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Does local resistance impact the transnational normative environment? The case of female genital mutilation (FGM)

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ABSTRACT

More than 200 million girls and women today are estimated to have gone through female genital mutilation (FGM). In this study, I make a novel contribution to the global literature on FGM by examining domestic resistance to the anti-FGM norm in the context of norm diffusion processes. I provide a novel theoretical perspective to the study of FGM by introducing a compromise-building approach. According to this approach, strong local resistance to a transnational norm that obligates the removal of harmful traditional practices might motivate some transnational norm advocates to support a compromise solution to minimize harm, leading to normative contestation in the transnational domain. This approach is illustrated by the rise of advocacy for medicalized and minor forms of FGM as a harm reduction strategy as a result of the continuation of traditional forms of FGM. The compromise-building approach also brings a new theoretical perspective to the literature on norm diffusion.

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Female genital mutilation (FGM) is a widely applied procedure in many parts of Africa and the Middle East despite the international anti-FGM campaigns that gained pace from the 1970s onwards. The empirical literature on FGM has largely focused on the explanations regarding the compliance and resistance against the anti-FGM norm. In this study, I analyze domestic resistance to the anti-FGM norm and its implications for the transnational normative environment in the context of norm diffusion processes. By drawing on the norm diffusion literature and introducing a compromise-building approach, the researcher aims to bring a novel theoretical framework to bear on the study of FGM. According to the compromise-building approach developed in this study, the persistence of a harmful traditional practice might motivate some transnational norm advocates to support a compromise solution to minimize harm. This approach is documented with the growing advocacy for medicalized and

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minor forms of FGM as a harm reduction strategy due to the continuation of traditional forms of FGM. Empirical findings and the theoretical approach of this study will enable public health specialists, gender scholars, and anti-FGM advocates to better understand the diffusion process of the anti-FGM norm.

Background

It is estimated that today there are more than 200 million girls and women who went through FGM (WHO, n.d.). FGM is internationally considered a human rights violation and a form of violence and discrimination against girls and women (Ruiz et al., 2017). The procedure's immediate complications include severe pain, bleeding urine retention, shock, hemorrhage, exposure to tetanus, HIV, and Hepatitis (Bishai et al., 2010; Dorkenoo, 2007; Nyangweso, 2014). Its long-term complications include infertility, difficulties in pregnancy, perinatal death, susceptibility to sexually transmitted diseases, and psychological & psychosexual trauma (Bishai et al., 2010; Brady, 1999; Kun, 1997).

Much attention has been devoted to analyzing the dynamics of compliance and resistance against the anti-FGM norm. For example, examining FGM practices in northern Tanzania, Winterbottom et al. (2009) argue that the anti-FGM campaigns, which initially framed the procedure as a primitive tradition, proved to be unsuccessful even if they used education, health, legal, and human rights-based approaches. Boyle and Carbone-López (2006) concluded that the very framing of the anti-FGM norm through health and human rights issues by transnational activists did not find resonance in the African context. Cloward (2015) shows that communities are more likely to abandon FGM when there are non-circumcising communities that live nearby and when local elites change their old mindsets (Cloward, 2016).

I aim to bring novel insight into the global literature on FGM by analyzing the implications of domestic opposition to the anti-FGM norm in the context of norm diffusion processes. Within norm diffusion research, while scholars have devoted significant attention to gender by studying the global diffusion of laws setting the minimum age of marriage at 18 (Ebetürk, 2021), the discrepancy between global gender equality norms and local understandings of gender, equality, and justice (Un, 2019; Yüksel et al., 2016), the impact of international women's movement on women's political representation (Paxton et al., 2006), the impact of local non-state actors on the diffusion of international women's rights (Levitt & Merry, 2009; Madsen, 2018), FGM has been under-researched. An exception to this is the study of Boyle et al. (2002). In examining the diffusion of the global norm against FGM in five African countries, the authors find that

education, mass media, and female employment decrease the likelihood of women's support for FGM.

In this study, I bring a novel theoretical perspective to the study of FGM by introducing a compromise-building approach. According to this approach, continued local resistance to transnational norms that propagate the eradication of harmful traditional practices can lead to a process termed "compromise-building," wherein some transnational norm advocates endorse a compromised solution in consideration of eradication efforts that have failed to bring about significant changes on the ground. This approach is illustrated with the rise of advocacy for medicalized and minor forms of FGM as a harm reduction strategy given the continuation of traditional forms of FGM through the method of process-tracing. This approach also brings a new theoretical perspective on the study of norm diffusion by focusing on transnational norm advocates in explicating the impact of domestic processes on the transnational normative environment.

Transnational norm diffusion

Earlier studies on transnational norm diffusion posited a linear and progressive trajectory. The norm life-cycle model developed by Finnemore and Sikkink (1998) identified a three-stage process: norm emergence, norm cascade, and internalization. In the first stage, transnational norm advocates aim to persuade states for normative change by launching information campaigns, drawing attention to issues, etc. (Finnemore & Sikkink, 1998). In the second stage, states comply with transnational norms because of their cost-benefit calculations (such as concern for their international image). Finally, transnational norms become widely accepted, no longer competing with rival domestic norms (Finnemore & Sikkink, 1998). According to the spiral model developed by Risse and Sikkink (1999), international human rights norms lead to a change in policies and laws through a myriad of processes that include adaptation, strategic bargaining, moral consciousness-raising, argumentation, persuasion, institutionalization, and habitualization.

The linear and progressive perspective of norm diffusion has been criticized on numerous grounds. For example, Epstein (2012) argued that an implicit assumption based on the teleological view of progressive change led to the neglect of bad norms and domestic resistance to normative change. Against this backdrop, scholars have focused on contestation and backlash in transnational norm diffusion processes (Deitelhoff & Zimmermann, 2020; Deitelhoff, 2020; Gutterman & Lohaus, 2018). Researchers revealed that local dynamics play pivotal roles in thwarting the linear diffusion of transnational norms at the domestic level (Checkel, 1997; Cortell & Davis, 1996, 2000; Flockhart, 2006; Bloomfield, 2016; Hertel, 2017).

Acharya (2004) shows that when there is a great deal of societal resistance, local norm-takers might ensure a transnational norm's congruence with local beliefs and practices by reconstructing it through discourse, framing, grafting, and cultural selection (congruence-building). Restoy and Elbe (2021) illustrate that non-state actors might follow successful norm domestication strategies (such as using legal mechanisms) even if governments reject transnational norms.

The latest wave of norm research has moved on to explore the impact of the local dynamics on the transnational environment. For instance, Wiener (2018) underlines the importance of local actors' proactive critique of transnational norms in transnational normative change. Acharya (2013; 2018) argues that local and regional actors might impact transnational normative processes with their attempts to export or universalize their locally constructed norms. As an example, he shows the important role played by African countries and the African Union in the creation and the diffusion of the norm of the responsibility to protect (Acharya, 2013). Chorev (2012) illustrates that as a result of states' reactions and divergent interpretations, the global norm regarding the intellectual property protection of AIDS drugs underwent modification to address demands for fair drug prices.

In this study, I theorize that local acts of resistance to transnational norms might lead to normative contestation in the transnational domain by motivating norm advocates to propose a compromised solution to reconcile local and transnational dynamics. This approach, which gives primary analytical weight to the agency transnational norm advocates in explicating the impact of domestic processes on the transnational normative environment, not only provides a better understanding of the diffusion process of the anti-FGM norm, but also broadens the analytical focus of the norm diffusion literature. The following section introduces the theoretical framework of the study.

Theorizing the compromise-building approach

In this section, I offer a novel approach to the study of FGM and norm diffusion in general by introducing a compromise-building approach. As mentioned earlier, transnational norms do not follow a progressive trajectory in the domestic arena, especially when transnational norms are incompatible with local beliefs and practices. When a transnational norm directly supports the removal of a local norm that has become an entrenched practice in society, there will probably be strong resistance against it. I argue that when local actors continue to implement a local norm that has harmful impacts on individuals despite transnational advocacy efforts, some norm advocates might start to advocate a compromise solution to minimize harm, leading to contestation in the transnational normative domain.

The theoretical and empirical scope of this article is limited to transnational norm advocates who aim to eradicate harmful traditional practices. Harmful traditional practices are norms followed based on local values and beliefs (United Nations, 2006; 2008). As underlined by Thrasher (2018), harm is a normatively-laden concept. It depends on "various other norms for its specification in particular contexts" (Thrasher, 2018, p. 203). Harm is equivalent to wronging. It involves pain, health complications (Thrasher, 2018), and psychological damage.

In this context, traditional practices are harmful if they inflict physical and psychological damage on individuals, even though they are considered appropriate and justified on numerous grounds by their followers. They include, but are not limited to FGM, forced feeding of women, early marriage, polygamy, early pregnancy, taboos that prevent birth control, traditional birth practices, son preference, and honor killings. These practices target mostly women and children (United Nations, 2006; 2008; Thrasher, 2018; Wadesango et al., 2011).

Harmful traditional practices are prevalent in patriarchal societies in which the role of women is reduced to motherhood and women's sexual behavior is suppressed (Osezua & Edobor, 2021; Thrasher, 2018). They emanate from and perpetuate ideas that "reduce women to sub-human assets belonging to men" (Wadesango et al., 2011, p. 121). It should be emphasized that harmful traditional practices are not limited to physical and psychological harm. They constitute serious violations of human rights; more specifically, the right to life, the right to bodily integrity, the right to freedom from torture and inhuman or degrading treatment, the right to freedom from discrimination, and the right to gender equality.

Norm advocates work on local, national, and transnational levels to eradicate harmful traditional practices that are prevalent in many communities throughout the world. Norm advocates are actors who oppose the prevailing normative order by promoting new norms or new standards of behavior (Wunderlich, 2014; Johnstone, 2007). In specific terms, they "bring a problem to public attention, signal need for action, provide information and expertise, suggest possible solutions and try to get their idea accepted as a new standard for behavior" (Wunderlich, 2014, p. 85). Empathy and altruism motivation can be considered the main characteristics of (philanthropic) norm advocacy (Becker, 1963; Nadelmann, 1990).

Transnational norm advocates include international organizations, non-governmental organizations (NGOs), trade unions, and churches (Finnemore & Sikkink, 1998, Haas, 1992, Klotz, 1995). Scientists and experts who work internationally to influence policies and bring about normative change also fall under the category of transnational norm advocates (Keck & Sikkink, 1998). In addition to realizing certain policy outcomes, norm advocates aim to change the terms and the nature of normative debates (Keck & Sikkink,

1998). Importantly, transnational norm advocacy is not a homogenous category, as there are also competitor norm advocates who are in the same normative community as norm advocates, but support a different version of the propagated norm (Bloomfield, 2016). Wunderlich (2014) distinguishes between revolutionary norm entrepreneurs who support the replacement of old norms with new ones and reformist norm entrepreneurs who advocate for progressive change within the confines of existing normative structures.

When local actors resist change promoted by transnational norm advocates who support the elimination of harmful local norms, friction might emerge among transnational norm advocates. Because these harmful practices are often deeply embedded in societies, revolutionary norm entrepreneurs may not always be successful in rooting them out. The drive to reduce the negative impact of the domestic norm might catalyze some transnational norm advocates to propagate an alternative solution. Put differently, to lessen the harm propelled by harmful local practices, some norm advocates might recommend an alternative strategy to build reconciliation between the foreign and local norms, which I term compromise-building.

Compromise-building differs from congruence-building (Acharya, 2004) and reformist entrepreneurship (Wunderlich, 2014). While congruence-building emphasizes the agency of local actors, compromise-building focuses on the agency of transnational norm advocates. As mentioned earlier, in congruence-building, local norm-takers play a constructive role in the norm transfer process by reconstructing transnational norms in line with local norms (Acharya, 2004). In sharp contrast, as it will be shown in the case study section, compromise-building is offered by some transnational norm advocates when local actors obstinately follow harmful traditional practices, despite advocacy campaigns.

Compromise-builders aim to find a way forward that accommodates both revolutionary norm advocates and local actors who resist change. Compromise-building echoes, but is distinct from reformist norm entrepreneurship introduced by Wunderlich (2014). This study proposes "compromise-building" as an alternative conceptualization that would allow one to retain the important insights offered in Wunderlich's conceptualization, while separating the distinct motivations of compromise-builders and reformist norm entrepreneurs. Reformist norm entrepreneurs and revolutionary norm entrepreneurs have *different visions* of societal change. For example, revolutionary norm entrepreneurs might support a regime change in an authoritarian state, whereas reformist norm entrepreneurs might support gradual social change through democratization. Reformist norm entrepreneurs might argue that the abrupt political change might lead to further deterioration of human rights by sinking the country into a civil war and instead advocate an evolutionary change of political regimes through the empowerment of civil society.

In contrast to reformist norm entrepreneurs, compromise-builders share the *same vision* as revolutionary norm entrepreneurs, as they both agree on the necessity of eradicating harmful traditional practices. In other words, compromise-builders also support the radical transformation of existing normative structures that legitimize harmful traditional practices, but offer a compromise solution given that projected societal changes do not occur. In this respect, compromise-building efforts emerge *only after* harmful traditional practices persist despite the eradication efforts of revolutionary norm entrepreneurs. Put differently, harm-reduction strategies offered by compromise-builders do not derive from their vision of social change, but from *local dynamics* that prevent the linear diffusion of the transnational norms to domestic settings. All in all, against the backdrop of persistent local norms, compromise-builders aim to offer the safest acceptable option with the hope of eventually getting to eradication.

Normative contestation "can be broadly defined as all instances of a questioning and/or rejection of norms" (Deitelhoff, 2020, p. 4). More specifically, norms are questioned or rejected based on their applicability, validity, and meaning (Wolff & Zimmermann, 2016). In proposing their harm reduction strategies, compromise-builders do not reject normative efforts geared toward the eradication of harmful traditional practices. Rather, their normative questioning revolves around the applicability of the transnational norm in question, as they show concern about the persistence of local norms and the best way to minimize their pernicious effects. Compromise-builders offer an intermediate strategy to provide a consensus between local actors and transnational advocacy campaigns for the complete eradication of harmful traditional practices.

However, compromise-builders' nuanced solution to the resistance of local practices (by taking cultural sensitivities into account) might be criticized by revolutionary norm entrepreneurs who adopt a zero-tolerance approach toward local norms that have harmful consequences. Overall, when a transnational norm faces domestic resistance, the normative sphere might witness contestations concerning the pros and cons of the norm that promulgate the complete removal of harmful traditional practices and the advocacy for a compromise solution.

The method

In this study, I document the emergence of advocacy for medicalized and minor forms of FGM as a compromise-building measure through the method of process-tracing. Process tracing refers to "the analysis of evidence on processes, sequences, and conjunctures of events" in a way that unpacks causal processes (Bennet & Checkel, 2015, p. 7). The main idea of process tracing is concatenation, which "is the state of being linked together, as in a chain or linked series" (Waldner, 2012, p. 68).

I first shed light on FGM by giving insights into its implementation throughout the world, its different types, and various cultural logics at play in its implementation. Secondly, I trace the development of the anti-FGM norm and document the dynamics of its diffusion in Africa and the Middle East. Thirdly, I illustrate that the continuing application of FGM has given rise to advocacy for medicalized and minor forms of FGM as a compromise-building measure, resulting in the contestation in the transnational normative sphere. These dynamics are documented through a systematic qualitative analysis of books and journal articles written by academics and health experts and statements of medical associations, international organizations, and NGOs that include proposals concerning FGM practices.

The case study

FGM

FGM refers to "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2008a, p. 1). There are four types of FGM. In Type I, the clitoris and/or the prepuce are partially or totally removed (clitoridectomy). In Type II (excision), the clitoris and the labia are partially or totally removed, with or without the excision of the labia majora. In Type III (infibulation), the labia majora and/or the labia minora is removed, and the vaginal opening is sewn together. Type IV refers to practices that include pricking, piercing, or incising of the clitoris and/or labia (Windle et al., 2009). Type I, Type II, and Type IV constitute around 90% of FGM cases in the world. It is estimated that over 8 million women underwent Type III, the most severe form of FGM (WHO, n.d.)

FGM is mostly carried out in Africa and the Middle East. Africa has the highest percentage of FGM cases in the world. African countries with the highest rate of FGM (above 80%) are Somalia, Guinea, Djibouti, Eritrea, Mali, Sierra Leone, and Sudan. In the Middle East, FGM is applied widely in Egypt, Yemen, Oman, Libya, Algeria, Lebanon, Iraq, and Palestine, and less extensively in Bahrain and Iran. (UNICEF, 2013). FGM practices are observed, albeit less extensively, in some Asian countries (such as Indonesia, Malaysia, Pakistan, and India) and some tribes in South America (in Argentina, Chile, and Brazil) (Nyangweso, 2014). With immigration, FGM has also spread to Western countries (Akinsulure-Smith & Chu, 2017; Goldberg et al., 2016; Ogunsiji, 2015).

It should be noted that the type of FGM applied shows variation across countries. For example, Type III, the most severe form of FGM, is prevalent in the north-eastern region of Africa (Sudan, Djibouti, Eritrea, Ethiopia, and Somalia) and West Africa (Guinea, Mali, Burkina Faso, etc.)

(WHO, n.d.). In Iraq and Yemen, 9 out of 10 FGM cases include flesh removal (UNICEF, 2020a). Age at cutting varies across countries. In Yemen, 96% of girls are cut before the age of 5, while in Egypt, most girls are cut in adolescence (UNICEF, 2020a). FGM cases also show within-country variation. In countries where FGM is practiced, the procedure in concentrated in rural areas, poor households, and populations with less education (UNICEF, 2020b).

FGM is not only a practice, but a norm that is followed as the right thing to do (Nyangweso, 2014; Berg & Denison, 2013). As Mackie (1996) underlines, in some communities, an uncircumcised woman is viewed as an outcast, unclean, and unworthy of continuing the family lineage (Nyangweso, 2014; Braddy & Files, 2007). Social stigmatization of non-compliant individuals ensures the continuation of FGM practices. In certain communities, perceived rewards associated with FGM also play a significant role in its persistence. Some communities view FGM as a practice that purifies, sanitizes, and beautifies a woman's body (Nyangweso, 2014). Religious justifications are also given for the practice even though no religion prescribes female circumcision (UNICEF, 2008). Religious justifications stem from a distorted understanding of religious texts (Alamri, 2016).

It is worth emphasizing that the local norms in favor of FGM are built on different cultural logics in different places and among different groups. As mentioned previously, wide variations exist across countries concerning FGM type (see also Windle et al., 2009). It is safe to argue that FGM is more a category of related practices than a single coherent practice with a unified logic. Communities that practice FGM cannot be generalized by kinship, religion, economy, family values, and the like (Shweder, 2000). Notwithstanding that FGM is attached to different logics, all these logics rest on the logic of appropriateness in which rather than reasoning, socially-imposed norms dictate human behavior (see March & Olsen, 1998).

The anti-FGM norm

During the era of colonialism, missionaries in Kenya and Uganda, British parliamentarians (along with British nurses), midwives, and teachers in Sudan condemned the practice of FGM and worked toward its abolishment. However, these efforts proved futile (Boddy, 2007a; 2007b; Windle et al., 2009). Local communities evaluated these advocacy efforts as a form of cultural imperialism and conducted FGM underground (Baer & Brysk, 2009). Jomo Kenyatta, an anti-colonial activist, and Kenya's first president, portrayed FGM as the defining characteristic of the Kikuyu people (the largest ethnic group in the country) (Baer & Brysk, 2009).

The United Nations (UN) started to address the issue in the 1950s. The anti-FGM approach gained widespread prominence internationally throughout the 1970s in part because of women's organizations' active campaigning (UNICEF, 2008; Boddy, 2007a). The UN Millennium Declaration (2000) and the 2005 World Summit held by the UN General Assembly are important developments in the global recognition of the norm against FGM. In 2006, the UN Secretary-General's report on violence against women urged states to prohibit FGM. The UNFPA-UNICEF joint program to eliminate FGM was launched in 2008. The World Health Assembly (the decision-making body of the WHO) adopted a resolution in 2008 (WHA61.16) that called for the eradication of FGM (WHO, 2008b).

In addition to the UN and the WHO, the Council of Europe, international professional health organizations (such as the World Medical Association), and international NGOs (such as END FGM European Network, International Action Against Female Genital Mutilation) have played active roles in the fight against FGM. The anti-FGM norm has also been promoted in Africa (the region with the highest FGM prevalence) at regional and local levels. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (created in 1984 in Senegal) has played a significant role in raising awareness against FGM. The 2003 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (known as the Maputo Protocol) urged states to eliminate traditional and medicalized forms of FGM (African Union, 2003). There are many NGOs in Africa that work toward the eradication of FGM such as the African Women's Organization and the Value Female Network.

The fight against FGM has created an enabling condition for the criminalization of FGM in many African and Middle Eastern countries. From 2007 to 2018, Zimbabwe, Uganda, South Sudan, Kenya, Guinea Bissau, Mozambique, the Gambia, and Cameroon criminalized FGM by adopting new laws or changing existing laws (Nabaneh & Muula, 2019). In Egypt, FGM was banned in 2008 (Adel, 2018). While the prevalence of FGM has decreased in Ivory Coast, Nigeria, Ethiopia, Burkina Faso, Liberia, Togo, and Kenya, it has increased in Chad and Sierra Leone. In Mali and the Gambia, the practice continued with stable high prevalence rates (Koski & Heymann, 2017; UNICEF, 2016). Despite the legislative measures against FGM in these countries, very few prosecutions or arrests have taken place against FGM perpetrators (Nabaneh & Muula, 2019). Taken together, even though the anti-FGM norm has been accepted at the state level through the criminalization of FGM in many countries in Africa and the Middle East, it has faced resistance at the local level. Medicalized FGM has increased in Egypt, Sudan, Guinea, Djibouti, Kenya, Yemen, Iraq, and Nigeria (UNFPA, 2018).

The compromise-building approach

In this section, I demonstrate that the medicalization of FGM is not only a practice adopted at the local level partially as a response to transnational normative pressure against FGM, but also a compromise-building strategy promoted by various norm advocates. The WHO (2010, p. 2) defines medicalization as the realization of FGM "by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere." Proponents of medicalization, on the other hand, define it more prescriptively. They view medicalization as a harm-reduction strategy that includes the mitigation of acute complications of FGM through the usage of aseptic techniques and anesthetic, in addition to the prioritization of symbolic procedures over more radical forms (Pearce & Bewley, 2014). Put differently, the pro-medicalization argument supports minor forms of cutting performed by health professionals to minimize the risks of FGM.

The UN institutions, WHO, and many international professional organizations strongly position themselves against the medicalized FGM. The 1982 statement of WHO and the 1997 Joint Statement by the WHO, UNICEF, and UNPFA warned health professionals not to practice FGM (WHO, 1982; WHO, 1997). In 1993, the World Medical Association condemned the medicalization of FGM, arguing that the involvement of physicians might legitimize the procedure (WMA, 2017). The International Federation of Gynecology and Obstetrics (FIGO) also disapproved of medicalization by referring to "the ethics of not to do harm" (FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 2010). The American College of Obstetrics and Gynecology and the American Medical Association also oppose all forms of FGM (Hernlund & Shell-Duncan, 2007).

Moreover, FGM practices in unclean environments by traditional practitioners (who may even use sharp stones or pieces of glass) lead to severe health problems (Skaine, 2005). The use of unsterilized instruments might have deadly consequences by causing infections such as tetanus, HIV/AIDS, Hepatitis B, and Hepatitis C (Nyangweso, 2014). Given the serious risks of FGM practices in unclean environments, doctors face a dilemma. For example, Dr. Doug Diekema, a pediatrician at Seattle's Children's Hospital and former chairperson of the American Academy of Pediatrics' bioethics committee, stated that the refusal of doctors to cut girls in the USA might lead to unintentional and deadly consequences, underlining that "[i]t's very easy to take the high road in cases like this. But when you're dealing with religious or cultural beliefs, saying 'no' sometimes is not sufficient for people and it will not necessarily eliminate the practice" (Adhikari & Salahi, 2010, p. 22).

The negative health consequences of FGM (including the most severe forms often carried out without anesthesia and using unclean instruments ranging from razor blades to broken glass) propelled some scholars,

hospitals, and medical associations to find a compromised solution to the issue. For instance, Shell-Duncan (2001), an anthropologist, argues that medicalization should be reappraised as a harm-reduction strategy that improves women's health in settings in which the eradication of FGM is not achievable in the short run. Valderrama (2002), a medical doctor who worked in Somalia in 1994, evaluated the medicalization of FGM as a wise intermediate strategy toward its complete eradication, underlining that it might save lives.

Gele et al. (2013; a public health epidemiologist, a sociologist, and a medical doctor respectively) show that there is pervasive resistance to the FGM eradication efforts in Somalia. Against this backdrop, the authors indicate their support for a medicalized and minor form of cutting as an interim strategy toward the total elimination of FGM. In a similar vein, Arora and Jacobs (2016; both medical doctors who specialized in obstetrics and gynecology), taking into consideration the limited success of the advocacy for the complete eradication of FGM, stress the necessity of a new strategy that would reconcile cultural dynamics and the health of female children.

The advocacy for medicalization has not been limited to the personal efforts of various medical doctors and social scientists, but has found some institutional support. In the 1990s, a Welfare, Health, and Culture Ministry report in the Netherlands suggested that doctors might be allowed to perform symbolic cutting as an alternative to infibulation for Somali immigrants. Harborview Hospital in Seattle suggested a similar proposal. However, both proposals were withdrawn following protests (Hernlund & Shell-Duncan, 2007). In a similar vein, in 2003, a Somalian gynecologist working in Italy proposed a "harmless and symbolic" alternative to FGM to prevent the most severe forms of FGM (Turone, 2004, p. 247). While this proposal was supported by the Bioethics Board of Florence, it was condemned in the media and was eventually rejected by the Regional Council of Toscana in 2004 (Hernlund & Shell-Duncan, 2007).

The Committee on Bioethics of the American Association of Pediatrics issued a statement, suggesting that medically performed ritual nick (Type IV) is not physically harmful and that a less severe form of cutting "may build trust between hospitals and immigrant communities, save some girls from undergoing disfiguring and life-threatening procedures in their native countries, and play a role in the eventual eradication of [FGM]" (Committee on Bioethics, 2010, p. 1092). Many advocacy groups protested against this statement. Following the protests, the American Association of Pediatrics rescinded the statement (MacReady, 2010). In 2010, the Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG)

was preparing to recommend medically performed "ritual nicks" to prevent girls from undergoing a more severe form of cutting. However, following public outcry, it positioned itself against medicalization (Mathews, 2011).

The publication of pro-medicalization proposals in various scientific journals that span a wide range of disciplines and major health associations' attempts to officially endorse the practice are indicative of a wide range of discontent about the zero-tolerance policy and the rise of advocacy for medicalization. Proposals of medicalization as a compromised solution have led to contestation in the transnational normative environment. The critics argue that while medicalized and minor forms of cutting minimize short-term risks, such as infection and pain, they do not eradicate the long-term risks that entail emotional and sexual problems (Nabaneh & Muula, 2019). Dorkenoo (1994; a Ghanaian-British campaigner against FGM) promulgates the view that minor forms of cutting do not necessarily lead to the eradication of the practice. Leye et al. (2019) (specialists on reproductive health) criticized the pro-medicalization argument by stressing that the reduction of harm in medicalized FGM is not empirically demonstrated. The authors further note that even if immediate physical risks associated with the procedure were eliminated, the long-term risks of FGM would persist.

The UN bodies, the International Federation of Gynecology& Obstetrics, International Council of Nurses, International Organization for Migration, World Confederation of Physical Therapy, and the WHO published a "global strategy to stop health-care providers from performing female genital mutilation" in 2010. The document dedicated a section titled "why some organizations support medicalization" summarizing the rationales of proponents of medicalization as the reduction of risks and pain, the limitation of the extent of mutilation and belief in its leading to the total abandonment of the practice (WHO, 2010). The document outlines that medicalized FGM violates ethical responsibility and raised concerns that it might lead some doctors to develop financial interests and most importantly contribute to the institutionalization of the practice. UNPFA (2018) published a brief, explaining that medicalized FGM violates medical ethics, poses immediate and long-term health risks, and undermines efforts toward the abolishment of FGM by attributing legitimacy to the practice. In 2020, UNICEF Executive Director Henrietta Fore also remarked that medicalized FGM is not healthy, moral, and defensible, arguing that it obscures the global progress toward the abandonment of FGM (UNICEF, 2020b).

Taken together, by utilizing the method of process-tracing, I showed that the domestic resistance to the anti-FGM norm has given rise to a compromise-building approach. Figure 1 illustrates the processes associated

with FGM. FGM practices applied in various regions of the world, especially in Africa and the Middle East, gave rise to the anti-FGM norm. However, the continued application of the procedure led some transnational norm advocates to propose an interim solution to minimize harm.

Compromise-builders, analyzed in the article, share the same motivation with proponents of the zero-tolerance approach (revolutionary norm entrepreneurs) with their ultimate objective of eradicating FGM. Yet, they differ from the latter by proposing medicalized and minor forms of cutting as a harm-reduction strategy in view of persistent local norms. They highlight that damage could be minimized and more lives could be saved through the consensus-building approach.

Strong international, institutional, and social resistance against this approach is indicative of the contestation in the transnational domain with respect to how to eradicate FGM. As seen clearly in the document titled "global strategy to stop health-care providers from performing female genital mutilation," international organizations, including the UN and the WHO, positioned themselves not only against *medicalization*, but also *the advocacy for medicalization*. In other words, as a result of the growing support for the compromise building approach, in addition to traditional and medicalized forms of FGM, the advocacy for medicalization itself became a target of international organizations that support a zero-tolerance approach.

Discussion and conclusion

By employing the method of process-tracing, I showed that the transnational normative environment on FGM has witnessed the rise of advocacy for medicalized and minor forms of cutting due to resilient local cultural dynamics. The pro-medicalization argument constitutes an attempt to integrate conflicting normative demands between local normative commitments to the practice of FGM and the zero-tolerance policy against FGM. Nonetheless, international responses to medicalization proposals as well as medical associations' withdrawal of their medicalization proposals after protests are conspicuous indications of the robustness of the anti-FGM norm.

Recent developments in FGM constitute another significant challenge to the pro-medicalization argument. For example, a study published in BMJ Global Health in 2018 indicates that the prevalence of FGM among children significantly declined in many parts of East, North, and West Africa. A study conducted by UNICEF (2021) indicates that the rates of FGM are declining in certain regions of Ethiopia and Kenya, albeit with slow progress. Another study by UNICEF (2020a) indicates that the percentage of girls (between the ages of 15 and 19) who underwent FGM in the world declined from 72% in 1985 to 51% in 2020. This study also indicates that support among women for FGM in Egypt, Sudan, Yemen,

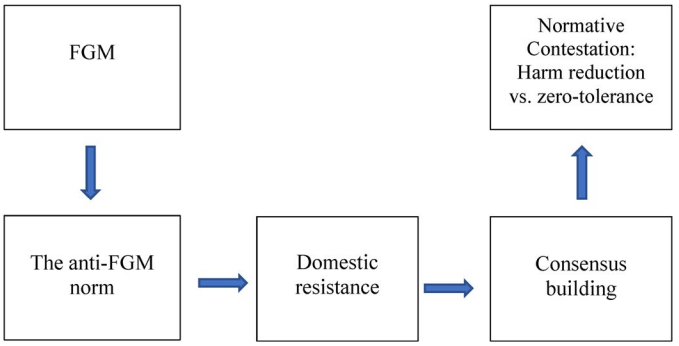

Figure 1. Consensus-building process.

and Iraq declined over the years, with the sharpest declines taking place in Sudan and Yemen (UNICEF, 2020a).

These developments might lead compromise-builders to reevaluate their approach or even create a split among them. Overall, while *transnational normative contestation* emerged due to the compromise-building approach, in view of institutional responses to the pro-medicalization argument, significant declines in the FGM rates as well as public support for the eradication of FGM in many parts of Africa and the Middle East, it is highly unlikely that the pro-medicalization argument will lead to *transnational normative change*.

Taken all together, in this study, I made a novel theoretical contribution the study of FGM and broadened the analytical focus of norm diffusion process by introducing the compromise-building approach. The compromise-building approach places particular focus on transnational norm advocates in explicating the impact of domestic processes on the transnational domain. The application of this approach in other traditional harmful practices might constitute a fruitful avenue for future research.

Data availability statement

I do not analyze or generate any datasets, because my work proceeds within a theoretical approach.

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