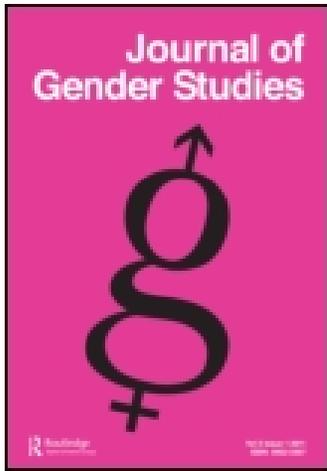


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RESEARCH ARTICLE

How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation

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Gender-based violence affects women in most societies. Chinese foot binding existed for nearly a thousand years and was seen as a sign of beauty and marriageability. Female genital mutilation (FGM) has existed for over two thousand years, affecting 140 million women across forty countries. Both practices have significant parallels and are examined historically, geographically, and by health consequences. An analysis is made of the elimination of foot binding and applied to the eradication of FGM. A model is created to identify the features which are most likely to lead to success. Three case studies taken from Somalia, Ghana, and Ethiopia are assessed against the success criteria for the eradication of foot binding. Conclusions and recommendations are drawn for future work in the stand against FGM.

Keywords: female genital mutilation (FGM); foot binding; health consequences; models of excellence; case studies – Somalia/Ghana/Ethiopia

Introduction

Gender-based violence exists in most societies, frequently focused on women. Further difficulties arise when the violence is undertaken by family members on young girls that neither have a voice, nor concept of the wrongs of the practice and understanding of alternative options.

Chinese foot binding (Chánzú¹) is an ancient tradition of forced deformity, passed generationally from mother to daughter, that lasted almost one thousand years. Its aim was to change the female's feet to conform to ideals of beauty and marriageability, with prospective mothers-in-law selecting their son's future wife by the appearance of her feet (Mao 2008).

Female genital mutilation (FGM) has existed for over two thousand years and is a painful and dangerous practice that alters the female genitalia (Momoh 2005). A major human rights and health problem, affecting up to 140 million women across 40 countries, FGM arouses a strong emotional response, coming under increasingly intense international scrutiny (Shell-Duncan and Hernlund 2001).

Although these practices have been carried out in different geographical and historical contexts for different reasons, there are significant parallels between the two (Circumcision.com 2009). Having worked in both China and African countries including

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Somalia, the author has spoken to women extensively of their experience of foot binding and FGM. The aim of this research is to gain a greater anthropological understanding of the two practices.

FGM in Somalia persists despite legal prohibition, public education campaigns, and modernisation. Foot binding lasted for a thousand years yet ended in a single generation (Mackie 1996). As such, the two practices will be examined in terms of their relevant historical, geographical, and health consequences. There will then be an analysis of the two practices before establishing what lessons can be learnt from the eradication of foot binding and applied to the abandonment of FGM. A model will be created to identify the successful components for achieving change. Then, current case studies will be assessed to see if any of their successes are due to the sharing of these key components or aspects of change. Finally, conclusions and recommendations will be drawn for future work in the stance against FGM.

Following the World Health Organization (WHO) guidance, and due to the radical type of procedure undertaken in Somalia, the term FGM is used instead of female circumcision or cutting. Due to limited current information sources regarding Somalia because of the civil war, data from Kenya and other neighbouring countries in Islamic North-East Africa are also used as the practices are identical, and this is also where many Somalis reside in internally displaced people (IDP) camps.

The past: Chánzú and FGM – the ‘rites’ and wrongs?

Chánzú

A historical summary

‘Chánzú’ was a custom practised on girls from three to eight years old, whereby the four smaller toes were curled underneath towards the centre of the foot’s sole until the bones were broken. The sole was then forced towards the heel until the foot was in line with the leg and the arch broke. The feet were initially bound night and day for two years in an attempt to stop growth (Crites 1995).

In tracing the history of Chánzú, much factual knowledge can only be drawn from the nineteenth and twentieth centuries (mainly through the literature detailing Western missionaries’ views and anti-binding societies) (Ko 2005). The historical origins of foot binding are vague, although as early as the late Han dynasty (847–850 CE) there are textual references to the preference for small feet (Vento 1998). Folklore offers stories of an empress in the Shang Dynasty (1700–1027 BCE) being born with a club-foot ‘asking the emperor to order court ladies to bind their feet so hers would not be out of place’ (Bowler 2011). Another legend says the empress was a fox and the Chánzú was ordered so that no one could distinguish her paws from human feet (Bowler 2011). The most likely provenance of Chánzú is the Sung Dynasty Prince Li Yu (937–978 CE) who had a fetish for tiny feet and made his concubine, Yao Niang, dance a ‘toe dance’ with her bound feet looking like ‘new moons’, whereby she appeared to ‘be skimming over the top of golden lilies’, atop a golden lotus pedestal (BBC 2003).

Chánzú appeared in the early Sung Dynasty (960–1279 CE), at a time of urbanisation, bureaucracy, and thriving trade. The status of women declined as the use of concubines and upper-class dowries increased and neo-Confucian views on female chastity, seclusion, and subordination emerged (Mackie 1996). The practice spread across three dimensions. Firstly it flowed from the imperial palace to court, then to the upper, then middle and lower classes, whereby the higher the social status, the greater the desire for a smaller foot.

Secondly, Chánzú supposedly originated from a dancer (though as the practice became more desirable and exaggerated over time, dance became impossible with bound feet). Thirdly, it radiated from the imperial capitals to the rest of the empire as a result of increased trade links (Mackie 1996). By the late twelfth century foot binding was widespread and had increased in its severity. The Mongols, supplanting the Sung Dynasty with their Yuan Dynasty (1279–1368), were great advocates of it, and by the time of the Ming Dynasty (1368–1644) Chánzú was accepted practice for all social classes, and the rationale for it associated with marriage and status (BBC 2003).

The seventeenth century saw a decline in Chánzú as the Manchu conquerors seized control (Qing dynasty 1644–1911). Abhorring all Han traditions including foot binding, imposing death penalties on those who did not unbind their feet, Emperor Zangxi tried to ban foot binding in 1665, yet three years later his ban was revoked by the Ministry of Rites (BBC 2003). Measured in 1835, Chánzú affected 50%–80% of women, exceptions being only amongst the lowest classes, where women worked in agriculture or manufacturing (Mackie 1996). An 1847 Manchu edict on Chánzú again failed (Mackie 1996).

The first anti-foot binding society was founded by missionaries, based on ‘pledging’ neither to bind nor seek bound girls for their sons to marry. The National Foot Society started in Shanghai in 1895, and the Anti-Foot Binding Society in 1897 eventually acquired 300,000 members who were guaranteed unbound marriage partners for their children (Mao 2008). By 1908, leading public opinion was opposed to Chánzú and led to the leadership of the Natural Foot Society being transferred to a committee of Chinese women (Mackie 1996). After the 1900 Boxer Rebellion and the 1911 Chinese Revolution, Chánzú was banned (1912), with the decree succeeding in larger cities and many locales especially amongst the upper classes (Drucker 1981). The year 1915 saw monetary fines issued by inspectors to those continuing the practice; yet despite the ban Chánzú continued in isolated regions until the 1930s (BBC 2003). However, in Tinghsien, a conservative rural area, the percentage bound reduced from 99% in 1889 to 94% in 1899 to zero in 1919 (Gamble 1943). It is estimated that over two billion women had their feet bound from 950–1949 (Gamble 1943, Wilson 2007).

Procedure and rationale

The ideal sought with Chánzú was a foot of no more than three inches as a leg extension, with a three-inch deep cleft (BBC 2003). The feet were treated at the stage of being pre-bone cartilage, that could easily be broken and be moulded to the ‘golden lotus’ shape. Toe nails were cut, and the feet dipped in animal blood and herbs. Massaged with alum, four toes were broken, folded under the foot, and bound by bandages changed every two days. The foot arch was broken so the foot could be pulled straight and the girls were encouraged to walk to crush the newly shaped foot into shape. Sharp objects were used in bandages to lacerate the feet, so flesh rotted and could be removed (Mao 2008).

The implications of this procedure were pain, disablement, immobility, isolation, and deformity (Crites 1995). Complications included ulceration, malodour, open wounds, septicaemia, arthritis, paralysis, gangrene, mortification of lower limbs, and death in 10% of girls (Mackie 1996). The rationale for the procedure included distinguishing the Chinese from the invading Mongols; promoting good health and fertility; higher status and love; and lasciviousness, modesty, and sexual fetish (Mackie 1996). Women’s seclusion led to fidelity, and a small foot promoted male erotic interest. ‘Mindful-body’ theory suggests binding helped survival in a male-dominated society (Blake 1994). Poorer families used Chánzú for social mobility (Taber 1997).

Female genital mutilation

Historical and geographical presence

FGM has been practised for over two thousand years (Slack 1988), encompassing procedures involving ‘partial/total removal of external genitalia or injury to organs, for cultural, religious or non-therapeutic reasons’ (Momoh 2005). With obscure origins, it has existed in civilisations throughout history and has not been not confined to one culture or religion. It is found in traditional group or community cultures that have patriarchal social structures. A second-century BCE Greek geographer and historian reported that a group by the Red Sea’s eastern coast excised their women in ‘Egyptian style’ and that another group ‘cut off in infancy with razors the whole portion that others circumcise’ (Agatharchides 1989).

FGM practice precedes Islam or Christianity, being traced by anthropologists and historians to fifth-century BCE Egypt, hence infibulations being referred to as ‘Pharaonic circumcision’ (Slack 1988). Egyptian mummies show women were infibulated, some believing the practice originated there, as mentioned in a Greek papyrus in the British Museum dated 163 BCE (Lightfoot-Klein 1991). Other anthropologists believe it existed among Equatorial African herders as protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as ‘an outgrowth of human sacrificial practices, or some early attempt at population control’ (Lightfoot-Klein 1983, p. 354). In 1609 Dos Santos reported a group near Mogadishu, Somalia who ‘had a custom to sew up their females, especially young slaves to make them unable for conception, which makes them sell dearer, both for their chastity’ and to prevent pregnancy, enabling them to be sold for more (Freeman-Grenville 1962, p. 180). Browne, reporting on his 1799 African travels, wrote that Egyptians practised female circumcision and infibulation to prevent pregnancy in women and slaves (Widstrand 1964). Other travellers to Egypt claim slave traders infibulated young captives; this was called ‘Sudanese circumcision’ by the Egyptians (Mackie 1996).

Today, FGM occurs in the African Sudanic belt, between the Northern Tropic of Cancer, and the Equator in the south; from the Western Atlantic Coast and Egypt to Kenya in the East (Mackie 1996). It is seen as ‘entrenched’ in Africa although its geographical dispersal occurs amongst such wide cultures, and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein 1983), aided by Egyptian slave raids for concubines and maids from Sudan, traded through the Red Sea to the Persian Gulf (Mackie 1996). The studies on the distribution and prevalence of FGM are based on Hosken’s African mapping exercise for the WHO from 1979 to 1992, culminating in her 1981 map that covered 40 African countries (Hosken 1989), 29 of which are cited for (1987–1999) data across Africa and Yemen. Twenty-six countries have a prevalence ranging from 12% to 100%, 17 of these being over 50% (Momoh 2005). Hosken’s data are based on interviews with medical personnel and government officials, and literature studies. Although other researchers have not succeeded in replicating her findings, the research provides the first attempt to map the extent of FGM and has further motivated systematic data collection (Shell-Duncan and Hernlund 2001).

FGM has been newly adopted in the 1980s by some African peoples (Leonard 2001), so its geographical presence is variable over time. The prevalence map is further expanded to Europe, the Americas, Australia, and New Zealand (Muteshi and Sass 2005) by children born to parents from FGM-practising communities or women refugees, asylum seekers, or students or their wives arriving from practising communities (Government Equalities Office 2009). Additionally, current global estimates are tentative since nationally

representative data do not exist for all countries (Shell-Duncan and Hernlund 2001) such as Somalia. However, national boundaries are not always important as distribution of FGM is better understood by ethnic groups, who straddle boundaries. Additionally, those communities that are close geographically do not necessarily all practise FGM, as shown by the fact that Kenyan Kikuyu and Somalis practise, whereas Kenyan Luo do not.

Rationale and health consequences

It was estimated in 1998 that 132 million women had experienced FGM (Shell-Duncan and Hernlund 2001); however, the range widened in 2005 to 120–140 million due to moves to standardise data collection. The research is hard to replicate in some war-torn countries such as Somalia (Momoh 2005). Annually 2 million girls are circumcised, many in Egypt where FGM has been banned yet ‘medicalised’ (Denniston *et al.* 2001). Standardised questions on FGM have been included in 17 African country Demographic and Health Surveys (DHS) and Yemen which will improve data accuracy until the 11 remaining countries undertake the survey enabling a profile for the whole of Africa (Measure DHS 2011). The WHO defines FGM types as I: partial excision; II: total excision; III: infibulation; IV: pricking, piercing, cauterisation; scraping or cutting the vagina; introduction of corrosives or herbs (Momoh 2005). A 1998 Somali survey stated 80% of FGM was infibulation and 20% clitoridectomies (Shell-Duncan and Hernlund 2001). Somalia has the highest prevalence in the world, cited at 96% in 1983, and 99%–100% after five surveys undertaken from 1982 to 1993 (Toubia and Izett 1998).

Traditional practitioners without surgical training perform FGM with razors, glass, or knives in unsterile conditions. No anaesthetic is used, and relatives hold the girl down. Twigs or rock salt are inserted afterwards to maintain a small opening for urine and menses. The area may be covered with soil or bark before the girl is sewn with thorns or gut, and has her legs bound for three weeks (Momoh 2005). As the environment is unsterile, there is a high risk of tetanus and sepsis. The girl may suffer urinary retention or a haematoma. Other complications include haemorrhage, severe pain, local/systemic infection, shock, and death (Shell-Duncan and Hernlund 2001). Although the actual number of girls dying from FGM is unknown, as many deaths go unreported, especially in areas of Sudan where antibiotics are unavailable, it is estimated that one-third of girls undergoing FGM will die (PATH 1997). Anecdotal evidence suggests that over 10% die at the time of the procedure, with the bodies often being disposed of in neighbouring villages until they are taken by animals (Wilson 2008). Longer-term, the stitched area may be so scarred that there is insufficient opening for menses, causing abdominal swelling. Study interviews have given reports of girls perceived as pregnant and killed to preserve family honour (Wilson 2008). Long-term complications include urinary tract infections, incontinence, difficulties in urination and menstruation, dysmenorrhoea, vulvic abscesses, neuroma, demoid cysts, and frigidity (Qazilbash 2005). Obstetrical complications include obstructed labour, fistulae, haemorrhage, and child and/or maternal death (Shell-Duncan and Hernlund 2001).

The rationale for FGM can be broken down into four key areas. Aesthetic considerations show Somalis consider the clitoris ‘ugly’ and external genitalia ‘unsightly’, their removal bringing ‘maturity’ perceived to allegedly maintain physical and mental health. Social justification states FGM is an initiation into female fertility and leads to instruction in wifely and maternal duties. Religious considerations, although not Qur’anic, deem FGM to have been adopted by Islam on the conquest of Egypt (742 CE). Fourthly, psychosexual justifications include virginity being a pre-requisite to marriage in many

cultures; and FGM removes the clitoris to protect women from their 'over-sexed' nature and temptation into 'disgrace', which would bring shame on the family. In Egypt and Sudan, FGM is believed to increase male sexual pleasure whereas the clitoris is seen as an aggressive threat to the penis, endangering an unborn baby (Momoh 2005). Many myths such as these, and the myth that 'a penis will grow to the knees if not cut', were heard by the author in Somalia and need challenging if FGM is to end (Wilson 2008).

Lessons from the past for the present

Comparisons and differences between Chánzú and FGM

Foot binding and FGM are both practices with long-lasting implications for health and activity levels. Both involved highly ritualised rites of passage to womanhood, being prerequisites for marriage in the cultures that used or use them (Keck and Sikkink 1998). FGM was practised by ancient Egyptians, for cultural rather than religious reasons (Toubia 1995), whereas binding's origins are in traditional folklore, as it was believed that unbound women would not marry (Little 1899). Both practices were/are deeply embedded in domestic life, socially mandated, but not legally required or enforced. Both customs affected/affect girls of diverse backgrounds and different classes and both were/are linked to controlling female sexuality and reproductive power (Keck and Sikkink 1998). Bound feet had erotic appeal to men (Scorolli *et al.* 2007), helping keep women confined to the home, 'feet' becoming the most risqué subject for conversation in the late 1800s (Little 1899). FGM is even more closely linked to sexuality due to the removal of the clitoris, a primary organ in sexual pleasure (Janssen 2004).

Binding and FGM were/are nearly universal where practised and persistently practised even by detractors. Both practices control access to females, ensuring female chastity, fidelity, and social/political isolation. Both were/are seen as necessary for marriage and family honour, acting as ethnic markers to minorities lacking the practices. Both practices were/are exaggerated over time, spread quickly, and the degree to which they were/are undertaken related to status. Women supported transmitting the practices by performing them usually on girls under the age of 10. Both were/are believed to promote health and fertility, being deemed aesthetically pleasing compared to the natural alternative. Both practices were/are said to exaggerate the compatibility of the sexes, making intercourse more pleasurable for men. Imperial China and Sudanic Africa both have histories of female slavery (Mackie 1996).

As a social phenomenon, eight parallels are seen: they are performed on girls, they give rise to pain and ill-health, this pain has significant duration, there is a possibility of fatality, sexuality of the female is controlled, they were/are used to achieve an aesthetic appeal, they were/are accepted with little dissent, and they are done without the recipient's consent (Circumcision.com 2009). Originally binding may have begun to enforce imperial males' exclusive sexual access to his consorts, ensuring chastity and fidelity. FGM also limits mobility, confidence, and equality in women (Qazilbash 2005). Upper-class Chinese women became confined to their boudoirs unable to walk away from the bedroom wall without leaning on a chaperone for support. A healthy girl was given a maid when first bound to carry her around the house, comfort her sleepless nights, and wash and bind her feet (Vento 1998).

The bound foot was seen as aesthetically pleasing; yet, with complications of ulceration, paralysis, and gangrene, the reality is that feet were often malodorous and crippled. In FGM, 'slicing off the clitoris and two black lips, sliced like meat' (Moschovis 2002) and leaving behind incontinence, odour, and pain would appear to be equally counter-aesthetic.

Chinese feet were concealed under binders, socks, shoes, leggings, and skirts, whereas Somali women are veiled from head to toe. Binding was seen as 'attire' not mutilation (Circumcision.com 2009).

Apart from involving different parts of the anatomy, there are few other differences between the processes. In China, with small feet the lower classes could become maids, concubines, or the wives of noblemen or merchants (Svoboda 2001), and there was elite concubinage; whereas in Africa polygyny is commonplace. The Chinese setting was agrarian and commercial, in contrast to Africa with its pastoral and horticultural setting (Mackie 1996).

How the eradication of Chánzú was achieved

Chánzú was surrounded by ritual preparation, including making pairs of tiny embroidered shoes. After years of bone-breaking, intense pain, and flesh removal, a three-inch foot was produced (Lim 2007). Yet women appear to have been proud of Chánzú as it was seen to support socialisation; the appropriation of female labour; the definition of gender, domesticity and nationhood; and prepared girls physically and psychologically for being dependent family members (Hopley 2005).

The anti-foot binding movement originated in late 1800s among foreigners, spreading later to China. China's defeat in the 1842 Opium War opened ports to an influx of missionaries and Western ideals. Chinese intellectuals saw reform was needed to avoid further humiliating defeats. Initially encouraging innovation and weaponry, after the First Sino-Japanese War where China was defeated by the Japanese, the Chinese sought social, cultural, and political reform. This included empowering women's status. Chinese intellectuals and politicians took over the campaign which culminated in banning Chánzú just after the 1911 revolution (Keck and Sikkink 1998).

The foot binding reformers worked in three key ways. Firstly, they used an education campaign which explained that other countries did not bind feet and that China was 'losing face' and being internationally ridiculed. Secondly, the advantages of 'natural' feet were explained, alongside the disadvantages of binding. Thirdly, natural foot societies were formed, with members pledging not to bind and only allowing sons to marry unbound girls (Vento 1998). Three groups were involved in the campaigns against foot binding: a group of Western missionaries focused on Chinese Christians, another group focused on Westerners and the elite, and a group of Chinese reformers campaigned with the non-Christian Chinese elite (Little 1899). A London Missionary Society (LMS) member founded the first anti-foot binding society in 1874, and in 1875 Mrs Little founded the first Natural Foot Society. Chinese groups followed and were the first to succeed in moves to eradicate the practice in 1897 (Hong 1997).

Each group took different approaches against Chánzú. The missionaries gave scholarships to unbound girls, later educating only unbound elite pupils under unbound Christian elite teachers. The anti-foot binding societies provided marriage partners for members, registering ages of children for convenient match-making. Mrs Little focused on powerful officials and wealthy elite women. A petition was sent to the Dowager-Empress and literature was translated into Chinese and circulated widely. Campaign meetings were 'social parlour affairs' (Keck and Sikkink 1998). By 1907, 200 meetings had occurred in 33 cities with up to 2000 present per meeting.

By 1908 the Natural Foot Society was under the direction of the Chinese state, a period of only 16 years passing from its formation to the 1911 ban. In 1905 70% of females had bound feet; in 1912 this figure was waning, and by 1919 there were no new *reported* cases

(Gamble 1943). The swift eradication of such a deeply embedded practice, that had lasted a thousand years, is unusual, as no economic or industrial change appears to account for it. Gladys Aylward was appointed as a government foot inspector in 1932, ensuring China's ban was upheld in the outlying provinces (Kiefer 1970). One scholar in 1920 wrote 'for all the wrongs Western culture did in China, Western missionary sisters aroused Chinese minds, that foot binding was absurd and wrong' (Drucker 1981). However, some aspects of abolition were chaotic and unfair, with sloganeering targeting bound woman who were forced to unbind, bringing more pain, humiliation, and suffering (Circumcision.com 2009).

A survey of five child body mutilations including Chánzú and FGM states that legal measures alone will not eliminate them, as people first have to desire and accede to change. In the case of Chánzú, working with native activists appears to have been more effective than denying education to bound girls (Wilson 2007). The latter is paralleled to lobbying against FGM from the 'developed' West which carries the stigma of its imperial and colonial past. In binding, activists shifted public opinion, and an educational and integrationist approach appears to have given rise to greater and speedier successes. After this, legal measures can assist in upholding transformation (Svoboda 2001). The research recommends that lobbyists must be familiar with local culture and religion, and sensitive to the terminology of FGM. Additionally the needs met by FGM, including initiation, belonging, and facilitating marriage, would need to be fulfilled by alternative means. Finally, accurate information would need to be disseminated regarding the directly attributable medical and sexual complications of FGM, and economic solutions such as new income generation activities found for existing circumcisers (Svoboda 2001).

The lessons learnt for achieving the eradication of the mutilation of females include avoiding hypocrisy and viewing other communities' issues through cultural lenses. Approaches need adaptation to specific locations while addressing perpetrators sensitively and avoiding the overt condemnation of a custom. Change agents need to be opportunistic in doing what works, whilst promoting literacy and education to help women and men make informed choices. Persuasion is usually the best strategy, but some combined 'reward and punishment' approaches can be beneficial. Multiple approaches are better than one, using as little foreign 'authority' as possible. Vigilance is needed to avoid swapping one practice for another, and common ground needs to be built patiently, whilst acknowledging in some instances how multiple circumstances can align for a quicker and sustainable change to occur. Finally, legal measures may be required but are not the first stage, as resolutions and statutes cannot change entrenched social norms (Keck and Sikkink 1998).

Applicability to a different issue or context

There was a concerted campaign against FGM in Kenya from 1923 to 1931, focused on the Kikuyu. It is likely that they were targeted because more British missionaries worked there, hence the high presence of medical missions and girls schools, exposing missionaries to the social pressure of FGM. Additionally, the Kikuyu were more open to missionary teachings and had more converts than the Masaai or tribes of Sudan and Somalia. The campaign was possible since, as had been the case with binding, the population was divided over FGM (Murray 2007, quoted in Smethers 2007).

In Kenya, British colonial administrators and missionaries used tactics similar to those used in the anti-foot binding campaign, with schools refusing to admit circumcised girls and churches suspending members for performing FGM. The missionaries asserted that the operation was medically unnecessary, dangerous, and 'un-Christian because the rituals were pagan and overtly sexual' (Keck and Sikkink 1998, pp. 66–67). Many African

members left the church, feeling that an 'eleventh commandment' was being imposed and, as women missionaries and Kikuyu were not involved, the campaign became associated with sexist and anti-colonial practices (Keck and Sikkink 1998, pp. 66–67). The Kikuyu elite defended the practice, Kenyatta stating in 1935 'it is impossible to imagine initiation without FGM' (Keck and Sikkink 1998, pp. 68–69). He travelled to the UK to rally 'overseas' support with Church leaders and the administrators without support from the missionaries. Unlike in China, African reformers like Kenyatta were holding up African ideas as an antidote to Western life-styles (Keck and Sikkink 1998, pp. 68–69).

Research conducted in 1973 showed that FGM in the Kikuyu had reduced from 100% in 1930 to 75% in 1973 (Ahlberg *et al.* 2000). Data from the Kenya DHS show a further reduction to 43% of Kikuyu being circumcised for the period 1973 to 1998 (Qazilbash 2005). The campaign to eradicate Chánzú in 1895–1911 used some similar elements to the campaign to end FGM in 1930s Kenya, yet nationalism in 1900 China was different from 1920s Kenya. Chinese nationalism saw tradition as weakness, and modernity as a requirement. Once opposition to Chánzú was stripped of its missionary origins, it was key to abandoning a feudal past. In Kenya, nationalism embraced tradition to defeat colonial order. In the Chinese campaign, Chánzú, previously a source of pride, became a symbol of the past (Keck and Sikkink 1998). In Kenya, FGM was associated with waning colonialism, and the circumcised girl as the emerging Kenyan nationalist. In China, male elite led the campaign, and missionary origins mattered less than their contribution. In Kenya, the anti-FGM campaigns never gained domestic sponsors. These comparisons show that the same type of campaign cannot be arbitrarily transplanted and achieve success (von der Osten-Sacken and Uwer 2007).

From research in Somalia in 2005, circumcisers perform 92% of FGM, traditional birth attendants (TBAs) perform 7%, and medical personnel perform 1% (Qazilbash 2005). Before the collapse of the Somali government in 1991, there had been support for a June 1988 campaign to stop FGM. The penal code prohibits 'very grievous hurt' (loss of an organ, or ability to procreate) with up to 12 years' imprisonment (Rahman and Toubia 2000). Today Somalia has the highest global rate of FGM despite TBAs' recognition of its complications. Due to strong religious and cultural beliefs, most parents continue to demand FGM, despite, one presumes, women's own childhood memories of the procedure. In the context of promoting change regarding FGM, change agents must use language acceptable to the target group, to avoid polarising the beneficiary population. Failure to do so will lead to misunderstanding, misinterpretation, and a perception by African Muslims of Westerners devaluing their culture (Momoh 2005).

Somali research in 1992 showed FGM was not originally present in the southern Sabiye tribe, who now have the same FGM rate as the northern clans, whose higher social status they wish to emulate. The rate is predicted for the next generation as being the same as for their mothers. Although stating that FGM is required for marriage, honour, proof of virginity, and modesty, often the explanation (experienced by the author in field-work) is 'such is the tradition here'. FGM is found only in or adjacent to Islamic groups. In the Kenya–Somali IDP Camps, 0.072% (180 out of the 250,000) Somali change agents, made up of groups of women, men, Imams, parents of uncut girls, ex-circumcisers, and youth, stand against FGM (Wilson 2008). Just as Western influence played a part in eradicating Chánzú, IDP camp medical and health education services can influence ending FGM, but a rejection of cultural relativism is insufficient justification for not treating FGM complications (Moschovis 2002).

One of the successes in eliminating Chánzú was sending out over a million tracts showing 'ten sighs [sadnesses] about foot binding' and 'ten delights about natural feet'

(Ko 2005). Mrs Little interviewed people in authority, and connected foot binding, honour, and marriageability. She then presented the arguments in Chinese Confucian terms rather than foreign Christian terms. The Empress was persuaded to back the cause, and it became a respectable choice not a radical reform (Mackie 2005).

In Somalia, the 'Water for Life Project' has allowed 1000 girls to undergo 'symbolic infibulations' involving anaesthesia, a nick in the clitoris provoking a few drops of blood, and legs bound to simulate infibulation (Shell-Duncan and Hernlund 2001). This could become more extensive, but still will not eradicate the beliefs behind FGM. In Senegal in 1999, FGM was prohibited but still practised. A non-governmental organisation (NGO) helped effect change, by using a holistic approach of advocacy, human rights, problem-solving, hygiene, literacy, and management. Historically 92% were circumcised, but in one village 3000 villagers took a pledge to abandon FGM. This spread, and, by 1999, 13 villages had pledged to abandon, with the grass roots movement expecting a total ban of all FGM-type activities by 2010 (Melching 1995).

A tripartite strategy of abandonment seemed to succeed in Senegal: education, public discussion, and public declaration. It may be easier initially to trigger change in groups where FGM is less fixed on chastity and fidelity rather than in cultures where it is connected to the modesty code. Sharing knowledge between communities who have succeeded in reducing, or preventing, FGM and those who still practise it would appear to be potentially effective in eradicating FGM in the remaining 40 countries where it is still widespread.

Model explaining the successful elimination of Chánzú

According to Gillespie, there are 31 traits that can be used to define a social convention (2005). Chánzú shows 28 of these, although chastity and marriageability were key (Warren 2003). The social convention of Chánzú was perpetrated by the belief that unbound women would neither marry nor escape the lowest social strata (Mackie 1996). A similar paradox exists with FGM, where parents feel socially obligated to perpetrate a harmful and painful traditional practice, believing that non-conformity will bring greater harm, shame, dishonour, social exclusion, and result in a daughter who cannot be married (Lewnes 2005).

As with any self-enforcing social convention, an individual family's choice to bind or cut its daughter is conditioned by the choice of others, otherwise marriage prospects might be ruined. While social pressure tends to perpetrate the practice, it can also be key to promoting rapid collective abandonment, such as with Chánzú. The work of the anti-foot binding reformers had three key features: the circulation of the knowledge that the rest of the world did not bind feet suggesting that China was 'losing face', the promotion of the advantages of unbound and the disadvantages of bound feet, and the creation of societies whose members pledged not to bind their daughters' feet nor allow sons to marry girls with bound feet (Vento 1998).

Three components of social convention were present in ending Chánzú. Firstly (A), the competition for the 'best marriage' had to be replaced with a market mechanism for 'new' marriage partners, namely the membership of the pledge societies, guaranteeing unbound girls and sons wishing to marry them (Mackie 1996). Secondly (B), the advantages of bound feet which limited mobility in slaves or concubines were replaced with the promotion of ideas of emancipation, labour potential, and higher survival rates. Thirdly (C), the belief trap of 'normality' was shattered at a time that China was seeking to gain military and economic advantage (Gillespie 2005). Timing is crucial, as it is often only when economic or 'image' advantages outweigh women's health disadvantages, that the holders of power will accept the benefits of change.

Despite numerous factors cited elsewhere, these three components (A, B, and C) of the anti-foot binding reformers had remarkable success. As such, a model is suggested which incorporates these three by further dividing them into six sub-components, namely: A1: pledge society membership; A2: marriage between members' children, and parents selecting partners for their children who have not suffered the anatomical modification; B1: promoting the advantages of not undertaking the practice; B2: showing the disadvantages of the practice; C1: the reminder that the rest of the world does not undertake the practice and that, C2: the host nation loses face. This six-aspect model and current good practice will be used to test acknowledged leading case study examples in the eradication of FGM, to establish if the positive examples use the same components that were shown to eliminate foot binding.

Looking to the future

Recent attempts to eradicate FGM

The first international symposium on FGM was held in 1979, recommending the adoption of clear national policies, establishment of national commissions, intensification of general public awareness, and TBA education. Although ground-breaking, it achieved little (Hosken 1989). The years since 2004 have seen a dramatic increase in cross-agency evaluated studies, papers, and articles recommending ways to eliminate FGM. Recommendations include actions and interventions being multi-sectoral, community-led, and sustained (Amnesty International 2005). Good governance recommends a multi-level approach incorporating participatory process-led methods taking into account cultural background, multi-level processes for societal transformation, negotiation processes, sustainability, and protection (Conze and Richter 2007). After many conferences and published papers, six key elements for abandoning FGM have become well accepted by NGOs and government bodies as good practice. These aspects are: (a) a non-coercive, non-judgemental human rights approach; (b) community awareness raising of the harmfulness of the practice; (c) the decision to abandon needs to be collective; (d) requirement of community public affirmation of abandonment; (e) intercommunity diffusion of the decision; and (f) a supportive, change-enabling environment (WHO 2008).

Identifying the most effective and appropriate strategies for eliminating FGM has been a bitterly contested issue covering moral, disease, and legal models. Adopting a universalistic stance, some activists argue that FGM should be condemned and punished by legislation (Rahman and Toubia 2000). However, formal legislation has been a poor instrument of cultural change (Atighetchi 2007). Simple education campaigns designed to impart knowledge on the adverse health outcomes of FGM can also be problematic, although innovative education campaigns have been partly successful (where the community is involved in identification of the issues) (Mackie 2001). Although most agree the health approach is not the most tenable, potential medicalisation can become an issue, and health staff need actively to participate in advocacy, being punished if they break national laws (Population Council 2005). The Coptic project in Egypt (PATH 1999) was successful in a culture that had medicalised FGM, and a harm reduction model is a better alternative to the disease or moral models (Shell-Duncan and Hernlund 2001) for societies still unwilling to abandon FGM (Shell-Duncan and Hernlund 2004).

Regarding Somalia, successful interventions giving rise to a short-term impact involve behavioural changes, through awareness-raising and increased capacity of individuals and communities to make choices that challenge the norm. Longer-term impact is achieved through interventions that alter these societal norms, moving the status of FGM from being

desirable to non-desirable within society at large (Black 2006). For the Somali community living in Kenya, efforts to encourage behaviour change cannot focus solely on health education, as the underlying reasons for FGM need to be discussed so that the desire for change emanates from the community itself (Population Council 2004). Somalis perceive efforts to abandon FGM to be driven by international interests, so NGOs need to establish trust and acceptance through credible individuals (CARE GAD 2008).

The Kenya–Somalia IDP programme in which the author worked in 2008 used a model (Qazilbash 2005) developed in 1987 in Sierra Leone (Koso-Thomas 1987). However, other programmes are surpassing this model. From 2002 to 2006 researchers listed 100 programmes in 19 countries to identify anti-FGM best practice. This was deemed to be programmes making a demonstrable, tangible impact on lives, programmes that are socially, culturally, economically, and environmentally sustainable and partner all sectors (Feldman-Jacobs and Ryniak 2006). The criteria against which success is judged are defined as the achievement of objectives, a measure of the impact on behaviour, the degree to which cultural sensitivity was observed, and the reproducibility of results using the same method in different contexts. In order for these to be measured effectively, there must be a recognised method for evaluating particular approaches. Although many more met the good practice guidelines mentioned previously, some were not evaluated. Ten programmes were deemed to be ‘promising’, and the final three were deemed to be the most effective. These case studies can be used to measure attempts to eradicate FGM against the model used in the eradication of foot binding.

Case studies

Case study 1: the Navrongo FGM experiment

Navrongo Regional Health Centre, Ghana started collecting data on FGM in 1995, finding three types were present in 80% of respondents, with 62% of them having being cut between the ages of 15 and 19 years. The rationale for FGM was a rite of passage and the maternal duty of acting in the daughters’ best interests, to ensure their marriage prospects. In addition, eldest daughters need FGM to perform at their mother’s funeral (Feldman-Jacobs and Ryniak 2006). Six villages were chosen, for a baseline survey in 1999 on 3221 girls, followed by 19,000 interviews conducted over five annual cycles until 2003, to monitor change. Four groups were selected to offer comparisons between (1) FGM education and prevention; (2) empowerment and livelihood skills; (3) a combination of both of these and (4) a comparison (or control) group (no intervention) (Feldman-Jacobs and Ryniak 2006).

The education programme featured anti-FGM night videos, clinic/school health programmes, singing and drama competitions, and radio programmes. The livelihood activities included craft making, marketing, micro-lending, income generation activities (IGAs), sources and procedures for finance, bookkeeping and management (Feldman-Jacobs and Ryniak 2006). The results showed that all three groups experienced a reduced number of FGMS, with the combined strategy having the most statistically significant result. Lessons learnt included the benefits of a multi-phased approach, systematic intervention, and scientific evaluation. The programme suggests that culturally sensitive, community-led education interventions can reduce FGM (Feldman-Jacobs and Ryniak 2006).

Case study 2: IntraHealth’s five-dimensional approach

From 2003 to 2005, IntraHealth implemented an approach focusing on health, gender, religion, human rights/law, and access to education in the Somali region of Ethiopia.

The project aimed at closing knowledge, attitude, and practice (KAP) gaps, strengthening communication links with policy-makers, empowering women and community leaders, and monitoring and evaluating results. It responded to the 2000 DHS which had revealed that 73% of women had one of the four types of FGM; 88% had been cut before the age of 10, and 50% of these had been cut during the first year of life. Here, the rationale for FGM was primarily religious, rather than as rite of passage. Women continue FGM to protect their daughters' reputation regarding chastity, enabling good marriage prospects, colluding with gender inequities based on anatomical myths (Feldman-Jacobs and Ryniak 2006).

The project launched with a national workshop for 40 senior government officials. Simultaneous regional workshops identified empowered women leaders, and they recommended a steering group of four prominent senior women leaders. A training-of-trainers workshop educated and mobilised regional leaders, forming four teams of men and women. They in turn trained district core teams of 20 men and women. Each grass roots team mobilised 100 community member representatives of mothers, fathers, and unmarried men and women. Each site organised a public declaration to ban FGM, with 2220 participating. A forum of Muslim and Christian leaders, Imams, and Shari'ia Court leaders was held (Feldman-Jacobs and Ryniak 2006).

Successes included: an anti-FGM penal code, over 80 religious leaders banning FGM, 4200 community members completing their training, public promises for circumcisers to stop practising, 2252 members publicly condemning FGM, 120 religious leaders and 13 mosques making anti-FGM declarations, and regular media and information, education, and communication (IEC) coverage. In 2005, a Somali development NGO took over the work, which continues. Lessons learnt include the necessity of programme designs that incorporate community needs from a multi-dimensional perspective, the provision of audio-visual and other aids, the provision of information to fathers simultaneously, respect for socio-cultural values, the mobilisation of community leaders, the use of traditional information channels, and the joining of government initiative with NGO practices (Feldman-Jacobs and Ryniak 2006).

Case study 3: Tostan's community empowerment program

Tostan's programme started in Senegal in 1991 and is also used in Somalia. Data from 2005 for rural communities where types I–III FGM are undertaken state that one-third of girls are cut just after birth, one-third under the age of six, and one-third during adolescence. The rationale for FGM includes the enhancement of marriage prospects, religious custom, the value placed on virginity in females, and social conventions ensuring community membership (Mackie 2001).

Tostan's method targeted 60 village participants and has been carried out in 2000 villages. It consisted of 200 sessions in five modules taught over three years (these modules were cumulative and interrelated). Year one covered 100 sessions on democracy, human rights, problem-solving, and health (FGM/sexually transmitted infections (STIs)). Subsequent years covered literacy, maths, and management, reinforcing earlier workbook themes (Feldman-Jacobs and Ryniak 2006). The community ownership values reinforced were trustworthiness, trust, as well as holistic, learner-centred, practical, and respectful focus on issues other than just FGM (Melching 2009). Tostan avoided the use of language that might humiliate, shock, or appear as judgemental. Three hour-long classes occurred on alternate days (Tostan 2007).

Tostan developed a system whereby programme knowledge encompasses wider circles of people via organised diffusion. Participants share via an 'adopt a learner'

strategy. This means that if 60 people of 300 (20%) attend training, each influences others in their family or community who may then also decide to abandon FGM. In turn, they influence others, and in turn communicate this to other intermarrying groups (Gillespie 2005). At some stage public declarations also influence the process leading to a change in convention.

This type of change occurred when two villages wished to abandon FGM, but the surrounding villages expressed strong criticism, as it affected intermarriage. A Muslim Imam and Tostan facilitator visited 10 neighbouring villages. Thirteen village representatives agreed to meet and in 1998 made a pledge – The Diabougou Declaration – to not perform FGM (Melching 1995). This became nationally and internationally recognised, and since then 1700 communities have publicly abandoned FGM. Villagers even addressed the National Assembly who were passing a law against FGM, stating that education and social mobilisation were also required (Feldman-Jacobs and Ryniak 2006).

Over eight years, Tostan learned that public declaration does not immediately lead to full abandonment. However, it demonstrated that a critical mass of those abandoning was key to success. If 40% abandon FGM in the earlier stages, this constitutes enough to influence others over time which leads to a tipping point where all abandon it (Gladwell 2000). Tostan's work was evaluated, and a 2004 survey showed that the proportion of women seeking FGM for their daughters was reduced from 70% to 10% (compared with 50% in the control group) (Reney 2004). This work had an impact on FGM reduction programmes; the proportion of girls under the age of 10 who were uncut increased, and intention to cut among parents significantly decreased (Wardlaw and Landgren 2008). Other evaluations showed that 83% of the population in 24 villages had abandoned FGM, and 693 attendees were literate and would be able to gain further skills whilst educating and passing on knowledge of FGM to others in the community (Diop *et al.* 2004).

Lessons learnt include the necessity of beginning with consciousness-raising activities and allowing time for reflection before full education programmes are enacted. It is also necessary to include adolescents in the studies and to ensure that those involved in declarations that were not involved in training have the benefit of it later. Community mapping also helps identify marriage-connected villages and influential leaders (Feldman-Jacobs and Ryniak 2006). Successes show anti-FGM activities cannot be separated from community-based education. Involvement of leaders is crucial, and whole villages signing up avoids stigma, with publicity helping the movement to spread (PATH 1999). Data from 2008 for all of Senegal shows support for FGM is 'lower than previously' (UNICEF 2009) when compared with FGM rates of 50% in 1999 (Momoh 2005). The Somali level of FGM has dropped from 99% to 97% (Feldman-Jacobs and Clifton 2008) when compared with rates of 98%–100% from 1982 to 1993 (Momoh 2005). These overall declines are not large and could possibly be increased significantly if the methodology used in case study 3 was adopted across all of Senegal and Somalia.

Evaluation of the case studies against the model

The model that was successful in acting as a focal point for societal change and behaviour shift enabled the new anti-foot binding to be as self-enforcing as Chánzú (Warren 2003). Although a theory was suggested in 1978 relating to the complexity of female purity, family honour, seclusion, chastity, and fidelity (Bratten 2008) which applies to both Chánzú and FGM, no model has adequately looked at the eradication of Chánzú (Mackie 1996) and added this to lessons of the last five years in anti-FGM thinking. Other behavioural change models focus on advocacy (Gopinath 2003), group behaviour change

(Hornick 2008), or developing effective behaviour change (Fishbein 2003) but have not been tested in the nuanced complexity of ending widespread social conventions.

The anti-foot binding success discussed earlier (Vento 1998) can be attributable to three components (A, B, C) comprising six sub-components (A1, A2, B1, B2, C1, C2). Six other aspects were cited (a, b, c, d, e, f) as good practice in the anti-FGM interventions since 2004 (WHO 2008). Each case study can now be examined here to assess if their successes were attributable to similar components as were found in the anti-foot binding movement and anti-FGM 'models'.

Case study 1 uses two educational sub-components of the anti-foot binding model, namely the 'advantages of not binding' (B1) (paralleled with drama and songs) and the 'disadvantages of binding' (B2) (paralleled with anti-FGM videos). Only one aspect of anti-FGM good practice is present, namely 'supporting the environment of change' (f) through training. This case study scores 25% (3/12).

Case study 2 uses one sub-component of the anti-foot binding model, namely 'rest of the world does not' (C1) (paralleled with government officials being sensitised). It also uses two aspects of the anti-FGM good practice, namely 'public affirmation of abandonment' (d) and 'supporting the environment of change' (f) through NGO involvement. This case study scores 25% (3/12).

Case study 3 uses all six sub-components of the anti-foot binding model: 'a public pledge' (A1), 'creating an intermarrying village critical mass to pledge marriages' (A2), against FGM/STIs etc. (B1), 'education via 200 sessions on health' (B2), 'by consciousness raising' (C1), and 'reflecting issues but in sensitive language to avoid shame' (C2) (adapted for a Muslim not Asian culture). This case also achieves all anti-FGM good practice aspects, namely 'care over language' (a), 'problem-solving training' (b), 'community ownership' (c), 'affirming abandonment' (d), 'organised diffusion' (e), and 'on-going timely training' (f). This case study scores 100% (12/12). Although this organisation does well in reducing FGM it can still benefit from focusing on the 'benefits to health' rather than the 'FGM is wrong' approach (Cassman 2007) whilst continually adding new learning initiatives such as training adolescents and those slower to abandon FGM (Feldman-Jacobs and Ryniak 2006).

Conclusion and recommendations

Over 2 million girls are at risk of FGM annually, meaning over 6000 girls have their bodies irreversibly changed and their basic human rights violated every day. Social convention theory provides a useful insight into how FGM and other harmful practices such as foot binding have been sustained over generations. Interdependent decision-making influences both individual choices and collective behaviour in such complex and profound ways that even families understanding the health risks still choose to have their daughters undergo FGM.

The last few years have recognised a human rights-based approach to development, creating protective environments in which the health, educational, and social welfare needs of individuals and communities can be addressed. Organisations such as Tostan implementing such strategies can help communities move towards large-scale collective abandonment of FGM.

In the Kenya–Somali IDP Program, where the author worked in the summer of 2008, there were anti-FGM initiatives which had been in place for eight years, yet little had changed in FGM rates. The lessons from this study should be brought forward into IDP programmes. Appendix 2 contains a spreadsheet, created by the author, showing how

the population in the Kenya–Somali IDP Camp could be trained in 36 weeks/8 months. This could be repeated until sufficient modules could be covered. This approach is likely to reach a tipping point once 40% of the relevant population have committed to stand against FGM. This would transform the health of girls in the IDP camps. In China, society abandoned Chánzú due to the opportunity presented by desiring success after the defeat in the Opium War of 1842. Social change occurred faster than would have happened naturally were it not for the influx of missionaries and other foreigners acting as catalysts for change. In parallel, in the Kenya–Somali IDP Camp, the civil war has meant other peoples from Uganda, Sudan, and Ethiopia have shown Somalis that not all people perform FGM and men can marry un-cut wives. Thus progress can be accelerated in the presence of other outside factors. Further research would be beneficial in the Kenya–Somali IDP Camps to assess whether this current influx of people could act as a catalyst for increasing the rate of reduction of FGM.

There are considerable parallels between Chánzú and FGM as shown in this study, with eight key identical elements (they are performed on girls, they give rise to pain and ill-health, this pain has significant duration, there is a possibility of fatality, sexuality of the female is controlled, they were/are used to achieve an aesthetic appeal, they were/are accepted with little dissent, and they are done without the recipient's consent). Lessons have been drawn from how the elimination of a thousand years of Chánzú was achieved. Chánzú was extensive in 1889, yet by 1907 it had all but disappeared. The small group of people who led this dramatic change possessed the insight to understand the mechanics of perpetuating knowledge in a way that enabled its end. The experiential impact of such efforts cannot be underestimated. The opportunity now exists for national and international communities to eradicate FGM for the tens of millions of girls and women in around 40 countries using the key findings of field studies, such as this research.

Note

1. A glossary of all terms used, and their abbreviations, appears at the end of this article.

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Appendix 1. Glossary

BCE	Before Christian Era
CE	Christian Era
Chánzú	Bound feet (pinyin Chinese)/Chinese foot binding
DHS	Demographic and Health Survey
Élite	(Relating to China 1880–1910): A small dominant group with privileged status and wealth. These were often perceived as being envied by others of the 'lower' order. They wielded political power, held leadership positions, were educated and influential
Excision – partial	Partial or total removal of the clitoris, sometimes referred to as clitoridectomy
Excision – total	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
FGM	Female genital mutilation
Foot binding	Chinese foot binding/binding
IDP	Internally displaced people (camp)
IEC	Information, education, and communication
IGA	Income generation activity
Imam	Islamic religious leader
Infibulation	Narrowing of the vaginal opening through the creation of a covering seal; the seal is formed by cutting and repositioning the inner or outer labia with or without removal of the clitoris
KAP	Knowledge, attitude and practice
KDHS	Kenya Demographic and Health Survey
LMS	London Missionary Society
NGO	Non-governmental organisation
NHRC	Navrongo Regional Health Centre, Ghana
Shari'ia	Islamic law
STIs	Sexually transmitted infections
TBA	Traditional birth attendant
Tostan	Breakthrough (Wolof language)
WHO	World Health Organization

Appendix 2

CARE Dadaab, Kenya: IDP Camp for Somali Refugees – Time to educate population

Units of time: 1 = 1 week, 2 = 2 weeks, 3 = 3 weeks, 4 = 4 weeks, 5 = 5 weeks, 6 = 6 weeks, 7 = 7 weeks, 8 = 8 weeks, 9 = 9 weeks, 10 = 10 weeks, 11 = 11 weeks, 12 = 12 weeks, 13 = 13 weeks, 14 = 14 weeks, 15 = 15 weeks, 16 = 16 weeks, 17 = 17 weeks, 18 = 18 weeks, 19 = 19 weeks, 20 = 20 weeks, 21 = 21 weeks, 22 = 22 weeks, 23 = 23 weeks, 24 = 24 weeks, 25 = 25 weeks

Training rate per person per week: 2
 Time taken to train 10: 5
 Failure rate (dropped-out, death, move): 20%
 Population growth rate per week (GR): 5%

Growth rate is assumed to be equal across each camp so the split the weekly growth rate by their relative size to the total e.g. if total pop was 100 and camp A had 50, then Camp A would take half the new people

Week 6, the original 60 trainers now take mentor role and those trained in the last 5 weeks now take the mantle

Camp	Population	GR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Camp1	75,000	0%	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000
Camp2	95,000	5%	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000
Camp3	95,000	5%	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000	95,000
Total trained in all camps	295,000	500	468	795	1,044	1,312	1,620	2,028	2,564	3,256	4,036	4,956	6,040	7,320	8,840	10,640	12,680	15,000	17,640	20,640	24,040	27,880	32,120	36,800	41,880	47,320	53,160
Total population	295,000	500	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000
Camp1	Population	GR	26	27	28	29	30	31	32	33	34	35	36														
Camp2	Population	GR	78,024	79,971	79,971	79,255	77,932	76,959	76,706	76,953	80,000	80,117	80,294														
Camp3	Population	GR	83,332	84,609	83,627	83,332	83,000	82,927	83,332	84,590	86,627	89,273	92,000														
Total trained	Population	GR	28,035	42,290	47,885	52,781	57,595	63,560	70,425	78,728	89,193	97,018	103,581														
Total trained in all camps	Population	GR	93,843	140,193	160,296	180,402	200,511	220,616	240,721	260,826	280,931	301,036	321,141														
Total population	Population	GR	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000	295,000