulation, and advocated that it be continued, did so because it made their bodies conform to these strong cultural values of enclosedness, cleanliness and purity. It was also an assertive and meaningful symbolic act because, although it minimised their sexuality, it emphasised their most powerful social resource, their fertility.

Common Cultural Characteristics of FGM-Practising Communities

Three specific social and cultural characteristics can be identified in most contexts in Africa where FGM is practised:

A: Collectivist Values

An important characteristic of most FGM-practising contexts is strong collectivist values, which encourage conformity to social norms, including those that support FGM.

Geert Hofstede, a Dutch social psychologist and anthropologist, coined the idea of ‘individualist’ and ‘collectivist’ cultures as two ends of a continuum along which different societies fall.²³

In relation to FGM, the distinction between ‘individualist’ and ‘collectivist’ values is found to be a useful framework for explaining why many programmes working on women’s and children’s health fail to have the desired results. They often work directly with young mothers, but do not appreciate how much young mothers are both influenced by elders in their extended families and communities and wish to conform to social norms.

Collectivist Values	Individualist Values
Interdependency and solidarity with others are highly valued	Independence, autonomy and individual achievement are highly valued
Individuals seek to conform to the group rather than being different	Individuals like to express their individuality
Sanctions for not conforming to social norms can be very costly	Sanctions for not conforming to social norms are less costly
Collective decision-making and following the decision of the groups are encouraged	Individual decision-making and action are encouraged
Multigenerational families and strong ties with extended family members predominate	Nuclear families predominate and ties with extended family members are weaker

Table 1: Differences between collectivist and individualist values²⁴

These crucial cultural characteristics need to be taken into account in FGM-programme design.

The following table describes some ways in which collectivist values manifest in society, and how FGM-abandonment programmes can best work with these dynamics to catalyse change.

Examples of Collectivist Values	Approaches to Promote Change
Cultural identity, roles and values are of critical importance to community members.	Programmes should view culture as a resource rather than as an obstacle and should explicitly identify and respect positive cultural roles and values. Communities are more receptive to programmes that promote integration of 'traditional' and 'new' values and ideas rather than only new ideas.
Individuals do not like to adopt practices that are not supported by the group. They are more open to <i>changing with the group</i> .	Priority should be given to peer-group and community-wide activities, as they are more effective in promoting change in individuals than activities that focus on individuals. Group activities allow group members to change together.
Individuals of all ages look up to and often adopt the attitudes and values of <i>leaders in peer groups and in the community at large</i> .	Programmes should identify both formal and informal leaders and actively involve them in community activities so that they lead and energise the change process.

Table 2: Approaches that can promote change in contexts with collectivist values²⁵

B: Respect for Elders

In many African societies, elders have traditionally played a critical role in transmitting knowledge to the younger generation, enjoying cultural authority, playing a leadership role and ensuring the social cohesion and survival of their family and community. The presence and role of elders is particularly felt when people live in extended family settings with several generations living close together or in the same household.

The following table describes some ways in which respect for elders and gerontocracy (where elders wield most authority) can manifest in society and how programmes can best work with these dynamics to catalyse change:

Examples of Respect for Elders	Approaches to Promote Change
Elders are respected, given their age and experience.	Programme staff and strategies should recognise and respect the role and experience of elders and explicitly involve them. When they are respected, they are more encouraged to participate and consider the proposed changes.
Elders provide guidance to younger generations on appropriate norms and practices.	Programme activities should allow elders to share their knowledge and experience with younger community members. This recognition encourages them to be more open to change.

Examples of Respect for Elders	Approaches to Promote Change
It can be very difficult for youth to reject rules about 'acceptable' behaviour without elders opposing them, feeling disrespected or causing intergenerational tensions.	Programmes should make sure they involve elders as well as youth in processes of social change.
Communication between the generations is traditionally valued. However, in many societies intergenerational relationships are strained nowadays.	Strategies should promote communication between generations so that consensus can be reached on how to combine both 'traditional' and 'modern' ideas.
Childrearing is not only the responsibility of the biological parents; it is multigenerational.	Programmes need to understand the influence of the extended family on women's and children's health.

Table 3: Approaches that can promote change in contexts where elders are respected²⁶

Ghanaian scholars Joseph Adjaye and Osei-Mensah Aborampah maintain that if development programmes ignore the experience and contributions of older generations to families and communities, this can contribute to further damaging relationships between young and old.²⁷

C: Gender-Specific Spheres of Activity and Authority

Another characteristic of FGM-practising societies in Africa is gender specificity in the activities of different family members. Here, the roles of men and women are generally quite distinct. Cultural norms dictate which activities males carry out and which ones are reserved for females.

A key starting point for working with communities on FGM, and women's and children's health generally, is to understand how they are organised with respect to gendered roles.²⁸

Gender specificity in activities also intersects with age and respect for elders to determine who is considered an authority or expert in which domain.

The following table describes how gender specificity in activities and spheres of influence manifests in families and communities, and how programmes can best work with these dynamics to catalyse change.

Examples of Gender Specificity	Approaches to Promote Change
Men are not necessarily as involved in the care of infants and young children as women because these are not their areas of expertise, although they can be responsible for providing necessary financial resources.	Programmes need to recognise the relative influence of men and women of different ages in the extended family and community. They should not over-attribute decision-making influence to men in female spheres.
Senior women, or grandmothers, are culturally designated to pass on knowledge and practices related to all aspects of children's and women's health from one generation to the next.	Programmes should recognise the central role of grandmothers in teaching younger family members how to promote the health and wellbeing of women and children. They should actively involve grandmothers in discussions of how 'traditional' and 'modern' practices can be combined.
Young women rarely make independent decisions regarding their children, and they are expected to follow the advice of older, more experienced women, such as their mothers and mothers-in-law.	Programmes on women and children's health should consider how young women and mothers are embedded in wider decision-making networks. They should not work only with them to change behaviour.

Table 4: Approaches that can promote change in contexts with gender-specific activities²⁹

The Argument for Culturally Sensitive Development

When development recognises culture it produces change rooted in a community's own values, knowledge and lifestyle and thus tends to be more successful. When development imposes external cultural values it damages the operating system by devaluing indigenous knowledge and local capacity on which that community is built.³⁰

Anthropologists working on FGM sometimes get accused of 'cultural relativism' because they devote time to explaining, without making value judgements, the deep culture around why people value the practice.

On the other hand, activists are sometimes accused of 'universalism' because they are seen as being aggressively critical of the culture of FGM-practising communities.

Donnelly³¹ sets out two extreme positions – 'radical cultural relativism' (where culture is deemed to be the sole source of the validity of a moral right or rule) and 'radical universalism' (where culture is irrelevant to the validity of moral rights and rules, which are universally valid).

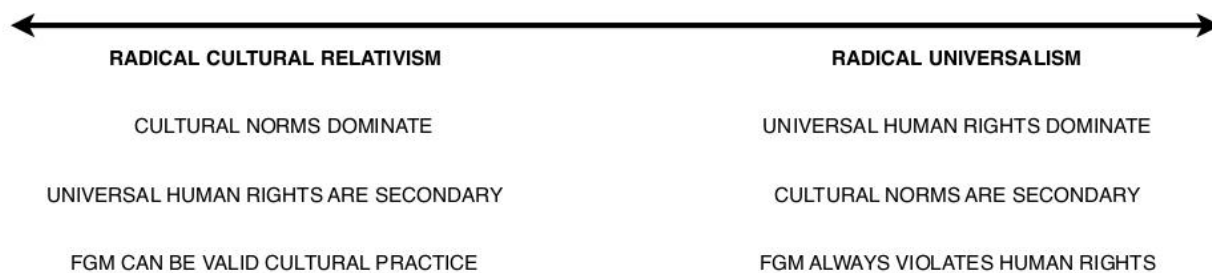


Figure 1: Radical cultural relativism versus radical universalism³²

Programming and policy formation therefore take place within this tension between cultural relativism and universalism. For many decades, the international development community framed non-Western cultures as barriers to progress. This tendency to see culture in negative terms was accompanied by the assumption that cultures could not change, or certainly could not change from within, so the solution to these issues must come from external ‘experts’.³³

However, programmes rarely prove successful if their activities and messages conflict with core cultural values. Even worse, such approaches often harm the communities involved by undermining local culture and contributing to a loss of identity and self-esteem. This sense of cultural loss and threat to cultural identity can actually reinforce FGM, as communities ‘hold on’ to the practice, as well as resist anti-FGM laws and campaigns. This has been noted in the context of the Maasai communities in East Africa:

[F]or some [FGM] became a symbol of the persevering nature of the Maasai people and the last hope to preserve Maasai culture in a rapidly changing world. The salience of FGC, by singling it out as a practice that must be ended, paradoxically makes it more important for those that are worried about the future of Maasai culture.³⁴

Overall, programmes often fail to see the potential of culture as a positive force that can promote beneficial change, yet there is much evidence to support an alternative approach to development that embraces and builds upon cultural values³⁵ – in particular, programming that is inspired by an ‘assets-based approach’ to culture.³⁶ This approach recognises that communities and their cultures contribute significant resources to the development process, rather than seeing them largely in terms of a source of problems.

Of course, not all cultural values and norms are positive; many, such as FGM and forced or child marriage, are harmful. Hence, we advocate an approach based on ‘cultural renewal’, defined as:

a dynamic process of goal-oriented cultural and structural change facilitated by pro-active indigenous communication transactions amongst local people . . . within the framework of preserving cultural integrity and intercultural harmony.³⁷

The concept of cultural renewal recognises the fact that all cultures are dynamic and changing and aims to revitalise local cultures in ways that foster positive social change.



Ebri
2013/03/07

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3. Lessons from Common FGM-Abandonment Approaches

Popular FGM-abandonment strategies often have limited effectiveness unless they are accompanied by community-wide processes of dialogue and consensus-building to promote shifts in behaviour. Below we review a number of common approaches to FGM abandonment.

Common Approaches to FGM Abandonment

A. Legislation

Most countries in Africa have some form of national legislation in place criminalising FGM. While laws on their own will not end FGM, they are important because they are a statement of intent and demonstrate a commitment to eradicating FGM.³⁸

Nevertheless, legislation remains a controversial instrument of cultural change, as legal norms are often in conflict with social norms and can feel imposed. While there are occasional arrests or prosecutions, enforcement can be poor if the laws are not an expression of popular will.³⁹ People are often reluctant to accuse their own family and community members for fear of shame or social repercussions.⁴⁰ Legislation can force the practice underground or across borders and lead to FGM being conducted on girls at younger ages.⁴¹ Attempts to legislate have even resulted in mass cutting by communities⁴² or even by girls themselves⁴³.

For further information on the law and FGM, see <https://www.28toomany.org/thematic/law-and-fgm/>.

B. Human Rights

A human-rights approach focusses on how FGM violates women's and girls' reproductive and sexual rights according to international treaties and conventions.⁴⁴ This approach can be useful for lobbying states and donors to fund and support FGM programmes and for providing a framework for coordinating actions across organisations.

However, the evidence is mixed as to whether informing practising communities of their rights translates into shifts in intention or behaviour relating to FGM.⁴⁵ Such approaches can have limited effectiveness at the local level because communities see 'human rights' as abstract and externally imposed. This approach often assumes that people will act autonomously and independently to realise their rights. That fails to take into account social norms that place more importance on social relationships and conformity.⁴⁶

C. Health-Risk Education

The health-risk education approach trains individuals (for example, doctors, nurses, midwives, teachers and facilitators) to deliver messages about the short- and long-term medical complications of FGM to members of practising communities. It is one of the oldest techniques

and is guided by the belief that knowledge of the health hazards of FGM will be enough to influence people to abandon the practice.⁴⁷

If undertaken in a non-directive way that builds on peoples' own experiences, raising awareness about health risks can contribute to changes in views and behaviour.

Unfortunately, some health education approaches do not follow these principles and are more directive. Particularly seen in relation to FGM, health messaging that does not reflect women's lived experiences can undermine the credibility of such campaigns.⁴⁸

Alo and Babtunde report that some female health professionals in south-west Nigeria are sceptical of criticisms of FGM when they do not fit with their personal experiences:

[M]ost of the discussants regard the associated health hazards as a calculated propaganda. In the words of a mid-wife: 'There is no health risk involved[.] I was circumcised as an infant, I have four children today and I have been living a normal sex life; so what are you talking about[?]'⁴⁹

Furthermore, women are often aware of the health risks and side-effects but continue the practice for other reasons. For example, in some communities, withstanding the initial pain of the procedure is often highly valued,⁵⁰ while in the longer-term women can gain social advantages from undergoing the procedure⁵¹ (see also Section 5 of this report).

D. Training and Converting Cutters

A popular strategy over the last few decades has been to educate traditional practitioners about the health risks associated with FGM, provide them with alternative means of income as an incentive to abandon their work, and train them as change agents in their communities.

However, without an accompanying approach that works to shift social norms in the wider community, such programmes often have little effect. Demand for FGM remains.

While alternative income-earning activities can address the economic benefits of performing FGM, they do not solve the potential loss of status and community recognition that often accompanies the traditional practitioner's role. Furthermore, cutters are not necessarily the community members with the most authority to convince others to abandon the practice.

E. Alternative Rites of Passage

Alternative rites of passage (ARPs) have been developed by NGOs since the mid-1990s as part of programmes to end FGM in communities where cutting forms part of the initiation of girls into womanhood, typically at puberty (for example, among the Maasai and Samburu in East Africa). ARPs can take various forms, but essentially 'aim to replicate traditional initiation rituals for pubescent girls who are transitioning to womanhood, but without FGM/C.'⁵²

While some programmes proposing ARPs have been successful in certain contexts, particularly when accompanied by extensive, community-based dialogue that involves the community as a whole and promotes consensus to abandon the practice,⁵³ success is by no means widespread:

*[T]he small body of existing literature on ARP, particularly produced by or for NGOs, donors and development agencies, tends to depict ARP as a (relatively) successful component of FGM/C eradication campaigns in Africa. The more scholarly research evidence challenges this assumption . . .*⁵⁴

That ARPs are usually imposed from ‘outside’, rather than being community-led, and that they often overlook kinship and deeper social norms at work within FGM-practising communities, is increasingly being recognised. This raises questions as to whether ARPs actually lead to long-term abandonment of FGM or simply represent a postponement of the practice.

A survey to assess a 2017 ARP intervention among the Maasai community of Kajiado in Kenya found that, while successfully committing the community to girls’ education and thus delaying early marriage,

none of the girls interviewed post-ARP considered themselves to be a woman in any traditional sense, neither were they considered as such by community members. It can be posed that the ARP is not an alternative rite of passage (into womanhood), but a rite that signifies an extension of childhood. Preventing school dropout and buying time through education is however no guarantee girls will not be circumcised at some later stage if what it means to be a woman is not redefined and embedded in daily life.⁵⁵

The evidence increasingly suggests, therefore, that ARPs are only an appropriate strategy when tailored to the specific cultural and local context in which they are used and are combined with community-wide dialogue to effect social-norms change.

F. Positive Deviance

This approach identifies individuals who have challenged or ‘deviated’ from societal expectations by abandoning FGM. They are encouraged to act as advocates and urge others to abandon the practice. Programmes of this type have had variable success and those which showed positive results did so because they built on locally relevant reasons for abandonment and recognised that the solution to the problem already existed within the community.⁵⁶

The positive-deviance approach is more likely to be effective in reducing FGM if the deviants carry authority within the community. This approach is also more likely to be successful if there are no social sanctions on either deviants or those who follow them; hence, the need for a collective process of community-level norms change whereby everyone agrees to a shift in behaviour.

G. Confrontational Approaches

In this approach to social change, struggle for power, conflict and competition are seen as essential parts of the change process.⁵⁷ However, confrontational approaches are often harmful when it comes to dealing with issues within communities themselves. This is because the approach divides the community into different groups with divergent interests, and, therefore, undermines the cohesion, consensus and collective problem-solving ability that are key to improving community health.⁵⁸

Splitting communities into factions with different points of view reduces the overall social cohesion of a community and hence its capacity to solve mutual problems through collective action. If severe, it can bring cooperative action among groups within a community to a halt.⁵⁹

Indeed, confrontational encounters over FGM may protect girls from immediate risk but make them vulnerable in new ways. Girls can become estranged from their families and dependent on others' support for their basic needs.⁶⁰ This approach also leaves few options open to girls and women who oppose harmful practices but are not ready to sacrifice the wellbeing, security and sense of belonging that comes with their conforming to dominant cultural norms.⁶¹

4. A Systems Approach to Community-Based Social-Norms Change

Many FGM-eradication strategies try to bring about changes in individual behaviour, yet the focus on individual behaviour does not take into account the influence of social structures and cultural values on people's beliefs and actions, especially in contexts with collectivist values. Evidence shows that, rather than focusing on individual behaviour change, it is more effective for programmes to focus on promoting changes in social norms, which in turn influence individual behaviour.⁶²

While there remains a lack of evidence of what actually works to promote shifts in social norms relating to FGM specifically, there is a long history of research into the best methods for shifting social norms relating to health more generally. A particularly useful approach is systems theory.

Defining a 'System' and 'Systems Change'

According to the systems theory approach, systems are collections of parts that, through their interactions, function as a whole (for example, a family, a village, an organisation, a coalition of organisations, etc.)

Systems change is rarely achieved through changing one part of a system:

Attention to only one or a few system characteristics when attempting to foster social change can create null results and even have dire consequences. . . . a sole emphasis on a unitary system part (e.g., policy change) is usually insufficient for sustained system transformation.⁶³

Conventional programmes assume that intervention activities or policies will have linear and predictable effects. However, systems theorists see programmes as more unpredictable because they interact with system elements to create new relationships and processes.⁶⁴

Addressing the Deep Structures of a System to Catalyse Change

To be effective, a programme must create change at two levels of a system: the external or apparent level (the obvious and visible structures like policies, procedures, roles and responsibilities) and the internal or deep structures (attitudes, values, beliefs and assumptions) that underpin the apparent level.

Development programmes fail, or have unintended negative consequences, if the programme staff do not understand the dynamics of the system that they are trying to change, the interactions between its parts or the complexity of the change process.⁶⁵ In particular, they often have limited knowledge of the deep structures of the system.⁶⁶

Systems Change

‘Systems change’ is defined as:

change efforts that strive to shift the underlying infrastructure within a community or targeted context to support a desired outcome, including shifting existing policies and practices, resource allocations, relational structures, community norms and values, and skills and attitudes.⁶⁷

The Four Dimensions of a System to Consider When Designing a Programme

There are four main dimensions of a system that should be taken into account when designing a systems change programme:

- **norms** – attitudes, values and belief;
- **resources** – economic capital, human capital, social capital, and cultural resources;
- **regulations** – enforcement mechanisms; e.g. laws, policies, social sanctions or rewards; and
- **decision-making** – decision-making processes and power dynamics.⁶⁸

While the four dimensions contribute to the causes of FGM, they also hold the key to levers that can be used to catalyse change across the whole system.

Table 5 below explains each dimension and gives examples of its relevance to FGM.

Dimension of the System	Characteristics	Relevance to FGM
Norms	Norms are the attitudes, values and beliefs that shape people’s behaviours. If norms align with a programme’s goals, they can facilitate change. If they do not, they can be a source of resistance and can delay or derail change efforts.	Legislation and health-risk education campaigns often fail to reduce FGM as they do not align with the worldviews of practising communities. Shifting attitudes surrounding FGM in a way that is compatible with, and sensitive to, local culture and values is therefore fundamental to achieving a change in relation to FGM.
Resources	Resources include economic resources (money or material wealth), human resources (knowledge or skills), social resources (relationships between people) and cultural resources (positive traditions). The absence of resources within a system can be a barrier to change, even if the norms are in favour of change.	There may be weak relationships and communication between groups in a community (a lack of social resources), meaning that experiences of FGM are not widely shared. People might be opposed to FGM and refuse to practise it, but lack the skills (human resources) to convince others to do the same. Increasing resources (through training or catalysing dialogue) can be the key to promoting change.
Regulations	Regulations are enforcement mechanisms that ensure that people’s behaviours align with the system’s norms. Regulations can be formal (such as laws) or informal (such as social sanctions and rewards). Regulations must be, or become, compatible with desired change for a programme to succeed.	Most FGM-practising communities are found in settings where collectivist values predominate and the state has limited influence. Informal regulations, such as rewards for conformity to dominant norms and social sanctions for nonconformity, tend to influence people’s behaviour much more than national laws or human-rights frameworks.
Decision-Making	Decision-making processes and power dynamics are important as they underpin patterns of behaviour. Recognising who exercises authority, and whether or not this authority supports the desired change, is essential. Programmes are more successful when power structures are, or become, aligned with the desired change.	In most cases, the people who exert the most influence over FGM (in particular, older women and grandmothers) are not often invited to participate in programmes because their influence and authority is not recognised. Alternatively, they are framed as a barrier to change and no effort is made to harness their potential to catalyse a shift in the social norms surrounding the practice.

Table 5: The four dimensions of a system and their relevance to FGM⁶⁹



5. Identifying the Characteristics of FGM in a Community

To enable effective social-norms change, interventions need to be tailored to the specifics of each context. However, identifying exactly how and the extent to which FGM is practised in a given context is difficult and poses challenges for programme design. There have been some improvements to this situation in recent years as statistics on FGM prevalence are collected through large-scale household surveys in some countries, predominantly the Demographic and Health Survey (*DHS*) and the Multiple Indicator Cluster Survey (*MICS*).

FGM data in these surveys is self-reported, however, meaning that it is not gathered via physical examinations. In general, UNICEF emphasises that self-reported data on FGM ‘needs to be treated with caution’⁷⁰ since women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice. They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

Measuring the FGM status of girls, who have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. However, these questionnaires tend to survey only women over the age of 15 and rely on mothers to answer questions about the FGM status of their daughters; therefore, they may not answer accurately for fear of implicating themselves, their families or other people who were involved. Survey questions also vary over time and between countries, making identification of trends difficult, and they do not clearly differentiate between all types of FGM. It is also important to note that survey results may be based on relatively small numbers of women, particularly when they are further broken down by location/religion/ethnicity/etc. Therefore, in some cases, statistically significant conclusions cannot be drawn from the existing data.

It is also worth noting that the assumption that FGM is an ‘entrenched’ practice ‘deeply rooted in tradition’ and ‘practised for thousands of years in parts of Africa’ masks how it can actually be adopted, or abandoned, very quickly, in the space of a few years or decades.⁷¹ Migration and intermarriage between ethnic groups can introduce the practice into areas where FGM prevalence had previously been low (for example, activists recently report an increase in prevalence in the south-eastern regions of Liberia due to migration).

A further assumption has been made in the past that patrilineal ethnic groups are more likely to practise FGM than those that are matrilineal. In patrilineal societies, husbands are economically responsible for their wives and raising her children, so there are more incentives for men to ensure biological paternity and to control women's sexuality.⁷² However, other factors play a role in influencing FGM, such as the presence or absence of widespread norms in favour of the practice in a given setting.⁷³ Many patrilineal societies do not practise FGM because it is not part of the local or regional culture, while some matrilineal societies practise FGM because other ethnic groups

around them do too. Some programmes have failed to target groups on the assumption that those groups did not practise FGM because they were matrilineal, when in fact they did.⁷⁴

Therefore, when planning a social-norms-change intervention, the following points need to be considered:

- A. which community to focus on;
- B. the FGM terminology in use within the community;
- C. the type(s) of FGM practised;
- D. the age of cutting; and
- E. why FGM is practised.

A brief analysis of each is outlined below.

A. Which Community to Focus On

Whether anti-FGM activism is carried out in FGM-practising countries (in Africa and beyond) or within diaspora communities, it is vital for programme staff to remember that FGM prevalence is linked primarily to ethnic group, rather than country (of origin).

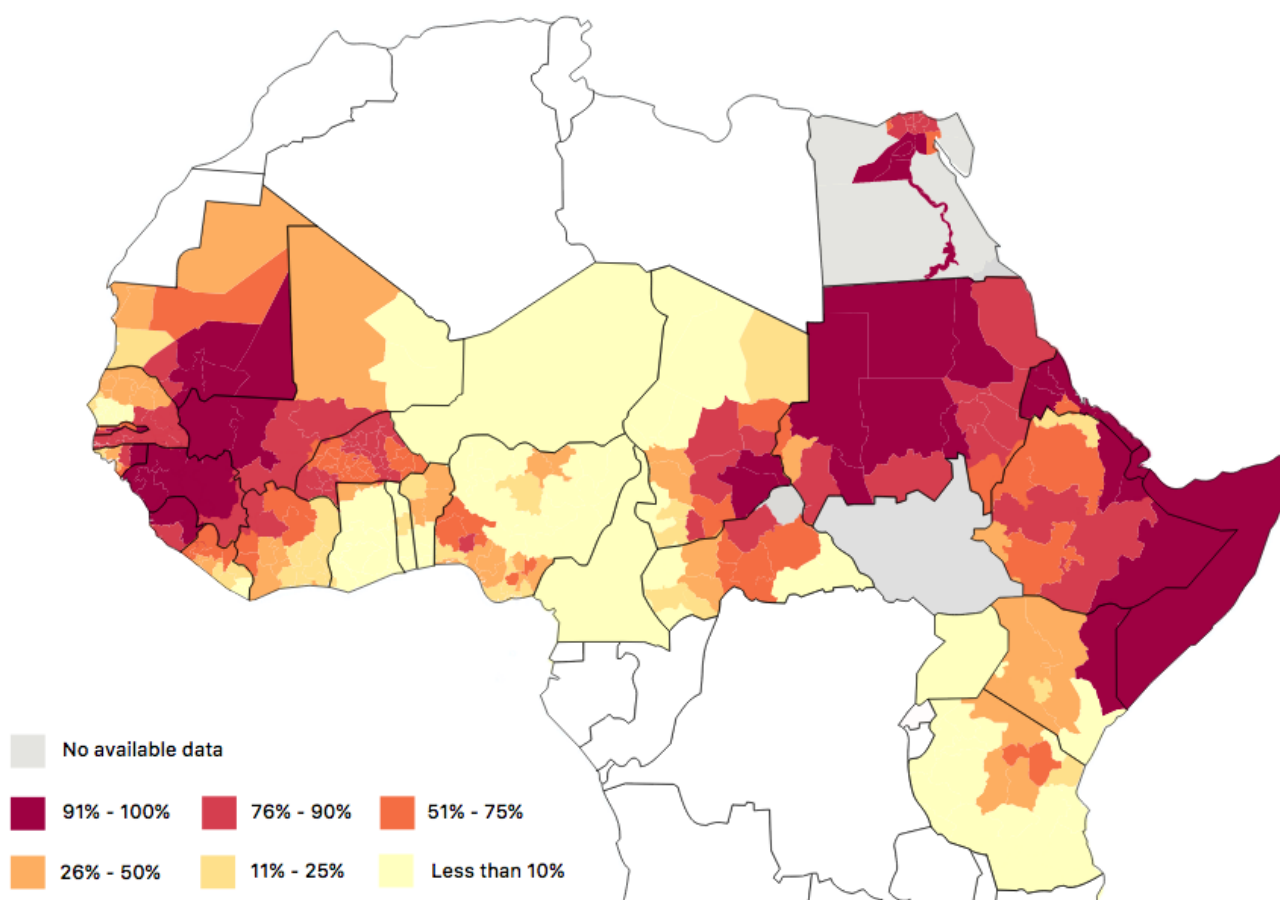


Figure 2: Prevalence of FGM in Africa (© 28 Too Many)⁷⁵

To some extent, ethnicity also speaks to geography; however, migration out of a high-FGM context does not necessarily mean a reduction of risk – many migrants continue the practice and, in many cases, reduction in FGM practice back home is resisted by diaspora communities. Prevalence also varies dramatically from country to country, and from region to region within many countries (see Figure 2 above).

For further detailed information on FGM prevalence by country and ethnicity, please refer to the maps and country profiles on the 28 Too Many website: <https://www.28toomany.org/>.

B. FGM Terminology in Use Within the Community

Debates continue internationally about the most appropriate terminology to use to refer to procedures for altering the external female genitalia for non-medical reasons.

Essentially, FGM is known by different names in different communities. It is important in interventions to both use the local terms and link these to the global literature and laws of a country. The terms used can also point towards the communicator's attitude towards the practice.

Terms most commonly used internationally include:

- **Female circumcision** – by drawing a parallel with male circumcision, this term creates confusion between two very distinct practices. It has been criticised for de-emphasising the severity of the procedure performed on female genitalia.
- **Female genital mutilation (FGM)** – the most widespread term in international use as adopted by UN agencies in 2008: 'The term is non-judgmental as it is a medical term describing what is done to female genitalia. Mutilation is the removal of healthy tissue.'⁷⁶ 'FGM' has a negative connotation and emphasises the gravity of the harm caused by the practice.
- **Female genital cutting (FGC)** – a more value-neutral term that is often used alone or alongside 'female genital mutilation' with the acronym **FGM/C**. FGC is used by some medical professionals and international organisations to avoid the stigmatisation of practising communities. Its use, however, seems to vary considerably between different practising communities and is seen by some local activists to not accurately reflect the gravity of the harm caused by the practice.
- **Excision** – the connotation can be positive or negative according to the speaker. In some practising communities, 'non-excised' girls are the ones who are socially mistreated.

There are numerous other national and local terms (and associated definitions) for the practice across Africa and beyond, including the word *sunna* (referring to all types except infibulation) in countries such as Somalia and Sudan and local variations such as *angurya* (the scraping of tissue surrounding the opening of the vagina) and *gishiri* (cutting of the vagina) in Nigeria.

For further information on FGM terminology see <https://www.28toomany.org/thematic/terminology-and-fgm/>.

Language to Use When Working with Communities: the More Neutral, the Better

Researchers, campaigners, activists, government officials and organisations will all have contrasting opinions on which term is best to use. However, the specific objective of this guide is to recommend practice that is most likely to effectively catalyse social-norms-change programmes in African FGM-practising communities. In such circumstances, the evidence on best practice in relation to terminology appears to be *the more neutral, the better*.

Sensitivity to language is an essential element of building trust with people in order to understand their perspectives and initiate change.⁷⁷ These findings suggest that programme staff should ascertain exactly how FGM is practised in the community touched by the intervention and, when speaking with community members, use the community's own terminology for describing the type of FGM it practises.⁷⁸

Tailoring Language to Different Stakeholders

Although neutral language is best used when working directly with communities, it is possible that an organisation may need to use different language with different stakeholders. For instance, when working with communities it may be appropriate to use local terminology, but when writing funding bids or reports for donors it may be more appropriate to use terms found in international discourse.

C. Type(s) of FGM Practised

The WHO identifies four main types of FGM (see Table 6 below). Other activists speak of many more sub-types. It is important to understand the type(s) of FGM practised in a community in order to address the specific health (and other) impacts of each type.

Type I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.]
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
Re-infibulation	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

Table 6: Types of FGM as classified by the WHO⁷⁹

It is possible for a local community to deny that they practise FGM or FGC because they simply use different terminology or do not conform to a specific type. There is a lack of understanding and agreement, for example, about types and definitions of FGM in Somalia and Somaliland; FGM

is commonly referred to as either ‘Pharoanic’ (Type III/infibulation) or ‘sunna’ (all other, ‘less severe’, types). Research suggests that in many cases even more severe types of FGM that include stitching are being labelled ‘sunna’. Sunna is believed by many Somalis to cause no health problems and to be condoned, even required, by Sharia law. Further misunderstandings surround the use of specific terminology such as ‘abandonment’ and ‘FGM’, both of which are commonly believed by Somalis to refer only to Type III FGM.

For further information on which types of FGM are practised in a given community, please see <https://www.28toomany.org/research-resources/>.

D. Age of Cutting

Cutting tends to happen during one of three age ranges: in the first few years of life, between ages 5 and 9, or between the ages of 10 and 15. Almost all FGM takes place before 15 years of age; however, FGM also takes place in some communities around marriage/child birth (often under extreme pressure from family members).

Different communities cut at different age ranges. For example:

- Ethiopia: most girls are cut before the age of four.
- Nigeria: most girls are cut before the age of five.
- Senegal: most girls are cut before the age of ten (and three-quarters of them by age five).
- Egypt: most girls are cut after the age of nine and up to puberty.
- Kenya: most girls are cut between the ages of 10 and 14.

It is therefore essential to identify when girls are most at risk and target interventions accordingly; for example:

- If a community cuts at birth (or in the first few years), interventions need to focus on and support older girls in schools (pre-marriage) and antenatal clinics (while pregnant). Other ways that the community can ‘mark’ infant girls as ‘belonging’ after birth need to be considered.
- Where a community cuts before or around puberty, interventions need to focus on primary-school girls, teachers and parents (before they cut) and take into account appropriate strategies (see also ARPs on page 23).
- If cutting is associated with marriage or childbirth, interventions need to focus on and support older girls (pre-marriage) and antenatal clinics (while pregnant).

E. Why FGM is Practised

While many activists refer to FGM as a harmful practice, practising communities do not aim to harm their daughters. It is therefore helpful to understand the perceptions that enable FGM in a target community and seek to address them directly through interventions. Research has shown that a number of common myths surround the practice. A target community will hold on to one or more of these reasons in order to justify the practice:

- FGM may be **an early marker of belonging** to a particular group, perhaps carried out when the child is only a few days or weeks old. In Enugu State in southern Nigeria, for example, FGM is usually carried out on the eighth day after birth, to coincide with the child's naming ceremony, which is a festive event during which mother and baby receive gifts and family and community celebrate together with refreshments. Local NGO Society for the Improvement of Rural People (*SIRP*) has found that young mothers, and usually those who are in the lower wealth quintiles, are unable to openly resist their baby girls undergoing FGM because it would also mean there would be no naming celebration. *SIRP* has therefore developed, through its community-dialogue programmes, an alternative naming ceremony, supporting the naming celebrations without the cut.⁸⁰
- In some communities FGM is seen as **a rite of passage** – an initiation into adulthood, occurring as the girl approaches puberty and 'becomes a woman'. In the Kenyan Maasai community, for example, the cutting of a girl between the ages of 12 and 15 to mark her transition into womanhood has traditionally brought families together in community celebration. The criminalisation of the practice through national legislation and the widespread campaigning against FGM has, in many cases, resulted in communities now cutting girls in secret, often at night or by taking them across borders to avoid prosecution (for example, into Tanzania).⁸¹
- In many communities FGM is carried out as **a way to control women's sexuality**, which is sometimes said to be insatiable if parts of the genitalia, especially the clitoris, are not removed. Practising communities believe it will ensure virginity and 'purity' before marriage and fidelity afterward; as such, FGM can also be required to preserve the family 'honour'.⁸²
- FGM is also commonly considered **a prerequisite for marriage**. Political scientist Gerry Mackie has made a strong argument that FGM is motivated by a concern to make women marriageable because the procedure (particularly infibulation) ensures premarital female chastity and hence assures biological paternity in patriarchal societies.⁸³ This theory has had a lot of influence over FGM intervention approaches.⁸⁴
- FGM may be required **to 'cleanse' a girl**: it is thought more hygienic if genital tissue is removed, stopping unpleasant secretions and odours. In Ethiopia, Kenya, Sudan, Senegal and Guinea Bissau, for instance, some consider FGM to be part of a cleansing and purification process, by which the *haraam* (sinful, forbidden or unclean) parts of the body are removed.⁸⁵
- FGM may also be performed for **aesthetic reasons**, to remove 'masculine' aspects of the female body. This is linked to myths and fear of the clitoris; for example, that contact with it during childbirth will damage the baby, or that unless it is removed it will grow into a 'third leg' like a 'penis', only perhaps longer, and may cause a girl discomfort when she becomes a woman.⁸⁶
- Some communities also believe FGM will **enhance men's sexual pleasure**, particularly in communities practising Type III (infibulation). However, a UNICEF report on 11 African countries found that only 1–7% of men felt that FGM increased their sexual pleasure.⁸⁷
- Although FGM is not required by any religious script, **supposed religious doctrine** is commonly used to justify the practice. FGM is often associated in people's minds with Islam, but in reality

it occurs among some people of all religious groups in Africa (Christian, Muslims, historically a small sect of Jews, as well as groups practising animist or traditional religions).⁸⁸ Evidence from many contexts support the idea that religious beliefs encourage FGM; for example, approximately 46% of Egyptian women and 50% of Egyptian men (aged 15–49) believe that FGM is required by their religion,⁸⁹ and around one-third of those practising traditional religions in both Burkina Faso and Nigeria also believe their religion requires FGM⁹⁰.

Understanding the ‘Social Benefits’ of FGM: Women’s Wellbeing, Status and Authority

As outlined above, fully understanding and addressing the reasons why FGM is still practised and supported by a community is vital to the success of an intervention. But it is not enough to just speak of the negative health and psycho-social impacts of the practice. In almost all contexts the reasons driving FGM are much deeper and more complex and it is necessary, though challenging, to unravel the perceived ‘social benefits’ of the practice for women and girls and what they feel they will lose if they reject it. FGM confers status and belonging to women in many practising communities. Without addressing these aspects and their underlying beliefs, unhelpful tensions are created between acceptance (i.e. belonging to/status in the community) and safety (including health impacts on an individual).

For example, while FGM for reasons of ‘culture’ or ‘tradition’ can clearly be forced upon girls, they may also embrace the practice because it makes them feel a member of a social group and gives them a stronger sense of belonging. Group membership confers pride, connection, honour, respect and acceptance. Girls and women who undergo FGM can be the focus of celebrations, receiving gifts, status and respect, or a higher bride price.⁹¹

FGM may also be practised by a community with the intention of ‘protecting’ a girls’ wellbeing (for example, from rape or extramarital sex and pregnancy, which are perceived within many cultures to be grave sins and/or to confer great shame). Therefore, it is essential to understand whether these underlying forces are at work, driving the practice in any focus community.

FGM may also integrate a woman into networks of support⁹² and confer on her a position of authority in the community. In Sierra Leone, for instance, initiation into the secret society known as *Bondo* is central to many women’s lives. Membership equates to respect within the community for women, freedom of movement and association when the ‘bondo bush’ is in session, and power within their communities to mediate social relations and living conditions. The cost of this social acceptance is FGM; failure to conform in communities such as these can lead to difficulty in finding a husband for the girl, shame, stigmatisation, as well as loss of social status, honour and protection, and a family’s social exclusion in the community.⁹³ In places lacking state social-security mechanisms, which is often the case for most FGM-practising communities, being part of such networks can make the difference between an individual’s protection and survival, or their destitution.

Case Study: Changes in FGM Practice Over Time in Velingara, Southern Senegal⁹⁴

In 2006, the Grandmother Project tried to obtain statistics on the prevalence and types of FGM in Velingara in southern Senegal, but these did not exist. Health workers had difficulty estimating prevalence, or the incidence of different types of FGM. It was also difficult to obtain information from community members. Men did not have detailed knowledge of FGM and most women were reluctant to discuss the practice, often stating that it had not been conducted since the ban in 1999. Teenage girls were extremely embarrassed to talk about it.

However, health workers suspected that FGM was widespread, although more extreme forms (Type III) were declining in favour of less severe forms (Types I and II). Interviews with health workers, teachers, development community workers and female leaders willing to talk about the practice indicated that girls used to be cut at ages of 8–13 during a collective ceremony in a dedicated hut in the bush, but that the procedure was now performed on infants at home, often individually, although still by a respected cutter. Since this shift, men knew even less about the practice and were often unaware that it was going to happen.

The shift from collective to individual cutting had begun some years earlier but accelerated after the ban in 1999. Other reasons included the belief that younger girls healed more quickly and that it avoided the costs of a large ceremony. Women expressed regret that the procedure was performed earlier, as the educational component of the initiation rituals surrounding the practice had disappeared. Some families stopped practising FGM entirely after the ban, while others continued, some taking girls to neighbouring countries where legal risks were reduced.

6. Working with Decision-Makers, Influencers and Cultural Authorities to Catalyse Shifts in Social Norms and FGM

To catalyse behaviour change in a community system, programme staff need to understand the *decision-making processes* and *power dynamics* that underpin those patterns of behaviour. Recognising who exercises authority and power within a system, and whether or not that authority supports the desired change, is essential. Programmes are more successful when power structures are, or become, aligned with the desired change.

The need to engage key authorities has been recognised by programme staff working on FGM. As Denison *et al.* note:

Because individual behaviour is strongly reinforced by social norms and belief systems in their communities, recruiting the larger community and individual norm authorities, who uphold social norms, to question unhealthy norms is critical.⁹⁵

Nevertheless, many programmes have failed because they have ignored key decision-makers and focussed on ‘positive deviants’ (i.e. people who oppose the practice – see page 24) to convert the rest of their community, without realising that the positive deviants chosen do not necessarily have the customary authority to lead behaviour change.

There are different levels at which people can be involved in the practice of FGM (see also Figure 4 below):

- the **girl or woman** who is cut;
- the **performer** or person(s) who carries out the procedure (and accompanying rituals, if any);
- **decision-makers**, namely the individuals who take the ultimate decision to cut or not cut a girl; and
- **influencers** – often a wider group of social actors who shape decision-makers’ views.

The distinction between decision-makers and influencers is needed because influencers may not even be in the same country as the decision-makers, yet still exert considerable authority.⁹⁶ It is therefore essential for programme staff to understand and work with the full range of actors in a given community who shape the practice and have authority over it, not just the performers (including cutters) and direct decision-makers.

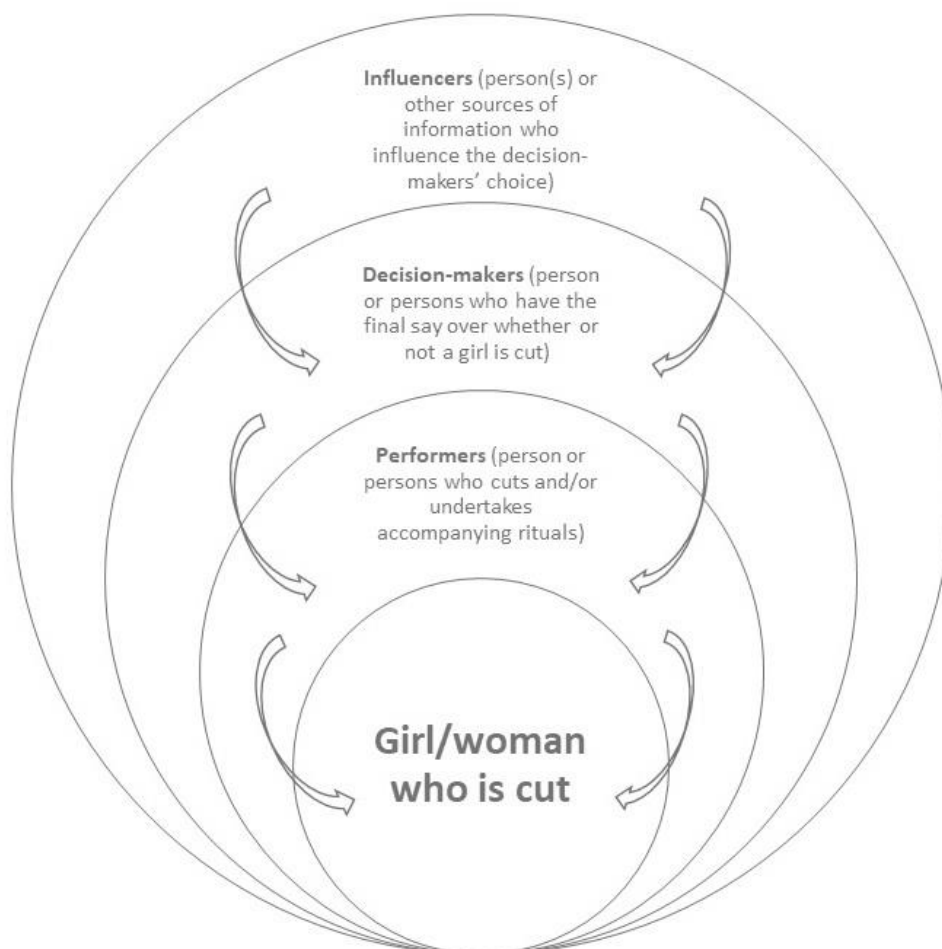


Figure 4: Key actors in the practice of FGM

The table below also sets out the importance of authority, or relative power, in shaping FGM practice in communities.

<p>Decision-making</p>	<p>Making a decision refers to the time-bound process involved in embarking on a particular course of action. It is usually a conscious process. It can be individual or collective.</p> <p>In the context of FGM, decision-making involves the specific discussions and actions that result in a girl being cut or not cut. In FGM-practising communities, decision-making is likely to be a collective rather than an individual affair, involving multiple members of the extended family.</p>
<p>Influence</p>	<p>Influence is a more diffuse process that shapes decision-making and can involve a wider set of actors and sources of information. It takes place over a longer period of time than making a decision, even from when a person is very young. Individuals can be subject to influence – or can influence others through their speech and behaviour – without being consciously aware of it. Influence can range from the subtle to the obvious.</p> <p>In relation to FGM, influence includes the process whereby individuals learn through everyday interactions about the deep or hidden aspects of their culture that support the practice, including general attitudes about women’s position in society, wider value structures and worldviews.</p>

Authority	<p>Authority refers to the power someone has to have their viewpoint respected and heard, their behaviour accepted and their desired outcome in a decision followed. They can encourage conformity to their examples and thus play a leadership role in their relevant social sphere.</p> <p>In the context of FGM, it is important to note that not everyone who is involved in the collective decision-making process to cut a specific girl, or who influences the community's views on FGM, will have the same power to dictate the final outcome; this privilege goes to those with the most authority.</p>
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Table 6: The impact of decision-making, influence and authority on FGM

Compared to the huge volume of literature on FGM prevalence and its causes, there is much less written about who plays key roles in decision-making and influencing the practice. There is even less investigation into who has the most authority to perpetuate and prevent the practice and what implications this has for programmes. The following section therefore provides an overview of the available evidence on different categories of family and community members and the relative influence and authority they may have over FGM in specific contexts.

A. Female Elders (Grandmothers)

The term 'grandmother' is used to refer to all more experienced, older women in the family and community who provide advice, supervision and support to parents and their children as they grow up.

Grandmothers can be between 30 and 80+ years of age but the older they are, the more their experience is recognised and the higher their status in the community.⁹⁷

There is an enormous amount of evidence that, in the majority of contexts where FGM is practised, female elders (or grandmothers) have significant input into the practice, as well as the cultural authority or power to change it.⁹⁸ They play all of the roles listed in Figure 4 above, including as performers of the procedure and accompanying rituals, ultimate decision-makers in a household and influencers of other decision-makers such as mothers and fathers. They also frequently wield authority in matters relating to the female sphere, meaning that others in the community will often defer to their opinion in this area.

Much of the time, grandmothers will take the initiative to have a girl cut. They can override the views of other family members, including fathers, and may take the girl to be cut without the parents' knowledge.⁹⁹ Grandmothers can also exert influence from a considerable distance; those in Africa can even shape the views of parents in the diaspora.¹⁰⁰

In Somalia:

[S]ome of the other older women told me their fathers had told them that they should not be circumcised, and it was the mother, grandmother, aunts, or other female relatives who overruled the father.¹⁰¹

Female elders are often the staunchest supporters of the practice and those most likely to resist campaigns to eradicate it.¹⁰² Nevertheless, they also have the most authority to shift the practice. Shell-Duncan *et al.* recently found that, in Senegal, it was grandmothers who were the most open to change relating to FGM and had the most authority in relation to it.¹⁰³

However, compared to other actors who shape the practice, grandmothers are much less likely to be explicitly invited to participate in anti-FGM programmes.¹⁰⁴ This discrimination against elders, and older women in particular, has been widely documented across the gender and development field.¹⁰⁵

However, when given the opportunity to participate in a way that respects and builds upon their cultural roles and knowledge, grandmothers have proven to be effective and dedicated actors in shifting social norms in their families and communities in favour of women and girls.¹⁰⁶

B. Mothers (Women of Reproductive Age)

In contrast to grandmothers, the extent of mothers' (i.e. women of reproductive age) influence and authority over FGM is more mixed. In some places, like Egypt,¹⁰⁷ and among Somalis in Ethiopia,¹⁰⁸ the mother appears to be the main person who decides whether or not her daughter is cut. In other contexts, the mother plays an important decision-making role, which can include initiating the discussion about whether her daughter should be cut, while other members of her extended family, such as grandmothers and fathers, also contribute to the decision.¹⁰⁹

Even more significantly, in some cases, mothers (and fathers) may have much less authority than older women in the decision-making process.¹¹⁰ There is less evidence that mothers are performers, be that cutting or organising ceremonies, as these too are responsibilities usually reserved for older women.¹¹¹

C. Female Adolescents and Young Women

In most contexts, girls' views align most closely with those of their wider family and community, and they are not generally considered influencers, decision-makers or performers. They can, however, pressure their peers to undergo FGM or demand that they undergo it to fit into society.¹¹² In Ethiopia, for instance, it has been observed that:

[I]t was girls – not adults – who most favoured genital modification, largely because of peer pressure; this in itself is a reflection of the importance girls attach to social acceptance and preserving their reputation in readiness for marriage. While younger girls in Oromia often refuse to be circumcised, teenagers are more likely to succumb to peer pressure.¹¹³

Some programmes use a girls'-empowerment approach to educate them on the risks of FGM and to coach them in critical-thinking skills and self-confidence to challenge their family members and resist the practice. However, this confrontational approach can have unintended negative consequences.

The effectiveness of a girls'-empowerment approach has also been challenged in other fields of gender and development, such as child marriage. According to a recent review of the most effective strategies to address child marriage, girls'-empowerment approaches, when used as the sole activity, had a limited effect in reducing the prevalence of child marriage. While girls targeted by these programmes were more confident and informed, which is clearly a positive development, they still lacked the cultural authority to challenge the practice. Girls'-empowerment approaches are only able to shift child marriage practices if accompanied by community-wide norms-change programming.¹¹⁴ It is likely that the conclusions drawn from the implementation of a girls'-empowerment approach in the context of child marriage would also hold true for FGM, given that both practices are usually upheld by social norms and are deeply engrained in the cultural fabric of communities with similar gender- and age-based power structures.

D. Male Members of the Community

Male members of the community (whether youth, brothers, husbands, fathers or male elders) are increasingly being included in anti-FGM programmes, but there is still limited research to date into the success of this approach.¹¹⁵

In some contexts, fathers appear to play an important role as decision-makers and do wield authority. In Burkina Faso, 88–89% of men and women stated that fathers play a critical role in determining whether to have a daughter cut, compared to the 38–46% of men and women who said that mothers have a role.¹¹⁶ Among Eritrean and Ethiopian families in Italy, mothers start the discussion regarding whether girls should undergo FGM, while the father is the ultimate decision-maker (who can oppose the mother's view) as well as the main financier of the procedure.¹¹⁷ In parts of Nigeria, fathers or paternal grandfathers make the decision to request FGM.¹¹⁸ In the Sudan, fathers can oppose the practice and older brothers can also be involved in the decision on whether or not a younger sister should be cut.¹¹⁹

In other contexts, the decision-making role and authority of husbands, fathers and brothers is much more minimal. In Senegal, men are typically not involved in decision-making and often do not know that the procedure is going to take place.¹²⁰ Among Somali families, in general, women make the decisions regarding FGM and in only about 8% of households surveyed in Somaliland were men and boys also involved.¹²¹

Regarding Somali women in Ethiopia, Abathun *et al.* write:

[S]ome mothers encourage their daughters to go to circumcisers without informing their fathers. . . . It is the mothers who have power when it comes to taking the decision. Even if the father does not want the daughter to be circumcised the mothers find ways to do it.¹²²

Regardless of whether or not they have an important decision-making role or authority, men may also influence the norms supporting FGM by refusing to marry uncut women,¹²³ refusing to eat meals prepared by uncut women¹²⁴ or subjecting young men to stigma and pressure to marry cut women.¹²⁵ Again, research on Somali men and their role in FGM concludes that ‘they are influential in creating the social climate within which decision-making about cutting takes place’, as only 4% of the unmarried men surveyed preferred to marry a girl who has not undergone FGM.¹²⁶

In contexts where FGM is medicalised, male doctors can also play a role as performers of the practice. It is therefore essential that they be included in anti-FGM programmes.¹²⁷ However, when traditional community practitioners do the cutting, it is extremely rare for men to be involved: research has found only one context (among the Hausa in northern Nigeria) where the customary cutter is a man, in this case known as a ‘barber’.¹²⁸

Given this diversity in men’s relative influence, decision-making and authority in relation to FGM, it is essential to understand the various power dynamics in a specific context when designing a programme.

E. Religious Leaders

When reports talk about ‘religious leaders’ participating in anti-FGM programmes, they are usually referring explicitly or implicitly to male religious leaders from different religions, including Islam and Christianity.

While there is little evidence that male religious leaders play a role as performers of FGM or as key decision-makers,¹²⁹ they can, however, have a very strong influence and authority over the practice. In some contexts, discovering that FGM is not mandated by Islam or Christianity plays a strong part in persuading people to abandon the practice.¹³⁰ Hence, it is essential for programme staff to engage with religious leaders when working within communities where there is a strong belief that FGM is performed to fulfil religious requirements.

Religious leaders, like most people, become resistant if they think/feel an external agenda is merely being imposed on them.¹³¹

In a recent evaluation of programmes that work to end child marriage, Le Roux and Palm¹³² developed the following five recommendations for engaging religious leaders (Table 7). Given that FGM and child marriage are informed by similar cultural factors and social norms, these recommendations can be considered equally relevant to anti-FGM programmes.

Optimal Strategies for Working with Religious Leaders	Tips for Programme Staff Working with Religious Leaders
Recognise and respect religious leader agency	<ul style="list-style-type: none"> ▪ Have a genuine respect for religious leaders, their religion and their positions in the community. ▪ Have at least a basic understanding of the faith and how it influences all aspects of their lives. ▪ Be non-judgemental. ▪ See religious leaders as partners, not targets, and involve them in defining and solving problems. ▪ Allow time for trust to develop by working with them in long-term processes of discussion and support.
Frame the programme objectives appropriately	<ul style="list-style-type: none"> ▪ Frame the objectives in holistic terms instead of focusing on one harmful practice as a standalone issue. ▪ Use an assets-based approach instead of framing religion or religious leaders as the source of problems. ▪ If your organisation is of a different faith, partner with another organisation of the local faith for greater legitimacy. ▪ Engage religious leaders initially with a staff member of the same gender who has good facilitation and communication skills and a good knowledge of the religion. ▪ Use culturally and religiously appropriate and sensitive language.
Build a critical mass of opposition to the practice	<ul style="list-style-type: none"> ▪ Do not focus on convincing all religious leaders of the value of ending the practice, but work with enough to ensure momentum in favour of the shift. ▪ Engage resistant leaders in dialogue if they are vocal in their support for the practice. ▪ Engage other authorities (for example, grandmothers and male elders) in the community alongside religious leaders.
Engage with religious texts	<ul style="list-style-type: none"> ▪ Engage in dialogue on religious texts and their interpretations or, in the absence of sacred texts, with religious myths, stories, songs, traditions and prayers. ▪ Introduce medical information on the practice alongside discussion of religious texts. ▪ Do not force a new interpretation of the texts, but facilitate discussion between religious leaders and other members of the community to reach new understandings. ▪ Ground discussions in concrete examples and experience of the practice, not abstract notions of values. ▪ Involve knowledgeable, respected and authoritative religious leaders in the dialogue process.

Optimal Strategies for Working with Religious Leaders	Tips for Programme Staff Working with Religious Leaders
Talk about sex and sexuality	<ul style="list-style-type: none"> ▪ Facilitate sensitive dialogue over time to open up space to discuss taboo topics of sex and sexuality. ▪ Facilitate discussions about the links between sex, religion and the harmful practice (and alternatives to the practice) that take into account religious leaders' concerns about virginity, purity, the sanctity of marriage, etc.

Table 7: Optimal strategies for working with religious leaders and their implications for programming¹³³

There is increasing evidence that the involvement of religious leaders in community dialogues around harmful practices can shift social norms, but interventions vary in approaches to their roles in the process. Some approaches aim to support them in convincing their followers in the community to abandon harmful practices such as FGM.¹³⁴ Others takes a more systems-theory approach, seeing religious leaders as embedded within their societies, responsive to their followers and sensitive to prevailing social norms. No matter the personal opinion of individual religious leaders on FGM, the community as a whole needs to shift together.

F. Health Professionals

A common approach used in FGM programmes is to train health workers such as doctors, nurses and midwives on the harms and illegality of the practice and in techniques to support girls or women who have been cut.¹³⁵ These initiatives are clearly important in improving health outcomes and support for women who have already been cut. They also have a role to play in potentially reducing FGM prevalence in areas where medicalisation is common and doctors are the main 'performers' of FGM.¹³⁶ However, the overall effectiveness of these training initiatives in reducing prevalence has been challenged.

Evidence¹³⁷ shows that programmes that work with health professionals are more effective in reducing FGM prevalence if:

- training programmes are not directive, but participatory and interactive, using case studies, simulations and discussions;
- health workers are trusted by communities and have a good understanding of the cultural context in which they work; and
- health workers are included as part of a wider strategy of community-based dialogue which involves other key decision-makers, influencers and cultural authorities.

G. Education Sector Staff

Education plays an important role in overcoming and changing attitudes that are still in favour of FGM. While at school, girls may have greater exposure to intervention programmes and

discourse about the practice. In many countries, the longer a girl is in school, the less likely she is to undergo FGM or early marriage. Girls and women who are more highly educated are also more likely to understand their rights, support the abandonment of FGM and feel equipped to challenge social norms.

There are many NGOs and community activists working to improve girls' education and taking FGM-sensitisation activities into schools within practising communities. In Somaliland, for instance, local NGOs undertake child-protection training with headteachers and their staff to provide them with the knowledge and skills necessary to effectively and sensitively tackle the issue of FGM. Inter-school games and football tournaments are successfully used to disseminate anti-FGM messages among schoolchildren, as well as 'child rights clubs' that provide information for parents and students.

One of the biggest challenges with this approach, however, is that teachers work predominantly with children and adolescents, who rarely have the cultural authority to convince their wider families and communities to abandon FGM. It is important, therefore, that education sector staff are included and work alongside other, more influential and authoritative stakeholders as part of a community-wide strategy.

Identifying Key Decision-Makers, Influencers and Cultural Authorities in a Community-Wide Approach

The conclusion to be drawn is that, when designing a programme to shift social norms around FGM, it is essential to both:

- work with the full range of stakeholders who have experienced FGM as well as those who play roles as decision-makers, influencers and performers in shaping FGM practice in a given community (which is likely to include most community groups as well as relevant categories of professionals who have contact with the community); and
- give particular attention and support to those stakeholders who have the most cultural authority to shape the practice (which is likely to include elders, and female elders in particular).

Case Study: A Collective Approach to Ending FGM in Eritrea

While Eritrea has historically had one of the highest rates of FGM in the world, most available statistics suggest that prevalence in Eritrea is now declining. The Eritrean Population and Health Survey 2010 (*EPHS 2010*)¹³⁸ calculated FGM prevalence at 83% (down from 88.7% in the Eritrea Demographic and Health Survey 2002¹³⁹), and one of the reasons suggested for this decline is the holistic approach taken in the national anti-FGM campaign, called in the Tigrinya language *Habarawi* (or ‘collective’).

The Habarawi methodology simultaneously includes all levels of society:

from the Government to religious leaders, youth and women’s organizations, community leaders, former circumcisers and victims. Each sector actively played a role in building this consensus.¹⁴⁰

It is aimed at improving the health and wellbeing of Eritrean women by changing social norms, behaviour and attitudes towards them. Habarawi has subsequently been translated into a set of policies, programmes and strategies that support a community approach to ending FGM known as *Hamadea*.¹⁴¹

Through anti-FGM committees set up in each region (*zoba*), the Habarawi approach mobilises whole communities, including men and boys as well as women and girls, and brings in religious leaders, traditional cutters, anti-FGM activists, local teachers and health workers, parents and children. Government ministries have run training courses for health workers and law-enforcement officials at all levels to ensure that all government employees understand the policies, laws and health consequences surrounding FGM. Religious leaders have been reached through workshops and conferences, during which discussions are held about the dangers of FGM and how abandonment does not need to offend religious sensibilities. At the village level, messages are disseminated about women’s and girls’ rights and the impact of harmful practices (including FGM, forced and child marriage, workers’ rights and girls’ access to education). Young people are also involved through youth clubs, by encouraging them to take part in the development of policies that will benefit them.

For further information on the Habarawi approach, see 28 Too Many Country Profile: FGM in Eritrea (2017) at <http://www.28toomany.org/countries/Eritrea/>.

7. Catalysing Community Dialogue and Collaborative Problem-Solving

Actively involving . . . community members in problem solving can lead to more effective, feasible and responsive solutions, prevent the repetition of ill-advised decisions, and enhance the acceptance and legitimacy of decisions.¹⁴²

Many health and development challenges, including FGM, are highly complex and cannot be solved by a single person or organisation. Without a systems approach and sufficiently broad-based collaboration, it is difficult to understand the underlying nature of these kinds of challenges or to develop effective and locally feasible solutions to address them. The diversity of local contexts also means that top-down, ‘one-size-fits-all’ solutions have limited effectiveness.

Instead, it is necessary to enhance the ability of community members to collaborate effectively in identifying problems, reaching consensus on goals, agreeing on strategies to implement these goals and implementing those strategies effectively.¹⁴³

However, many communities lack the ability to engage in collaborative problem-solving. One reason is the dominance of confrontational approaches to social change. These approaches hinder rather than strengthen cohesion and consensus, which are necessary foundations of collaborative problem-solving.¹⁴⁴

Another hindrance is the limited role sometimes given to community members by governments and development organisations.¹⁴⁵ Many people want to be actively involved in addressing problems that affect their lives, but they are not always treated as equals in problem-solving. Instead, a funder usually identifies the problem to be addressed and a lead agency develops an intervention to address the problem. Community members can, at times, be treated as the source of problems or as ‘targets’ or beneficiaries of problem-solving efforts. If they are asked to provide feedback and input into the lead agency’s plans, it is usually to help the agency secure community ‘buy-in’ to carry out the pre-determined programme. This approach can devalue community members’ contributions and lead to feelings of helplessness and dependency.¹⁴⁶

Even though the international assistance community has developed procedures to encourage the participation of recipients in planning and implementing projects, the vast majority of people in recipient societies report that they do not feel included in the critical decisions about assistance they receive. In their experience, many of these decisions have been made before an aid agency arrives in their area and there are few, if any, opportunities to add their ideas as the effort unfolds.¹⁴⁷

In contrast, this section presents concepts and methods based on broad-based participation and empowerment of communities to diagnose and solve their own problems. In particular, we draw on the Community Health Governance model¹⁴⁸ and the Communication For Social Change approach¹⁴⁹. These models were intentionally designed to be flexible and applicable to a wide variety of social contexts. They can therefore be realised in many different ways, depending on the unique circumstances of the local environment.¹⁵⁰

According to this philosophy, the role of an outside organisation or lead agency is to catalyse, rather than impose or direct, the process of social change. A catalyst is a trigger that initiates community dialogue and leads to collective action. Individuals or agencies wishing to design a community-based social-norms programme should build on existing catalysts that have sparked dialogue on FGM in practising communities, or should sensitively introduce a catalyst as part of their programme activities.

*The catalyst . . . represents the particular trigger that initiates the community dialogue about a specific issue of concern or interest to the community. . . . This catalyst leads to dialogue within the community that, when effective, leads to collective action and the resolution of a common problem.*¹⁵¹

We present five key processes below that need to be facilitated to ensure an effective community-based social-norms programme: individual empowerment through participation, bridging social ties, dialogue, convergence and consensus, and collective action.

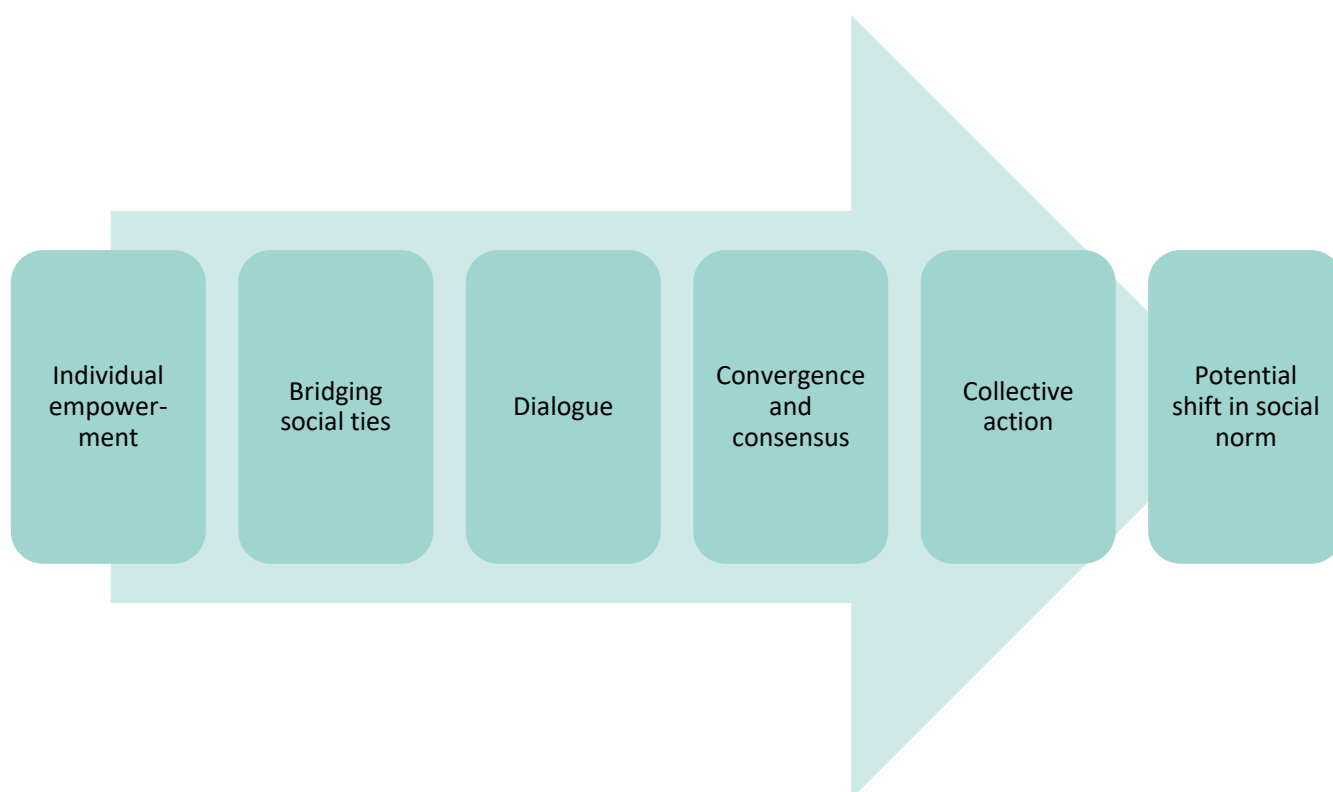


Figure 5: Processes required to enable collaborative problem-solving

A. Individual Empowerment Through Participation

Individual empowerment through participation involves getting people directly and actively involved in addressing the challenges that affect their lives. People are empowered when they believe that they have the ability to exert control over forces that affect their lives; they have the knowledge, skills and resources to do so; and they are actively involved in making decisions and taking actions.¹⁵²

Effective collaborative processes need to engage and empower all members of the community affected by the challenge. In particular, programmes need to empower people who have not been involved previously in community-level problem-solving. Collaborative processes also need to make participation feasible by making it logistically possible.

*Individual empowerment is the ability of people to make decisions and have control over forces that affect their lives.*¹⁵³

Programmes also need to ensure that participants have real influence and control over all phases of problem-solving, including identifying and framing problems, understanding the causes of problems, and developing and implementing solutions. This can be achieved by preventing certain parties from dominating and ensuring that priorities are not defined by outside experts or powerful stakeholders. Everyone in the process needs to participate on an equal basis, regardless of their position in the social hierarchy.¹⁵⁴

Individual empowerment through participation – the sense of feeling in control and owning the process – has a direct, positive impact on the individual by reducing stress and improving mental and, hence, physical health.

B. Bridging Social Ties

In addition to empowering individuals through enabling them to participate, collaborative problem-solving processes also need to create relationships between different groups in the community and between communities and outsiders. To strengthen social cohesion for mutual benefit, connections often need to be built between people. To obtain the full range of knowledge, skills and resources needed to understand and solve complex problems, ties need to be created between people directly affected by the problems as well as those with different kinds of professional expertise.¹⁵⁵

Bridging social ties strengthens community problem-solving by:

- promoting the development of trust between people and groups;
- strengthening the sense of social identity and membership within a community; and
- creating networks that enable people to provide each other with support.

The development of bridging ties can be supported by deliberately creating activity settings – programme activities that regularly bring together groups of people who would not normally spend much time together or communicate their opinions and experiences to one another.¹⁵⁶

C. Dialogue

Diversity in knowledge and attitudes about FGM occurs within communities, and it is possible that many men and women are likely to already have misgivings about the practice before a community dialogue begins.

While people in a community might disagree with FGM, however, barriers in communication and fears of going against social norms mean that most continue to practise it.¹⁵⁷ In many practising communities, it is extremely difficult to talk about FGM across gender or generational lines, because of codes of social decency and shame.¹⁵⁸ In many cases, women overestimate the extent to which men support the practice, which is a major factor resulting in its perpetuation. The ‘silent culture’ around FGM is a major obstacle to change.¹⁵⁹

This situation demonstrates the need for *dialogue* across the community, including between men and women and across generations,¹⁶⁰ so that these differing opinions come to light. Community-based norms-change programmes are likely to be more effective if:

- they create spaces for dialogue between peer groups and across different groups in society;
- they encourage open discussion of sensitive topics to bring taboos and painful experiences out into the open; and
- they build on diversity and ambivalence within the community, as many people may already oppose FGM even if they still practise it.

A collaborative process needs to promote ongoing, meaningful discourse [dialogue] among a diverse group (or groups) of people. This kind of discourse [dialogue] – in which participants from different backgrounds get together on a regular basis to listen to each other, talk with each other, and influence each other – is at the heart of collaborative problem solving.¹⁶¹

It is important to note that ‘dialogue’ is not simply a synonym for ‘talking’.¹⁶² Dialogue is very different to talking at each other; in those situations, powerful voices dominate and the objectives are advocacy, persuasion or transmission of information rather than understanding.¹⁶³ Instead, in a true dialogue all parties listen to each other and genuinely make efforts to appreciate the others’ points of view, so that all arrive at a point of understanding different to where they started from.¹⁶⁴

Figueroa *et al.* define dialogue as a ‘cyclical process of information sharing which leads to mutual understanding, mutual agreement and collective action’.¹⁶⁵

Dialogue across different groups therefore contributes to the collaborative problem-solving process because, through it, participants can:¹⁶⁶

- develop healthy scepticism and respect for other viewpoints by having their ‘accepted wisdom’ challenged;

- increase their critical thinking skills by weighing up different kinds of information;
- acquire sensitivity to new ideas and perspectives;
- obtain more accurate information about the concerns and priorities of different categories of people;
- see the ‘big picture’ (i.e. understand different issues in relation to each other and in the wider community context); and
- understand the local context, including values, politics, resources and history, and use this information to identify solutions that will work in that context.

However, it is very important to bear in mind that catalysing dialogue around sensitive topics like FGM carries risks and requires great expertise among facilitators. Firstly, interventions must be extremely sensitive to power relations in the community. More privileged participants who are used to having their voices heard must be trained (coached and mentored) to recognise the valuable contributions of more disadvantaged participants and to incorporate their insights into decision-making. Likewise, disadvantaged participants need to be supported to realise the value of their contributions, to have the confidence to speak up and to communicate effectively.¹⁶⁷ Secondly, dialogue can reveal significant differences in opinion; facilitators need the skills to negotiate or even arbitrate in the case of conflict or large differences in values and priorities.

For these reasons, facilitators need to ensure that crucial characteristics are present from the beginning of the dialogue process to achieve a productive outcome (see Figure 6).

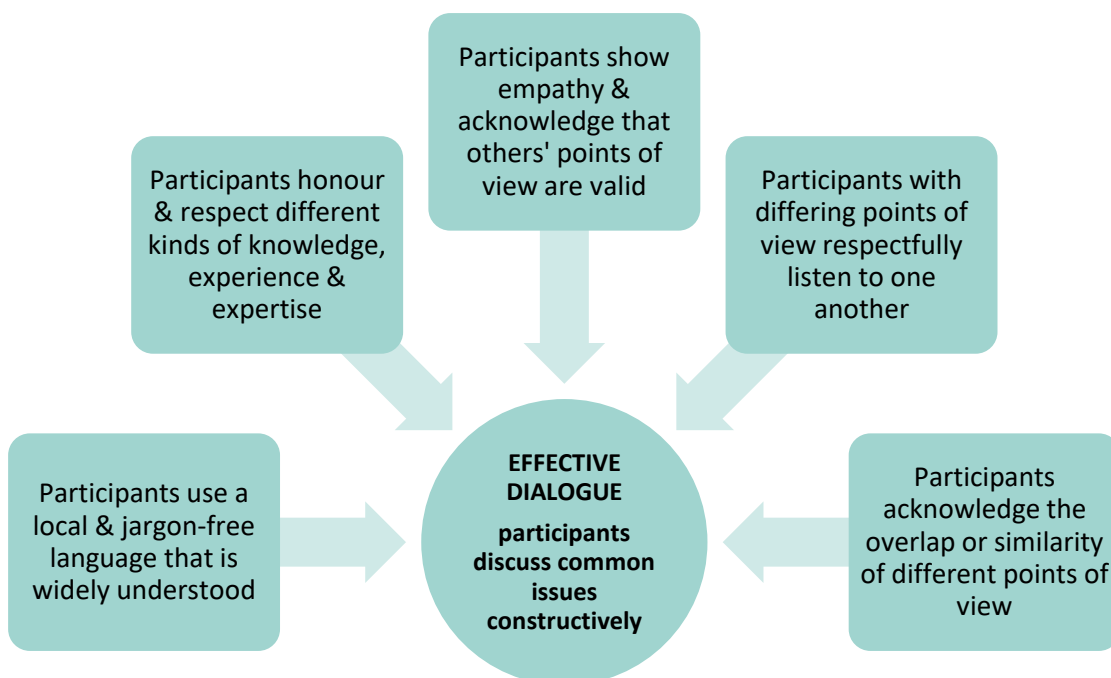


Figure 6: Factors required for effective dialogue¹⁶⁸

D. Convergence and Consensus

Convergence is the process whereby people with divergent views gradually come together towards a greater degree of mutual understanding, shared beliefs and agreement. The understandings and beliefs of each individual gradually shift to become more similar to those of others.¹⁶⁹ Convergence can strengthen community problem-solving by promoting consensus and a sense of collective purpose.¹⁷⁰

Practitioners working in community development have shown that consensus and democratic decision-making are more effective in promoting community-based norm change than confrontational approaches, which often lead to conflict. Rather than agreeing to a solution that a person or organisation advocated at the start, a group of people who achieve convergence in perspectives develop a consensus around ideas and strategies going forward that everyone is happy with.¹⁷¹ Consensus is based on values of respect, equality and sharing of power. It involves working cooperatively to make sure that everyone's needs are met and that individuals' and the group's needs are taken into account.¹⁷² Consensus does not require anyone to 'give in' or 'give up'.

When a broad group of people develops and 'owns' a solution that makes sense to all its members, strategies are more likely to be implemented smoothly and are more likely to be sustainable over a long period.¹⁷³ Building a social-norms-change programme based on consensus in Africa is also culturally appropriate because many FGM-practising communities have strong collectivist values, and consensus is therefore a very important ideal.

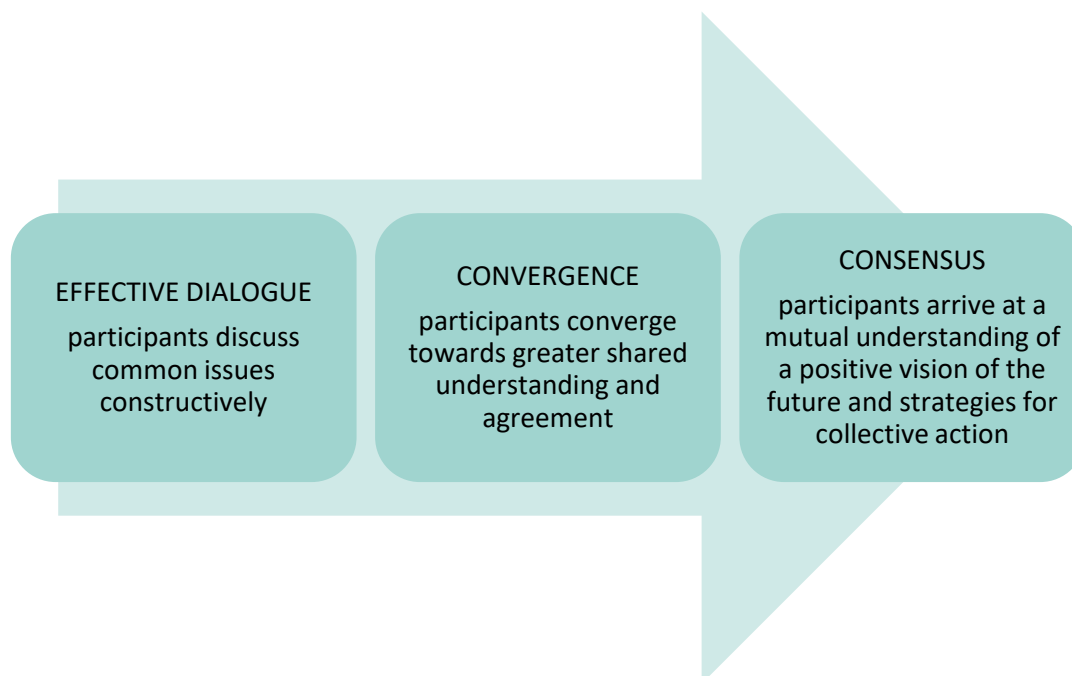


Figure 7: The relationship between dialogue, convergence and consensus¹⁷⁴

Participants in a collaborative problem-solving process need to come to a consensus on the following:¹⁷⁵

- recognition of a problem, or problems, to be addressed;
- a common ideal vision for the future;

- an assessment of the current situation (how far it diverges from the ideal vision for the future);
- objectives for action going forward that are realistic in terms of resources and timeframe;
- options for possible strategies to achieve the objectives (which are, again, realistic); and
- an action plan which includes strategies (selected based on which ones are the most important and feasible), the order the strategies will be done in, who is responsible for specific tasks, when they have to be implemented by and when feedback should take place.

Of course, arriving at a consensus on an action plan is not necessarily straightforward and simple, as people may continue to disagree. Power relations between participants can mean that a person or group with authority tries to impose a viewpoint through threat, influence or use of positive or negative sanctions. Prevailing social norms may mean that people feel unable to agree to something that lies well outside of usual practice. Skilled facilitators are needed to promote consensus in such situations. Negotiation may be necessary among the opposing individuals or groups until they reach a compromise and a mutual agreement that allows collective action to proceed.¹⁷⁶

E. Collective Action

Collective action refers to the process of effectively implementing the action plan and evaluating its outcomes. It involves the following five steps:¹⁷⁷

- Assignment of responsibilities within an agreed timeframe to individuals, existing community groups or organisations, or to a specifically formed task force. People can either volunteer or be assigned tasks, but there must be at least one individual who monitors the process to make sure tasks are accomplished.
- Mobilisation of organisations for tasks that cannot be undertaken by the community alone, or to provide resources to support community endeavours.
- Implementation of the action plan. All individuals or groups charged with taking action should also monitor whether activities are done on time and everyone is fulfilling their responsibilities.
- Measurement of outcomes of the activities undertaken.
- Participatory evaluation, comparing the outcomes with the shared vision for the future and the original objectives, by all those involved in the change process. The outcomes may or may not be what the community originally intended or planned in order to realise their objectives. To ensure group motivation and reward, it is important that as many people as possible participate in the evaluation process, so that lessons learned about what worked and why can be shared.

The collective action process is cyclical (as shown in the diagram below). Once a first round of action and assessment is completed, the community can renew the process, either taking further action on the same problem or addressing a new problem. The process of engaging in collaborative problem-solving that results in social change increases the community's collective

capacity to solve new problems. In this way, the community becomes empowered and strengthened to maintain and improve the change, which in turn promotes the sustainability of the change.

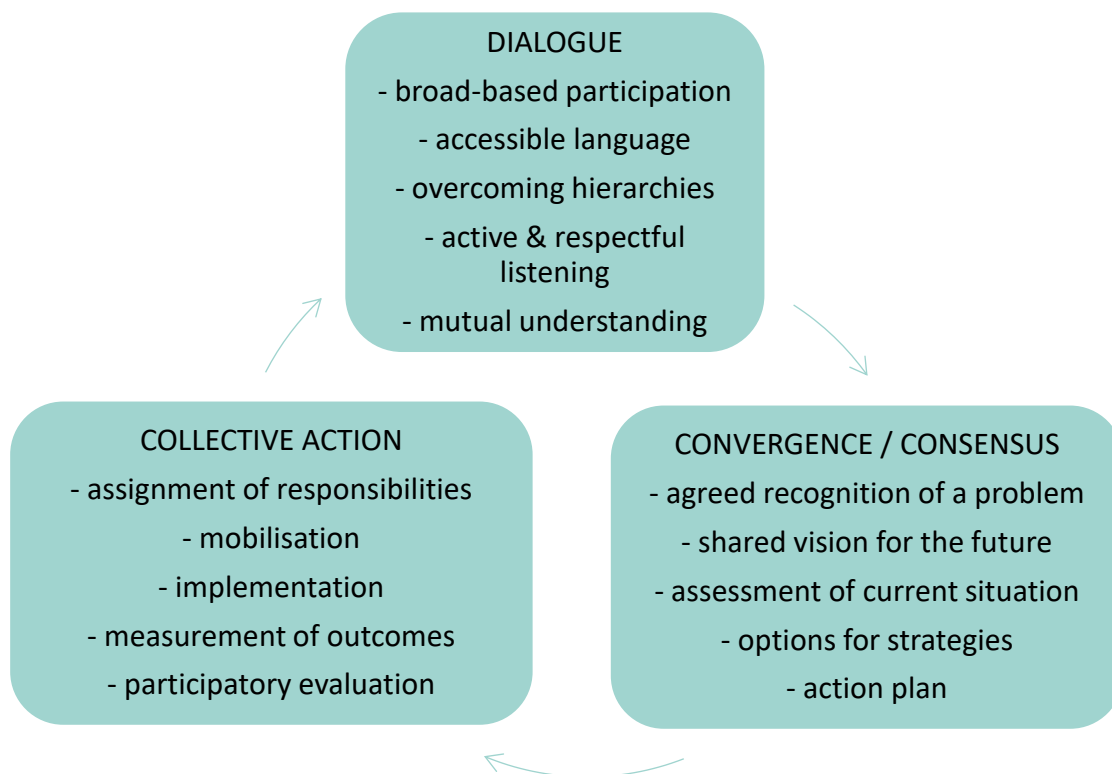


Figure 8: The cyclical process of dialogue, collaborative problem-solving and collective action¹⁷⁸

If implemented successfully, the dialogue and collaborative problem-solving process should improve the specific issue addressed by the programme, but also:¹⁷⁹

- the community's **self-efficacy**: the confidence that together they can succeed in future projects;
- the community's **sense of ownership**: the degree to which they feel themselves to be responsible for the programme's success and thus deserving of credit and benefits;
- **social cohesion**: the extent to which members trust and get along with others in the group and want to cooperate with them on other projects;
- **democratic social norms**: changes in the accepted rules for participation that broaden who has the right to participate, speak and be heard; and
- **collective capacity**: the overall ability of a community to engage in effective dialogue, identify problems and design solutions, and engage in collective action in the future.

The Grandmother Project, Senegal

The Role of Grandmother Leaders in Promoting the Abandonment of FGM in Senegalese Communities

The prevalence of FGM in the Kolda region of southern Senegal is estimated to be 63.6% among women aged 15–49.¹⁸⁰ FGM is a deeply rooted tradition in the predominant ethnic groups in that area, namely the Halpulars and Mandinka. In addition to FGM, other issues that threaten girls' rights and development at the family level are limited support for girls' education, child marriage and teenage pregnancy.

Since 2008, **Grandmother Project – Change through Culture**, an American and Senegalese NGO, has implemented the Girls' Holistic Development (GHD) programme in two communities in the Kolda Region of Senegal (Velingara Department). This ongoing programme promotes positive family and community roles and values to support multiple facets of girls' development. GMP believes that communities are more supportive of programmes, and that those programmes are more effective, when more than one of the issues concerning communities and development organisations are addressed simultaneously. In the GHD programme, while FGM is a priority issue, various aspects of girls' development are simultaneously addressed.

In addition to the abovementioned challenges that girls face, critical features of the Velingara context prior to the development of GHD were:

- the limited social cohesion and communication between generations;
- grandmothers' culturally designated role to socialise and support adolescent girls;
- grandmothers' cultural responsibility for perpetuating FGM; and
- that grandmothers did not question the practice, even though they understood the risks.

The innovative GHD programme to address FGM, girls' education, child marriage and teen pregnancy is intended to promote community-wide change to the FGM social norm and is based on several key concepts:

- recognition and inclusion of elders, given their role as norm-setters and advisers to younger generations;
- active involvement of grandmothers, specifically, building on their role regarding all aspects of GHD;
- strengthening communication between generations and between the sexes;
- close collaboration with community leaders, both formal and informal, and strengthening their confidence and capacity to promote change;
- communication methods based on dialogue and consensus-building; and
- a systems approach to community-wide change that involves three generations of community actors (elders, adults and adolescents), including traditional and religious leaders and teachers.

The overall goal of GHD is to empower communities to critically reflect on FGM and other cultural norms, and to catalyse collective action to abandon harmful practices. GMP's efforts to promote community-driven abandonment involves a wide range of actors, but, importantly, targets leaders, both formal and informal, given their influence with communities.



Grandmother leadership training: to increase grandmothers' knowledge and collective confidence to actively support and protect adolescent girls

The programme has expanded over time into more than 70 rural communities. Key activities in the GHD programme are:

- **Intergenerational forums:** to strengthen communication between community and religious leaders, parents, grandparents, teachers and adolescents on issues of concern.
- **Days of Praise of Grandmothers:** to recognise and encourage grandmothers to play an active role in families and communities, and to increase respect for them among other community members.
- **Under-the-tree participatory, non-formal education sessions:** to involve grandmothers, mothers and adolescents in dialogue on priority GHD topics.
- **Grandmother leadership training:** to increase natural grandmother leaders' knowledge and encourage collective action to support and protect adolescent girls regarding FGM, child marriage and teen pregnancy.

All GHD activities use adult education methods based on dialogue and critical thinking. *Communities are never told to abandon the practice.* Adult education methods such as 'Stories-Without-An-Ending' challenge participants to critically reflect on both their past ideas and experiences and new information shared with them, in most cases, by respected community

actors like imams and midwives, and to come to their own conclusions about whether to maintain or abandon the social norm.

In early 2019 a study was conducted to investigate the process of FGM abandonment in communities where the GHD programme had been implemented during the past several years and where it was apparent to GMP development staff, from the available evidence, that FGM had been abandoned. The study sample consisted of 15 communities in which GMP development staff had worked for several years and were very familiar with the grandmothers, women and elders. The study aimed to understand which community actors played key roles in the abandonment process.

By triangulating the information collected, the study concluded that the abandonment of FGM had come about primarily due to the efforts of the grandmother leaders (see Figure 9 below). These were the natural community leaders who had participated in the GMP leadership training in 2015.

The study identified three main factors that contributed to the grandmother leaders' strong commitment to promote the abandonment of FGM in their own communities:

- **The information they received concerning the harmful effects** of FGM on girls and women that they had ignored in the past and **the realisation that Islam does not require the practice.**
- **Grandmother leaders' increased confidence** due to the grandmother leadership training in which they participated, which empowered them to participate in public events and be able to express their ideas in public.
- The creation of **safe spaces for open and intergenerational discussion** on previously taboo issues dealing with girls' development, including FGM.

Once convinced of the need to abandon the practice, the grandmother leaders proceeded to convince other grandmothers, women of reproductive age and male community leaders, including religious leaders, to support their idea. Using their own initiative, the grandmother leaders organised individual and group discussions to share their ideas about why FGM should be abandoned.

All interviewees said that it was the intergenerational activities organised by GMP that elicited open-ended discussion of a previously taboo topic and contributed to developing a consensus among community actors that the practice should be abandoned. However, it was the assertiveness of the grandmother leaders that catalysed the ongoing debate on the issue and led to one community after another arriving at a consensus on the necessity of abandonment.

Many of the community elders interviewed expressed that they felt obliged to follow the advice of the grandmothers, saying, for example, 'We could not refuse the advice of the grandmother leaders to stop the practice, given their authority and our respect for them', and, 'They are the ones responsible for FGM, just as it is the men who are responsible for circumcision of boys. It is their affair, and if they decide to stop the practice, we will not stop them.'

The study results suggest that the process of community-wide consensus-building towards FGM abandonment, led by the grandmother leaders, was similar in all the sample communities.

GMP therefore believes that many elements of the GHD approach can be used in other African communities where FGM is prevalent.



Grandmother leaders working with the community to shift social norms

The Girls' Holistic Development programme is an important example of a CtC approach, recognising the culturally designated role of elders, and specifically grandmothers, in the process of dialogue and critical reflection on FGM, and the benefit of allowing community members to draw their own conclusions about the continuation or abandonment of the practice. GMP's use of an unconventional intergenerational and grandmother-inclusive approach demonstrates the importance of fostering communication between a range of community actors to promote support for social-norms change. It also shows grandmothers' openness to reconsidering an age-old tradition and their ability to assume active leadership roles in their communities to promote the wellbeing of girls and women.

One elder, who is also a city councillor, said:

I am very satisfied with the work of the [grandmother] leaders. What they have done to promote FGM abandonment, no one else could have done. Before, they were the ones who defended the practice. They have an authoritative voice when they talk about FGM because they are at the heart of the practice. They know what they are talking about.

GMP has published a number of evaluations of its GHD programme and intergenerational-dialogue methods, as well as producing the community dialogue tool 'Stories-Without-An-Ending: an adult education tool for dialogue and social change' (see <https://www.28toomany.org/thematic/social-norms-and-fgm/>).

Role of grandmother leaders in promoting abandonment of FGM/C in southern Senegal

Summary of results of interviews with grandmother leaders, women of childbearing age, and elders in Kandia Commune, Dept of Velingara, Senegal

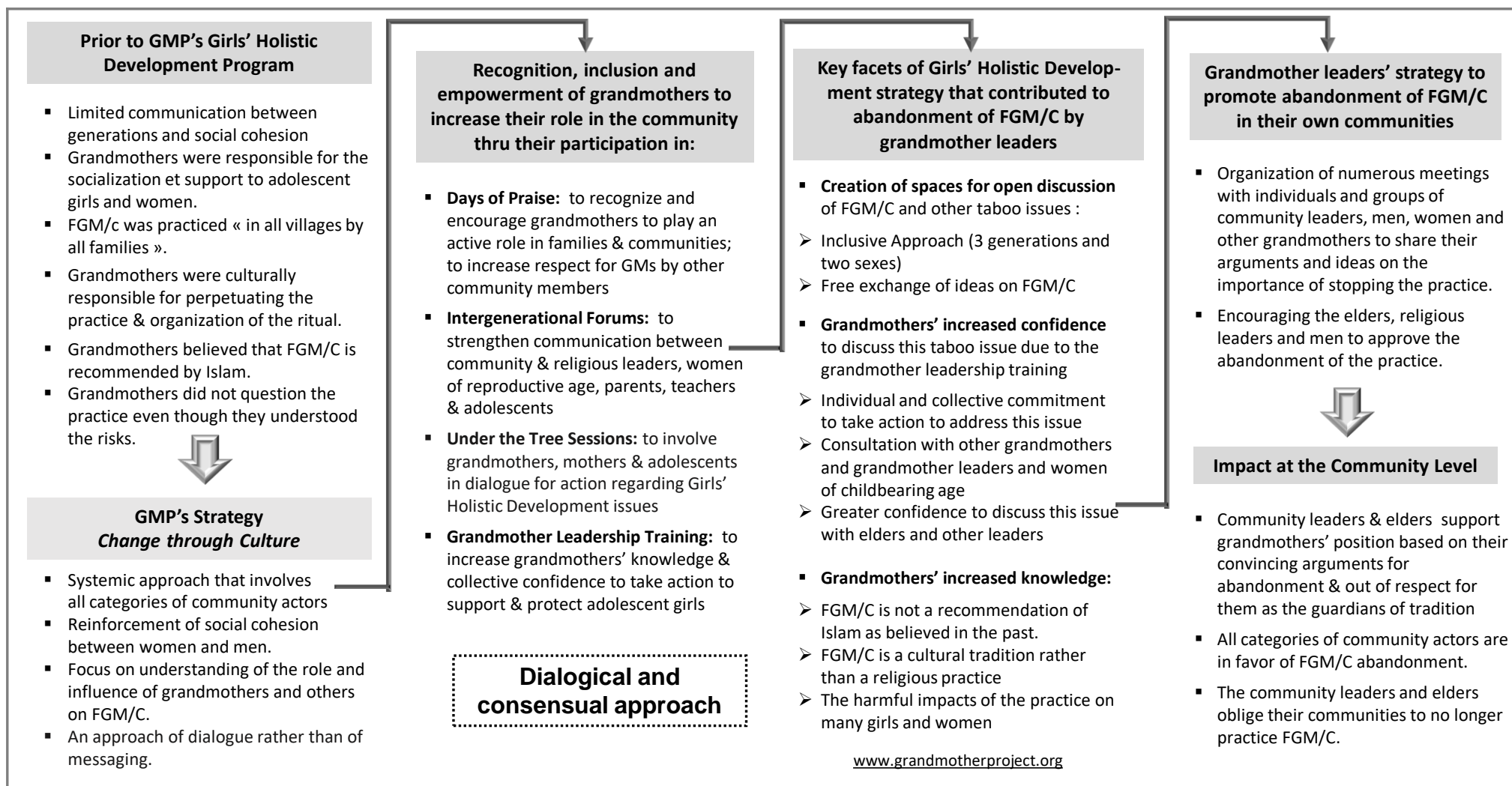


Figure 9: The Role of Grandmothers in Promoting the Abandonment of FGM in Southern Senegal (© Grandmother Project)



8. Identifying and Training Facilitators

Many development organisations hire staff based on their educational qualifications and technical expertise. They may have a relevant university degree, prior experience working with NGOs or international organisations, or training in project management, campaigning or advocacy. While such knowledge is clearly important and useful, there are other types of skills, characteristics and knowledge that are essential for staff to possess if FGM programmes are to be culturally-sensitive, context-specific and, hence, effective.

These staffing practices can result in ‘outsiders’, and not members of FGM-practising communities, designing and implementing interventions. This distance between those who design and implement programmes and those who are affected by them is common in development more generally.¹⁸¹ In their initial qualitative scoping study in southern Senegal, the GMP found that cultural loss due to ‘outsider influence’ was a significant preoccupation among community members, and this shaped their perceptions of anti-FGM campaigns.

The Importance of Insider Knowledge

Best practice requires that team members have extensive and recent personal knowledge of the cultural context in which the intervention will be carried out. They should be involved at all stages of the intervention cycle, from design to implementation to evaluation. This involvement needs to go beyond ‘consultation’ on decisions already taken, to an equal contribution to agenda-setting. This increases the likelihood that the perspectives of community members on FGM and their wider needs and priorities are taken into account.

Local people understand the needs, opportunities, priorities, history and dynamics of the community in ways that professional non-residents do not. . . . People directly affected by problems have important insights into the root causes of problems and ways to address problems.¹⁸²

To be able to work effectively with communities, it is important for organisations to have a good understanding of the characteristics of both family and community systems and to show great respect for them. Sometimes community-health-development workers are much more aware of community problems, or deficits, than they are of their strengths or assets. In a community-dialogue approach, programme staff must identify community strengths and respect community experience, values and strategies. In other words, they need to shift from focusing on community deficits to giving primary attention to community assets.

Respect for Local People and Their Culture

Rarely mentioned in development guides is the importance of values and ‘soft’ interpersonal skills among programme personnel. In all societies, the quality of the relationships that exist

between development staff and community actors is a critical factor in determining community interest and involvement in programme design and, in turn, programme outcomes. The personal values and attitudes of field workers have a direct impact on the quality of the relationships they develop with community members. It is essential that, even if they disagree with the practice of FGM, intervention staff respect the local culture and the integrity of the people.

It is also essential that development staff, and particularly facilitators, are fluent in local languages required for effective communication. A 'crash course' in language skills accompanied by a short stay in a community prior to the start of a programme will not produce effective results.

Case Study: Social-Norms Change in Ethiopia¹⁸³

A UNICEF study of FGM-practising communities in Ethiopia demonstrates that community dialogue will only succeed when interventions are fully integrated into community life, take place within the community itself, are facilitated by both local organisations and community members, and engage key decision-makers and influencers throughout the process.

In the Gewane District of the Afar region, where the population is primarily migratory, pastoralist and clan-based, rapid abandonment of FGM has been attributed to:

- community dialogue facilitated by local organisations as well as traditional clan and religious leaders, women, youth and elders who have actively engaged community members in discussions during the course of daily life (for example, during coffee-drinking or *khat*-chewing sessions, or walking with pastoralists as they graze their cattle);
- inviting all village members to attend discussions that address a wide range of community concerns and not FGM in isolation;
- active engagement of traditional and religious leaders throughout in clan-based societies;
- a monitoring and support mechanism put in place through local committees to monitor implementation of community agreements, as well as pregnancies and births, and provide ongoing counselling to families against practising FGM; and
- the establishment by clan leaders of traditional enforcement mechanisms for those who continued to perform FGM (such as the requirement to slaughter a cow, a pastoralist's most prized possession).

In other FGM-abandonment interventions included in the Ethiopian study, although community dialogue formed the basis of activities, the discussions often took place at a sub-district rather than a village level and were standalone rather than forming part of wider community-development discussions. Thus, they proved insufficient to bring about behavioural change and reach a sufficient degree of consensus to shift social norms.

Facilitation Skills to Promote Learning and Change

To design and implement anti-FGM social-norms programmes, workers need:

- skills in community development;
- knowledge of adult education principles and practices;
- group facilitation skills; and
- knowledge of participatory communication methods.

Programmes should therefore develop training activities to ensure that field staff progressively develop these key categories of knowledge and skills, as outlined in Table 8 below.

Community Development	Adult Education	Group Facilitation	Participatory Communication
<ul style="list-style-type: none"> ▪ Focuses on community assets rather than deficits ▪ Identifies formal and informal community leaders ▪ Develops rapport and collaboration with community leaders ▪ Develops community autonomy in decision-making ▪ Strengthens skills of community leaders in participatory problem-solving ▪ Builds up the ability of community actors to communicate and collaborate effectively ▪ Helps community groups to link with outside organisations and institutions to access resources 	<ul style="list-style-type: none"> ▪ Understands characteristics of adult learners ▪ Uses a problem-solving approach, not a banking approach, to education ▪ Uses facilitation, not instruction ▪ Creates a learning environment that facilitates learning ▪ Develops critical-thinking skills ▪ Stimulates group learning 	<ul style="list-style-type: none"> ▪ Takes on the role of facilitator in group activities ▪ Has strong listening and questioning skills ▪ Gives and receives feedback ▪ Has strong verbal and non-verbal communication skills ▪ Restrains group members who dominate the discussion ▪ Encourages shy group members to contribute their ideas to group discussions ▪ Has conflict-resolution skills 	<ul style="list-style-type: none"> ▪ Develops and uses a variety of these methods: <ul style="list-style-type: none"> ○ stories ○ songs ○ role plays or skits ○ community theatre ○ community meetings ○ games ○ discussions ○ pictures ○ case studies

Table 8: Knowledge and skills needed by community-health-development workers to promote change in communities¹⁸⁴



9. Conclusions and Recommendations

This report presents the growing evidence that community-based social-norms programmes appear to be the most effective strategy for catalysing shifts in FGM-related attitudes and behaviours. From this research come a number of methods and tools to assist practitioners and policy makers in designing and implementing community programmes, which the authors of this report will publish in due course as a follow-up to this discussion.

In the meantime, however, while there is no simple blueprint, the evidence suggests that organisations should heed the following recommendations:

- **FGM is often a social norm.** This means that, even if they are aware of its risks, people practise it because they believe that everyone else does it; they have never questioned behaving otherwise; they receive social, religious or economic benefits from conforming to the norm; and they fear sanctions from others for deviating from the norm. The perceptions that different community members have of the benefits and sanctions of practising FGM must be taken seriously and addressed if programmes are to be effective.
- Unlike Western societies, in which individualist values prevail, **FGM-practising communities tend to have collectivist values**, where an individual's sense of self is linked to their membership of a social group. Group members are dependent on, and strongly influenced by, other members of their group, and are often reluctant to 'stand out from the crowd' by deviating from dominant norms. Decisions, like whether or not to cut a girl, are also taken collectively rather than individually. Programmes that catalyse shifts in social norms at the level of the whole community simultaneously are therefore more likely to be effective than programmes that focus on individual behaviour change.
- **Programmes are more effective if they involve the decision-makers, influencers and cultural authorities who have the most influence over FGM** and, therefore, the most power to change it. It is thus essential for organisations to identify exactly who these categories of people are in the specific contexts in which they work. Evidence shows that respect for elders and gender-specific spheres of activity are cultural characteristics that tend to prevail within FGM-practising communities. Hence the influential actors tend to be elders, particularly female elders or grandmothers. Respectfully involving these individuals should be a priority for organisations, even if they are initially strongly supportive of FGM.
- **Cultural values and beliefs profoundly influence the practice of, and social norms underpinning, FGM.** It is therefore essential for organisations to acquire a deep understanding of the specific context in which a programme is to be implemented, in terms of what kind of FGM is practised and why, and how the practice is underpinned by the deep cultural characteristics of the society. This is best achieved by collaborating in programme design with individuals intimately familiar with the context and by using qualitative and participatory research methods rather than quantitative surveys.

- **Development programmes that catalyse shifts in social norms are more likely to appeal to community members if they first celebrate and build upon the positive cultural values, behaviours, roles and resources within that community** than if they frame the culture and community as the source of problems. Programmes should therefore identify and reinforce positive aspects of the local cultures through their activities and build trust and rapport with the community before opening up discussions around harmful practices like FGM.
- **Programmes are more effective in shifting attitudes and behaviours if they consult with a broad range of community members to define the problems they face and empower them to engage in dialogue and collaborative problem-solving.** The remit of the programme should therefore be framed positively and in broader terms than just FGM, to address wider community concerns and priorities.
- **To promote dialogue and collective mobilisation, programmes need to overcome cultural taboos on talking about sensitive topics like FGM.** This will often involve building people's confidence to speak more openly to their peers and wider community members, especially if they tend to be sidelined from formal decision-making for reasons associated with their age, gender, etc. Programmes also need to improve trust, relationships and communication between different genders and generations, and between communities and relevant external stakeholders.
- **Programmes that aim to catalyse processes of collaborative problem-solving are more effective if they work directly with both formal and informal leaders,** who can represent and mobilise all categories of people in their communities to promote change towards a common goal.
- **Non-directive methods that allow community members to discuss the pros and cons of FGM, draw on their prior experiences, develop critical thinking skills and come to their own conclusions are more effective in catalysing shifts in attitudes than directive messaging that tells people what to think or do.** Organisations should therefore develop materials that allow people to discuss scenarios likely to occur in their social settings, that are culturally-sensitive and affirmative and that build on indigenous forms of communication and education.
- **Key to successful norms-change programmes are relationships of trust and respect between communities and organisation staff.** Organisations should use culturally sensitive imagery and neutral, non-judgemental language to refer to FGM. They should work with staff who have in-depth knowledge of the cultural and religious context and proven skills in facilitation and community development.

In conclusion, as we publish this report, we are witnessing increasing discussion among anti-FGM organisations and activists around the relevance and importance of social norms in the work to end the practice. 28 Too Many welcomes this debate, encourages further investigation and calls for detailed, adequately funded community-level research and the integration of social-norms-change strategies into programme design moving forward.

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Please note that the use of a photograph of any girl or woman in this report does not imply that she has, nor has not, undergone FGM.



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