

COUNTRY PROFILE:
FGM IN MALI
September 2014

28 TOOMANY
FGM...
let's end it.



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Foreword

In September 1995 the 4th UN Conference on Women held in Beijing noted a ‘[l]ack of or inadequate documentation and research on domestic violence, sexual harassment and violence against women and girls . . .’¹ Since I began humanitarian aid work in 2001 and anti-female genital mutilation (FGM) work in 2005, that has been my experience and was my reason for founding 28 Too Many. The charity addresses the Beijing Platform for Action’s goals of ‘promoting research, collecting data, compiling statistics and promoting research into the causes, nature, seriousness and consequences of VAWG [“violence against women and girls”]’, particularly redressing the lack of research relating to FGM. As we join with the Inter-African Committee and others at the UN in Geneva in November, we see progress in the field of knowledge sharing, yet more research is needed, as is more sustainable funding.

It is against this backdrop that we know in excess of 125 million women and girls alive today have experienced FGM. Three million are predicted to be affected in this next year – one girl cut every ten seconds. While 28 Too Many’s initial focus is the 28 countries in Africa where certain communities still practise FGM, increasingly knowledge is coming from Middle Eastern and Asian countries that FGM is prevalent and growing. International migration also means FGM affects diaspora communities across all continents, as the practice is maintained on re-settlement.

This Country Profile shows that FGM in Mali has not decreased in prevalence in the last 20 years. The estimated prevalence of FGM in women and girls (aged 15–49) in 2012–2013 was 91.4%. This is sometimes reported as an increase from 85.2% in 2006, but the 2013 survey does not include three northern regions and, when the data is adjusted for a direct comparison, the prevalence is not significantly different at 92% in 2006 and 91.4% in 2013. The prevalence of FGM according to women’s faith shows that for Muslims it is 92.8% and for Christians it is 65.2%. More than 65% of adult Malians consider FGM to be a religious requirement, although it is not a requirement of either faith.²

73% of women in Mali had FGM before the age of five, and there is some evidence that the age of cutting is lowering. There are also indications that some women who have not themselves undergone FGM have had their daughters cut, and 38.1% of those girls are ‘sewn closed’ (Type III). There is no Malian law specifically criminalising FGM, and a major challenge is that more than half of men and women see no benefit in *not* cutting girls, feeling that it is a cultural practice and traditionally justified.³

In a small number of cases, women who themselves had not undergone FGM chose to have their daughter(s) cut. In these cases, the daughters predominantly experienced a ‘cut [with] flesh removed’, but 38.1% were ‘sewn closed’. However, these figures are based on small numbers of girls and should be interpreted with caution.⁴

FGM has serious immediate and long-term physical consequences: 52% of Malian women who suffered a complication from FGM suffering a haemorrhage; 34% of Mali’s maternal deaths are due to haemorrhage.⁵ Greater risks of neonatal death, maternal death and fistula often follow FGM, which can also be linked with child marriage – in Mali, child marriage can happen from the age of ten.

FGM in Mali is performed for complex reasons, entrenched with historical diversity, including caste, ethnicity and age. I have visited 12 countries where FGM is practised in Africa, in addition to diaspora communities across the world, and I have heard the stories of over two thousand survivors, not one

of whom was pleased she was cut. This is what gave me the passion to become involved in the campaign to help end FGM.

There is, however, some hope, as shared by our in-country researcher, and we are encouraged by the meetings she has had with a number of organisations in Mali that are seeing progress in tackling FGM locally. Successful interventions reflect the specific context of each community, and a good example is using *Griots* (traditional storytellers) to take anti-FGM messages to communities where literacy rates are low. The case study below also shows the good work of non-governmental organisation Sini Sanuman, as a result of which nine villages signed a community declaration against FGM in 2005.

As the impact of the unrest during 2011 to 2013 settles, I look forward to seeing further progress and talking with activists in my forthcoming visit.

Dr Ann-Marie Wilson
28 Too Many Executive Director

Case Study of Community FGM Abandonment



The non-governmental organisation Sini Sanuman has worked with nine villages in Mali to facilitate complete abandonment of FGM. The declaration made by the first village (Moussala) was signed on 12 March 2005 by the people whose authority is recognised in the community. The declaration reads:

We, the women and men of Moussala, in Kalabancoro, circle of Kati, Mali, have taken the decision to never again excise girls in our village. We have seen that there are many drawbacks and no advantages to this practice. Our girls don't deserve this traumatizing and degrading experience and they have the right to their whole bodies. This decision has been taken for the health and well-being of our girls, the women of tomorrow. We encourage every Malian to take this same decision, individually and collectively, so that excision will disappear from Mali.

The declaration was signed by:

- (1) President of the Women of Moussala Djénéba Traoré

'We will mobilize all our women for our well-being.'

- (2) Wife of the Imam of Moussala, Madina Doumbia

'I will call on the Imam to preach and convince the men.'

- (3) Village Chief of Moussala Fasoko Samaké

'I will make sure that the end of excision in my village is total.'

- (4) President of the Committee of Moussala Bréhima Traoré

'I will spread the message to the whole village and surrounding area to safeguard our women.'

-
- 1 United Nations (1995) *Report of the Fourth World Conference on Women Beijing, 4–15 September 1995*, p.50 (D.120). Available at <https://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf>.
 - 2 DHS 2012–2013, pp.296 and 303; DHS 2006, p.287.
 - 3 - DHS 2012–2013, p.296.
- DHS 2006, pp.299–300.
 - 4 DHS 2012–2013, p.301.
 - 5 Heidi Jones, Nafissatou Diop, Ian Askew and Inoussa Kaboré (1999) 'Female Genital Cutting Practices in Burkina Faso and Mali and Their Negative Health Outcomes', p.224, *Studies in Family Planning*, 30(3), pp.219–230.

Information on Country Profiles

Background

28 Too Many is an international research organisation created to end female genital mutilation (FGM) in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework of knowledge and tools that enable in-country anti-FGM campaigners and organisations to be successful and make sustainable changes to end FGM. We hope to build an information base including detailed country profiles for each country practising FGM in Africa and the diaspora. Our objective is to encourage all those working in the anti-FGM sector to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes.

Purpose

The prime purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Mali, many programmes are making positive, active change.

Use of This Country Profile

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

When referencing this report, please use: 28 Too Many (2014) *Country Profile: FGM in Mali* (2nd ed., 2020). Available at <http://www.28toomany.org/Mali/>.

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28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, as it would not have been possible without their collaboration.

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

For more information, please contact us on info@28toomany.org.

The 2014 Team

Producing a Country Profile such as this is a collaborative process. We are very grateful to the following key contributors:

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Ann-Marie Wilson founded 28 Too Many and is the Executive Director. Since 2011 she has published three papers and three posters on FGM and has worked in numerous countries in Africa.

Mark Smith created the custom maps used in this Country Profile.

Rooted Support Ltd donated time through its Director Nich Bull in the design and layout of the original version of this Country Profile, www.rootedsupport.co.uk.

We are grateful to the rest of the **28 Too Many Team** who have helped in many ways.

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Cover: © Ferdinand Reus (2007) *Bozo Girl in Bamako*.

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

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBO	community-based organisation
CEDAW	Convention on the Elimination of Discrimination against Women
CHVs	community health volunteers
CHWs	community health workers
CRC	Convention on the Rights of the Child
CSCOMs	community health centres
DHS	Demographic and Health Survey
FC	female circumcision
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
IAMANEH	International Association for Maternal and Neonatal Health
ICCPR	International Covenant on Civil and Political Rights
INGO	international non-governmental organisation
LGBT	Lesbian, gay, bisexual, transgender
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PNLE	Programme National de Lutte Contre la Pratique de l'Excision
SIGI	Social Institutions and Gender Index
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting
US	United States
USAID	US Agency for International Development
WHO	World Health Organization

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 2012–2013' refers to:

Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT et ICF International (2014) *Enquête Démographique et de Santé au Mali 2012–2013*. Rockville, Maryland, USA: CPS, INSTAT, INFO-STAT et ICF International. <https://dhsprogram.com/pubs/pdf/FR286/FR286.pdf>.

'MICS 2010' refers to:

Cellule de Planification et de Statistique du secteur santé, développement social et la promotion de la famille (CPS/SSDSPF), Institut National de la Statistique (INSTAT) (2011) *Enquête par Grappes à Indicateurs Multiples 2009–2010, Rapport final*. Bamako Mali. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS4/West%20and%20Central%20Africa/Mali/2009-2010/Final/Mali%202009-10%20MICS_English.pdf.

'DHS 2006' refers to:

Cellule de Planification et de Statistique du Ministère de la Santé (CPS/MS), Direction Nationale de la Statistique et de l'Informatique du Ministère de l'Économie, de l'Industrie et du Commerce (DNSI/MEIC) et Macro International Inc. (2007) *Enquête Démographique et de Santé du Mali*. Calverton, Maryland, USA: CPS/DNSI et Macro International Inc. Available at <https://dhsprogram.com/pubs/pdf/FR199/FR199.pdf>.

A Note on Data

Statistics on the prevalence of FGM are compiled regularly through large-scale household surveys in developing countries, predominantly the Demographic and Health Survey (*DHS*) and the Multiple Indicator Cluster Survey (*MICS*). For Mali, the main surveys are the 2006 DHS, the 2012–2013 DHS (which does not include data for the northern regions) and the 2010 MICS.

At the time of original publication of this report, very limited data had been released from the 2010 survey and it has, therefore, not been widely used in this report. There is limited data on the reasons for FGM in the 2013 survey, so in many cases the 2006 survey was the most recently available source of information. The reports are referred to as the DHS 2006, the DHS 2012–2013 and the MICS 2010 throughout this country profile.

It should be noted that, due to armed conflict, the three northern-most regions of Mali (Tombouctou, Gao and Kidal) were not surveyed in 2012–2013. These are some of the less populous areas of the country (the three regions combined represent around 10% of the total population of Mali). These are also regions with a (relatively) lower prevalence of FGM – in the DHS 2006, the prevalence of FGM in these regions did not exceed 23%. The DHS warns that the omission of the northern regions from the 2013 survey means that comparisons of the country-wide prevalence of FGM between 2013 and either 2010 or 2006 should be interpreted with caution, since in practice they measure two different things.

DHS reports do not use World Health Organization FGM typology. The categories of FGM used in the DHS surveys for Mali are 'cut, flesh removed', 'nick, no flesh removed', 'sewn closed' and 'don't know/missing'.

UNICEF highlights that self-reported data on FGM needs to be treated with caution since women may be unwilling to disclose having undergone FGM due to the sensitivity of the subject or its illegal nature in some countries. In addition, they may be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age.

Measuring the FGM status of girls, who have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. Alternatively, responses to this question can indicate the effect of laws criminalising the practice or a shift in societal attitudes towards the continuation of the practice, which may make it harder for mothers to report that FGM was carried out, as they may fear incriminating themselves. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM after the age of 14.

As for any dataset, it is also important to note that some results of these surveys may be based on relatively small numbers of women, particularly when the data is further broken down by, for example, location or age. Therefore, in some cases the trends observed should be interpreted with caution.

It should be made clear that any limitations of the data sources used in this report do not mean that the data is not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions, and 28 Too Many has accordingly taken that approach when researching and writing this country profile.

Executive Summary

This Country Profile provides comprehensive information on FGM in Mali. It details the current research on FGM and provides information on the political, anthropological and sociological contexts of FGM. It also includes an analysis of the current situation in Mali and reflects on how to improve anti-FGM programmes and accelerate the eradication of this harmful practice. Its purpose is to enable those committed to ending FGM to shape their own policies and practices to create positive, sustainable change.

According to the 2012–2013 Demographic and Health Survey (DHS), in Mali the proportion of girls and women aged 15–49 who have undergone FGM is 91.4%.¹

This figure at first appears to have increased from the 85.2% found in the 2006 DHS; however, three northern regions of Mali were not included in the 2012–2013 report.² The adjusted figure for 2006 (excluding the northern regions, to make it comparable to 2012–2013) is 92%. **Thus, the prevalence has not changed significantly during that time.**

FGM is only marginally more common among Malian women aged 15–49 who reside in rural areas (91.8%) than among those in urban areas (90.5%). Prevalence is highest in the western and southern regions of Kayes, Sikasso, Koulikoro and Bamako, and lowest in the north-eastern regions of Kidal and Gao.³

FGM in Mali is a social norm. **The perceived benefits of practising** it include social recognition, hygiene, greater pleasure for the man, better marriage opportunities, the belief that it is a religious requirement and ensuring virginity, among others. FGM is practised by religious and non-religious Malians. The country has a large Muslim majority, among whom the prevalence is 92.8%. 65.2% of Christian women have undergone FGM, 77.2% of Animists and 91.4% of Malians with no religious affiliation (though these last two groups are minorities).⁴

FGM is carried out primarily by traditional cutters. Most women with FGM in Mali were cut before the age of five (73% of women aged 15–49). 14.6% were cut between the ages of five and nine, and 6.7% between the ages of ten and fourteen, and 0.4% after the age of 15 (5.3% did not know when they were cut).⁵

The DHS surveys for Mali do not classify **FGM types** using the World Health Organization's definitions (I, II, III, IV). Instead, women aged 15–49 report whether they have been 'cut, flesh removed' (48.9%), 'nicked, no flesh removed' (14.6%), 'sewn closed' (10.6%) or 'don't know/missing' (25.9%).⁶ The 'don't know' category is possibly so high because of the early age at which girls are cut. Type III infibulation ('sewn closed') for girls aged 0–14 is most common in the Sikasso region at 26.2%, and least common in the Kayes region at 11%.⁷ There is also worrying data that, of girls who have been cut, 15.4% have mothers who have not undergone FGM themselves. 38.1% of those who were 'sewn closed' also had mothers who had not undergone FGM.⁸

The majority of Malians have knowledge of FGM: 98.3% of women aged 15–49 are aware of the practice, as are 98.8% of men aged 15–59.⁹ Regarding continuing the practice of FGM, 71.9% of women aged 15–49 were in favour, a 78.9% of men.¹⁰ When surveyed, more than half of individuals felt that there was no benefit in *not* performing FGM, indicating that this practice is a firmly embedded cultural custom that is viewed as a justified tradition.¹¹

There are numerous international and local non-governmental organisations working to eradicate FGM using a variety of strategies, including addressing the harms and health risks of FGM, educating cutters and offering alternative sources of income, educating about the rights of women and girls, and media campaigns. A comprehensive overview of these organisations is included in this report. To highlight a few success stories, the organisation **TAGNE** visits villages with an anatomical model, teaching community members about female reproductive health and the dangers of FGM. **Sini Sanuman** works with cutters to encourage them to abandon their profession, and have thus far recorded 150 women who have stopped practising. **USAID** collaborates with religious networks and individuals to disassociate FGM from Islam. Finally, in 2009, there was a **mass communication strategy** to educate the public on FGM through theatre, TV, radio, and publications. Media campaigns are proving effective in Mali, which has a low literacy rate.

There is currently no law specifically criminalising FGM in Mali. The Penal Code should be interpreted as covering FGM under its outlawing of grievous bodily harm. The National Plan for the Eradication of FGM declared that FGM should be prohibited under the Penal Code, although enforcement remains an issue. The 2011 Personal and Family Code (Portant Code Des Personnes et de la Famille, 2011) also covers harmful traditional practices. NGOs including RML/MGF and Plan – Mali are working to produce petitions for new legislation.

We propose the following measures:

- **Adopting culturally relevant programmes** – in Mali, this means tailoring projects to be mindful of social hierarchies and the authority that men and elders have in women’s and girls’ lives.
- **Sustainable funding** – this is an issue across the third sector, but for Mali maintaining funding is a particular challenge as the Government continues to deal with the conflict in the north.
- **Considering FGM within the Millennium Development Goals and post-MDG framework** – Mali has made progress towards achieving its MDGs, but will likely not reach all of its targets. Targets will need to be evaluated in the coming year as new goals are drafted.
- **Facilitating education** – literacy levels are low in Mali. By gaining an education, Malians are better able to understand health information and the consequences of FGM. Education will help to change views on continuing FGM.
- **Improving access to health facilities and management of health complications of FGM** – Mali’s healthcare system requires continued improvement, and we encourage the Government and other organisations to sustain their programming, which has shown success.
- **Increased advocacy and lobbying**, particularly for the introduction of comprehensive anti-FGM laws.
- **The criminalisation of FGM and increased law enforcement** – Mali does not yet have a law criminalising FGM, though organisations and the Government continue to push for new legislation.
- **Fostering the further development of effective media campaigns**, such as the 2009 mass-communication strategy.
- **Encouraging faith-based organisations and leaders** to act as agents of change and be proactive in ending FGM.
- **Increased collaborative projects and networking**, with support from the Programme National de Lutte Contre la Pratique de l’Excision.
- **Further research into FGM** in particular Malian contexts.

- 1 DHS 2012–2013, p.296.
- 2 DHS 2006, p.287.
- 3 DHS 2012–2013, p.295.
- 4 DHS 2006, p.297; DHS 2012–20113, p.295.
- 5 DHS 2012–2013, p.297.
- 6 DHS 2012–2013, pp.295–296.
- 7 DHS 2012–2013, p.300.
- 8 DHS 2012–2013, pp.299–301.
- 9 DHS 2012–2013, p.293.
- 10 DHS 2012–2013, p.303.
- 11 DHS 2006, pp.299–300.

Introduction

'It is now widely acknowledged that [FGM] functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.'

~ The General Assembly of the United Nations¹

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (FGM) is defined by the World Health Organization (WHO)² as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence (GBV) and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.³

History of FGM

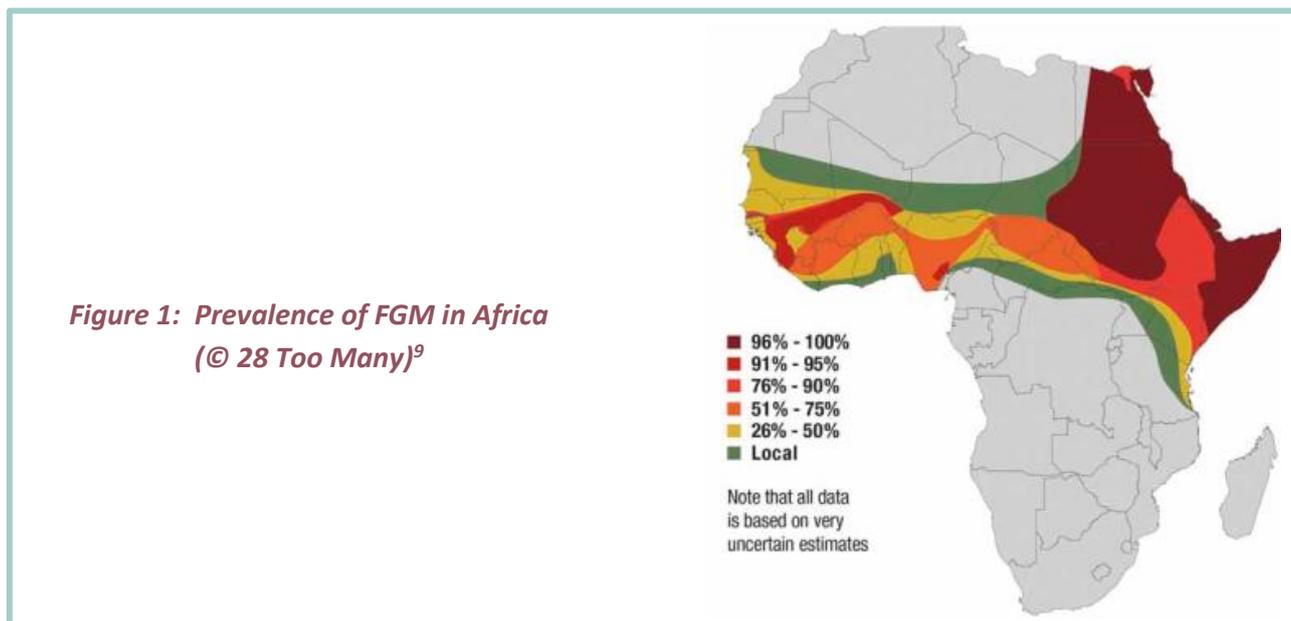
FGM has been practised for over 2,000 years.⁴ Although it has obscure origins, there has been anthropological and historical research conducted into how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM predates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, when infibulations were referred to as 'Pharaonic circumcision'.⁵ Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young women, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'⁶. There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves.

FGM is practised across a range of cultures and it is likely that the practice arose independently among different peoples⁷, aided slave raids from Sudan for Egyptian concubines and the trading of maids through the Red Sea to the Persian Gulf⁸.

Global Prevalence and Practices

FGM has been reported in 28 countries in Africa, mainly along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and to the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices,

FGM is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.



The WHO¹⁰ classifies FGM into four types:

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

Table 1: Types of FGM as classified by the WHO

This report follows the categories of FGM used in the DHS survey, which are 'cut, flesh removed', 'nick, no flesh removed', 'sewn closed' and 'don't know/missing'.

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious texts require the practice, practitioners

often believe it has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic.¹¹ Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, psychological problems, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.¹²

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation, and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we connect with many anti-FGM campaigners, community-based organisations, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally and internationally.

1 UN General Assembly (2009) *The girl child: report of the Secretary-General*, p.17. Available at <http://www.refworld.org/docid/4ac9ac552.html>.

2 World Health Organization (2015) *Female Genital Mutilation*. Available at http://www.who.int/topics/female_genital_mutilation/en/.

3 UNICEF (2016) *Female Genital Mutilation/Cutting: A Global Concern*, p.2. Available at http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf (accessed June 2016).

4 Alison T. Slack (1988) 'Female Circumcision: A Critical Approach', *Human Rights Quarterly*, Vol. 10, pp.439.

5 *Ibid.*, p.444.

6 Lightfoot-Klein cited in Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22:1, p.4. Available at <http://dx.doi.org/10.1080/09589236.2012.681182>.

7 *Ibid.*

8 Mackie cited in Ann-Marie Wilson, *op. cit.*

9 *Afrol News* [no longer available online].

10 World Health Organization (2016) *WHO guidelines on the management of health complications from female genital mutilation*, pp.2-4. Available at <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (accessed 18 June 2017).

11 *Ibid.*, p.1.

12 World Health Organization (2016), *op. cit.*, p.vii.

General National Statistics

This section highlights a number of indicators of Mali's context and development status.

Population

15,704,199 (9 September 2014)¹

Growth rate: 3% (2014 est.)

Median age: 16 years

Human Development Index

Rank: 176 out of 187 in 2014²

Health

Life expectancy at birth (years): 54.6³

Infant mortality rate (per 1,000 live births): 80 deaths⁴

Child mortality rate (per 1,000 live births): 128 deaths⁵

Maternal mortality rate: 540 deaths/100,000 live births⁶

Fertility rate, total (births per woman): 6.16 (2014 est.)

HIV/AIDS

- adult prevalence: 0.9% (2012 est.)
- people living with HIV/AIDS: 100,300 (2012 est.)
(country comparison to the world: 44)
- deaths: 4,900 (2012 est.)

GDP (in US dollars)

GDP (official exchange rate): \$11.37 billion (2013 est.)

GDP per capita (PPP): \$1,100 (2013 est.)

GDP (real growth rate): 4.8% (2013 est.)

Literacy (percentage who can read and write)

Adult (age 15 and over): 33.4% (female – 24.6%; male – 43.1%)

Youth (ages 15–24): female – 38%; male – 56%⁷

Urbanisation

Urban population: 34.9% (2011)

Rate of urbanisation: 4.77% annually (2010–2015 est.)

Bamako is the 7th-largest urban centre in Africa, and the 6th-fastest growing city in the world. The official population was 1.8 million according to the 2009 census. The World Bank estimated that 33% of Mali's total urban population lived in Bamako in 2010.

Religions

Muslim – 94.8%, Christian – 2.4%, Animist – 2%, no affiliation – 0.5%, unspecified 0.3%⁸

Ethnic Groups

Mandé – 50% (Bambara, Malinké, Soninké), Peul – 17%, Voltaic – 12%, Songhai – 6%, Tamachek and Moor – 10%, other – 5%

Languages

French (official), Bambara – 46.3%, Peulh/foul-foulbe – 9.4%, Dogon – 7.2%, Maraka/Soninké – 6.4%, Malinké – 5.6%, Sonraï/djerma – 5.6%, Minianka – 4.3%, Tamachek – 3.5%, Sénoufo – 2.6%, unspecified – 0.6%, other – 8.5%

Unless otherwise stated, all statistics are taken from Central Intelligence Agency (2014) *The World Factbook: Mali*, 9 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ml.html>.

1 Country Meters (2014) *Mali*, 9 September. Available at <https://countrymeters.info/en/Mali>.

2 UNDP (2014) *Human Development Index*. Available at <http://hdr.undp.org/en/content/human-development-index-hdi>.

3 UNICEF (2012) *Mali: Statistiques*. Available at https://www.unicef.org/french/infobycountry/mali_statistics.html.

4 *Ibid.*

5 *Ibid.*

6 *Ibid.*

7 UNESCO IBE (2012) *World Data on Education 2010/11* [accessed September 2014].

8 2009 census.

Millennium Development Goals

The eradication of FGM is pertinent to six of the UN's eight Millennium Development Goals (MDGs). Throughout this report, the relevant MDGs are discussed within the scope of FGM.

Post-MDG Framework

As the MDGs are approaching their 2015 deadline, the UN is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace. Currently, the UN is working with its partners on an ambitious post-2015 development agenda and striving for open and inclusive collaboration on this project.¹

The UN is also conducting the MY World survey, in which citizens across the globe can vote offline and online (including using mobile technologies) on which six development issues most impact their lives.² These results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).³ Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's 16 areas of focus for development.

On the issue of gender violence, there has been a growing call for the post-MDG agenda to include a distinct focus on ending violence against women.⁴

Though FGM will not be eliminated in Mali by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM. The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the Decade For African Women will certainly assist in promoting gender equality and the eradication of gender violence in Mali.



1 United Nations (2014) [website]. Available at www.un.org.
 2 United Nations (undated) *My World: The United Nations Global Survey for a Better World*. Available at <http://www.myworld2015.org/>.
 3 The World We Want (undated) [website]. Available at <http://www.worldwewant2015.org/>.
 4 Caroline Harper (2013) 'Gender, Violence and the Post-2015 Framework,' *Overseas Development Institute*, 24 January. Available at <https://www.odl.org/comment/7220-gender-violence-and-post-2015-framework>.

Political Background

Historical

The first Mali Empire was formed by the Soninké people in the 8th century.

In the 11th century, Almoravids arrived from the north, defeated the Empire and converted the Soninké to Islam. The Keita people, resisting Islam, split off and became the Dogon people. Soninké who emigrated settled along the Niger River, becoming the Bozo people of the Mali Empire.

In 1325 the Mali Empire conquered Timbuktu and Djenne, establishing a trans-Saharan trade monopoly.

In the 14th century, the Songhai broke away from the Empire's control, conquering it in 1375 and establishing the Songhai Empire. This Empire thrived until it was defeated by the Moroccans in 1591, and they controlled the region until 1737.

In 1880, during the so-called European 'scramble for Africa', the French claimed territory initially called 'Upper Senegal'. This Malian territory became part of the Sudanese Republic. There were numerous rebellions against French rule. In 1915 and 1916, French forces destroyed Bobo villages following revolts. Between 1922 and 1946, Islamic leaders spurred several unsuccessful revolts. After World War II, the French permitted the formation of political parties, and in 1956 the territory gained the right to self-representation. In 1958, the Sudanese Republic was granted complete internal autonomy.

In 1959 the territory joined Senegal to form the Mali Federation, which gained independence on 20 June 1960. Senegal, however, seceded two months later, and, in September 1960, the Sudanese Republic withdrew from the French Community and Franc Zone, declaring itself the Republic of Mali.

After independence, President Modibo Keita declared a one-party state. In 1967 the country rejoined the Franc Zone, owing to its struggling economy. A bloodless military coup occurred in 1968, commemorated as Liberation Day.

Subsequently, a military-led regime under President Moussa Traoré attempted to reform the economy, but was hindered by a severe drought between 1968 and 1974. In 1974 Traoré introduced a new constitution in response to citizens' demands for a multi-party democracy. In the 1979 elections Traoré rewarded himself with 99% of the vote, resulting in demonstrations.

Partly driven by rising ethnic violence in the north, in 1990 Tuareg separatists (who call themselves *Tamachek* in Mali) attacked government facilities in Gao. Reprisal attacks by the Malian military prompted rebellion. The March Revolution against Traoré in 1991 was comprised of student protests and riots and resulted in over 300 fatalities. President Traoré ordered the massacre of dozens of peaceful protesters; he and his associates were later convicted and received the death sentence for their actions. March 26th remains a national holiday in commemoration of the tragedy.

A new constitution permitting full democracy was approved by 1992, and Malians elected President Alpha Oumar Konaré. Enhanced regional self-governance was given to the Tamachek and in 1994 Libya backed a faction of Tamachek rebels who again attacked Gao. A peace agreement was reached in 1995, and disarmament began in 1996.¹

Current Political Conditions

In 2002 Amadou Toumani Touré was elected President of Mali; he was re-elected in 2007.

Ethnic tensions remain problematic in the north. In October 2011, the National Movement for the Liberation of Azawad (MNLA), a coalition of Tamachek groups, was formed. On 21 March 2012, soldiers of the Malian army mutinied at Gao and Bamako, angered by a lack of resources and poor leadership in dealing with the Tamachek rebellion. The March 22nd coup removed president Touré from power.

The country was then in a state of emergency from 12 January to 6 July.² Mediation efforts were led by the Economic Community of West African States, which returned power to a civilian administration in April 2012 with the appointment of interim President Dioncounda Traore.

After the coup, Islamic extremist organisations took over control from the expelled Malian military. Hundreds of thousands of northern Malians fled the violence, which intensified food insecurity. In late 2012, a French and Malian military intervention force was formed in an attempt to retake the north, which was achieved by January 2013. In the process of regaining control in the north, military members committed many human-rights abuses, including executions, torture, abuse of Tamachek and ethnic Arab rebels, and forced disappearances of civilians with connections to rebels.³

Ibrahim Boubacar Keita was elected president in the July 2013 elections.

In July 2014 peace talks were held between the Malian Government and rebels in Algeria. These were preceded by an exchange of prisoners. The Malian Government is currently refusing to discuss demands for full autonomy.⁴ French forces remain in Mali in an effort to combat jihadist extremist groups. The UN also retains its peacekeeping force in the country.⁵

Unless otherwise stated, all statistics are taken from Central Intelligence Agency (2014) *The World Factbook: Mali*, 9 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ml.html>.

1 *Minority Rights* (2013) [website]. Available at <https://minorityrights.org/>.

2 US Department of State (2014) *2013 Country Reports on Human Rights Practices – Mali*. Available at <https://www.refworld.org/docid/53284aa814.html>.

3 *Ibid.*

4 Reuters (2014) *Mali peace talks start in Algiers after prisoner swap*, 16 July. Available at <https://www.reuters.com/news/picture/mali-peace-talks-start-in-algiers-after-idUSKBN0FL1MD20140716>.

5 Reuters (2014) 'France to Shift Mali Troops to Battle Regional Terrorism', *The New York Times*, 13 July. Available at <https://www.nytimes.com/2014/07/14/world/africa/france-to-shift-mali-troops-to-battle-regional-terrorism-north-africa.html>.

Anthropological Background

The DHS collects FGM data on the ten most populous **ethnic groups**. There are many other ethnic groups in Mali, but not all will be covered in this Country Profile. The Government recognises 13 official languages, but 80% of the population speak Bambara as a first or second language and only 9% speak French as a first language.

The Mande people are the predominant ethnic group in Mali, comprising 42.8% of the population. Within the Mande ethnic group, there are two main sub-groups¹: Bambara (34.1%) and Malinké (also known as Mandingo or Mandinka) (8.7%) Other important groups include the Peuhl (also known as the Fulbe, Fula or Fulani) (14.7%), Soninké (also known as Marka) (10.8%), Songhai (also known as Sonrai or Songhay) (1.6%), Dogon (8.9%), Sénoufo (also known as Minianka or Supyire) (10.5%), and Bobo (2.9%), with smaller groups making up the rest of Mali's diversity². The Senoufo, Peuhl and Mande ethnic groups are predominantly sedentary farmers. The Soninke are largely merchants and the Songhai are mainly subsistence farmers³. Ethnic classifications, however, are not as rigid as the figures above imply and have been fluid, historically.

With minor exceptions, FGM is practised among all ethnic groups.

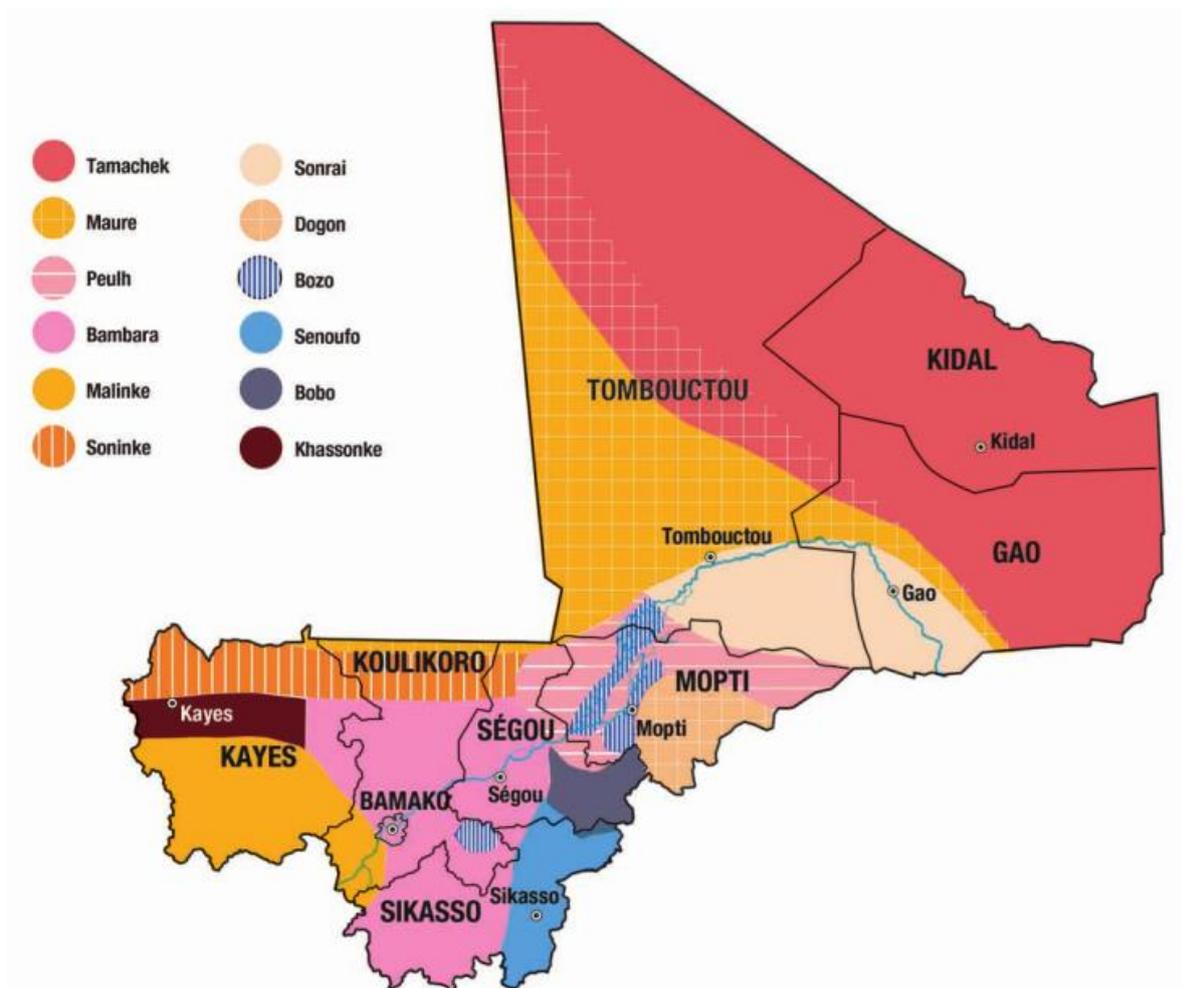


Figure 2: Geographical distribution of ethnic groups within Mali and the district boundaries in which they live

Marriage between ethnicities is welcomed as long as they are between compatible castes (see below). Ethnicity is inherited from the father, and, in the event of divorce, the children usually stay with the patrilineal family.

Mali society is divided into many **spheres of power**, which are jealously guarded. Divisions by gender define the work that people do and often lead to women and men living separate domestic lives. Patriarchy gives ultimate authority to older men, but also to men in general, and age structure gives older women authority over younger women's behaviour and sexuality.

Given the limited power bestowed on women, it is understandable that older women sometimes resent men's involvement in the anti-FGM campaigns, as it intrudes on their authority.

It follows that interventions directed solely at young mothers will not be effective, given their relative low status and authority within a society wherein to question one's elders is unthinkable.

It is important to understand this power structure in Malian society in order to comprehend the reasons that keep FGM in place even after many years of government and NGO campaigns for its abandonment.

The Mandé people groups, who make up 50% of the population, share many of the social structures that are significant in keeping FGM in place. Their structures of social division of caste and class as well as many social norms are also shared with the Fulani people. **The Mandé and the Fulani** (together about 67% of the population) are both patriarchal and gerontocratic, meaning authority is in the hands of men and society is structured around age. Respect and obedience are due to any elder person, whether a younger sibling to an older one, or a wife to her mother-in-law. This respect for age is historical and not limited to the living. **Ancestors** are revered and placated through offerings. In the case of FGM, it is seen as a tradition passed down from the ancestors and cannot therefore be questioned without questioning the authority or wisdom of age.

Polygamy is common among many Malian ethnic groups. 34.8% of married women aged 15–49 are in polygamous marriages, including 20.1% of married girls aged 15–19. The percentages vary in rural (38.2%) and urban (21.6%) locations, but also with the education of the woman: 37.6% of women with no education compared to 15.3% with secondary education.⁴



Songhay Women
(© KweeKudee: Trip Down Memory Lane)

Upon marrying, women go to live with the husband's family, leaving young women isolated and vulnerable, and viewed with suspicion as their allegiance is seen to be to their brother's lineage, not to their husband's.

By law men are the head of the household and wives must obey them. This authority is maintained through male ownership of resources and the threat or use of physical violence.⁵

All villages have a male chief, who is assisted by an all-male village council. This council in turn is advised by the all-male Council of Elders.

Case Study: Authority of Older Siblings over Younger Ones

A woman in her forties working in the field of reproductive health on a project funded by the UN, for which part of her mandate was to educate the population on the harmfulness of excision, was told that her *koromuso* (elder sister) had given birth to a baby girl – her twelfth pregnancy. The woman unsuccessfully tried to talk her sister out of FGM. The sister arranged for the excision, but she was not able to find anybody to help hold the girl down for the excisor, so she requested the woman to do it, and she could not refuse because she was a younger sibling.⁶

The next level of structure is **age association**, both male and female. Historically able to settle women's social disputes, the women's associations are now in decline and they turn to the men for arbitration.⁷ Women's power is felt and expressed as mothers (a highly respected role in society⁸), and men's success and status are measured by the number of children they have. A man with no children faces pity and ridicule, whereas a man with multiple wives and children is powerful because he controls the lives of others.⁹

The **caste system** is another social structure shared by many of the ethnic groups in Mali. There are three main levels of caste, which vary in name between groups and languages. All caste levels consist of free people/nobles, endogamous (hereditary) professional groups (blacksmiths, griots, carpenters etc.) and the slave castes, made up of captured peoples and their descendants. The relative size and importance of this last group is variable, but is still found among the Tamachek. Recent studies have shown that, in urban areas, the exercise of a given profession is no longer limited to people with the appropriate family background, meaning the caste systems are more relaxed.¹⁰ In contrast to the nobles' code of behaviour, which demands modest and controlled manners, the professional groups and the slave castes have more freedom of expression. In particular, *griots* (traditional story tellers) may voice opinions outside of the norm and have become useful allies in some of the interventions that use traditional communication to spread the anti-FGM message.

Ethnic Tensions

Before 2006, ethnic rivalries were not a major feature of the Malian political scene and ethnic groups often worked cooperatively. Farmers do not produce sufficient surplus to become marketplace rivals, and the fact that they grow different crops means they do not compete for the same land.

The **northern regions** have suffered repeated droughts, which have made the lives of the area's traditional pastoralists harder, and many are moving south to graze their cattle. This leads to certain tensions which, when added to the perception of political and economic exclusion of the northern areas and peoples, have created resentment between ethnic groups. The Tamachek have always felt marginalised; this surfaced into violent conflict in the 1990s and intermittently to the present day.

While religious tolerance and acceptance continues to be the norm in Mali (with no legal obstacles to conversion or attending religious ceremonies), the imposition of Sharia law under some militant groups in 2012/13 and the involvement of extreme Islamist groups in violent conflict has added a new dimension of discord in the north.¹¹

Looting and incidents of rape by the MNLA and Arab militias were reported by Amnesty International in April 2012.¹² Following the takeover of large parts of the north by Islamist groups, a number of

human-rights abuses were reported as being related to the imposition of strict Sharia law. Amnesty reported that a majority of those punished with amputation by Tamacheks (who are light-skinned) were black.¹³ Ongoing violence has created further ethnic tensions and prejudice, as light-skinned Malians are now being associated with Islamist extremists.¹⁴ The US Commission on International Religious Freedoms reported that the Christian population of northern Mali fled the area after an attack on a church in Gao. The French and Malian Government made assurances that every effort would be taken to prevent and prosecute violent reprisals by the Malian Army when retaking the north in 2013.

Societal discrimination against black Tamacheks (colloquially referred to as *Bellah*) continues. Black Tamacheks are deprived of basic civil liberties by some ethnic groups and are forced into traditional servitude relationships with slavery-like practices. It was also reported that black Tamacheks in Menaka face discrimination by local officials, who limit their abilities to obtain identity documents, housing, school enrolment and various forms of legal protection and development aid. The practice of kidnapping children as *Bellah* slaves also continues.¹⁵

Ethnic Groups

Bambara (Bamana)

The Bambara are a Mandé speaking group of settled agriculturalists living mainly in the south and west of Mali. They make up the largest part of the Mandé in Mali, historically deriving from Mandinka groups who founded the Mali Empire. The Bambara formed their own empire in 1740, which was an aggressive state that armed itself with guns in exchange for slaves. The term 'Bambara' was at one time given to all slaves from the interior of Africa shipped to the Americas via Senegambian ports. Bambara is the *lingua franca* for 80% of the Malian population.

The majority of the Bambara did not become Muslim until the late 19th century and this was in resistance to French colonial power. Today, most practise Islam alongside traditional ancestor worship.

They live within a gerontocratic society, which often is, as in all Malian ethnic groups, deeply unequal in terms of gender.

95% of Bambara women aged 15–49 have had FGM.¹⁶

Bobo

There are an estimated 110,000 Bobo Fing living in Mali and Burkina Faso, the majority in the latter. They speak a Mandé language and are known in Bambara as 'Bobo Fing' to differentiate them from the Bobo Oule (Bwa).

The Bobo are traditionally farmers of millet, sorghum, yams and cotton for trade, living in villages without a central political authority. A chief is, for the Bobo, seen as an aberration. They are ruled instead by a council of male elders from all lineages. The lineage is the main social unit of the village and is headed by the eldest male. The Bobo are seen as conservative and resistant to change, and they guard their traditions.¹⁷

63.5% of Bobo women aged 15–49 (in Mali) have had FGM.¹⁸ However, it should be noted that this figure is based on a small number of women and should therefore be treated with caution.

Bozo

The Bozo are often referred to as fishers of the middle Niger River. The group numbers around 132,000 in Mali.¹⁹ They are believed to be descendants of Soninké (Saracolé). The various Bozo along the Niger speak four recognised, distinct languages; the closest related language is Soninké.

They took possession of the banks of the Niger in the 10th century, coming to dominate fishing and river transport, a role they still hold as the so-called 'masters of the river'. They founded the cities of Djenne and Mopti, and many Bozo are still master builders.

Predominately Muslims, the Bozo also have kept some animists traditions, among which is the animal totem of the bull, whose body represents the Niger and whose horns represent the Bozo fishing boats.

FGM among the Bozo used to be a rite of puberty, and girls were cut by the river in groups of 200 or more during the dry season.²⁰ There is no current data on the age of FGM for this group specifically, but, given the very low numbers of girls cut after age ten in Mali, it is possible that it is no longer a rite of passage. In 1998, a Bozo woman interviewed by Gosselin about the late age of FGM put her reply in the past tense, saying, 'All Bozo went there at that time.'²¹

Bwa (Bobo)

Theo Bwa mostly live in the San and Tominian districts (*cercles*) in the Segou region of Mali. Their estimated population is 125,000. The Bwa think of themselves as indigenous and record in their oral histories that there were no earlier inhabitants of their lands. 'Bobo-Oulé' is a Dioula term that means 'Red Bobo', to distinguish the Bwa from the Bobo, whom the Dioula called 'Black Bobo'. They are descendants of the Soninké diaspora and speak a Voltaic language they call *Bwamu*, as opposed to the Mandé language spoken by the Bobo.

Bwa farmers have retained traditional beliefs and customs, although many have become Christians.²² The Bwa are reported 'to be very open and receptive to change. They are quick to adopt new ideas or forms that they find useful, and to adapt or transform these discoveries to fit their own specific needs.'²³ Openness is an important distinction between these two Bobo groups in terms of interventions and changing social norms.

There are no figures published by the DHS of FGM prevalence among the Bwa.

Diawara

With a population of around 100,000 (as of 1996), the Diawara live mainly in the districts (*cercles*) of Nioro in the Keyes region and Nara in the Koulikoro region. They speak a Soninké language, due to their adoption of the surrounding Soninké people's culture, but they are not a subgroup of the Saracolé. They are mainly Muslims.²⁴

There are no figures published by the DHS of FGM prevalence among the Diawara.

Dogon

The Dogon live mostly in the Mopti plateau region. Some Dogon have also migrated to Bamako. Most are agriculturalists, but there is also a small caste of craftsmen.

During the 2012 rebellion in the north, the Mopti region was the frontier line between northern and southern Mali. The Dogon reported suppression of their animist religious practices by Islamist militants when they seized control of the area. Many Dogon still practise their traditional religion, although around one-third have converted to Islam.

The Dogon maintain a belief in a creator god, and some of their myths relate the story of the first female FGM as occurring when the creator tried to mate with the earth and was impeded by a large ant hill, which he cut down, forming a precedent for clitorodectomies.²⁵ The first peoples created were twins, and the Dogon still believe that children contain both male and female aspects, which are removed through FGM.²⁶



Dogon circumcision artwork. Red and white are the colours associated with FGM for the Dogon. Although the painting's subject may be publicly known, the symbolism remains a closely guarded secret, known only to the initiated (© 150-days-ghana.blogspot.com).

90% of Dogon women aged 15–49 have had FGM.²⁷

Malinké/Mandingo/Mandinka

The Malinké also speak a Mandé language and live in the south-west and west of Mali, as well as other countries in West Africa. They are descendants of the original Mali Empire.

They grow rice, sorghum and millet for consumption and peanuts and cotton as cash crops. A few richer Malinké own cattle, which are used for milk and kept as a status symbol.

Settlements are large, and a family compound will include all brothers and their wives and children. Travel is not encouraged for women, who therefore rarely leave their village. Girls are often betrothed at birth to a boy who is generally about the age of 12. Traditionally, the preferred marriage pattern was for the daughters to marry the mother's brother's son.²⁸

FGM was traditionally a rite of passage to adulthood, but in Mali it has come to be performed earlier than puberty, with the majority of girls now cut before the age of nine.²⁹

92.4% of Malinké women aged 15–49 (in Mali) have had FGM.³⁰

Maure (Moors)

The Maure are a Berber population who migrate between Northern Mali and Mauritania. They are traditionally herders of goats and sheep, as well as providers of transport by camel and donkey. Their society is divided into castes and they practise Islam.

The Maure do not practise FGM.

Peulh (Fulbe, Fula, Fulani)

Peulh is the French term for the Fula people group and is the term used in the DHS and MICS surveys. In Mali they call themselves *Fulbe*. The Peulh are the largest migratory group in West Africa and, as such, were traditionally pastoral nomads, living in settlements for only a couple of months at a time. There are also sedentary groups of Peulh in many countries in West Africa who, if they are able, keep a herd of cattle as a status symbol, which are tended by other Peulh groups. Additionally, the Peulh tend the cattle of the agricultural Bambara people, who also consider cows as a sign of wealth and status.

Peulh women wear their wealth as gold jewellery, including distinctive nose rings (see the photograph to the right). She also has indigo lip dyeing/tattooing, which is a sign of beauty among the Peulh and some Bambara women.



*Fulani woman dressed in traditional blue to mourn the death of her husband
(© moroccanmaryan.typepad.com)*

Peulh in Mali live by a strong moral code of behaviour called *Pulaku*, which allows them to retain a Peulh identity across national boundaries. This code is made up of four parts, which govern (a) patience/self-control; (b) modesty and respect for elders, often translated to mean ‘shame’; (c) personal responsibility; and (d) courage and hard work. Bearing the pain of excision stoically is required under this code. Child marriage is common in some Peulh groups, with girls married at 12 or 13 years of age.³¹

93.1% of Peulh women aged 15–49 (in Mali) have had FGM.³²

Sénoufo/Minianka/Supyire

The Sénoufo (of which the Minianka and Supyire are sub-groups) are found in south-east Mali, Burkina Faso and Côte d’Ivoire. Many Sénoufo have also migrated to urban areas in Mali. Most are sedentary farmers. There are many branches from the main Sénoufo people, all of which speak related Gur languages, including the Minianka and Supyire.

‘The people in the village have understood that there was nothing in the traditions of the Sénoufo ethnic group – from which I come – that justifies excision. It was valid at the time of grand initiation, which has now disappeared and been replaced by the school. But even in this case, it is easy to see that a girl no longer needs to be excised to take her place in the Sénoufo world.’

~ Mr. Mélégué Traoré³³

The Sénoufo resisted Islam more than other peoples, and many continue to adhere to traditional beliefs. Inheritance is matrilineal, via the mother’s brother. The domestic unit is the extended family

with a father, his wives, his sons and their wives and children. Marriage is traditionally by parental arrangement, and polygyny is common. Inheritance and succession are matrilineal.

Initiation rites for adolescents are the introduction to adult tribal responsibilities. After the Peuhl, the Sénoufo are the second-largest group in Mali that perform FGM on or after the age of ten. 11.6% of women aged 15–49 were cut on or after the age of ten, 21.8% were cut between the ages of five and nine and 59.1% were cut before the age of five.

Overall, 87% of Sénoufo women aged 15–49 (in Mali) have had FGM.³⁴

Soninké (Saracolé)/Marka

The Soninké, or Saracolé, live in north-west Mali, in the Sahelian zone along the Senegal River. They have lived in the region for thousands of years.

Traditional Soninké society is characterised by a rigid caste system similar to the Mandé and Peulh. In the past, there were more *Komo* (slaves) than *Hooro* (free men), providing a large labour force for agriculture, which gave them dominance over other ethnic groups. Many Soninké now are merchants and travel throughout West Africa and beyond.

The Soninké are one of the few ethnic groups in Mali that traditionally practised FGM on infants. 96% of Soninké women aged 15–49 have had FGM.³⁵

Sonraï/Songhai/Songhay

The Sonraï are mostly settled subsistence farmers living in south-eastern Mali in the Niger valley from Djéne to Ansongo, although some nomadic groups are dispersed across Mali, Niger, and into Algeria. They are descendants of the 15th- and 16th-century Sonraï Empire of Gao, which was destroyed by the Moroccans in 1591. The Sonraï were converted to Islam in the 13th century.

Sonraï families tend to be large. In rural areas, brothers traditionally live with their father, mother, wives and children in large communal compounds. In some cases, more than one hundred people might live in a rural compound. Men and women lead separate lives within the compound. When married, the women's primary allegiance remains with her kin, from whom she will inherit her wealth and with whom she distributes any money she may earn. Children are socialised into their gendered roles when young: boys learn to farm millet and sorghum, cultivate rice, fish and hunt, while young girls learn cooking, child care and other domestic chores. Some parents see formal schooling as a loss because educated sons and daughters often move to towns and cities. In urban areas, families are scattered and smaller in size.³⁶

Historically, boys were circumcised at a late age by travelling specialists, but now are cut as toddlers by physicians in a medical setting. Female initiation did not involve FGM, but was a ritual purification prior to marriage called *Gosi*.³⁷ However, the DHS 2012–2013 reported the FGM prevalence in Sonraï women aged 15–49 to be 59.5%.³⁸ This figure was based on only a small number of women and should be interpreted with caution.

Tamachek/Tuareg (Kel Tamasheq)

Traditionally women have held a position of strength within Tamachek society: the society is matrilineal and monogamous. In Tamachek society it is the male who wears an indigo veil to hide his face at all times, and the women do not. Women were charged with the education of the children

into the traditions, music and poetry of their groups. Being nomadic herders and traders, the men often travelled, leaving the women for long periods of time, who were trusted to maintain customs and fidelity. This social structure has in many places broken down in recent years with the conflict and warfare in their homelands in the north of Mali. Many have had to flee the conflict further into southern Mali and areas of northern Niger and Burkina Faso, where they live in marginalised positions. There is evidence that they have started to adopt the social norms of their new neighbours and polygamy and FGM are on the rise.³⁹

In the DHS 2012–2013 the FGM prevalence among Tamachek women aged 15–49 was found to be 62.7%.⁴⁰ However, this figure is based on interviews with less than 100 women, and so the result should be interpreted with caution.

Case Study: The Supyire

There are around 300,000 (as of 1991) Supyire living in southern Mali within a 40 km radius of the town of Sikasso. They speak a Sénoufo family language.

The Supyire in Jemphrey's ethnography⁴¹ live in a village called Farakala. They practise FGM on their daughters at any age up to around 12. Traditionally, it was practised on girls on their wedding day, but, like so many groups, the age is lowering and the original connection between marriage and FGM has been lost. However, the word for 'marriage' still means 'woman cutting' (*cikwoore*). On their wedding day, women are still ritually washed as they would have been after being cut.

Girls are undressed, remove all jewellery and sit straight-legged together in a round hut, draped in scarves. Once cut, the girls return to the hut and are made to sit quietly. In the past it was a dishonour to cry from the pain, but there is more leeway now that the girls are cut so much younger. Two women are required to hold a child still while she is cut. Each cut is made with a fresh razor blade to limit infection. The cut flesh is dropped into a prepared hole and covered by a stone, which remains as a marker after the hole is filled in.

Immediately after being cut, the girls are washed in a liquid prepared with ebony tree leaves, and cooled ash is pressed onto the wound to stop the bleeding. Finally, *karite* butter is pressed onto the wound on a piece of fresh, unspun cotton and held in place between the legs with strips of cotton tied on a strip round the waist. All materials are provided by the mothers. In addition, they bring soap for washing the wound for the two weeks it takes to heal. Washing is conducted by the cutter, who inspects the wound for infection. If an infection is found, the wound is opened, made to bleed and then sealed with spit and ash. The final application of butter is mixed with the cutter's saliva, and secret incantations are recited before application.

Traditionally among the Supyire, the cutters were a guild of women who knew the secret incantations and treatments. They used a small iron knife. The practitioner observed to produce the Jemphrey account was not a Supyire, as the last traditional cutter in the village had died 50 years previously.

Jemphrey's ethnography gives several reasons for the Supyire's practise of FGM. The first is the belief that it is not possible to give birth without FGM, as the opening would be blocked. A second is to control a woman's sexual pleasure so she will not be unfaithful to her husband. Another is that it is tradition and impossible to conceive of women who are not cut.⁴²

- 1 Minority Rights Group International, World Directory of Minorities and Indigenous Peoples - Mali, November 2017, available at: <https://www.refworld.org/docid/4954ce5bc.html> [accessed 21 December 2020]
- 2 DHS 2012–2013
- 3 Minority Rights Group International, World Directory of Minorities and Indigenous Peoples - Mali, November 2017, available at: <https://www.refworld.org/docid/4954ce5bc.html> [accessed 21 December 2020]
- 4 DHS 2012–2013, p.53.
- 5 Claudie Gosselin (2001) *Campaigning against excision in Mali: global and local hierarchies, hegemony and knowledge* [PhD Thesis]. Available at <https://tspace.library.utoronto.ca/handle/1807/15848>.
- 6 Case study taken from Gosselin (2001), *op. cit.*
- 7 Claudie Gosselin (2001), *op. cit.*
- 8 *Ibid.*
- 9 Katherine A. Dettwyler (1994) *Dancing Skeletons: Life and Death in West Africa*. Waveland Press.
- 10 World Culture Encyclopedia (2014) *Culture of Mali*. Available at <https://www.everyculture.com/Ja-Ma/Mali.html>.
- 11 *Minority Rights* (2013) [website]. Available at <https://minorityrights.org/>.
- 12 Amnesty International Publications (2012) *Mali: Five Months of Crisis: Armed Military Rebellion and Military Coup*. Available at <https://www.amnesty.org/download/Documents/16000/afr370012012en.pdf>.
- 13 *Ibid.*
- 14 IRIN (2013) *Mali conflict inflames ethnic tensions*, 23 October. Available at <http://www.thenewhumanitarian.org/news/2013/10/23/mali-conflict-inflames-ethnic-tensions>.
- 15 US Department of State (2014) *2013 Country Reports on Human Rights Practices – Mali*. Available at <https://www.refworld.org/docid/53284aa814.html>.
- 16 DHS 2012–2013, p.295.
- 17 Christopher D. Roy (undated) 'Do in Leaves and Wood Among the Bobo and the Bwa', *Art and Life in Africa*. Available at <https://africa.uima.uiowa.edu/topic-essays/show/39>.
- 18 DHS 2012–2013, p.295.
- 19 2000 census.
- 20 Claudie Gosselin (2000) 'Feminism, Anthropology and the Politics of Excision in Mali: Global and Local Debates in a Postcolonial World', *Anthropologica* 42(1), pp.43–60. Available at [https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds\[\]=citjournalarticle_283004_38](https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds[]=citjournalarticle_283004_38).
- 21 *Ibid.*
- 22 Minority Rights Group International (2014) *World Directory of Minorities and Indigenous People*. Available at <https://minorityrights.org/directory/>.
- 23 Christopher D. Roy, *op. cit.*
- 24 James Stuart Olson and Charles Meur (1996) *The Peoples of Africa: An Ethnohistorical Dictionary*. Greenwood Publishing.
- 25 Claudie Gosselin (2001), *op. cit.*
- 26 David W. Machacek and Melissa M. Wilcox (ed.) (2003) *Sexuality and the World's Religions*. ABC-CLIO.
- 27 DHS 2012–2013, p.295.
- 28 World Culture Encyclopedia (2014) *Malinke*. Available at <https://www.everyculture.com/wc/Japan-to-Mali/Songhay.html>' .
- 29 DHS 2012–2013, p.298.
- 30 DHS 2012–2013, p.295.
- 31 Jennifer C. Seely in Susanna D. Wing (2012) 'Constructing Democracy in Transitioning Societies of Africa: Constitutionalism and Deliberation in Mali', 2008, *African Studies Review* 55(1), pp.223–224. New York: Palgrave Macmillan.
- 32 DHS 2012–2013, p.295.
- 33 Inter-Parliamentary Union (2001) *Dossier: Female genital mutilation: an attack on dignity*. Available at <http://archive.ipu.org/press-e/news/3-3.htm>.
- 34 DHS 2012–2013, p.295.
- 35 DHS 2012–2013, p.295.
- 36 World Culture Encyclopedia (2014) *Songhay*. Available at <https://www.everyculture.com/wc/Japan-to-Mali/Malinke.html>.
- 37 *Worldmark Encyclopedia of Cultures and Daily Life* (2009) Vol. 1. Pennsylvania: Pennsylvania State University.
- 38 DHS 2012–2013, p.295.
- 39 Aboucacrine (2014) *Indigenous Affairs*.
- 40 DHS 2012–2013, p.295.
- 41 Miranda Jemphrey (1997) 'Knives to razors: Female circumcision among the Supyire of southern Mali', *Notes on Anthropology and Intercultural Community Work* 27, pp.25–38.
- 42 *Ibid.*

Laws Relating to Women and Girls

For information on international and African regional laws relating to FGM, please refer to the **law factsheet** on our website.

International and Regional Treaties¹

Mali has signed and ratified several international human-rights conventions that provide a strong basis for the characterisation of FGM as a violation of international human rights. The ratification of these conventions places a legal obligation on Mali to work towards fully adhering to the provisions of these conventions, with the aim of eradicating FGM:

- Convention on the Elimination of Discrimination Against Women (*CEDAW*), which was ratified on 10 September 1985;
- Convention on the Rights of the Child (*CRC*), which was ratified on 20 September 1990;
- Universal Declaration on Human Rights (*UDHR*) (cited in the 1992 Constitution);
- International Covenant on Civil and Political Rights (*ICCPR*), which Mali acceded to on 16 July 1974;
- International Covenant on Economic, Social and Cultural Rights, which Mali acceded to on 16 July 1974;
- African Charter on the Rights and Welfare of the Child, which was ratified on 3 June 1998;
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (the *Maputo Protocol*), which Mali ratified on 13 January 2005; and
- African Charter on Human and People's Rights (the *Banjul Charter*), which Mali ratified on 21 December 1981.

The African Union declared the years 2010 to 2020 to be the **Decade for African Women**, and Mali is expected to consolidate its efforts to promote and protect the rights of women.

In December 2012, the **UN** passed a historic unanimous resolution calling on countries to eliminate FGM, and in 2013 the 57th **UN Convention on the Status of Women** agreed on conclusions including a reference to the need for states to develop policies and programmes to eliminate FGM as well as other forms of violence against women.²

In proving its commitment and fulfilling its legal obligation to eradicate FGM, Mali will need to adopt and implement laws, policies and programmes that work towards the elimination of FGM and all other forms of violence against women.

FGM has long been considered discriminatory as a practice exclusively directed towards women and girls, with the effect of interfering with their enjoyment of their fundamental rights. Discrimination on the basis of gender is prohibited under **Article 2 of the UDHR** and has since been included in all international and regional human rights treaties and conventions.

The CEDAW and the CRC explicitly prohibit traditional practices that discriminate against women and harm children. **Article 2 of CEDAW** directs 'State Parties . . . (f) To take all appropriate measures,

including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.’ Additionally, **Article 5** states,

State Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes . . .

Article 24(3) of the CRC states, ‘State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.’ In addition, **Article 19(1)** provides that ‘State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse.’

Under the **ICCPR**, FGM is a violation of a person’s physical integrity, liberty and security of person. The ICCPR protects individuals from ‘torture or cruel, inhuman or degrading treatment’ and arbitrary or unlawful interference with his or her privacy (**Articles 7 and 17**). The ICCPR states that everyone has the ‘right to liberty and security of person’ and that ‘[e]very child shall have . . . the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State’ (**Articles 9 and 24**). FGM thus violates the convention because it threatens a person’s safety due to its negative, life-threatening physical consequences.³

Under the **ICESCR**, FGM is a violation of the right to health. **Article 12(2)** provides: ‘The steps to be taken by State Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for: (a) The provision for . . . healthy development of the child . . .’ ‘Health’ is defined so as to include ‘maturity, reproductive and sexual health’. FGM thus violates the convention due to the numerous health consequences, as discussed in the section Women’s Health and Infant Mortality on page 66.

Article 4(1) of The African Charter on the Rights and Welfare of the Child requires that the ‘best interests’ of the child be paramount in any decision concerning a child. **Article 5(1) and (2)** stresses the inherent right to life of every child and requires that state parties ‘ensure to the maximum extent possible, the survival, protection and development of the child.’ Under **Article 14(1)**, ‘Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.’ States are further required to pay particular attention to the reduction of infant and child mortality, which increase in cases of women who have undergone FGM. **Article 21** requires member states of the African Union to abolish customs and practices harmful to the ‘welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status.’

Under **Article 4(2) of The Maputo Protocol**, member states are required to adopt legislative, administrative, social and economic measures to ensure the prevention, punishment and eradication of all forms of violence against women. The Protocol also explicitly refers to FGM under **Article 5**, whereby ‘state parties shall prohibit and condemn . . . through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them . . .’

The **Banjul Charter** under **Article 16** includes ‘the right to the best attainable state of physical and mental health.’ The right to physical integrity is provided for under **Articles 4 and 5**.

National Laws

Age of Suffrage, Consent and Marriage

Under **Article 281 of the Personal and Family Code**⁴, the legal minimum age for women to marry is 16 years. However, they can be married when aged at least 15 with a civil judge's permission and parental consent.⁵ Most marriages are conducted under customary law and are not registered, so marriages of girls as young as ten can occur without legal repercussions. The age of suffrage in Mali is 18 for both men and women.

Constitution

Article 116 of the Malian Constitution states, 'Treaties and accords that are properly ratified or approved have from the time of their publication, superior authority over law of the state.' Mali has ratified instruments such as the **CEDAW** and the **Maputo Protocol**, which prohibit FGM. In light of this, Mali is not only in violation of its international obligations as signatories of these instruments, but also it is arguable that FGM is illegal in Mali, given the status of these international instruments within national law.

Anti-FGM Law

FGM is not specifically illegal in Mali as it has not been addressed in the constitution or any specific law enacted to criminalise the practice. However, there are provisions in the Penal Code outlawing assault and grievous bodily harm, which might cover FGM.

The Government of Mali, in its **National Plan for the Eradication of FGM by 2007**, had stated that this practice may be prohibited under **Articles 166 and 171 of the Penal Code**. Article 166 of the Penal Code prohibits voluntary cutting or injuring a person, or committing any violence against a person. Article 171 states that anyone who administers willingly any procedure or substance to an individual without consent, causing illness or disability, is punishable by six months' to three years' imprisonment. If a girl were excised against her mother's will (by a relative such as a grandmother, mother-in-law or co-wife), the mother could press charges under these provisions of the Penal Code. However, this option is virtually never used because traditional respect for family ties precludes bringing relatives to court.

As a result of the recommendations made at the **June 1997 national seminar**, the Government charged the **National Action Committee** to submit to the National Assembly draft legislation making these practices illegal in Mali. In October 1998, the Committee adopted a draft action plan against these practices for submission to the Ministerial Council. So far no law has been passed making the practice illegal. A government decree prohibits FGM in government-funded health centres. Government information campaigns regarding FGM reached citizens throughout the country, and human-rights organisations reported that FGM has decreased among children of educated parents.

The **Personal and Family Code** adopted in 2011 opened the door for a possible law against the practice: **Article 5** of the Code forbids 'the impairment of a person's physical integrity, even in the context of a religious or traditional practice, when this is harmful to the person's health'.

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- 1 ***Unless otherwise stated, all references in this sub-section are to*** Chi Mgbako, Meghna Saxena, Anna Vave, Helen Shin and Nasim Farjad (2010) 'Penetrating the Silence in Sierra Leone: A Blueprint for the Eradication of Female Genital Mutilation', *Harvard Human Rights Journal*, Vol. 23, p.111. Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=171913.
 - 2 United Nations (2012) *Advancement of Women: Report of the Third Committee*, October 2012.
 - 3 UNFPA Centre for Reproductive Rights (2006) *Productive Rights: A Tool for Monitoring State Obligations*. Available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Monitoring_Tool_State_Obligations.pdf.
 - 4 République du Mali (2011) *Portant Code Des Personnes et de la Famille*. Available at <https://data.unicef.org/wp-content/uploads/2017/12/mali-code-2011-personnes-famille-2.pdf>.
 - 5 République du Mali (2014) *Primature*. Available at <http://primature.ml/>.

The Role of Women in Society

Mali was ranked 86 out of 86 in the 2012 OECD Social Institutions and Gender Index (SIGI), falling further from its position of 99 out of 102 in the 2009 Index. This decline in the country's ranking indicates the deteriorating status of women's rights in the country.¹

In the overall distribution of costs by sector for the MDGs, the promotion of gender and the empowerment of women is only 1%.²

Rogaia Abushara explains that, if the current circumstances continue, women's positions will not change, nor the rate of FGM:

To get married and have children, which on the surface fulfils gender expectations and the reproductive potential of females, is, in reality, a survival strategy in a society plagued with poverty, disease, and illiteracy . . . The socioeconomic dependency of women on men affects their response to female circumcision.³

The rights of women are further undermined by **discriminatory national laws** such as the 2011 Personal and Family Code, which still supports practices such as early marriage and stipulates that a wife should obey her husband.⁴

In Mandé culture, singing is considered a feminine activity; therefore, aside from hunter's *jeliw* (hereditary class of musicians), men do not sing and women dominate musical performances. *Wassoulou* is a popular type of **music** which, due to the lack of male singers, tends to focus on issues of gender from the female viewpoint.

As a singer is judged on her skill with words rather than the quality of her voice, a lot of attention is paid to the meaning of the songs, allowing women to address women's issues and express themselves despite their subservient positions to men in Mandé society.⁵



Missalabougou girls singing in 2007
(© Sini Suniman)

The Personal and Family Code

The **legal minimum age for women to marry** is 16 years. The law, however, allows for girls to be married at the younger age of 15 with a judge's permission and the consent of their parents.⁶ Underage marriage is a problem throughout the country. In some regions, girls marry as young as ten. It is common practice for a girl who is aged 14 to marry a man twice her age.⁷

The DHS 2012–2013 shows that, among women aged 25–49, 20.6% were married before the age of 15 and 52.2% before the age of 18. The median **age of first marriage** for women aged 25–49 is 18. Moreover, the median age of marriage for women is significantly less than that of men entering their first marriage, who marry roughly eight years later than women. The delay in men's marriage is often due to the difficulty of raising the bride price to pay the wife's family. The age of first marriage among women differs from one place of residence to another. Women living in rural areas marry earlier than those in urban areas (17.7 compared to 19).⁸

34.8% of women under the age of 50 who are currently married are in a polygamous marriage. The levels of **polygamy** decrease as women's levels of education increase: 37.6% of those with no formal education are in polygamous marriages, as are 15.3% who have a secondary or higher level of education.⁹ Under Article 307 of the Personal and Family Code, polygamy is legal and men may marry up to four women. The husband must obtain the permission of the first wife before he marries again, although consent is often obtained through coercion and abuse.¹⁰

Under the Personal and Family Code, wives are legally obliged to obey their husbands, and the husband has sole family and parental **authority**.¹¹ Husbands decide where the family will live and their wives are obliged to obey.¹²

Legally, either spouse may petition for **divorce**, but in rural areas women rarely initiate proceedings because of strong social pressure.¹³

Malian women do not have the right to pass their nationality on to their children, in instances where the children's father is not a Malian citizen.¹⁴ **Inheritance** is governed by sharia, customary and civil law, depending on the identity of the person concerned. Under sharia law, daughters are entitled to receive only half the share received by sons.¹⁵ A further discrimination is that women can inherit only poor quality land that is not very fertile.¹⁶ Customary law, followed by certain ethnic groups, views the wife as part of the inheritance and obliges her to marry a brother of her deceased husband, who then receives all of the estate and assumes custody of the children. This practice, known as **Levirate**, exists mainly in the south of the country and very frequently among the Sénoufu, Peulh and Soninké communities. Given the restrictive nature of women's inheritance rights, this practice ensures that a woman has support for herself and children, instead of being disinherited and potentially losing her children on the death of her husband. In other communities, when a woman dies, her younger sister is expected to marry the widower; a practice known as *Sororate*.¹⁷

Physical Integrity

There is no specific law in Mali to address violence against women in general, and there is a high level of tolerance. **Domestic violence** against women, including spousal abuse, is prevalent. Most cases go unreported. Spousal abuse is a crime, but the law does not specifically prohibit domestic violence.

Assault is punishable by prison terms of one to five years and fines of up to 500,000 CFA francs (USD\$1,030) or, if premeditated, up to ten years' imprisonment.¹⁸ Public opinion generally accepts that men have a 'right' to beat their wives. Three in four (76.3%) of women think a man has a right to beat a woman.¹⁹ Police are reluctant to intervene in cases of domestic violence. Many women are reluctant to file complaints against their husbands because they fear their husbands would interpret such allegations as grounds for divorce, meaning they would be unable to support themselves financially, and so they seek to avoid social stigma. The Government's planning and statistics unit, established to track prosecutions, is not operational.²⁰

The law criminalises **rape** and provides a penalty of five to 20 years' imprisonment for offenders. However, the Government does not enforce the law effectively. Rape is a widespread problem. Authorities prosecute only a small percentage of rape cases, since victims seldom report rapes due to societal pressure, and particularly since attackers are frequently close relatives. No law specifically prohibits **spousal rape**, but law enforcement officials stated criminal laws against rape apply to spousal rape. Police and judicial authorities are willing to pursue rape cases, but have previously stopped if parties reached an agreement prior to trial. The law does not prohibit **sexual harassment**, and it routinely occurs, including in schools, without any governmental efforts to prevent it.²¹

Resources and Entitlements

Civil law provides for equal property rights, but ignorance of the law prevents women from taking full advantage of their rights.²² While legally men and women have the same access to land, in reality, many other obstacles prevent women from exercising their rights, including a lack of access to credit to purchase agricultural equipment, meaning that they have to rely on the goodwill of family members. Women's access to education and employment is limited, making it even more challenging to assert their rights to property. Women experience economic discrimination due to social norms that favour men. The Government is the major formal-sector employer and ostensibly pays women the same as men for similar work, but differences in job descriptions permit pay inequality.²³

Civil Liberties



Girls returning from bathing in the Senegal River (© 28 Too Many)

Women's freedom of movement is limited, as the current Personal and Family Code states that it is up to the husband to decide where the family will live, and the wife is legally obliged to live with him, meaning that women are not free to move in order to work.²⁴

On a day-to-day basis, 61.6% of women reported that they could not go and visit female friends and relatives without their husbands' permission, indicating considerable restrictions on women's freedom of movement.²⁵

- 1 Social Institutions & Gender Index (2014) *Mali – 2014 Results*. Available at <https://www.genderindex.org/country/mali-2014-results/>.
- 2 Plan Project (undated) *Project to support and promote initiatives in favour of the abandonment of excision in Mali*.
- 3 Rogaia Abushara (1995) 'Rethinking Feminist Discourses on Female Genital Mutilation: The Case of Sudan' *Canadian Woman Studies*, 15:52–54.
- 4 République du Mali (2011) *Portant Code Des Personnes et de la Famille*. Available at <https://data.unicef.org/wp-content/uploads/2017/12/mali-code-2011-personnes-famille-2.pdf>.
- 5 Lucy Duran (2000) 'Women, Music, and the "Mystique" of Hunters in Mali' in Ingrid Monson (ed.), *The African Diaspora: A Musical Perspective*. New York, NY: Garland Publishing, pp. 137-86.
- 6 République du Mali, *op. cit.*
- 7 US Department of State (2014) *2013 Country Reports on Human Rights Practices – Mali*. Available at <https://www.refworld.org/docid/53284aa814.html>.
- 8 DHS 2012–2013, pp.55 & 56.
- 9 DHS 2012–2013, pp.53.
- 10 United Nations (2004) Convention on the Elimination of All Forms of Discrimination against Women, 17 June. Available at <https://www.un.org/womenwatch/daw/cedaw/statesmeeting/thirteenth/CEDAW-SP-2004-2E.pdf>.
- 11 FIDH (2011) *Mali's new Family Law: women's rights denied, discrimination upheld*. Available at https://www.fidh.org/IMG/article_PDF/article_a11044.pdf.
- 12 United Nations, *op. cit.*
- 13 *Ibid.*
- 14 US Department of State, *op. cit.*
- 15 Kelsey Jones-Casey, Anna Knox and Zoey Chenitz (2011) *Women, Inheritance and Islam in Mali*. Focus on Land in Africa. Available at <http://www.focusonland.com/download/5214c5891f981/>.
- 16 United Nations, *op. cit.*
- 17 United Nations, *op. cit.*
- 18 US Department of State, *op. cit.*
- 19 DHS 2012–2013, p.284.
- 20 US Department of State, *op. cit.*
- 21 *Ibid.*
- 22 *Ibid.*
- 23 *Ibid.*
- 24 United Nations, *op. cit.*
- 25 UNICEF (2007) *The State of the World's Children 2007: Women and Children – The Double Dividend of Gender Equality*. Available at https://www.unicef.org/publications/files/The_State_of_the_Worlds_Children_2007_e.pdf.

FGM: National and Regional Statistics and Trends

This section gives a broad picture of the current state of FGM in Mali. Other sections of this report give more detailed analyses of FGM prevalence set within anthropological and sociological frameworks, and of efforts towards its abandonment. For example, an analysis of the relationship between FGM and education may be found in the Education section.

The prevalence of FGM in Malian girls and women (aged 15–49) is 91.4% (as at 2012–2013). This figure does not include the three northernmost regions of the country – Tombouctou, Gao and Kidal – which were not surveyed due to armed conflict in the region.

According to UNICEF, Mali is classified as a Group One country (a country with a prevalence of over 80%).¹

In 2006, the prevalence of FGM in women aged 15–49 was found to be 85.2%.² However, since this survey covered the entirety of Mali, including the three northernmost regions, this is not directly comparable with the 2013 figure.

To find two comparable indicators, the prevalence in 2006 can be recalculated to exclude the three northernmost regions. The results reveal a prevalence of 92% for 2006, meaning there was virtually no change between 2006 and 2012/2013 (see Figure 3).

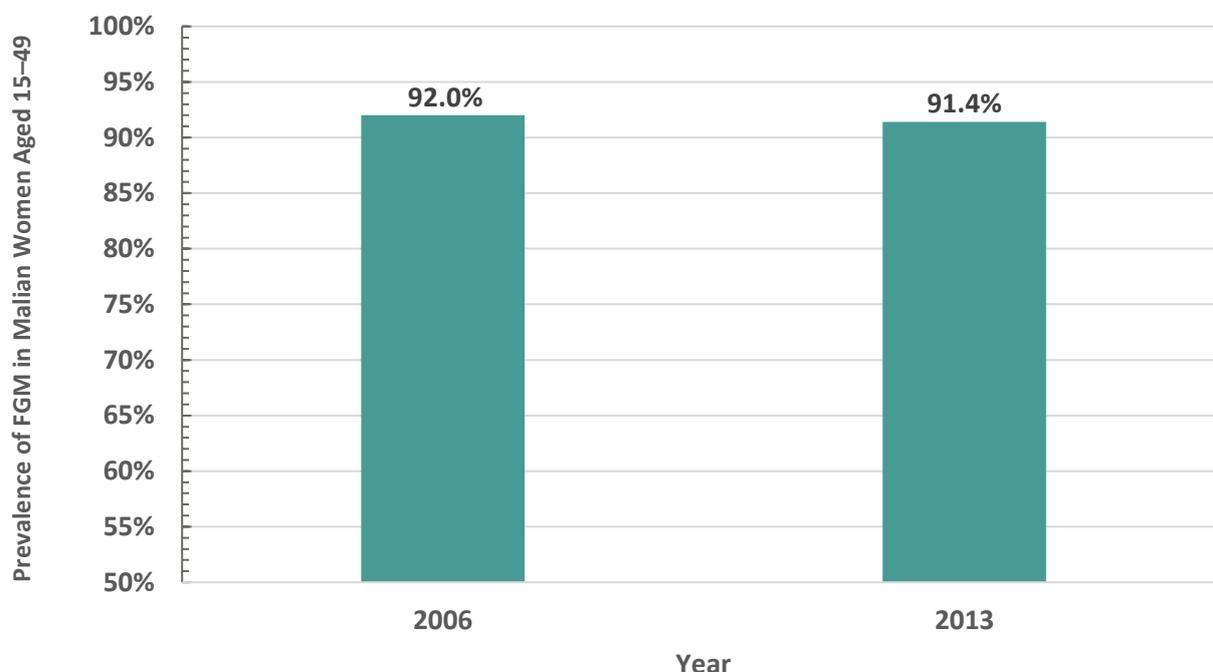


Figure 3: Comparison of prevalence of FGM in Mali – excluding Tombouctou, Gao and Kidal – in 2006 and 2012/2013³

Prevalence of FGM According to Place of Residence

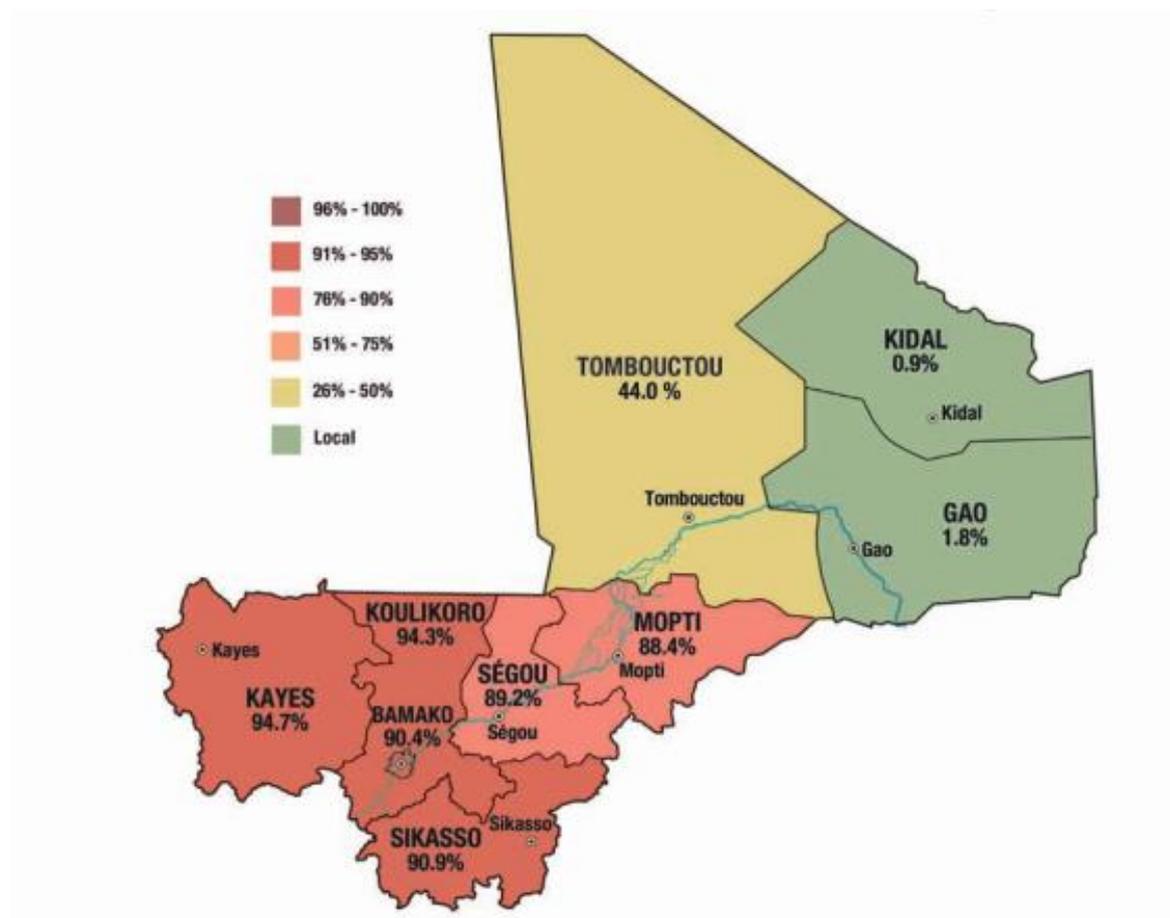


Figure 4: Prevalence of FGM in Mali among women aged 15–49, according to their region of residence⁴

NB: The data in this map is predominantly from 2012–2013. However, the figures for the three northernmost regions (Tombouctou, Gao and Kidal) are from 2006, since during 2012–2013 it was not possible to survey these regions due to armed conflict.

Mali has significant regional variations in prevalence, from around 2% up to 98%. These regional differences reflect the diverse ethnic communities. Prevalence of FGM within individual communities is discussed in Anthropological Background and below in the section Prevalence of FGM According to Ethnicity.

As shown in Figures 4 and 5, rates of FGM are highest in the western and southern regions – Kayes, Koulikoro, Sikasso and Bamako – and lowest in the north-eastern regions of Kidal and Gao. It should be noted, however, that the data on Kidal and Gao is based on small numbers of women and therefore must be interpreted with caution.

The prevalence of FGM is extremely high in both urban and rural areas.

In 2013 it was found to be 90.5% (urban) and 91.8% (rural), excluding the three northernmost regions of the country. It is not possible to make a direct comparison with the DHS 2006 data, since this survey included the northern regions.

However, in 2006 the prevalence was found to be 80.9% (urban) and 87.4% (rural), suggesting that, across the country as a whole (with the inclusion of the northern regions), FGM is slightly more prevalent in rural areas. For context, in 2010, the total population living in rural areas was 66%.⁵

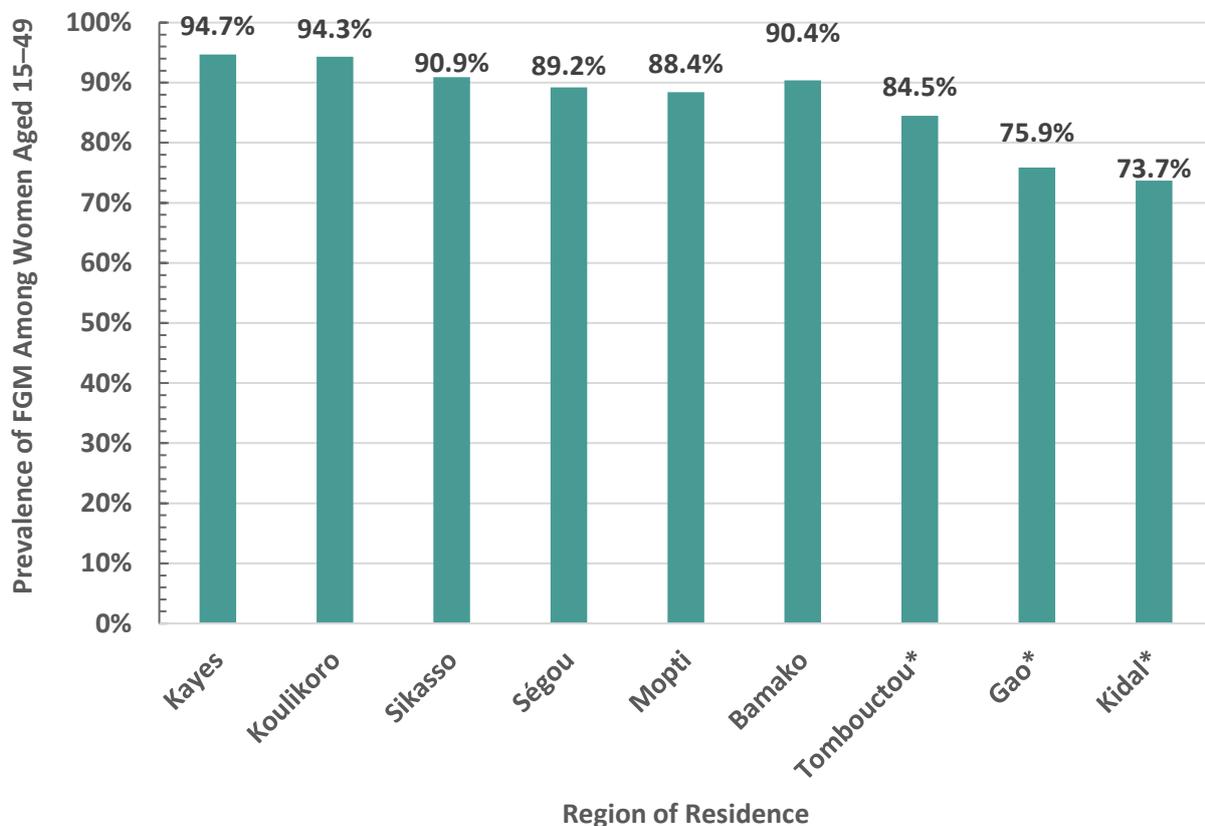


Figure 5: Prevalence of FGM among Malian women aged 15–49, according to their region of residence⁶

NB: As for Figure 4, data for Tombouctou, Gao and Kidal is from 2006, as it is the last available.

Prevalence of FGM According to Household Wealth

The DHS 2012–2013 shows that the prevalence of FGM is constant across women in all five wealth quintiles, at around 90% (see Figure 6).

In girls aged 0–14, however, there is a trend towards higher prevalence among those whose families are in the richer wealth quintiles. 64.3% of girls in the poorest quintile were cut, compared to 74.8% of girls in the richest quintile.

This trend is distinct from the majority of African countries, in which girls from wealthier families typically have a lower risk of being cut.

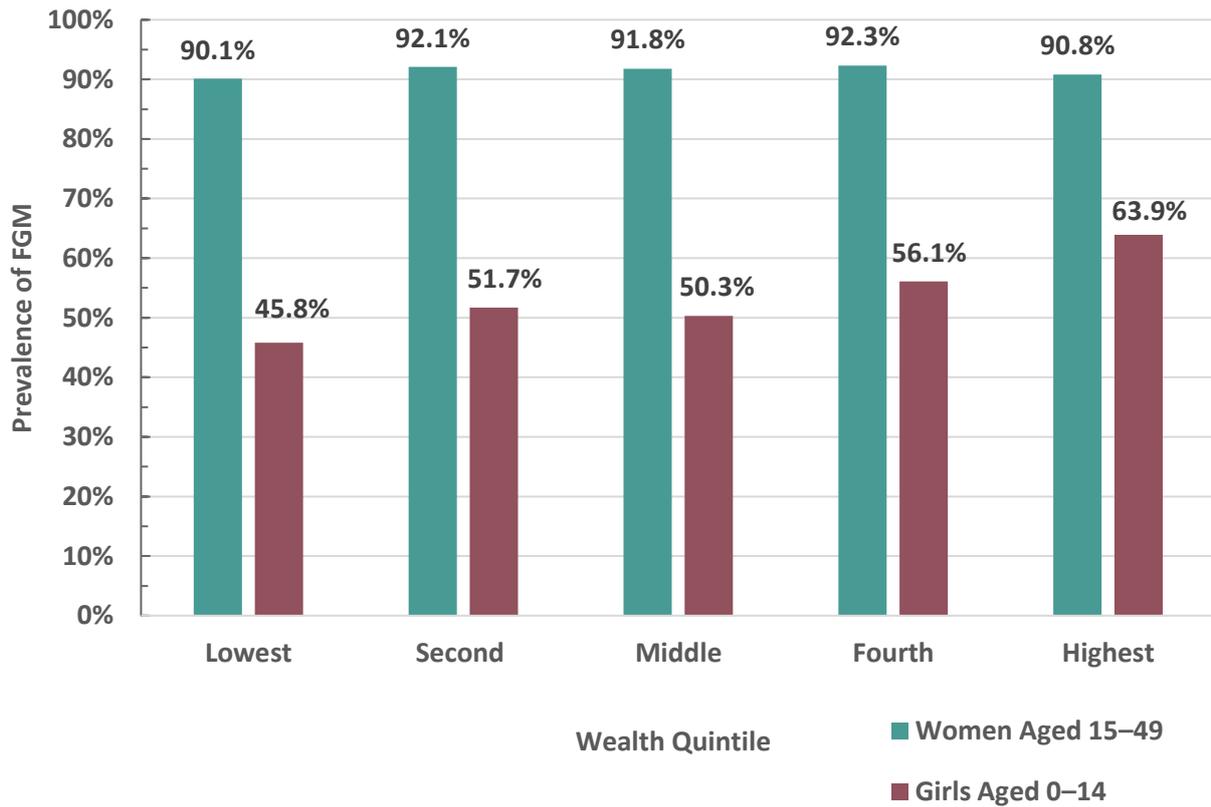


Figure 6: Prevalence of FGM among Malian women aged 15–49 and daughters aged 0–14, according to their levels of wealth⁷

Prevalence of FGM According to Ethnicity

The prevalence of FGM in Mali varies between ethnic groups, as shown in Figure 7, ranging from 59.5% in Sonrai women (aged 15–49) to 95% or more in the Bambara and the Sarakolé/Soninké/Marka.

However, it should be noted that the figures for some ethnic groups, especially those for the Tamachek/Bélla and Sonrai, are based on small numbers of women and therefore must be interpreted with caution. In particular, the interviews of Tamachek women were not conducted in regions where the Tamachek traditionally live (which were excluded from that report).⁸

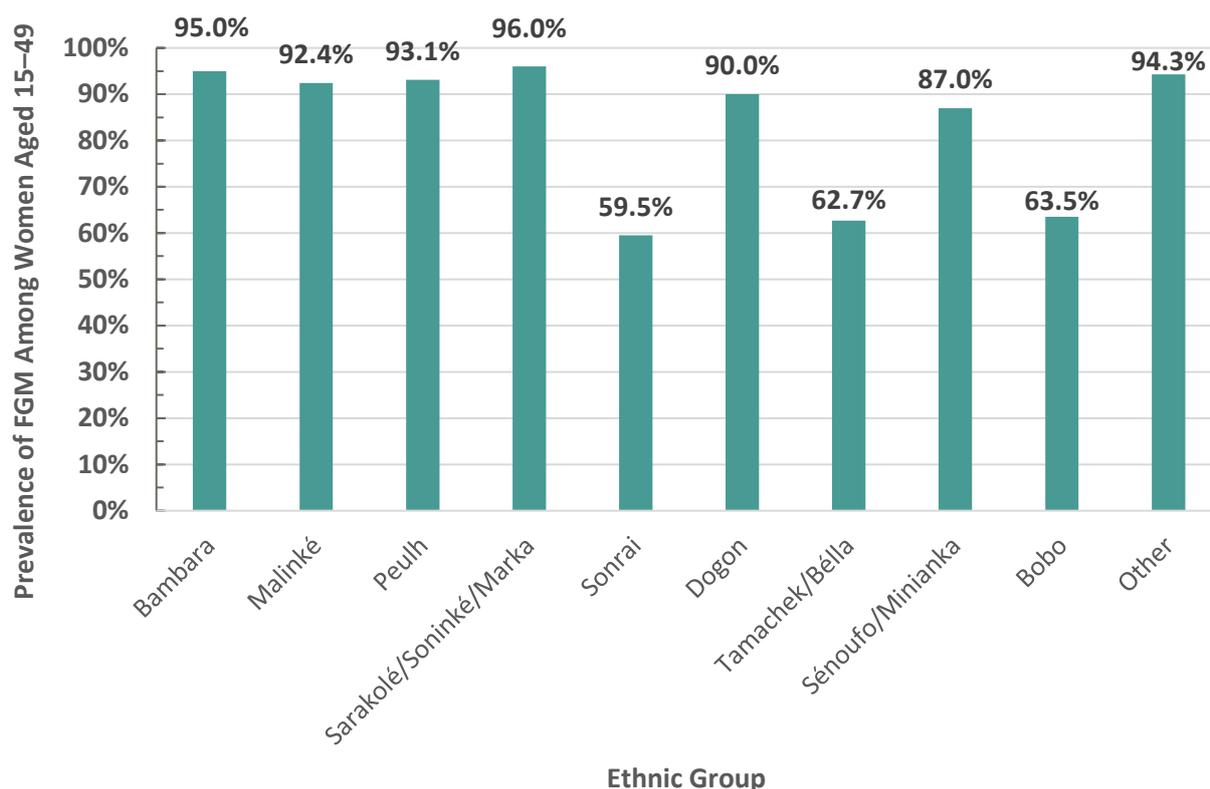


Figure 7: Prevalence of FGM among Malian women aged 15–49, according to their ethnicity⁹

Types of FGM Practised

Around half of Malian women (48.9%) aged 15–49 who have had FGM experienced a ‘cut, [with] flesh removed’, while 10.6% of women were ‘sewn closed’, as shown in Table 2. However, around a quarter of women do not know what type of FGM they experienced.¹⁰

Type of FGM	Prevalence
Cut, flesh removed	48.9%
Nick, no flesh removed	14.6%
Sewn closed	10.6%
Don’t know/missing	25.9%

Table 2: Percentage distribution of the type of cutting in Malian women aged 15–49 who have undergone FGM¹¹

The type of FGM undergone by girls is strongly influenced by the type their mothers underwent. This is demonstrated in Figure 8, which shows the percentage distribution of the type of FGM experienced by girls, broken down by the type of FGM experienced by their mothers.

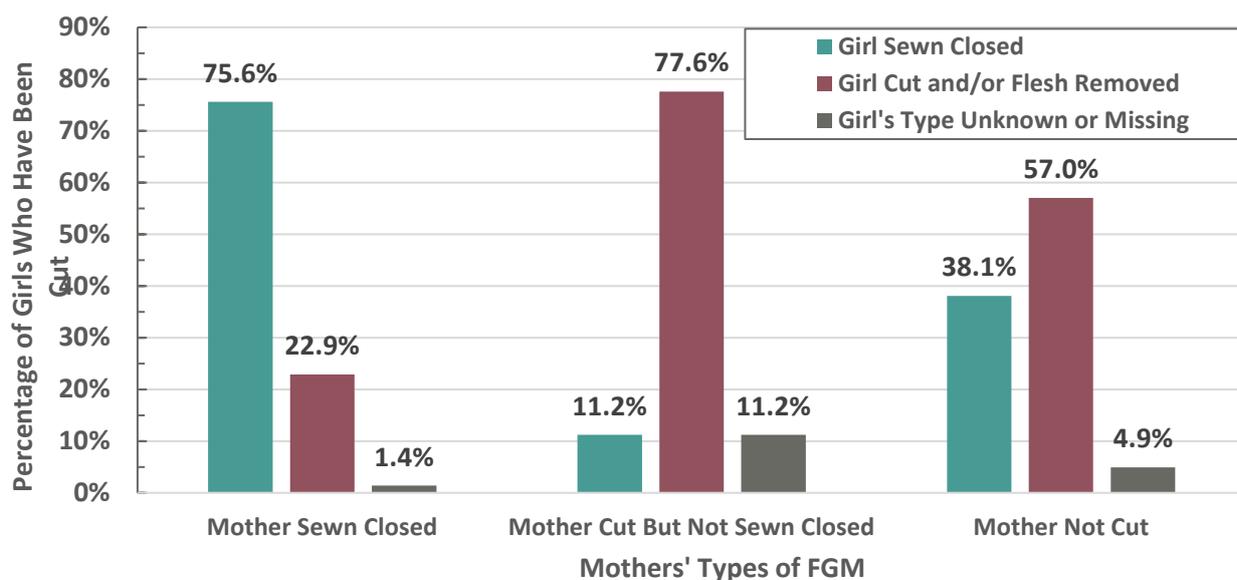


Figure 8: Percentage distribution of types of FGM experienced by girls aged 0–14, according to their mothers' types of FGM¹²

In a small number of cases, women who themselves had not undergone FGM chose to have their daughter(s) cut. In these cases, the daughters predominantly experienced a 'cut [with] flesh removed' (57%), but 38.1% were 'sewn closed'. However, these figures are based on small numbers of girls and should be interpreted with caution.¹³

Practitioners of FGM

In general, FGM in Mali is not medicalised, but traditionally performed by a woman from the blacksmith's caste. These women are well versed in traditional medicine and are believed to have special powers to ensure a successful procedure.¹⁴

Performing FGM can be a valuable source of income. According to IAMANEH Suisse, cutters would need to be offered alternative sources of income before they would be willing to abandon the profession. It notes that about half of the former cutters surveyed now work as midwives.¹⁵

Practitioner of FGM	Girls	Women
Traditional cutter	91.9%	88.1%
Traditional birth attendant	4.9%	2.6%
Other traditional	1.0%	0.2%
Doctor	0.9%	0.5%
Nurse/midwife	1.1%	0.2%
Don't know/missing	0.2%	8.4%

Table 3: Type of practitioner who cut Malian girls aged 0–14 and women aged 15–49 (percentage distribution)¹⁶

Table 3 provides a breakdown of type of practitioner for both Malian women aged 15–49 who have been cut and girls aged 0–14 who have been cut. Two percent of the girls were cut by medical staff (1.1% by nurses/midwives and 0.9% by doctors), as opposed to less than one percent (0.2% by nurses/midwives and 0.5% by doctors) of the women.¹⁷

Age of Cutting

The prevalence of FGM in girls currently aged 0–14 is 69.2%.¹⁸ This is lower than the prevalence in women aged 15–49 (91.4%); however, the two figures cannot be compared directly since many of the girls may still be at risk of FGM.

In Mali, the risk of FGM is highest when a girl is below the age of four (see Figure 9 below, which shows the age of cutting of women and girls).

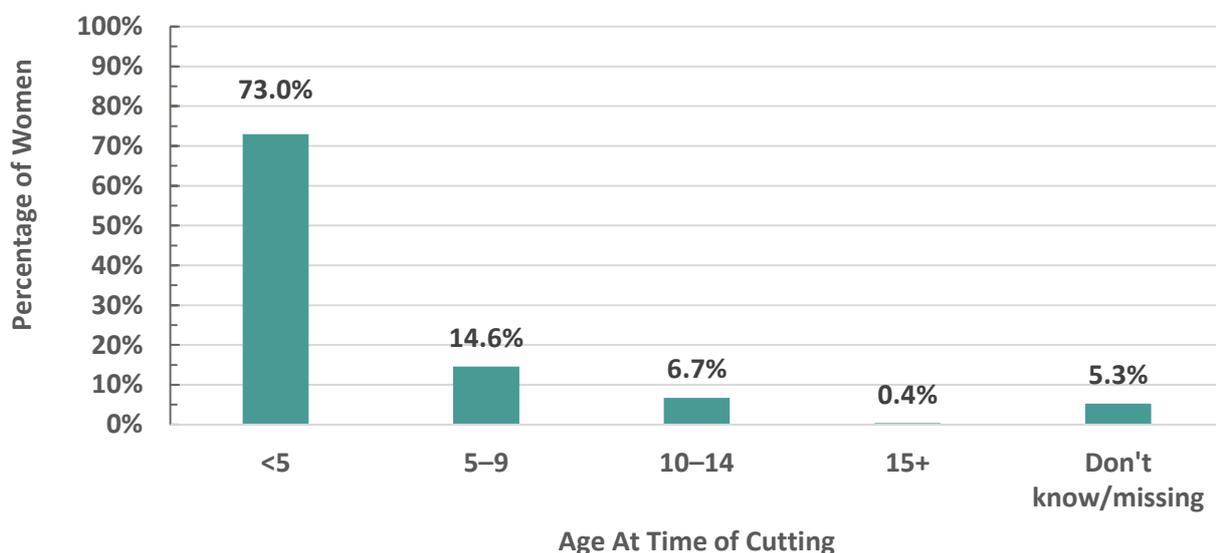


Figure 9: Age at which Malian women (aged 15–49) who have had FGM were cut¹⁹

73% of the women interviewed were cut before the age of five; a total of 87.6% were cut before the age of ten. There are many possible explanations for the preference for cutting at a young age, but important is the belief that young girls heal faster and are more able to cope with the pain. It is also claimed to be easier to manage a very young girl during the process.²⁰

There is some evidence that cutting is taking place at younger ages. Figure 10 shows the percentage of women aged 15–49 who experienced FGM and were cut before the age of five, broken down by their current age group. 63.1% of women aged 45–49 were cut before the age of five, while the corresponding figure in women now aged 15–19 is 78.4%.²¹

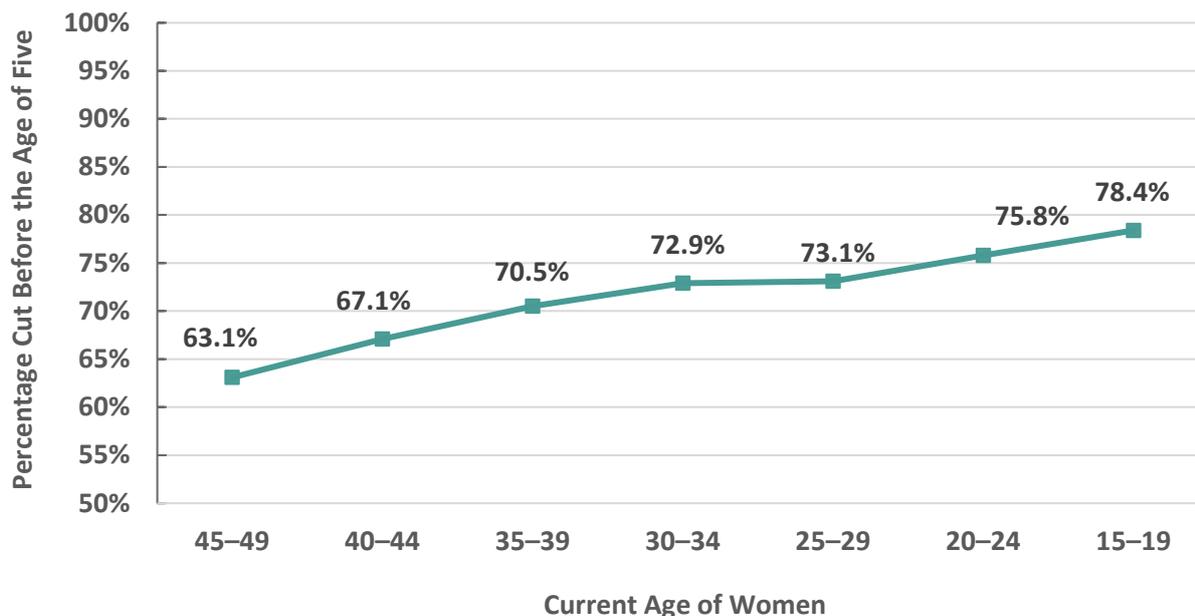


Figure 10: Percentage of Malian women who were cut before the age of five, according to their current ages²²

- 1 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, p27. Available at https://www.unicef.org/publications/index_69875.html.
- 2 DHS 2006, p.287.
- 3 - DHS 2006, p.287. *Comparable indicator calculated by 28 Too Many from the original dataset.*
- DHS 2012–2013, p.296.
- 4 - DHS 2006, p.286.
- DHS 2012–2013, p.296.
- 5 World Bank (2014) 'Mali', *Trading Economics*. Available at <https://tradingeconomics.com/>.
- 6 - DHS 2006, p.287.
- DHS 2012–2013, p.296.
- 7 DHS 2012–2013, p.296.
- 8 DHS 2012–2013, p.295.
- 9 DHS 2012–2013, p.295.
- 10 DHS 2012–2013, p.295.
- 11 DHS 2012–2013, p.296.
- 12 DHS 2012–2013, p.301.
- 13 DHS 2012–2013, p.301.
- 14 Canadian International Development Agency (2011) *Mali: L'excision: un rite de passage en voi d'être dépassé*.
- 15 IAMANEH Suisse (2013) *Annual Report*. (Refer to <https://www.iamaneh.ch/en/meta/publications/annual-report-annual-accounts/> – no longer available online).
- 16 DHS 2012–2013, pp.301.
- 17 DHS 2012–2013, pp.301.
- 18 DHS 2012–2013, p.299.
- 19 DHS 2012–2013, p.297.
- 20 Poricho (2006) *Excision in the Church Districts of Bamako, Bougouni, and Mana. Perceptions, Attitudes and Practices*.
- 21 DHS 2012–2013, p.296.
- 22 DHS 2012–2013, p.296.

Understanding and Attitudes

Taboos and Mores¹

*'Taboos are cultural or religious practices that are based on a precautionary principle, forcing individuals to comply or face punishment or stigma. Taboos can be forbidden actions; nourishment; words and themes; ideas, books and pictures; and signs. In African traditional religion, taboos are considered crimes; in African society, customs that are sacred and secular are often inseparable. To break a taboo means that an individual faces societal punishment or suffers from guilt. A person who breaks a taboo is then tabooed, as he or she is a threat of luring others to follow suit.'*²

Traditionally, in Malian society, **menstruation, pregnancy and sex** are taboo subjects and are often a source of embarrassment for women. For example, menstruation is believed in Dogon to make women impure. Women are kept separate from the community during this time, reside in separate houses and are exempt from their ordinary duties. Strassman, however, found during her two-year field study among the Dogon that menstrual hut use is predicated on the religion of the husband, not the religion of the wife. Women who had animist husbands used the huts; women whose husbands were not animists did not.³

The Dogon religion states that FGM is a procedure to spiritually cleanse women. This is because the first incidence of FGM is said to have been performed on Mother Earth.⁴

More widely in Mali, **the clitoris** is believed to connote masculinity, and the foreskin, femininity; hence, both must be removed in order to transition into adulthood.⁵

Today FGM is most often performed on girls under the age of five, whereas historically it was practised on teenagers as a rite of passage.⁶

A study from the 1950s on FGM among the Bamanan discussed male circumcision and FGM as serving to remove **the wanzo** ('evil spirit'). FGM was performed by a blacksmith's wife, who would protect herself from the wanzo by wearing special jewellery and covering her eyes with black paste. Today practitioners of FGM wear special protective medicine and a leather cord around their waists.⁷

The reluctance of wives to discuss pregnancy and sex not only with their husbands, but also with other women has led to ignorance of pregnancy and sexual-health issues, especially among first-time mothers. **Africare's Child Survival Project**, working in southern Mali in the late 1990s, found a way of increasing communication and health-seeking behaviours during pregnancy by adapting a pre-existing cultural practice. The *pendelu* is a short, white cotton undergarment traditionally worn by a married woman in her husband's presence to discretely initiate sexual relations; it also serves to wipe away bodily fluids. The *pendelu* has deep cultural significance and is an effective method of non-verbal communication of intimacy for married couples. It triggers a caring, protective reaction in the husband. The project produced a number of green (symbolising origins/growth) *pendelus* to be worn

by pregnant women to communicate their pregnancy to their husbands. Information on the project was passed through the community via *griots* (oral historians, praise-singers and social mediators), and a song was created to educate communities about maternal healthcare and promote the green *pendelus*. The programme significantly increased communications about maternal health and, remarkably, 85% of respondents who were uninvolved with coordinating the project were able to communicate the concept.⁸ This use of traditional symbols and communication methods was effective in changing behaviours and could lend itself to other behaviour-change interventions, especially those in relation to sexual health and FGM.

Breastfeeding is the norm in Mali. Breast milk is thought to both produce strong and healthy offspring and strengthen blood ties. Babies are breastfed on demand, and the average age of weaning is 19 months. The primary reason for weaning is pregnancy, as there is a widespread belief in Mali that a pregnant woman's stomach produces a heat that will cause a breastfeeding child to become ill.⁹ In Malian culture breast milk is sacred; if two children have been breastfed by the same woman, regardless of whether they are biologically related or not, they are considered milk siblings and cannot marry.¹⁰

LGBT persons in Mali face discrimination, and homosexuality is taboo. The law prohibits association 'for an immoral purpose'. LGBT individuals experience 'physical, psychological, and sexual violence, which society views as corrective punishment'. LGBT individuals generally isolate themselves and keep their sexual identities hidden. There have been reports of violence (including mob violence) against LGBT individuals during which the police did not intervene.

Persons living with **HIV/AIDS** face societal discrimination, though the Government has implemented campaigns to reduce discrimination. Persons living with disabilities are not specifically protected under the Constitution and law. The Government does not prioritise protecting their rights and many such individuals rely on begging.

Knowledge of FGM in Mali is near universal. 98.3% of women aged 15–49 are aware of FGM, as are 98.8% of men.¹¹

Reasons for Practising FGM and its Perceived Benefits

Figure 11 shows the percentage of women and men aged 15–49 who have heard of FGM and believe that it should be continued, both for the country as a whole and broken down by age cohort.

71.9% of women believe that it should continue, and the figure is slightly higher in men at 78.9%.

There is no notable difference in attitudes across the age cohorts. Across all age cohorts, about 10% of men and women are unsure of their opinions. Women who have not been cut are far less likely to support the continuation of FGM (15.8%) than those who have (76.1%).¹²

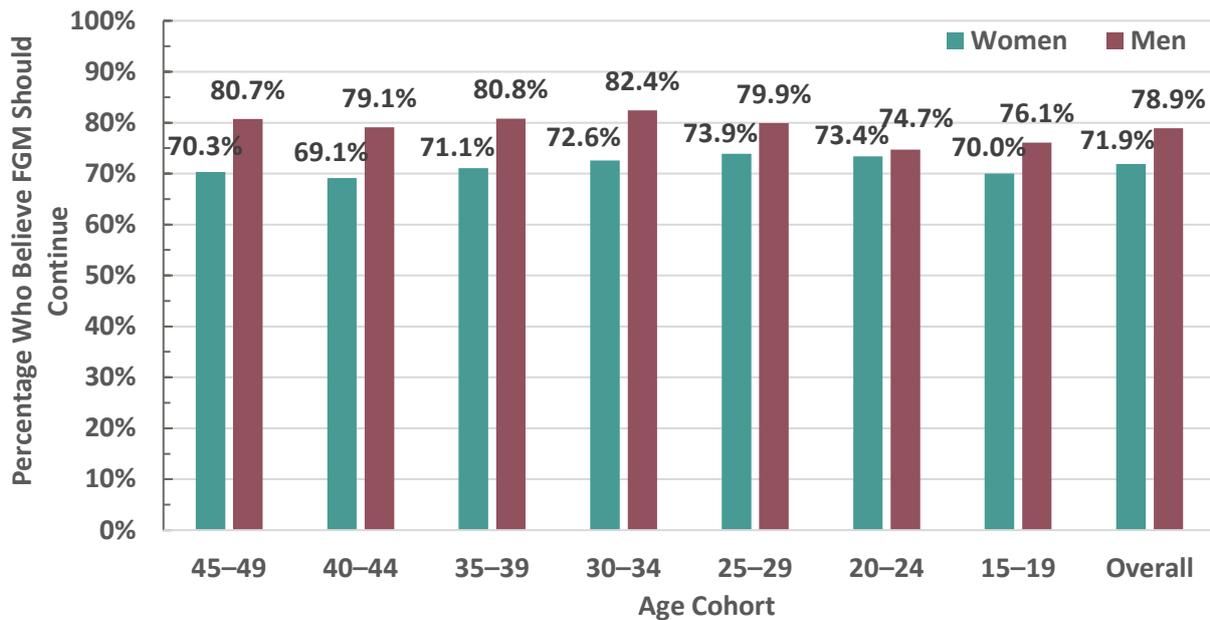


Figure 11: Percentage of Malian women and men aged 15–49 who have heard of FGM and believe it should continue¹³

Social norms theory can help explain why the practice of FGM continues. FGM is a regular facet of society. Individuals believe that, even if they wanted to stop, other community members do not want them to and they would therefore face ostracism if they did not follow custom. Moreover, because FGM is a taboo subject, there is little opportunity for dialogue in which to express views on the practice. Individuals are forced by societal custom to continue, even though many community members might want FGM to be abolished.

The DHS 2006 survey asked women aged 15–49 and men aged 15–59 **what, if any, advantages they perceived in performing FGM on girls.**¹⁴ There is a marked difference in views between men and women, depending on their locales.

Among men in all regions, the most common responses are ‘ensuring virginity’ (21.8%), FGM being a ‘religious requirement’ (24.4%) and ‘no advantage’ (23%).

Among women, ‘social recognition’ is the most common response in both rural and urban areas, but this is more important for women in rural locations and for those with no formal education. More positively, women with higher levels of education were also more likely to see no advantages (29.6% of those with secondary or higher levels of education compared to 15.3% of those with no formal education).

Among both sexes the ‘other’ category is chosen more often than most other categories, but it is unclear from the literature what the parameters of this category are.

It appears that younger men (15.7% of those aged 15–19) are less likely than older men (33.3% of those aged 50–59) to believe that ‘religious requirement’ is a benefit of FGM. Younger women (29.6% of those aged 15–19) are less likely than older women (42.2% of those aged 45–49) to believe that ‘social recognition’ is a benefit. However, more data would be needed to fully understand these apparent trends.

The DHS 2006 offers a further interesting perspective on the population's views of FGM. Instead of asking respondents to choose between defined benefits of cutting girls, the survey asked about the **benefits of *not* cutting girls.**¹⁵

More than half of respondents see no benefit in *not* performing FGM (meaning FGM is considered beneficial). Even ethnic groups that do not traditionally practise FGM see little benefit in not doing so. Urban residents see marginally more benefits to not cutting girls than their rural counterparts, except in the 'other benefits' category, which is recognised by more rural residents.

More detailed work is needed with individual ethnic groups to understand the drivers of FGM.

Social Acceptance/Cultural Identity

The most common reason given for continuing FGM among most cohorts and both genders is social acceptance.¹⁶ Research on various ethnic groups points to the control of women's sexuality before and after marriage as being of huge import to a family's honour and social standing.¹⁷ This is why it is not the sole choice of a girl's parents whether or not to perform FGM, as it reflects on the family as a whole. There are many cases of children being cut against their parents' wishes by grandmothers or other female relatives.¹⁸

Cleanliness and Hygiene

This is seen as an advantage of FGM more frequently by Malian women than by men. The women of the Dogon, Tamacheck and Sonrai, who perform the least FGM, see it as an advantage less frequently than other groups. However, the number of Tamacheck women interviewed was small, so this result should be interpreted with caution. Among the wealthiest quintile of women, hygiene is seen as a benefit more frequently than among poorer women. More research and education is needed to counteract this false belief.¹⁹

Better Marriage Prospects

Less than 10% of Malian women and only 5.1% of men aged 15–49 see FGM as a route to better marriage prospects.²⁰

Preservation of Virginit

Unsurprisingly in a patriarchal society, more Malian men than women believe that FGM acts as a method of ensuring women's virginit. The literature indicates that they believe it makes a woman more faithful in marriage. 29.2% of men in Bamako, compared to 19.5% in rural locations, believe that FGM will ensure a girl's virginit.²¹ For example, a father of 12 girls interviewed in Kayes believes it reduces their arousal, stops debauchery and preserves their virginit. Though women also express the belief that FGM stops promiscuity, when pressed they admit that it makes no difference to behaviour and that women from non-cutting communities behave well.²²

Religious Requirement

Wahabism preaches that, without FGM, women will be sexually promiscuous and their prayers will not be recognised.²³ The term often used in Mali to refer to FGM, *selidjili*, is a compound word that implies ritual purity and is the same word used for ablutions made before praying at the mosque.

Although 23.5% of the women and 24.4% of the men surveyed cited 'religious requirement' as a benefit of FGM, when they were asked directly whether or not FGM was required by their religion, 63.6% of women and 38.2% of men said that it was.²⁴

Other Perceived Benefits

It is not clear from the DHS literature what these perceived benefits may be. However, some Bambara and Dogon believe that if the clitoris comes in contact with the baby's head during birth, the child will die.²⁵ Many Dogon have a deeply held belief that both the female and the male sex exist within each person at birth, and it is necessary to rid the female body of vestiges of maleness to overcome any sexual ambiguity. The clitoris represents the male element in a young girl, while the foreskin represents the female element in a young boy. Both must be removed to clearly define the sex of the person.²⁶ Another extreme belief of Bambara men is that, upon entering an uncut woman, a man could be killed by the secretion of a poison from the clitoris. This folk belief acts as a rationale for clitoral excision.²⁷

No Benefits

Among the Mande and Peulh people (the majority of the population), only a small proportion of women see no benefits of FGM for girls. FGM being non-beneficial is recognised more by non-practising people groups, but even there it is not universally recognised.²⁸

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- 1 **Unless otherwise stated, all information is from** US Department of State (2014) *2013 Country Reports on Human Rights Practices – Mali*. Available at <https://www.refworld.org/docid/53284aa814.html>.
 - 2 Olatunji Ogunyemi (2007) 'The Implications of Taboos Among African Diasporas for the African Press in the United Kingdom', *Journal of Black Studies*, 38(6). Available at <https://journals.sagepub.com/doi/abs/10.1177/0021934706290341>.
 - 3 Lost Womyn's Space (2014) [website]. Available at <http://lostwomynspace.blogspot.com/>.
 - 4 Bettina Shell-Duncan and Ylva Hernlund (eds.) (2001) *Female Circumcision in Africa: Culture, Controversy, and Change*.
 - 5 David W. Machacek and Melissa M. Wilcox (2003) *Sexuality and the World's Religions*. ABC-CLIO.
 - 6 Claudie Gosselin (2001) *Campaigning against excision in Mali: global and local hierarchies, hegemony and knowledge* [PhD Thesis]. Available at <https://tspace.library.utoronto.ca/handle/1807/15848>.
 - 7 Poricho (2006) *Excision in the Church Districts of Bamako, Bougouni, and Mana. Perceptions, Attitudes and Practices*.
 - 8 Lydia Clemmons and Yaya Coulibaly (1999) 'Cultural Resources and Maternal Health in Mali', *Indigenous Knowledge (IK) Notes*, No. 12. World Bank, Washington, DC. Available at <https://openknowledge.worldbank.org/handle/10986/10826>.
 - 9 Salif Coulibaly, Dicko Fatoumata, Seydou Moussa Traoré, Ousmane Sidibé, Michka Seroussi et Bernard Barrère (1996) *Enquête Démographique et de Santé, Mali 1995–1996*. Calverton, Maryland, USA : Cellule de Planification et de Statistique du Ministère de la Santé, Direction Nationale de la Statistique et de l'Informatique et Macro International Inc. Available at <https://dhsprogram.com/pubs/pdf/FR74/FR74.pdf>.
 - 10 Virginia Friends of Mali (2014) [website]. Available at <http://vafriendsofmali.org/>.
 - 11 DHS 2012–2013, p.293.
 - 12 DHS 2012–2013, p.304.
 - 13 DHS 2012–2013, p.304.
 - 14 DHS 2006, pp.297–298.
 - 15 DHS 2006, pp.299–300.
 - 16 DHS 2006, pp.297–298.
 - 17 Claudie Gosselin, *op. cit.*
 - 18 Poricho, *op. cit.*
 - 19 DHS 2006, pp.297–298.
 - 20 DHS 2006, pp.297–298.
 - 21 DHS 2006, pp.297–298.
 - 22 Claudie Gosselin, *op. cit.*
 - 23 Claudie Gosselin, *op. cit.*
 - 24 DHS 2006, pp.297–298 & 302.
 - 25 Clare Chambers (2008) *Sex, Culture, and Justice: The Limits of Choice*. Penn State University Press.
 - 26 David W. Machacek and Melissa M. Wilcox, *op. cit.*
 - 27 US Department of State (2001) *Mali: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)*. Available at <https://2001-2009.state.gov/g/wi/rls/rep/crfgm/10105.htm>.
 - 28 DHS 2006, pp.297–298.

Media¹

Freedom of the Press

The Malian Constitution provides freedom of speech and the press, but in recent years the Government has restricted press freedom.² Since 2012, journalists have had difficulty accessing information concerning the northern conflict. Journalists have been detained and assaulted, and the media has had to practise self-censorship.

In the north, rebels banned Western music in 2012 and demanded that radio programming feature Koranic recitations. Though some media outlets were forced to close due to rebel attacks, some of these resumed operation in 2013. French troops entered the region in 2013, and, since that time, there has been essentially a media blackout concerning all logistics, operations and rates of injury, mortality, and aid.³

Access to Media

Exposure to media in Mali is dependent on a person’s place of residence. 53.8% of women and 24.8% of men (aged 15–49) living in rural areas are rarely exposed to the media, whereas the rates are lower in urban areas at 21.3% and 9.2% respectively.⁴

Table 4 shows the percentage of Malian women and men who read a newspaper, watch television or listen to the radio at least once per week.

Medium	Women	Men
Reads a newspaper	5.5%	11.6%
Watches television	32.8%	46.5%
Listens to radio	46.9%	72.1%
Accesses all three media	4.2%	9.6%
No media	45.8%	21.0%

Table 4: Percentages of Malian women and men (aged 15–49) who access various media at least once per week⁵

Radio

Radio is Mali’s most popular medium,⁶ possibly because of low literacy rates. The Media Foundation for West Africa said in 2012 that 369 private stations were on the air.⁷ The BBC broadcasts in Bamako (88.9 FM), and Radio France Internationale is widely available on the FM band.

Newspapers

Newspaper circulation is low and largely confined to newsstands in Bamako and the main towns. French-language, state-run *L’Essor* is the only title that claims national distribution.

Some of the major news sources are:

- *L'Essor*, a state-owned national daily;
- *Le Republicain*, a national daily;
- *L'Independent*, which is privately owned;
- *Info Matin*, a privately owned daily;
- *Les Echos*, a daily;
- *MaliWeb*, an online news portal;
- *Malikounda*, an online news portal;
- *Malijet*, a news website; and
- *aBamako*, a news website.



An anti-FGM campaign poster from Sini Sanumans

Television

Television was introduced to Mali in 1983. There is the Office de la Radiodiffusion Television du Mali (*ORTM*), which operates public channels (*ORTM TV* and *TM2*). Programming is in French and local languages. A private station is *Africable TV*.

The Internet and Social Media

The Government does not restrict access to the internet. Bamako has many internet cafés, but home internet remains limited due to cost.⁸ The International Telecommunication Union estimates that, in 2013, internet use was 2.7% (4.7% according to *BuddeComm*).⁹

Socialbakers claims that Facebook had a 1.6% penetration rate in Mali in 2013.¹⁰

Despite the northern conflict, information and communication technology is progressing in Mali.

Mobile Phones

In 2012, 89.5% of the population used mobile phones.

Although information and communication technology was affected by the 2012 coup, most infrastructures is based in Bamako and not heavily affected by the northern conflict.

At the end of 2014, it is expected that the *ACE* cable will be implemented, along with a third mobile operator, and these should lower internet costs.¹¹

The Media and FGM

Mali celebrated the International Day of Girls in ICT with an open house at *Orange Mali* on 26 April 2012.

There have been several successful media campaigns in Mali to raise awareness about the dangers of FGM and promote abandonment. For instance, the NGO *Sini Sanuman* installed billboards in Bamako proclaiming that a girl's body is sacred, so leave girls complete (whole). *Groupe de Recherche, D' Étude, de Formation Femme Action (GREFFA)*, in collaboration with *Norwegian Church Aid*, conducts radio broadcasts on FGM and fistula. Additionally, *UNICEF Mali* uses theatre and cinema productions to communicate information about the downsides of FGM.

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- 1 BBC News (2013) *Mali*. Available at <https://www.bbc.com/news/world-africa-13881373>.
 - 2 US Department of State (2014) *2013 Country Reports on Human Rights Practices – Mali*. Available at <https://www.refworld.org/docid/53284aa814.html>.
 - 3 Aljazeera (2014) [website]. Available at <https://www.aljazeera.com/>.
 - 4 DHS 2012–2013, pp.28–29.
 - 5 DHS 2012–2013, pp.38–39.
 - 6 DHS 2012–2013, pp.38–39.
 - 7 The Media Foundation for West Africa (2012) [website]. Available at <https://www.mfwa.org/>.
 - 8 US Department of State, *op. cit.*
 - 9 - International Telecommunication Union (2014) [website]. Available at <https://www.itu.int/en/Pages/default.aspx>.
- BuddeeComm (2014) *Mali – Telecoms, Mobile and Broadband – Statistics and Analyses*. Available at <https://www.budde.com.au/Research/Mali-Telecoms-Mobile-and-Broadband-Statistics-and-Analyses>.
 - 10 Socialbakers (2014) [website]. Available at <http://www.socialbakers.com>.
 - 11 OAfrica (2014) [website]. Available at <https://oafrika.org/>.

Religion

Over 90% of Malians are **Muslim**, and mosques therefore form an important part of society and culture. Most are Sunni Muslims who belong to one of two main Sufi brotherhoods: the Quadiriya, who came to West Africa in the 15th century, and the Tijaniya, founded in the 18th century and popularised in Mali during the 19th century.

Sufism is a mystical movement within the Islamic faith, in which believers try to achieve an understanding of the divine beyond normal human experience. To do this, Sufis use special types of prayers and practices.

Mali is one of only a few Muslim-majority countries to be governed by a fully democratic system. Today, its tolerant version of Islam is under threat from more extreme movements from outside the country and Wahabia nationally (see Political Background). 20% of Muslims now belong to the Wahabia school, which preaches a 'pure' Islam based on a literal translation of the Koran. They do not accept the different forms of Islam practised by most Malians and accuse the Sufis of complicity with the former colonial regime. Large numbers are found in and around Bamako.

In Mali, **Christian** minorities make up around 4% of the population, of whom approximately two-thirds are Roman Catholic and one-third are Protestant.

6% of Malians follow **traditional African beliefs** or profess no religious affiliation. Groups adhering to indigenous religious beliefs reside throughout the country, but are most active in rural areas. Many Muslims and Christians also adhere to some aspects of indigenous beliefs. The majority of Malians are said to believe in the evil eye and the ability to cast curses and spells.¹

The Constitution and other laws and policies protect **religious freedom** in the regions of the country over which the Government retains control. The Government does not currently have control over the northern regions occupied by extremist groups. Mali is defined as a secular state and allows for religious practices that do not pose a threat to social stability and peace. Passports and national identity documents do not designate religious identity. Public schools do not offer religious instruction, although there are a number of private, parochial and other religious educational institutions, both Muslim and Christian. The Government observes the following religious holidays as national holidays: Mawloud, the Prophet's Baptism, Easter Monday, Eid al-Fitr (Ramadan), Eid al-Adha (Tabaski) and Christmas.



*Women standing outside Djenne Mosque,
Mopti (@ kjoyran.blogspot.com)*

The **Malian High Council of Islam (HCIM)**, an umbrella organisation representing all significant Muslim groups, serves as the main liaison between the Government and those groups. Before making important decisions on potentially controversial national issues, it is the Government's policy to consult with the HCIM and the **Committee of Wise Men**, a group including the Catholic Archbishop of Bamako, Protestant leadership and other Muslim leaders.

Religion and FGM

Sunna is a term often applied to FGM, but it has varied meanings in different regions and countries.

FGM predates the major religions and is not exclusive to one religious group. Some have tried to justify it under Islam, yet many Muslims do not practise FGM and many agree it is not in the Koran.

‘Under Islamic law if medical experts are of the opinion that FC inflicts physical or physiological harm on girls and deprives them from enjoying sexual pleasure, then the legislature of Muslim state must prohibit the practice through legislation. According to Muslim jurists of all schools of thought, such a law would be binding even on those that were against it before its enactment. Moreover, violators of such law could be punished and the decisions of the courts would be binding on those who were against such legislation. Once such legislation is enacted muftis in that country will not be able to issue fatwas (verdicts) against such law. Exceptionally, if medical experts are of the opinion that FC be carried out because it avoids some greater harm, or because it is medically necessary, then exceptions are always there.’²

Wahabia Islam in Mali, however, promotes FGM on the religious grounds of making women ‘pure’ and ‘acceptable’ to pray and fast. To distance Wahabia Islam from traditional practices and religions, they advocate for FGM to be performed by health professionals in the same way as most male circumcision is done in Mali.³

The Christian Bible does not mention FGM, meaning that Christians in Mali who practise FGM do so because of tradition.

‘The Bible says, “The body is the temple of the Holy Spirit.” Let’s not mutilate this body uselessly.’

~ Pastor Thadée Diarra, Evangelical Church of Mali

FGM prevalence in Mali varies according to religious affiliation: 92.8% of Muslim women aged 15–49 have been cut, 77.2% of Animists and 65.2% of Christians (see Figure 12, although for all but Muslim women these statistics are based on relatively small numbers of women).⁴

Table 5 shows the percentages of Malian men and women aged 15–49 who have heard of FGM and believe that it is a religious requirement. A change in the beliefs and practices of Muslims in relation to FGM would have the biggest impact on the numbers of girls mutilated, because Muslims make up over 90% of the total population and are most likely to believe that FGM is a requirement.

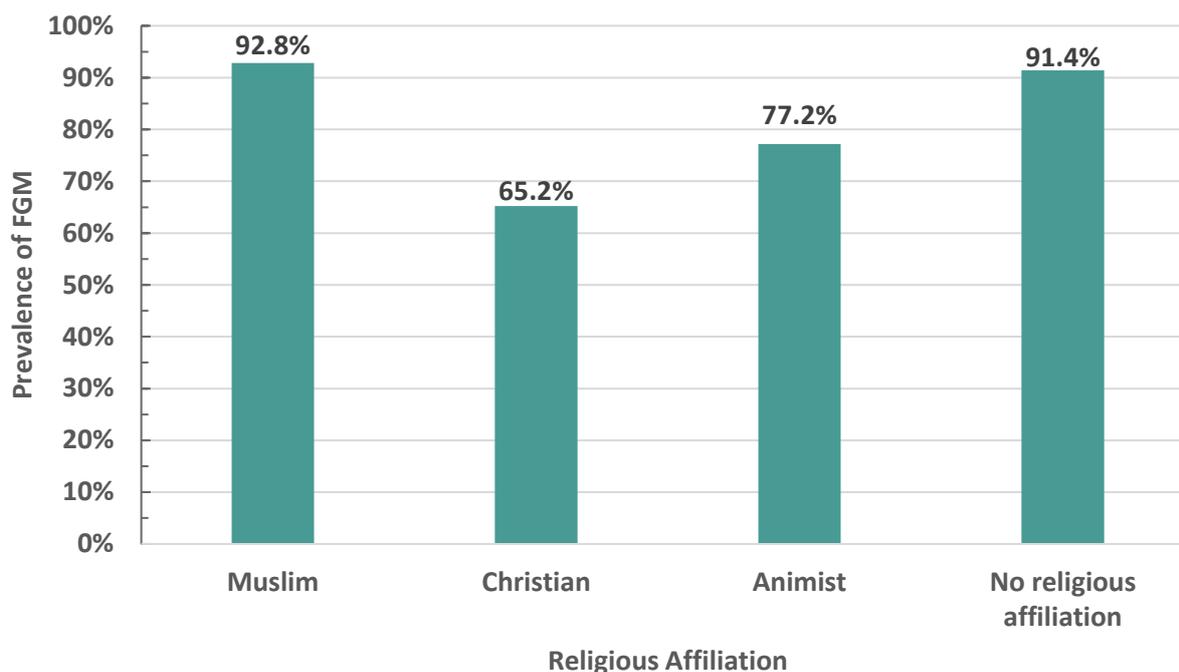


Figure 12: Prevalence of FGM in Malian women aged 15–49, according to religious affiliation⁵

Religious Affiliation	Women	Men
Muslim	73.5%	68.6%
Christian	28.3%	21.8%
Animist	37.0%	Insufficient data
No religious affiliation	49.5%	Insufficient data

Table 5: Percentage of Malian women and men aged 15–49 who have heard of FGM who believe it is required by their religion, according to their religious affiliation⁶

More men than women attend mosques, and it is mainly older women who attend Friday prayers. Historically, sermons were delivered in Arabic, limiting attendance to those who could understand the sermon’s message. In recent years a movement has started in Bamako to deliver sermons in Bambara, opening up the possibility that women will attend more services to hear Imams preach against FGM and deny any religious connection.⁷

The UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (*UNJP*) has worked in Mali in the last few years, addressing and educating religious leaders on the harmful effects of FGM and passing on teachings by other religious leaders who believe the practice should be abolished. In 2011, four regional forums were held with 150 religious leaders to discuss FGM and Islam. Financial and technical aid was given to the Association of Young Muslims to train teachers and heads of madrasas.

All quotes in this section were collected by Sini Sanuman.

- 1 Pew Research Centre (2014) *Religion and Public Life*. Available at <https://www.pewforum.org/>.
- 2 Dr Muhammad Munir (2013) *The Rights of Children in Islam: The Case of Female Genital Mutilation or Female Circumcision*.
- 3 Claudie Gosselin (2000) 'Feminism, Anthropology and the Politics of Excision in Mali: Global and Local Debates in a Postcolonial World', *Anthropologica* 42(1), pp.43–60. Available at [https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds\[\]=citjournalarticle_283004_38](https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds[]=citjournalarticle_283004_38).
- 4 DHS 2012–2013, p.295.
- 5 DHS 2012–2013, p.295.
- 6 DHS 2012–2013, p.302.
- 7 Mamadou Diouf and Mara A. Leichtman (2009) *New Perspectives on Islam in Senegal*. Palgrave Macmillan.

Education

Literacy rates are low in Mali at 56% and 38% for men and women aged 15–24 respectively, and 33.4% for the general population.¹ School lessons are taught in French, which often is not the mother tongue of pupils.

Mali has a 6-3-3 **formal education structure**. In principle, public school is free and compulsory through to the end of Grade 9 (approximately age 14). Primary school has an official entry age of seven and has six grades. Secondary school is divided into two cycles: lower secondary, consisting of Grades 7–9, and upper secondary, consisting of Grades 10–12. Basic education comprises ‘enseignement fondamental’ (the first nine grades) together with pre-primary and non-formal schooling. Students sit for the Diplôme d’études fondamentales at the end of Grade 9, and the baccalauréat at the end of Grade 12. The academic year lasts about 24 weeks.²

Table 6 shows a drop-off in **attendance** as pupils move from primary to secondary education. The pass rate for the primary education diploma is approximately 33% (2010/11), a figure that has fallen substantially over the last five years. Of those who do attend secondary school, only a further 35% pass their baccalauréat, allowing entry to tertiary education.³

2008–2012	Male	Female
Youth literacy rate (15–24 years)	56.0%	38.8%
Pre-primary school participation – gross enrolment ratio	3.3%	3.5%
Primary school participation – net attendance ratio	60.2%	54.6%
Secondary school participation – net attendance ratio	36.0%	23.1%
	Administration Data	Survey Data
Primary school participation – survival rate to last primary grade	75.5%	90.0%

Table 6: Education participation statistics relating to the years 2008–2012⁴

The education sector in Mali still suffers from the UN and IMF Bank structural adjustment programmes of the 1980s and 1990s. In particular, the World Bank’s requirement that Mali reduce the size of its civil service led to a large decline in the number of trained teachers. Around 1,000 teachers, approximately 12.5% of the teaching workforce, had their posts made redundant, while public spending cuts led to the closure of five out of the eight teaching institutes. The effects of these cuts are still an issue for the education sector today.⁵

Mali faces a shortage of **basic education resources**, forcing multiple pupils to share seats and textbooks. The budget for books and materials from the Government amounts to between US\$0.50 and US\$1 per pupil per year. Schools consequently request subsidies from parents, turning free education into an unaffordable luxury. For the poorest families, the costs of sending children to

school, as opposed to having them work, can also seem high, particularly for girls, who are expected to help with domestic duties. Children from rich households are between two and three times more likely to attend primary school than children from low-income households.

There is also a serious **shortage of schools and classrooms**. Nearly 7% of pupils have to walk more than five kilometres to reach their primary school, and less than one in five schools have a separate classroom for each year group.⁶

The absence of **separate toilets for boys and girls** in the majority of schools significantly deters girls from attending class.

Since the 2012 **northern conflict**, schools in the regions of Timbuktu, Gao and Kindal are barely operational or are closed.⁷

The ratio of **teachers** at primary level is as little as one to every 54 pupils, and there can be as few as one teacher per 100 pupils. It is worth noting that this statistic considers all available teachers, trained and untrained alike. Therefore, the ratio for trained teachers is one to 105 pupils overall, and one to 81 pupils in public schools. As of 2009, there was a workforce gap in Mali of at least 27,000 teachers. Government efforts to recruit approximately 2,500 teachers per year are not enough to decrease, let alone close, the deficit of trained teachers. The quality and level of training for teachers has also been sacrificed in an effort to boost numbers. Oxfam states that, across the profession, the average period of training teachers is 5.2 days, while as many as 80% of community school teachers are untrained. There are 13 training colleges in Mali, and the Government's in-service training is inadequate.⁸

In 2005, a **new curriculum** was introduced with the aim of teaching in each child's mother tongue, rather than in French. However, it has proven difficult to find teachers capable of teaching in languages relevant to each region. As of 2009, the new curriculum had been suspended, continuing to hinder education improvements. Oxfam states that, in Mali, 'formal education can still be perceived as offering "irrelevant" French education', and that the popularity of madrasas (schools of Islamic teaching), which educate more than 10% of primary school students, supports this. An effectively implemented new curriculum could alter this perception of 'irrelevant' French education.⁹

Despite the struggles in the education sector, initiatives from both domestic and international organisations have been successful. The **Quality Educators for All in Mali** programme was set up in 2010 in the Kayes, Koulikoro and Sikasso regions and is financially and technically supported by Comic Relief, Oxfam, Novib and Education International. Its aim was to train 3,000 teachers. Workshops to promote programmes such as Every Child Needs a Teacher were also held in Ségou in 2012.

The provision of **basic necessities** has also been proven to attract children to school. For example, a refurbished water pump at the N'gouraba primary school has meant that children do not need to miss lessons in order to collect clean drinking water. Moreover, absences caused by cases of diarrhoea and menstruating girls have reduced.¹⁰

Education and the MDGs

The African Development Bank Group has described Mali as a 'trailblazer' on the African continent for achieving MDG targets, one of which includes universal primary education by 2015. However, as has already been discussed, Mali is still struggling to achieve most of its MDG targets. As of 2012, the

total net enrolment ratio in primary education of both sexes in Mali was 73.3%, a significant increase from the estimated net enrolment of 47.2% in 1999.¹¹

The following three MDGs directly relate to improving Mali's education system.

Goal 1: Eradicate Extreme Poverty and Hunger

Mali is listed by the Food and Agriculture Organization as a 'low-income, food deficit' country. According to the World Food Programme, following a series of food, political and security shocks in the past three years, Mali is experiencing a sustained but fragile recovery. As of March 2014, the WFP documented that more than 1.5 million people were in food insecurity, and that this number is expected to increase to 1.9 million during the lean season between June and October. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity.¹² As a result of continuing political instability, UN peacekeeping forces arrived in Mali in July 2013 to help stabilise the country, and a new government was elected. Families who had been displaced as a result of conflicts, particularly in the northern regions, are beginning to return to their homes, placing a huge strain on communities already sharing sparse resources. The new Government faces considerable obstacles to tackling both the ongoing conflict in the north and extreme food shortages.

Goal 2: Achieve Universal Primary Education

The aim of this MDG is to provide universal primary education – the target is all boys and girls completing a full course of primary schooling by 2015. Currently, given the levels of enrolment and attendance, Mali is making significant gains towards achieving universal primary education for boys and girls. However, the disparity between gross and net enrolment, and gross and net attendance show that there are still hindrances, as discussed above. Still, by spending 4.3% of its public expenditure on education, Mali is meeting the World Bank recommendation that developing countries spend 4% of their GDP on the education sector. This expenditure does, however, fall short of recommendations by the Dakar Framework for Action to spend 6% and by the Global Campaign for Education to spend 20%.¹³

Goal 3: Promote Gender Equality and Empower Women

The aim of this MDG is to eliminate all gender disparity in primary and secondary education by no later than 2015. This is highly relevant, given that FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. Moreover, there is a correlation between the level of a woman's education and her attitude towards FGM.

As of 2012, the gender parity index in primary level enrolment was 0.88, while in 2011 the gender parity index in secondary level enrolment was 0.72.¹⁴ Both statistics are still a way from a gender parity index score of 1.00, though the Government of Mali has increased initiatives in the education sector to encourage more women into the teaching profession and more girls to enrol. According to government figures, children are more likely to stay in school if their teacher is a woman, while organisations based in northern Mali report that more girls enrol and stay in school if female teachers are employed.¹⁵

Marriage could be considered the greatest hindrance to a girl's education: across the nation, 25% of girls are married by the age of 15, while nearly two-thirds of girls are married by the age of 18. In certain regions, this statistic is even greater, with 39% of girls married by the age of 15 and 83%

married by the age of 18 in the Kidal region.¹⁶ It is likely that early marriage and dropping out of school results in the women's literacy rate lagging behind that of men. The high adolescent birth rate, at 190 per 1,000 births, which is linked to early marriage, also supports the disparity between literacy rates.

Education and FGM



Education campaign by Oxfam that reads, 'My protection starts with my education.'

It has been shown by some studies that 'educational attainment alone did not change attitudes and practices[;] rather that it acted as a mediating variable through which other processes, such as the diffusion of new information, operate.' Education's effects may not be immediate or direct, but it is believed to be the best long-term intervention to address FGM. With education, girls are better able to resist family and peer pressures and engage with information about their rights and the harm of FGM.¹⁷

The desire to continue the practice of FGM decreases with the levels of women's and men's education, as shown in Figure 13. Men have slightly less interest in stopping FGM than do women.¹⁸

Access to secondary education is mainly found in urban centres, and may influence some of the differences in FGM statistics between urban and rural areas. For instance, the age of cutting in daughters is lower for those who have mothers with secondary and higher levels of education, and younger cutting is also more common among those living in urban areas.¹⁹

Higher levels of education in mothers are no protection against the most severe form of FGM: girls with mothers educated to a secondary level or higher appear to be more likely to be infibulated (22.4%) than those of mothers with primary educations (19.1%) or no formal education (18.4%).²⁰ Due to the small differences, however, more data would ideally be collected to ascertain whether this is a genuine trend.

When viewing the data about behaviour and attitudes of those with secondary education it is important to remember that they are a small minority of the population, and the vast majority of girls who undergo FGM are from families where the mother has no formal education, or only primary level education.

The benefits of *not* performing FGM are more commonly recognised by both men and women who have received a secondary education than those with less education. Still, only 22.4% of men and 23.3% of women with secondary or higher level of educations recognise the increased health benefits of *not* being cut. 41.7% of men and 44.2% of women with higher levels of education still believe that there are no benefits to be had from not undergoing FGM.²¹

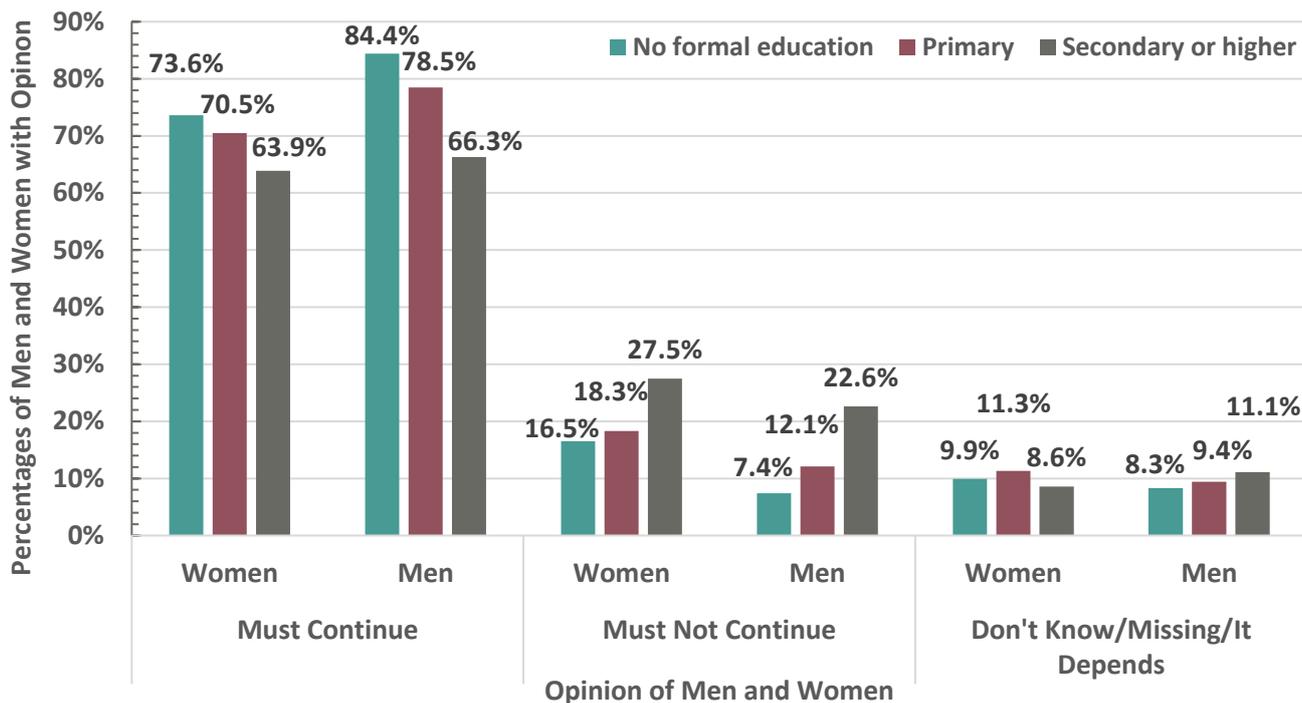


Figure 13: Percentage distribution of Malian women's and men's opinions on whether or not FGM must continue, according to their level of education²²

- 1 UNESCO IBE (2012) *World Data on Education 2010/11* [accessed September 2014].
- 2 IBE-UNESCO (2010/2011) *World Data on Education, VII Edition*. Available at <http://www.ibe.unesco.org/en/document/world-data-education-seventh-edition-2010-11>.
- 3 *Ibid.*
- 4 UNESCO (2013) 'Schools in northern Mali are barely functioning, concludes mission by UNESCO', *UNESCO Media Services*, 19 November. Available at <http://www.unesco.org/new/en/media-services/in-focus-articles/schools-in-northern-mali-are-barely-functioning-concludes-mission-by-unesco-and-government-of-mali/>.
- 5 Oxfam International (2009) *Delivering Education For All in Mali*, 12 June. Available at <https://www.oxfam.org/en/research/delivering-education-all-mali-report>.
- 6 *Ibid.*
- 7 UNESCO (2013) *op. cit.*
- 8 Oxfam International, *op. cit.*
- 9 *Ibid.*
- 10 Plan International (2014) *Mali*. Available at <https://plan-international.org/mali>.
- 11 United Nations (2014) *Millennium Development Goals and Beyond 2015*. Available at <https://www.un.org/millenniumgoals/>.
- 12 Pasquale De Muro and Francesco Burchi (2007) 'Education for Rural People: A Neglected Key To Food Security', *University Roma Tre Department of Economics – Departmental Working Papers of Economics*. Available at https://www.researchgate.net/publication/24125377_Education_for_Rural_People_A_Neglected_Key_To_Food_Security.
- 13 Oxfam International, *op. cit.*
- 14 United Nations, *op. cit.*
- 15 Oxfam International, *op. cit.*
- 16 Population Council (2004) *Child Marriage Briefing: Mali*. Available at <https://www.popcouncil.org/uploads/pdfs/briefingsheets/MALI.pdf>.
- 17 UNICEF (2007) *The State of the World's Children 2007: Women and Children – The Double Dividend of Gender Equality*. Available at https://www.unicef.org/publications/files/The_State_of_the_Worlds_Children_2007_e.pdf.
- 18 DHS 2012–2013, pp.302–303.
- 19 DHS 2012–2013, p.299.
- 20 DHS 2012–2013, p.301.
- 21 DHS 2006, pp.299–300.
- 22 DHS 2012–2013, p.304.

Healthcare

Mali has some of the lowest **health indicators** in the world. Life expectancy currently stands at 54.6 years.¹ Malaria is the leading cause of morbidity and mortality. Although the use of mosquito nets is common (84% of households own a net), the disease is still prevalent, with 52% of children carrying malaria parasites during the high transmission period.²

Community health centres (*CSCOMs*), community health volunteers (*CHVs*) and community health workers (*CHWs*) are the main **sources of public-sector primary healthcare** and high-impact health services in Mali. There are around 20,000 CHVs reporting to CSCOMs in Mali, but while there are some hundreds of trained CHWs working in southern Mali, thousands more are needed to extend primary-care services to the rest of the country, especially to geographically isolated populations.³ According to the WHO, there are just 0.8 physicians to serve every 10,000 people and 4.3 nurses and midwives per 10,000 people (compared to regional averages of 2.6 and 12 respectively).⁴

The total **expenditure on health** per capita is US\$74, which is higher than the WHO's recommendation for the minimum spend per person per year needed to provide basic, life-saving services (US\$44).⁵ The total expenditure on health is 5.8% of GDP.⁶

Since the 2012 crisis, Mali's **health infrastructure** has been compromised. With Jihadist rebels controlling the north, most health facilities were destroyed or damaged, health workers fled and many health care services stopped functioning.⁷

In addition, the WHO⁸ reports the following problems arising from the conflict:

- limited access to healthcare and interruption of health services (94% of northern community health centres are no longer functional);
- shortages of medical supplies and medicines; and
- a large influx of people to services in southern regions, which were not prepared and became overwhelmed.

Health and the MDGs⁹

Goal 4: Reduce child mortality

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

- Infant mortality rates fell from 229 per 1,000 births in 2001 to 80 in 2012.
- Child mortality rates fell from 253 per 1,000 children under five years in 1990 to 128 in 2012.¹⁰

Goal 5: Improve maternal health

Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

- The maternal mortality rate has declined from 860 per 100,000 live births in 2000 to 540 in 2012.¹¹
- The UNDP's MDG Report for Mali projects that Mali will not meet this target.

Goal 6: Combat HIV/AIDS, malaria and other diseases

Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

- HIV/AIDS prevalence fell from 1.7% in 2001 to 0.9% in 2012.¹²
- The UNDP progress report for Mali states that meeting this MDG target is dependent on rapid governmental change and the development of affordable vaccines and medications.

The Minister of Foreign Affairs and International Cooperation stated in 2010 that the Malian Government was committed to achieving the MDGs in a sustainable manner, as evidenced by the adoption of its 2006–2015 plan. This strategy focuses on poverty reduction and socio-economic development (particularly agriculture, food security, education and health).¹³

USAID stated in 2009¹⁴ that Mali is not on track to meet its MDGs by 2015, and argued that a major contributing factor to this challenge is the continuous, rapid growth of the population. Mali has a high unmet need for family planning (FP), and USAID highlighted the importance of strengthening FP services in Mali in order to slow population growth and make the MDGs more achievable. The costs of achieving five MDGs were calculated, with the unmet need for FP remaining constant and with it being gradually met by 2020, and clear evidence was found to show that reducing the unmet need for FP would significantly reduce the costs of meeting the following MDGs:

- Goal 2: Achieve universal primary education;
- Goal 4: Reduce child mortality;
- Goal 5: Improve maternal health;
- Goal 6: Combat HIV/AIDS, malaria and other diseases; and
- Goal 7: Ensure environmental sustainability.

USAID estimated that the saved costs that would outweigh the additional cost of FP by a factor of almost two to one.

Women's Health and Infant Mortality

In countries with almost universal FGM prevalence, the complications that arise directly from FGM either in general healthcare or during childbirth are often not recognised by health workers or survivors as being related to FGM.

The adolescent fertility rate is high: 188 births per 1,000 women aged 15–19, contributing on average 12% of all births. There is some discrepancy in adolescent fertility between the wealth quintiles. 60% of women in the poorest quintile have their first child before the age of 18, compared to 43% of women in the richest quintile.¹⁵

There has been little research into the impact of FGM on general health and complications in childbirth in Mali. Jones *et al.* recorded complications related to FGM in patients undergoing pelvic examinations in four rural and four urban clinics in Mali (the study also took place in 21 rural clinics in Burkina Faso) (Figure 14). Those found to have undergone FGM were asked to report complications they had experienced. 94% of women examined in Malian clinics had undergone FGM and most (74%) had experienced Type II FGM.¹⁶ Of the 1,468 Malian women who attended the clinics to give birth, 24% experienced complications.

Haemorrhage was the most commonly reported gynaecological complication in Mali – of those affected by FGM, over half (52%) had suffered a haemorrhage. The study asserts that the complications found in women who had undergone FGM were likely to be directly caused by the FGM. However, due to research staff mistakenly omitting complications found in uncut women, the data for uncut women was not included in the analysis. Of the 174 uncut women correctly recorded (in both Burkina Faso and Mali), only two had suffered any complications (both haemorrhages). In addition, the likelihood of experiencing complications during delivery increased with the severity of FGM type. 5% of women with Type II and 36% of women with Type III faced complications.

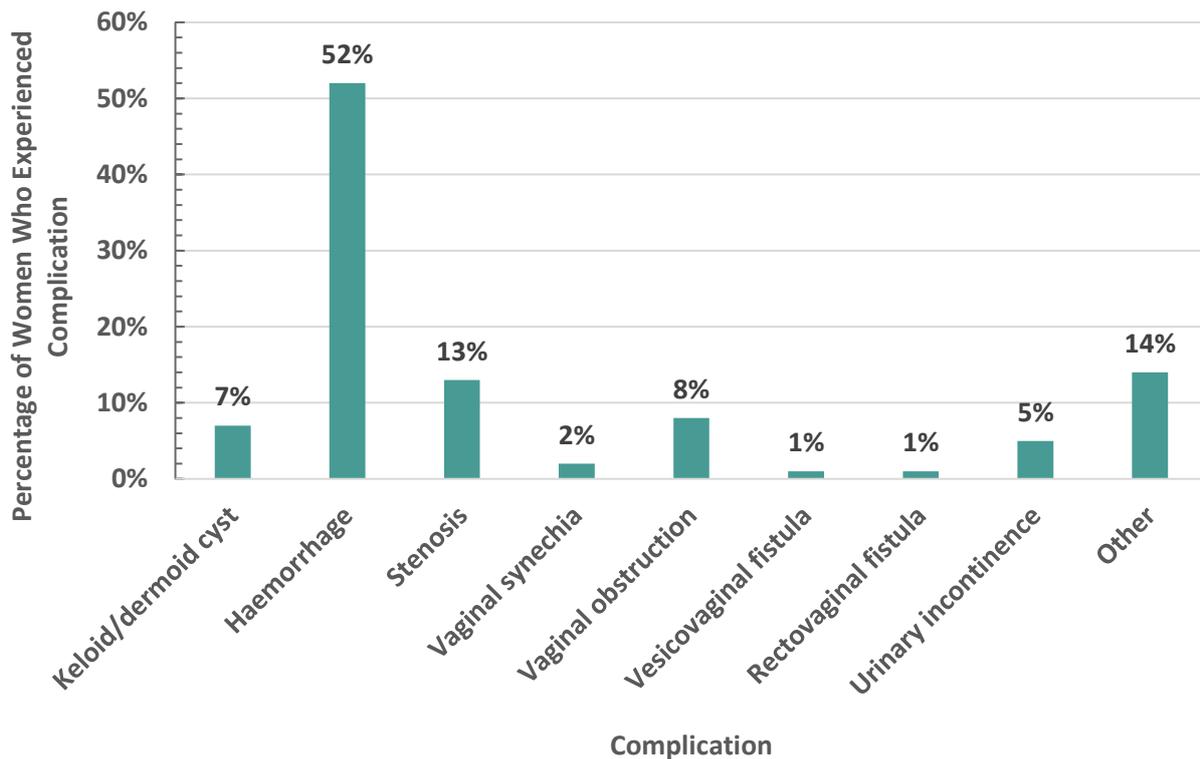


Figure 14: Distribution of all cut women with at least one gynaecological complication, by type of complication¹⁷

Reproductive Healthcare

Mali has one of the highest fertility rates in the world, with each woman likely to give birth 6.1 times in her lifetime.¹⁸ This rate has decreased since the DHS 2006. Prior to that it had remained static at 6.6 since 1996.¹⁹ The DHS 2006 recorded differences in fertility rates according to financial status, with the poorest women expecting 7.6 births compared to 4.9 for the richest women. The disparity was even greater in terms of location and educational attainment. While women in rural areas could expect to have 7.2 births, women in Bamako had on average 2.8 births. Those with no education could expect to give birth 7 times, whereas women with a secondary or higher level of education could expect 3.8 births.²⁰ In the DHS 2012–2013 the trends continue, but rates are lower overall. For example, women in rural areas still have more children than urban women, but can now expect 6.5 births and urban women 5 births.²¹

Modern contraceptive use is uncommon in Mali. While use is slightly more frequent among urban women, educated women and wealthier women, there is still a great unmet need for contraception for women who want to limit their family size or space their births in Mali. Reasons commonly given

for not using modern contraceptive methods are opposition to modern methods, wanting more children, and a lack of knowledge of modern contraceptives or where to acquire them. Concerns regarding contraceptive costs and access are not as common, and The World Bank suggests these findings indicate a need to strengthen family planning services.²²

While HIV prevalence is relatively low in Mali (0.9% in 2012, with 50,000 women affected), there is a knowledge-behaviour gap regarding HIV and condom use. Despite the majority of young women being aware of condoms as HIV prevention, only 3% had used a condom at last intercourse. Due to the use of condoms lessening during marriage, this knowledge gap widens with age.²³

74.2% of women who had had a baby in the five years prior to the DHS 2012–2013 accessed some form of medical care during their most recent pregnancy. Women in urban areas are more likely to access care during their pregnancy (93.2%) than women in rural areas (69.3%). Educational attainment is also a factor in whether or not a woman will access antenatal care: only 70.7% of women who have had no formal education will access antenatal care compared to 95.2% of women with a secondary or higher level of education.²⁴

Despite Mali having a high total fertility rate, the number of women accessing maternal health services is low. 41.2% of women reported attending the four or more antenatal appointments recommended by the WHO and only 39.9% received healthcare in the 48 hours following delivery.²⁵ The likelihood of women accessing all recommended antenatal appointments, delivering in a healthcare facility and receiving adequate postnatal care greatly increases when their mothers-in-law believe in the efficacy of these treatments and decreases when mothers-in-laws favour traditional methods.²⁶

Reproductive Health Complications

Mali's maternal mortality rate is 540 per 100,000 births.²⁷ Women in Mali have a 1 in 28 lifetime risk of dying in childbirth. Each day there are 287 birth complications, 184 in rural locations, and only three midwives in the whole country per 1,000 live births.²⁸ Haemorrhage is a known birth complication for women who have had FGM of all types, because of the inelasticity of the scar tissue, which leads to tearing during delivery and, potentially, excessive blood loss. 26% of maternal deaths in sub-Saharan Africa are due to haemorrhage and 34% are in Mali. Even mothers who give birth in a health facility may not receive proper treatment, as there is a shortage of donated blood throughout Mali.²⁹

Physicians for Peace asserts that the primary cause of new mothers dying from haemorrhage is the inadequate access to clean, safe blood transfusions.³⁰ This reflects numerous studies that have demonstrated a direct link between maternal deaths following haemorrhage and the lack of blood transfusion services. Mali only has one (poorly equipped) blood bank in Bamako. Elsewhere in the country patients needing blood transfusions must rely on family members. Due to the lack of facilities to collect, screen or process blood, such transfusions are often performed using a rudimentary technique known as vein-to-vein transfusion. Patients who have unwilling or incompatible family members often resort to sourcing suitable blood from paid donors (often from high-risk groups), potentially exposing themselves to transmittable infections. Plans are currently in place to introduce a second blood bank to the country in Segou.

A WHO multi-country study³¹ found that women who had undergone FGM were more likely to suffer adverse obstetric outcomes (C-section, postpartum haemorrhage, extended maternal hospital stay,

infant resuscitation, stillbirth and early neonatal death) than their uncut counterparts, and that the risks of such outcomes increased with the severity of FGM. The annual cost is estimated to be US\$3.7 million and ranges from 0.1% to 1% of government spending on health for women aged 15–45.³²

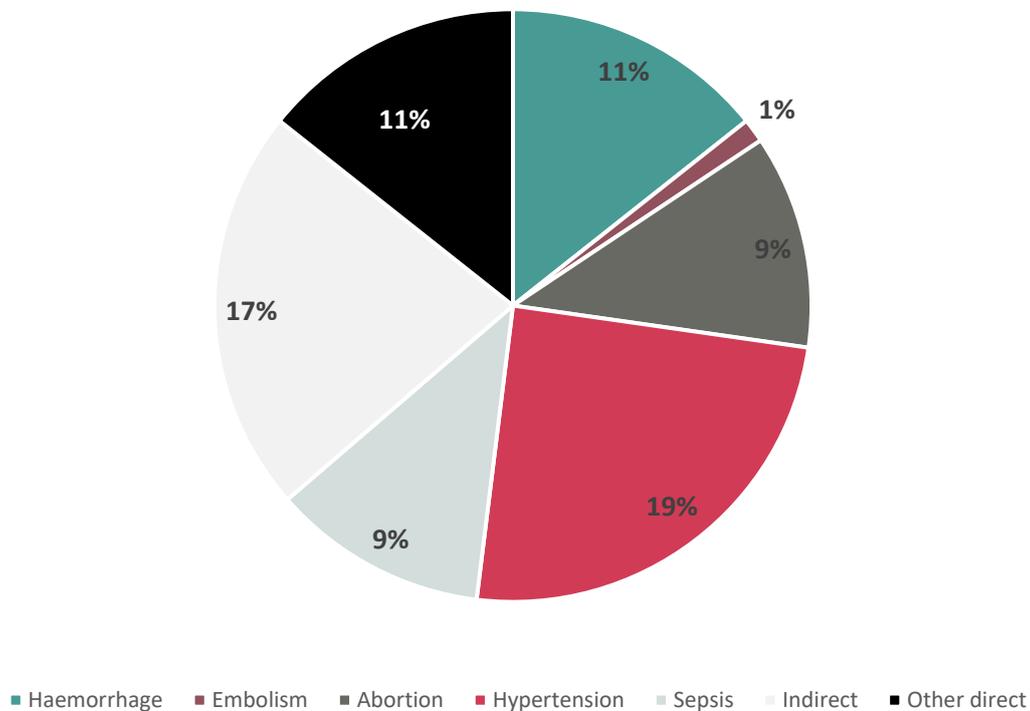


Figure 15: Percentage distribution of causes of maternal deaths in Mali³³

Table 7 shows the relative risks of complications for a cut or uncut woman giving birth. A figure of one means that the risk is the same for each woman. A number larger than one shows an increased risk of problems for a woman with FGM (depending on type) compared to uncut women; conversely, a number smaller than one indicates a decreased risk.

Complication	Type I	Type II	Type III
Caesarean section	1.03	1.29	1.31
Postpartum haemorrhage	1.03	1.21	1.69
Extended maternal hospital stay	1.15	1.51	1.98
Infant resuscitation	1.11	1.28	1.66
Stillbirth or early neonatal death	1.15	1.32	1.55
Low birth weight	0.94	1.03	0.91

Table 7: Relative risks of birth complications for a woman with FGM versus a woman without³⁴

FGM is also believed to result in an extra one or two deaths per 100 deliveries, and 22% of perinatal deaths in babies born to women who had undergone FGM were a direct result of the procedure.

Fistula

Fistula is a debilitating condition that causes embarrassment and discomfort to those affected. It is caused by long and obstructed labours. Prolonged pressure from the baby getting stuck in the birth canal damages the tissues between the vagina and the urethra and/or the rectum, resulting in incontinence. Prolonged and obstructed labours are more common in young mothers, due to underdevelopment, and 80% of fistula victims are under 15. It is estimated that around 2–3.5 million women and girls worldwide are affected by fistula.³⁵ In Mali there are around 1,800 women at risk of obstetric fistulas every year and 1,000 new cases annually.³⁶

Between 2008 and 2013, IntraHealth and Engender Health collaborated in the Fistula Care Project in Mali, working to improve services for women affected by fistula. A National Strategy for Fistula Prevention and Treatment and a National Quality Standards on Prevention and Treatment of Obstetric Fistula were developed and disseminated throughout the country. A meeting was held to discuss integrating fistula services into FP services, and 500 midwives were educated on fistula at a national midwives' conference. Despite the project having to relocate due to the political crisis in 2012, it was able to ensure the following: 460 women received fistula repair interventions, 13 surgeons were trained in simple fistula repair, 301 providers were trained in fistula and FP counselling, 109 providers were trained in infection prevention, and 184 nursing students were trained in fistula prevention and treatment.³⁷

Place of Delivery

55% of births in Mali take place in a healthcare facility. As with antenatal care, the likelihood of accessing medical care during delivery is strongly linked with women's area of residence, level of wealth and educational attainment. In rural areas only 46.4% of deliveries took place in a healthcare facility, compared to 91.4% of births in urban areas.³⁸

FGM Treatment

Mali has taken positive steps in creating a national programme to accelerate FGM abandonment. Programme National de Lutte contre l'Excision Programme National de Lutte Contre la Pratique de l'Excision (*PNLE*) and all healthcare courses now include FGM in the curriculum, meaning that doctors, nurses and midwives are trained to understand and treat complications arising from the practice. In 2013, 350 healthcare workers and 50 supervisors/nurses' aides were trained to treat both the physical and psycho-social complications that arise from FGM. This led to the additional FGM-related treatment of 864 women and girls in 19 community health centres assessed by Malian NGO Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles. An added benefit of this increase in FGM training is that many women treated have become allies in the fight to end FGM in Mali.³⁹

1 UNICEF (2012) *Mali: Statistiques*. Available at https://www.unicef.org/french/infobycountry/mali_statistics.html.

2 USAID (2013) *Mali: Health Strategy*, 11 September. Available at https://www.usaid.gov/sites/default/files/documents/1864/USAID-Mali_Health_Strategy_2014-2018.pdf.

3 *Ibid.*

4 WHO (2012) [full details of original reference no longer available]

5 WHO (2012) [full details of original reference no longer available]

- 6 World Health Organization (2012b) *Spending on health: A global overview*, 17 April. Available at <https://www.who.int/news-room/fact-sheets/detail/spending-on-health-a-global-overview>.
- 7 USAID (2013), *op. cit.*
- 8 World Health Organization (2014) *Implementation report on the health activities in response to the humanitarian crisis in Mali*. Available at https://www.who.int/hac/crises/mli/sitreps/mali_implementation_report_april2014.pdf?ua=1.
- 9 UNDP (2004) *Rapport de suivi de la mise en oeuvre des Objectifs du Millénaire pour le Développement (OMD)*. Available at <https://www.undp.org/content/undp/en/home/librarypage/mdg/mdg-reports/africa-collection.html>.
- 10 UNICEF (2012) *Mali: Statistiques*. Available at https://www.unicef.org/french/infobycountry/mali_statistics.html.
- 11 World Health Organization cited in The World Bank (2013) [website]. Available at <https://www.worldbank.org/>.
- 12 UNICEF (2012), *op. cit.*
- 13 United Nations (2010) *Mali H.E. Mr. Moctar Ouane, Minister for Foreign Affairs and International Cooperation*. Available at <https://www.un.org/en/ga/65/meetings/generaldebate/View/SpeechView/tabid/85/smId/411/ArticleID/263/reftab/234/t/Mali/Default.html>.
- 14 USAID (2010) *2009 NGO Sustainability Index for Sub-Saharan Africa*. Available at <https://www.usaid.gov/africa-civil-society/2009>.
- 15 The World Bank (2013) [website]. Available at <https://www.worldbank.org/>.
- 16 Heidi Jones, Nafissatou Diop, Ian Askew and Inoussa Kaboré (1999) 'Female Genital Cutting Practices in Burkina Faso and Mali and Their Negative Health Outcomes', p.224, *Studies in Family Planning*, 30(3), pp.219–230.
- 17 *Ibid.*
- 18 Central Intelligence Agency (2014) *The World Factbook: Mali*, 9 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ml.html>.
- 19 The World Bank (2011).
- 20 The World Bank (2011).
- 21 DHS 2012–2013, p.66.
- 22 The World Bank (2011).
- 23 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, p27. Available at https://www.unicef.org/publications/index_69875.html.
- 24 DHS 2012–2013, p.106.
- 25 DHS 2012–2013, pp.108 and 114.
- 26 Darcy White, Michelle Dynes, Marcie Rubardt, Koman Sissoko and Rob Stephenson (2013) 'The Influence of Intrafamilial Power on Maternal Health Care in Mali: Perspectives of Women, Men And Mothers-in-Law', *International Perspectives on Sexual and Reproductive Health*, 39(2), June. Available at <https://www.guttmacher.org/journals/ipsrh/2013/influence-intrafamilial-power-maternal-health-care-mali-perspectives-women>.
- 27 UNICEF (2012) *op. cit.*
- 28 UNICEF (2007) *The State of the World's Children 2007: Women and Children – The Double Dividend of Gender Equality*. Available at https://www.unicef.org/publications/files/The_State_of_the_Worlds_Children_2007_e.pdf.
- 29 UNICEF (2012), *op. cit.*
- 30 Physicians for Peace (2014) [website]. Available at <https://www.physiciansforpeace.org/>.
- 31 WHO study group on female genital mutilation and obstetric outcome (2006) 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries', *The Lancet*, 3 June. Available at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68805-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68805-3/fulltext).
- 32 World Health Organization (2011) *An update on WHO's work on female genital mutilation (FGM)*. Available at https://www.who.int/reproductivehealth/publications/fgm/rhr_11_18/en/.
- 33 UNICEF (2012) *Mali: Statistiques*. Available at https://www.unicef.org/french/infobycountry/mali_statistics.html.
- 34 WHO study group on female genital mutilation and obstetric outcome, *op. cit.*
- 35 UNFPA (2012) *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Annual Report 2012*. Available at <https://www.unfpa.org/publications/unfpa-unicef-joint-programme-female-genital-mutilationcutting-annual-report-2012>.
- 36 Michel Brugière (2012) 'Obstetric fistulas in Mali, Combating maternal and child mortality', *Field Actions Science Report*, 5(2012) Women's and Children's Health. Available at <https://journals.openedition.org/factsreports/2707>.
- 37 IntraHealth (2013) *Voices from the Mali Fistula Care Project*. Available at <https://www.intrahealth.org/resources/voices-mali-fistula-care-project>.
- 38 DHS 2012–2013, p.112.
- 39 UNFPA (2014) *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change: Summary Report of Phase I 2008–2013*. Available at <https://www.unfpa.org/publications/unfpa-unicef-joint-programme-female-genital-mutilationcutting-accelerating-change>.

Interventions and Attempts to Eradicate FGM

Background

NGOs have been working to eradicate FGM in Mali since the 1960s. However, NGOs and other organisations are facing sustainability issues, partly due to the ongoing conflict in northern Mali.

It is evident from the DHS 2006 figures that, although attitudes towards FGM may be changing among the younger age groups, who will all be eight years older at the time of this report, this has had little effect on prevalence. As has already been noted, young people have little power or say in society, and it may take a generation before these attitudes towards FGM are turned into action. Meanwhile, the early age at which FGM occurs leaves little room for interventions with school-aged children to resist the practice. Anecdotally, mothers-in-law and grandmothers are generally implicated in deciding on FGM. Evidence from White *et al.*'s study shows clearly the importance of a woman's ability to decide on and access maternal healthcare independently, and that the strongest factor in access is the mother-in-law's attitude.¹

Reasons given for FGM vary between genders, ages and ethnic groups. It is therefore imperative that interventions are tailored to these individual groups' beliefs; otherwise, the programmes may be ineffective. Public dialogue to stimulate private discussions within families will ultimately affect decisions to carry out FGM on children.

Government Policy and Support

It has been reported that Mali's legal environment for NGOs is one of the most supportive in Africa. NGOs can easily register and are generally free to express their views on policy issues, although they face difficulties in applying for tax exemptions and government tenders.²

In Mali, 25,965 leaders have pledged in favour of abandoning FGM; 200 of them have made public statements.³

Programme National de Lutte Contre la Pratique de l'Excision (PNLE)

The PNLE was established in 2002 by the Government as part of the Ministry of Woman Promotion, Child and Family. It is in charge of coordinating programming related to eradicating FGM. Its action plan 2010–2014 has a strategic outcome of reducing FGM from 85% to 65% by the end of 2014.

The roles of PNLE include:

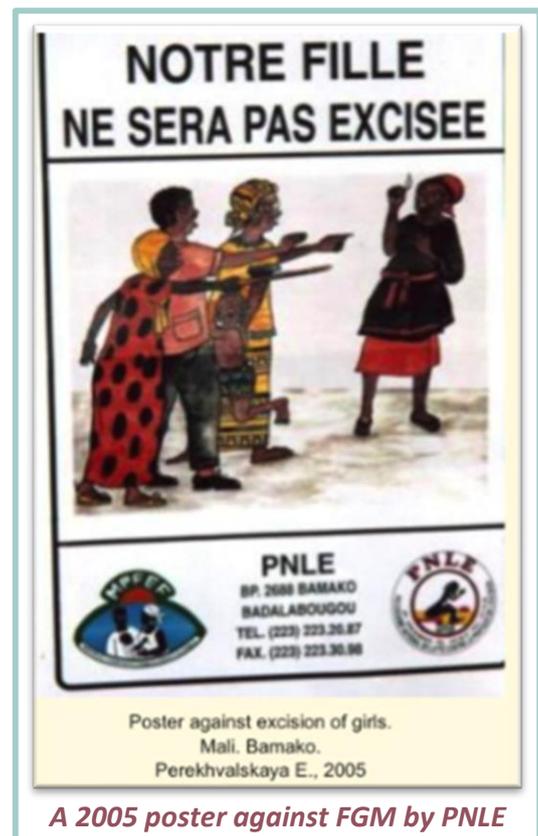
- coordinating activities to eradicate FGM;
- researching the history of FGM in Mali;
- developing an information and communication strategy to encourage abandonment and planning national programmes with partner groups;
- evaluating and supervising anti-FGM programming;

- creating a database of FGM-related information; and
- supporting the preparation of an anti-FGM curriculum and introducing it into schools of medicine and education.

The PNLE also sponsors the Comité National d'Action pour l'Abandon des Pratiques Néfastes à la Santé (CNAPN). This committee provides training and education, conducts research, attempts to reform legislation, and supports NGOs working on eradicating FGM.

Population Services International's (PSI) evaluation of the PNLE shows that significantly fewer men and women with an uncut daughter intend to cut her in the future, a decline from 51% to 38%.⁴

The PNLE also created a training workshop in partnership with Plan Mali. This two-day event for journalists was on the theme of child rights and FGM. The journalists were required to master the information in order to properly address the issues surrounding FGM.



A 2005 poster against FGM by PNLE

Overview of Interventions

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM in Mali. Often, a combination of the interventions and strategies below are used.

- Health risk/harmful traditional practice approach.
- Addressing the health complications of FGM.
- Educating traditional excisors and offering alternative income.
- Alternative rites of passage (not used widely in Mali).
- Religious-orientated approach.
- Legal approach.
- Rights approach/'Community Conversations'/Intergenerational Dialogue.
- Promotion of girls' education to oppose FGM.
- Supporting girls escaping from FGM/child marriage.
- Media influence.
- Working with men and boys.

Health Risk/Harmful Traditional Practice Approach

Strategies that include education about the negative consequences of FGM have been the most frequently used globally for the eradication of the practice and are a common element of programmes within Mali. However, convincing people in areas with a very high FGM prevalence of the health problems can be a challenge. Difficult childbirth and long post-partum recovery periods, which are often exacerbated by FGM, are often seen as the norm. Communities may not, therefore, attribute the complications of FGM to the procedure itself.⁵ In Mali, many of the complications are explained in terms of magic and taboos.

In a 2006 study, most interviewees were able to list direct and indirect complications related to FGM, according to their own beliefs and superstitions.⁶ Additionally, some religious men surveyed were also aware of direct and indirect complications related to FGM.

Some said that bleeding could happen during FGM if one of the girl's parents does not approve of the hired practitioner. If a girl is taken to another village to be cut, she will likely have bleeding. If bleeding occurs, the girl is blamed for infringing a social taboo. Haemorrhage can happen when the excisor is mystically betrayed by someone. FGM can cause death; therefore if someone accuses another of anthropophagy (eating of human flesh), a newly cut girl will die from tetanus. The community will assume that the girl's parents are responsible for her death. There is thus a need for educating about the health consequences of FGM to correct these misapprehensions.

ASDAP is an NGO that works with local health centres and recruits women to talk with men and women in their communities about the health consequences of FGM. The NGO **TAGNE** tours around villages with an anatomical model of the female body, teaching basic health information and the consequences of FGM. **HELVETAS Swiss Intercooperation** also works to raise awareness about the health complications of FGM.

Addressing the Health Complications of FGM

The national policy officially recognised FGM as a public health problem in 2011, but, until then, government health workers showed little interest in the issue. Therefore, PNLE and other partners, including the UNJP, developed a plan to train medical workers to treat the consequences of FGM.

Since local radio stations have been broadcasting health professionals' explanations of the medical complications of FGM, the number of women and girls seeking medical help for such problems has increased. With support from the UNFPA, 63 cases of complications resulting from FGM were treated in 2011 and a further 864 women and girls in 2012. Reports reveal that the demand for treatment continues to outstrip supply.

The fistula care project run by **Intrahealth** and partly funded by **Norwegian Church Aid** is based on prevention (awareness raising), treatment (reconstructive surgery), and special care and support. This includes lobbying for a law that will give women access to free fistula operations. Prevention is a major component of the work.⁷ Intrahealth regularly speaks with local authorities and traditional and religious leaders, who play significant roles in FGM intervention.⁸ Its aim is to ensure that communities understand and accept that obstetrical fistula is a medical condition that can be treated

and is not a non-curable curse causing stigmatisation and fatalities. The NGO **GREFFA** also works on treating fistulas and educating villagers about prevention.

Educating Traditional Excisors and Offering Alternative Income

The **Population Council** and **CNRST** evaluated three NGO programmes and found that traditional practitioners continue to perform FGM despite stating that they had abandoned the practice.⁹ More positively, **Sini Sanuman** has recorded 150 excisors who have stopped practising, many of whom have joined its anti-FGM initiatives.¹⁰

‘Our president, Siaka Traoré, was the fifth person to approach our first exciser, Djarawélé Sinagnoko. She told us she was very angry at the first person who criticized her “profession.” She was still upset, but less so, at the second person. By the time the fifth person said the same thing to her, she decided that she didn’t want to go against the whole community and stopped. The early people might have felt that they failed, but they were part of the process of convincing her. Speaking up is a powerful tool and Sini Sanuman encourages everyone, if they are against FGM, to say so.’

~ NGO Sini Sanuman on educating traditional excisors



*Excisors who have abandoned their practice
(© Sini Sanuman)*

Religious-Orientated Approach

A religious-orientated approach refers to approaches that demonstrate how FGM is not compatible with the religion of a community, thereby leading to changes of attitudes and behaviours. A study of excision in Mali in 2006 questioned religious leaders on the role they saw for themselves in action against FGM. They said, ‘We can take part in the fight against excision if we are well informed about the consequences of the practice.’¹¹

USAID's Health Policy Initiative identified three main audiences for its action plan: (1) officials who are afraid to publicly support a ban on FGM because of the influence of Islamic religious leaders on the electorate; (2) doctors and nurses who do not fully understand the health consequences of FGM; and (3) religious leaders and their constituents who believe that FGM is a practice endorsed by Islam. USAID worked with religious networks including the Réseau Islam Population et Développement (Islam, Population and Development Network or RIPOD), Union Nationale des Associations de Femmes Musulmanes du Mali (Federation of Muslim Women in Mali or UNAFEM) and the Haut Conseil Islamique (High Islamic Council). An advocacy tool was developed to be used by religious leaders to educate the population and decision-makers about FGM and Islam.

In 2011, 1,230 religious leaders, teachers and community-level officials attended awareness-raising workshops about the effects of FGM. With support from the **UNJP**, four regional forums brought together 150 religious leaders to discuss the practice in the context of Islam. **Save the Children Sweden** believes that religious leaders are the gatekeepers for change and its project with **Centre Djoliba** focuses on dialogue with these individuals.

'Excision is a custom; it's not an obligation in the Muslim religion. Everything that hurts our health is rejected and condemned by Islam, because it can decrease the number of people who practice the religion, by leading them toward death.'

~ Ali Coumaré and Lamissa Dembélé, Malian marabouts and professors of Arab (Sini Suniman)

Legal Approach

Many NGOs continue to advocate for a law banning FGM, and petitions are raised and taken to parliament regularly. The NGO **RML/MGF** has established a goal, involving regional councils and regional health directorates, of achieving a law passed against FGM. **Plan – Mali** has also declared that it aims to make FGM illegal by 2016.

The lack of legislation criminalising FGM has created the risk of Mali becoming a refuge for those from neighbouring countries determined to have the practice performed. In 2012, **AWEPA** convened two workshops for parliamentarians from Burkina Faso and Mali and representatives from Côte d'Ivoire, Niger and Togo. The workshop produced a network of parliamentarians who are committed to achieving legislation against FGM.

Rights Approach/'Community Conversations'/Intergenerational Dialogue

A rights-based approach acknowledges that FGM is a violation of women's and girls' rights. This approach is sometimes used alongside other strategies to eradicate FGM based on the social abandonment theory of FGM (derived from the social change theory behind foot-binding in China). The components of this theory include: (i) a non-judgemental human-rights approach; (ii) community awareness-raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective one by the entire community; (iv) the requirement of community public affirmation of

abandonment; (v) intercommunity diffusion of the decision; and (vi) a supportive, change-enabling environment, including the commitment of the Government.¹² This approach was pioneered by Tostan in Senegal. The approach is based on the principle of listening and questioning between different generations, aided by a facilitator. It enables participants to reflect on their values, customs, traditions and expectations and to consider whether, when, how and under what conditions change should take place.¹³

The differences between rights in/over people as held in Malian society and the rights of individuals as adopted by human-rights interventions need to be phrased carefully to avoid antagonising participants. For instance, campaigning for women's right to enjoy sex would discredit an anti-FGM campaign in the eyes of the majority of the population.¹⁴

The collaboration between **UNICEF**, the **Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSPOT)** and **Tagné, 'To move forward'**, and the NGO **Sini Sanuman**, which started in 2009, resulted in a total of 1,405 community discussions, plus 3,202 additional community-based interventions in 2012. In total, 133 communities publicly abandoned FGM in 2012 – comprising more than 830,000 people. **APSEF** also works in many locations throughout Mali, educating communities on the rights of children and especially girls, with many successes reported in places where it works. **IAMANEH Suisse** and **SDI** report that they have successfully convinced 27 villages in the Segou region to abandon FGM, with a further eight to declare abandonment by the end of 2014.

Griots (oral historians) can also play an important role in facilitating community dialogue.

Promotion of Girls' Education to Oppose FGM

The NGO **Musow-Jiji** holds talks at literacy centres on the importance of abandoning FGM.

Supporting Girls Escaping from FGM/Child Marriage

IAMANEH Suisse has a project in Mali that provides counselling and shelter for women suffering from domestic violence (including FGM).

Media and Communication

In 2009 an **integrated mass-communication strategy** was started, which includes theatres, forums, travelling cinemas, and local and national radio and TV stations. Since then, a number of workshops have been held to train journalists to report accurately on FGM. **PNLE**, with a number of NGOs, organised a national forum on FGM for journalists and traditional communicators to build the capacities of media professionals to report on child rights and FGM. A documentary film on the forum funded by the UNJP was broadcast on AFRICABLE TV.

Pan-African TV channel, a worldwide network, broadcast 60 programmes featuring the sermons of an eminent Imam denouncing FGM. National radio is also used regularly to raise awareness about the need to abandon FGM. In addition, a number of private, local radio stations covered various activities of the campaign against FGM. In print media, articles about FGM are often published. In

total the UNJP counted more than 3,500 press releases, radio and TV programmes in 2012, up from around 500 in the previous year.¹⁵

Sini Sanuman uses popular media such as theatre, songs and music videos in its anti-FGM initiative. It works in collaboration with famous singers and traditional songwriters such as griots to tailor the message to the Malian audiences.

The Population Council is working with the **Malian Government** on a mass-media campaign to dispel the myth that FGM is required by Islam.

Working With Men and Boys

UNICEF Mali conducts separate male and female dialogue sessions to give everyone an opportunity to speak without being influenced. It works with many NGOs, the Government, and other organisations on various anti-FGM projects. **AMSOPT** also holds discussions with men on general health and reproduction.

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- 1 Darcy White, Michelle Dynes, Marcie Rubardt, Koman Sissoko and Rob Stephenson (2013) 'The Influence of Intrafamilial Power on Maternal Health Care in Mali: Perspectives of Women, Men And Mothers-in-Law', *International Perspectives on Sexual and Reproductive Health*, 39(2), June 2013, pp.58–68. Available at <https://www.guttmacher.org/journals/ipsrh/2013/influence-intrafamilial-power-maternal-health-care-mali-perspectives-women>.
 - 2 USAID (2010) *2009 NGO Sustainability Index for Sub-Saharan Africa*. Available at <https://www.usaid.gov/africa-civil-society/2009>.
 - 3 - UNJP (2012) *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change Annual Report 2012*. Available at https://www.unfpa.org/sites/default/files/pub-pdf/UNICEF-UNFPA%20Joint%20Programme%20AR_final_v14.pdf.
- UNJP (2014) *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change Summary Report 2008–2013*. Available at <https://www.unfpa.org/sites/default/files/pub-pdf/Joint%20Programme%20on%20FGMC%20Summary%20Report.pdf>.
 - 4 Population Services International (2007) [website].
 - 5 Anna Winterbottom, Jonneke Koomen and Gemma Burford (2009) 'Female Genital Cutting: Cultural Rights and Rites of Defiance in Northern Tanzania', *African Studies Review*, (52)1, pp.47–71.
 - 6 Poricho (2006) *Excision in the Church Districts of Bamako, Bougouni, and Mana. Perceptions, Attitudes and Practices*.
 - 7 Norwegian Church Aid (2011) *Country Plan 2011–2015*.
 - 8 IRIN (2012) *Unrest hinders fight against fistula*, 20 March. Available at <https://www.thenewhumanitarian.org/report/95113/mali-unrest-hinders-fight-against-fistula>.
 - 9 Diop and Askew (2007) 'Strategies for Abandonment of Female Genital Cutting in Female Circumcision', *Multicultural Perspective*. University of Pennsylvania Press.
 - 10 Sini Sanuman (2014) [website]. Available at <http://www.sinisanuman.info/en/home/>.
 - 11 Poricho, *op. cit.*
 - 12 Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22(1), p.4. Available at <http://dx.doi.org/10.1080/09589236.2012.681182>.
 - 13 GIZ (2011) *Female Genital Mutilation and Behaviour Change*. Available at <https://www.giz.de/en/html/index.html>.
 - 14 Claudie Gosselin (2001) *Campaigning against excision in Mali: global and local hierarchies, hegemony and knowledge* [PhD Thesis]. Available at <https://tspace.library.utoronto.ca/handle/1807/15848>.
 - 15 - UNJP (2012), *op. cit.*
- UNJP (2014), *op. cit.*

International Organisations

Équilibres & Populations

Founded in 1993, this INGO is based in sub-Saharan Francophone Africa. It focuses on human rights, women's welfare, freedom and responsibility, and social justice and equity. It aims to promote sustainable development through improved living conditions and the status of women, and focuses on health and sexual/reproductive rights. Partners include other organisations and community-based organisations (CBOs), traditional leaders, women's groups, health personnel, researchers, journalists and political figures. It has been working in collaboration with AMSOPT on the project Protéger la Prochaine Génération, which centres on abandoning FGM in Kayes, western Mali.

Helvetas Swiss Intercooperation (HSI)

HSI has been working in Mali since 2007 in Sikasso and Kayes. Working closely with PNLE, it initiated a programme named Soutien aux initiatives locales de lutte contre l'excision (SILE), which aims primarily to sensitise populations to the dangerous effects of FGM through education, radio programmes and theatre in villages, health centres and schools. Target groups include men, village chiefs, women, youth, those working in community services and religious leaders. HSI gives financial and technical assistance to national, grassroots NGOs and associations. In partnership with these organisations, HSI formulates plans to sensitise communities.

Its most effective activities have included theatre performances, achieving the backing of community leaders, using local radio and negotiating abandonment with communities. These have had a measurable effect: all areas covered by SILE now have a ban on FGM. It evaluates its progress not only through the number of girls who have not undergone FGM in villages, but also through village consultations at the end of each project phase. However, it maintains that changing mindsets of communities takes a long time and that the effects of educating girls will only be visible when those girls become mothers.

HSI is a member of a group of technical and financial partners against FGM that includes UNICEF, United Nations Population Fund, Aide de l'Église Norvégienne, IAMANEH Suisse and GIZ.

IAMANEH Suisse

IAMANEH Suisse has projects in West Africa for women and children, focusing on initiatives for those facing poverty and exclusion. Two areas of specialisation are maternal and child healthcare and protection against violence. It provides psychosocial counselling and shelters for women and work on fighting FGM. Its project Lutte contre les mutilations génitales féminines attempts to get people to understand cutting as a violation, with negative consequences for women's health including haemorrhages and, potentially, the spread of HIV. It also has a programme that aims to reduce maternal morbidity and mortality due to fistula, a common complication of FGM.

Its 2013 report states that, with the help of its partner SDI, it has successfully persuaded 27 villages in the Segou region to abandon FGM, with a further eight expected to sign agreements in 2014. Part

of its objective is to provide a source of alternative income for cutters. Another co-project teaches health information in schools in an effort to warn about the dangers of FGM. In 2013 it also supported a regional meeting on FGM in Segou to identify all locales where organisations are working and facilitate collaboration.

Inter-African Committee (IAC)

The IAC's mission statement is 'To promote gender equality and contribute to the improvement of the health status, social, economic, political, human rights and quality of life of African women and children through elimination of harmful traditional practices and the promotion of beneficial ones.' The IAC has a Mali chapter, which is the NGO AMSOPT (see profile in the following section).

Plan International – Mali

Plan's Project to support and promote initiatives in favour of the abandonment of excision in Mali is based in Kangaba, Kati, Kita and Barouléli. The project's time frame is April 2010 to March 2016 and has a budget of US\$3,714,600. The overall aim is to reduce the prevalence of FGM among girls aged 0–14 by 10% before June 2016. Plan also hopes to increase the number of village-wide FGM abandonments from 25 to 65 in the project area. It advocates for Malian policy-makers to make FGM illegal by 2016. This project's target group is 45,000 girls and 130,000 women, but, indirectly, they aim to influence 50 health and social workers, 50 traditional birth attendants, 18 community leaders, 200 religious leaders, 180 CBOs, 90 child organisations and 4 NGOs. Its approach is rooted in community ownership and it encourages community leaders to create their own abandonment plans. At a national level, it meets and trains several ministries, including the Ministry for the Promotion of Women, Children and Family.

Plan's project has the following aims:

- Capacity-building: training NGO partners, other CBOs and organisations in the FGC network on issues of FGM and violence against women and children; training members of the legal and media communities to push for the criminalisation of FGM.
- Advocacy: hosting advocacy forums and community dialogues; working with MPs, the High Islamic Council and other groups to create a draft bill criminalising FGM.
- Monitoring, evaluating and researching: hosting regular meetings and conducting inspections to measure actions and support local initiatives.
- Communication for behaviour change: creating content for media output covering the dangers of FGM.

Population Council – Mali

The Population Council has been operating in Mali since 1981. It conducts research and runs programmes in areas related to health and development, including anti-FGM initiatives. Population Council assisted the Malian Government in developing its policy on FGM and creating its national strategy against the practice.

Population Services International – Mali (PSI)

The Mali branch of PSI was founded in 2001 with an aim to focus on improving reproductive health and child survival. In 2007 it introduced programmes to reduce the incidence of FGM. It is currently working with the Malian Government on mass-media campaigns to dispel myths that FGM is an obligatory Islamic practice. It has many partners and donors, including the Malian Ministry of Health, Malian Ministry for the Promotion of Women, Children and the Family and local organisations.

Save The Children – Sweden

Save the Children – Sweden has collaborated with The Centre Djoliba on FGM intervention programmes since the 1980s. It focuses on a rights-based approach, particularly child rights, and recommends the continued advocacy for national legislation against FGM. Save the Children – Sweden believes that dialogue with religious leaders, who are gatekeepers, is key for social and cultural change. Its project with The Centre Djoliba is called *Lutte contre la pratique de l'excision au Mali de l'approche santé à l'approche basée sur les droits de l'enfant*. This work is also done in collaboration with the Population Council.

Tostan

Tostan takes a human-rights approach, building the capacity of communities to form long-lasting social change. It works mainly with people who have never had an education, teaching skills in relation to human rights, problem-solving, health and sanitation. It also regularly appears on the radio.

Tostan's human-rights approach is based on theories of social norms and abandonment; accordingly, they use a non-judgemental approach when speaking to communities about creating better societies, explaining that abandoning FGM is not about struggling against tradition, it is about promoting the development of the community.

Three years after the implementation of their Programme de Renforcement de Capacités Communautaires (PRCC) in 38 communities in Yerimadio and Koulikoro, 44 communities declared they had abandoned the practice. Tostan is currently extending the PRCC into 40 more communities in Koulikoro.

Tostan is a member of CNAPN, which is overseen by PNLE.

UN Women

In partnership with the UNFPA, UN Women implemented the National Programme for the Fight against Violence against Women and Girls 2012–2017. Its objectives included reducing the prevalence of FGM to 65% by 2014.

UNICEF Mali

UNICEF seeks to tackle FGM by encouraging a multi-sector approach that includes increasing access to medical care, psychological aid and judicial support. UNICEF also invests in changing social norms

by challenging individual and group behaviours. It works with civil society and financial partners towards FGM abandonment and also works closely with the Government of Mali. Its work is funded by the Ministère de la Promotion de la Famille de la Femme et de l'Enfant via the PNLE programme. It partners with the nine Directions Régionales Promotion Femme Enfant Famille (DRPFEE), which are decentralised organisations of the MPFEE. It also partners with National NGOs AMSOPT in Kayes, TAGNE in Koulikoro, Family Care International in Mopti, and Sini Sanuman in Bamako.

UNICEF aims to build the capacity of its partners by providing resources and health kits, training health and social workers, providing medical and psychological care for survivors of FGM and supporting any further actions against it, targeting priority areas Kayes, Koulikoro and Sikasso. The following are UNICEF's key aims.

- **Prevention:** To begin a dialogue about FGM, UNICEF targets large groups of people with theatre and with Cinéma Numérique Ambulant on the theme of excision, alongside visiting the homes of families and community leaders.
- **Response:** Build the capacity of communities seeking to tackle FGM, health workers, educational bodies, elected officials and those in positions to communicate, such as the media. The work is reinforced by theatre and cinema productions. It also ensures medical, socioeconomic and psychological structures are in place for survivors of FGM. It aims to provide proper training and reference manuals to improve the care offered to these women.
- **Separate dealings with men and women:** Women and girls are spoken to separately from men and boys, to give each group the opportunity to speak without being influenced and in the safety of confidentiality.
- **Monitoring and evaluation:** UNICEF organises discussions every quarter with local organisations working on FGM, child marriage and other child-protection issues. This allows organisations to exchange best practices. UNICEF also then organises follow-up with its various partners.

UNICEF has achieved a number of successes in Mali, including having effective aid in place for survivors of FGM. Providing medical help with complications, for instance, gathers support for anti-FGM activities. Women who have been helped at these centres are more likely to become advocates in their communities.

UNICEF and the UNFPA partner with the Government of Mali and civil society under a joint programme titled Programme Conjoint des Nations Unies pour Accélérer le Changement Social en faveur de L'abandon des MGF/E. This has historically covered 15 countries in its first phase. Mali was included in the second phase, which began in 2011.

UNICEF-UNFPA Joint Programme – Mali (UNJP)

The UNJP, in collaboration with UN Women, has been attempting to develop a cross-border project with Burkina Faso. However, implementation has not yet been possible because of the conflict in northern Mali.

USAID

The US Government has supported FGM abandonment worldwide since the 1990s. In 2000, USAID incorporated the elimination of FGM into its development agenda. In Mali, USAID worked with the Ministry of Health to develop and pilot a training curriculum for primary medical providers, in order for them to effectively identify and treat FGM complications. It also trained the medical practitioners on how to speak with their patients on the negative aspects of the practice. From this project, a network was created with NGOs, and community and religious leaders. USAID reports that its work has shown success, with the percentage of women favouring the abandonment of FGM rising from 15% to 62%. The percentage that intended to cut their daughters reportedly fell from 81% to 33% among the participants surveyed.

World Vision – Mali

World Vision Mali has the Sourountouna Program, which works in 58 villages to encourage FGM abandonment. World Vision has partnerships with other organisations and community leaders in Mali. It has reported a drop in FGM practice in the Sourountouna region, which is 600 km from Bamako. In a survey conducted to measure the impact of World Vision's efforts, it was reported that 65.5% of those polled believed FGM was bad and that 63.5% would participate in the programme. In this region, World Vision works with Islamic and Christian leaders to fight the notion that cutting is a religious requirement.

National and Local Organisations

Aid for the Development of Traditional Medicine (*AIDEMET*)

Aidemet is an NGO working across Mali to promote traditional medicine in relation to health, economic sustainability and social development. It works extensively with traditional healers and midwives, and through this is able to mobilise against FGM. In 2011 it launched a book advocating for changes to the approach against FGM in Mali titled *The Fight Against Female Genital Mutilations, Experiences and Reflections*, which is comprised of examples of anti-FGM activities throughout Mali.

Association Malienne pour le Suivi et L'Orientation des Pratiques Traditionnelles (*AMSOPT*)

AMSOPT is an IAC member that works to defend women's health, sexual and reproductive rights. Part of its work is a phased action plan against FGM, during which it meets with community authorities and villagers to ensure their help with projects. Each village it works with is required to nominate two male and two female volunteers to work alongside AMSOPT while it is there and then sustain the project once AMSOPT has left.

AMSOPT's behaviour-change activities include providing information and encouraging discussions between target groups of women, men, community leaders and youth. It rarely speaks directly on FGM, but incorporates it into general health-and-reproduction education. AMSOPT is a provider of information only and does not use a direct approach of asking villagers outright to abandon FGM. By asking strategic questions during workshops, conducting mass awareness campaigns and providing aid to those experiencing complications from FGM, AMSOPT seeks to change the minds of people, but allow them to come to their own conclusions. AMSOPT can then facilitate the writing of a public statement and share best practise across areas. AMSOPT also works with migrant populations, aiming to involve them in dialogues so that diaspora populations have a strong understanding of FGM.

Appui à la Promotion des Aides Familiales (*APAF*)

APAF is an NGO based in Bamako and a member of the Malian network against FGM. The organisation was established in 1991 to protect immigrant girls hired as 'housekeepers' from exploitation and violence. It hosts training sessions and meetings to teach girls about the health risks of FGM (and other health issues). Once girls have been taught, they will return to their villages and spread the word about the dangers of FGM. President of the organisation, Ms Urban, reports that 'social pressures are strong and that many girls are waiting to be mature enough and strong enough to return to their villages with their children in order to protect them from excision', which will be demanded by grandparents and community members. APAF partners with Save the Children Canada, UNICEF, the UNDP, ILO, World Vision and the PAREHF UNAIS, but is currently suffering from a lack of sustainable funding.

Association pour le Progrès et la Défense des Droits des Femmes Maliennes (APDF)

APDF was created in 1991 and promotes the development of women and girls. Its mission is to defend women and girls against violence and discrimination and to organise and educate women to create awareness for their mobilisation and participation in their own development. APDF leads community activities to teach women and girls about FGM and protect them. The services it offers include:

- training and education;
- information and sensitisation;
- lobbying and advocacy;
- micro financing; and
- legal advice and assistance.

Some of its activities include seminars on FGM, awareness workshops for the police and health workers on violence against women, and a study on the adverse effects of FGM. It has visited schools and also conducted programming on TV and national radio, including organising a panel of experts on regional FGM practices and religious and legal perspectives on the practice.

Association of Support in the Development of Activities of the Population (ASDAP)

ASDAP aims to end FGM across Mali, working closely with the Ministry of Health to increase its access to towns and villages. Targeting women over 30, it works to spread information about the damaging effects of FGM and promote the rights of women and girls to have healthy births. It focuses on five main strategies:

- advocacy;
- behaviour change;
- capacity-building;
- managing complications that arise due to FGM; and
- research.

Within these strategies it then uses techniques including the use of pictures, film, theatre productions and posters, often explaining the health consequences of FGM. Using these techniques, ASDAP aims to target a range of stakeholders including men, girls and community leaders. Some of its most successful work has come from collaborating with community health centres to create a network of people willing to talk about the negative effects of FGM with target populations, and also its work to create a strong resource base such as reference manuals, films and data sheets.

ASDAP is a founding member of the CNAPN, coordinated by the PNLE. ASDAP is also a member of Réseau Malien de Lutte contre les Mutilations Génitales Féminines (RML/MGF), and du Réseau Malien pour l'Élimination de la Fistule Obstétricale and sits on the administrative council of a group of health NGOs, the Groupe Pivot Santé Population GP/SP.

Association pour la promotion des Droits et pour le Bien-Être de l'Enfant et de la Famille (APSEF)

APSEF was formed in 2006 with the aim of promoting the rights of women and encouraging the abandonment of FGM. Taking a grassroots approach, APSEF works closely with villages through educational courses and community theatre, and it also uses radio to reach people. It targets strategic groups such as community and religious leaders and tries to ensure that every village has a surveillance committee so that lessons are not forgotten after the programme finishes.

This year, APSEF organised a five-day study project with the support of Oxfam Germany in Nyamina. The project was conducted among the communities of Babougoukoroni and included the association of former circumcisers (set up by APSEF through Djoliba) and groups of men and women covering all target groups: religious, communal and village authorities and youth. The project aimed to enable communities in Nyamina to have a better understanding of women's rights and share best practices from across Mali in the field of tackling FGM and women's economic empowerment. Women's groups from Siribala and Choulanaï shared their experiences to help representatives from Nyamina formulate their own strategies.

Comite d'Action pour les Droits de l'Enfant et de la Femme (CADEF)

Based in Bamako, CADEF works in Kayes, Ségou, Sikasso, Markala and Koutiala to ensure that CEDAW and the CRC are followed in Mali. Using these two conventions as a backbone, the organisation aims to promote, protect and defend the human rights of women and children, much of which comes under the umbrellas of health and education. CADEF also works with a number of national and international partners, including various ministries within the Malian Government.

Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)

CARMMA began as an African Union initiative in partnership with the UNFPA and other UN agencies. The initiative aims to expand the availability of health services, especially those related to sexual and reproductive health. CARMMA frequently blogs about the status of FGM on its website, using case studies and inviting guest bloggers to share expertise. It started work in Mali in 2014.

Centre Djoliba

Centre Djoliba has been working towards the abandonment of FGM in Mali since the mid-1980s, having been created as an organisation in 1962. Based in Bamako, the organisation seeks to raise awareness of a number of harmful traditional practices and also offers development initiatives for women and youth. Centre Djoliba targets village communities and local authorities, but also seeks out NGOs and women's groups for collaboration. For its extensive group sessions, which can include over 500 people, teachers, cutters, religious leaders and local authorities are offered training on the complications of FGM. In villages, the organisation manages clubs against FGM in schools and universities and uses theatre to increase awareness among the public.

Développement Hositique Africa au Mali (DHA)

The DHA was established in Bamako in 1998. It focuses on ethical human welfare. Currently, it operates in Bamako, Kati and Dogon. It works with other grassroots associations in communities to improve living conditions, and its vision is to foster physical, social, cultural, economic and spiritual development. The aims of DHA are to:

- promote access to education for disadvantaged children;
- foster literacy for young and disadvantaged women;
- promote maternal and child health, including fighting against FGM; and
- encourage self-promotion through mobilising local resources.

It is a financial partner of both the Ministry for Basic Education and PNLE.

Groupe de Recherche, d'Étude, de Formation Femme Action (GREFFA)

GREFFA, based in Gao, works on gender-based violence and health education. Much of its work focuses on treating fistulas and educating villagers on prevention. The founder, Fatima Toure Songhai, recently received an international prize for female courage, partly due to her exceptional work speaking out on FGM.

In collaboration with Norwegian Church Aid, GREFFA carries out radio broadcasts on FGM and fistula and trains obstetric staff. It also works to help communities openly discuss sensitive topics, with the aim of enabling them to more easily seek treatment in hospitals. It targets the public, but also community leaders, educating them on the causes, consequences and prevention of fistula, through which they can speak about FGM.

Musow-Jigi

Musow-Jigi tackles FGM within its other developmental programmes, which include women and children's health and education. Its activities are based in Kayes, Segou and Bamako, where it has set up a number of literacy centres, within which talks are held for local women. Often these talks are based on an integrated approach to development, combining information on micro-credit and income-generating activities with reproductive health and FGM. It uses trained 'relay-agents' to then spread the word to their peers.

Nyeta-Sira

Nyeta-Sira was created in 1996 primarily to promote the socio-economic status of women within Mali. Women are its main target group, and it enacts revenue-generating activities and awareness campaigns to achieve its goals. It also targets young girls with reproductive health education and has a listening centre that encourages children in difficult circumstances to speak out. The organisation has 25 local branches.

FGM is the main focus of Nyeta-Sira's awareness campaigns, alongside sexually transmitted diseases. One example of its successful campaigning was in the town of Benena, where Nyeta-Sira's work contributed to abandonment when an official communal proclamation came after much awareness-raising work.

Réseau de Lutte Contre les Mutilations Génitales Féminines (RML/MGF)

RML/MGF is a network of organisations working against FGM and based in Bamako. The RML/MGF works to overcome the main challenges facing its organisations and to develop tools to help them. It organises regular workshops, encouraging organisations to continue learning from each other. Training revolves around four main themes: excision and child rights, information/education/communication, general information on excision and counselling.

In recent years RML/MGF has established a goal of achieving a law passed against FGM, involving regional councils and regional health directorates. During meetings with these high-level people RML/MGF informed them about the harms of FGM and encouraged them to sign a petition. The NGO also carried out a comparative study on Burkina Faso, a country that had passed a law against excision. Together, these actions helped to raise the profile of the organisation, and consequently, the fight against FGM.

Sini Sanuman

Sini Sanuman, an NGO based in Bamako and the surrounding areas, mainly uses media to get its message across to the public. Its album, *Stop Excision*, was released in 2000 and has eight songs in five local languages sung by top Malian musicians. It has also produced TV clips and posters picturing Malian celebrities with messages against FGM. It estimates that four million people have seen or heard the message through radio or television.

The organisation also works directly with villages by inviting people to sign its Pact Against Excision, which now has 60,000 signatures. Signatories are asked to refrain from practising FGM on girls and to support a law against FGM in Mali. 30,000 signatures have been presented to the National Assembly already.

As a result of its public discussions, 11 villages have abandoned FGM and 150 cutters have renounced the practice.

It has worked extensively in Bamako with local authorities to ensure that all newly married couples are spoken to about not cutting their daughters.

Sini Sanuman is a member of the Comité National de Lutte contre l'Excision.



NGO Sini Sanuman uses media to help eradicate FGM in Mali

TAGNE

Created in 1998 and run by women with first-hand experience of FGM complications, TAGNE works towards the abandonment of FGM, alongside a wider approach to the reproductive health of women and girls. A member of RML-MGF and PNLE and funded by UNICEF and Oxfam DE, TAGNE works closely with networks across Mali to provide support to women and advocate for change.

TAGNE is based in Kati, Koulikoro. It provides free psycho-social support to survivors of FGM and conducts awareness and mobilisation activities in villages, targeting ten villages every year. Of the ten districts in Kati, two have declared total abandonment. It has also been successful in providing survivors of FGM with training and economic-empowerment activities to help them regain confidence and independence. Examples of its awareness-raising work include a football tournament with the words 'We must abandon FGC' on the kit, and talks with village members using a model of a woman's body. The organisation states, 'Our work begins when you have to explain to people how the human body looks and works. The anatomy of the female body is the most unknown. Then we talk about the consequences of circumcision. If we show it on the basis of a model and explain with pictures, this clarity is convincing in most cases.'

Ending FGM: Challenges

A UN periodic review stated:

[I]n response to the question about the chief obstacles to the implementation of the agreement in Mali to abandon the practice of excision, the delegation said that the sole obstacles were cultural in nature and that many communities had abandoned the practice even without having signed the agreement.¹

That said, because FGM is a social norm and an ancestral tradition, a community-wide (and society-wide) change of attitude is needed before FGM can be completely abandoned. Given that there are varying perceptions of the practice, large-scale intervention is challenging.

There are numerous **infrastructure challenges** to the work of campaigners. Electricity can be unreliable in Mali, even in Bamako, meaning that poor internet access can make communication difficult. Poor roads to rural communities can also be problematic.

As in most countries, **a lack of sustainable funding** is cited by several organisations in direct contact with 28 Too Many as being a major limitation to effective long-term programming.

Lack of communication via email and **staff shortages** were particular hindrances for 28 Too Many in trying to contact organisations. **Unavailable or out-of-date information on organisation websites** was also a challenge when we were attempting to profile NGOs.

The **ongoing northern conflict** has affected many NGOs in the area. NGOs have had to withdraw staff, schools have closed and infrastructure has been ruined. Women have also been made to wear hijab. The UNJP project with UN Women to develop a cross-border anti-FGM programme with Burkina Faso was suspended due to the conflict.

The World Bank notes that serious challenges regarding **child protection** remain; particularly, 'resistance to social change and the sensitivity of issues linked to child protection, which affect personal values, beliefs, traditions and experiences, still remains a major handicap.'² This is significant, given that children have no societal authority until they take on adult roles. Moreover, **poverty** continues to drive child marriage, though the girls have usually already undergone FGM.

With respect to educating communities on the health risks of FGM, **a lack of education** (especially in the older population) is a major challenge. There has also been an increase in the number of new practitioners who are not 'experts' carrying out FGM. These new practitioners are motivated by the financial benefits. Hence, these **new cutters** are even more dangerous and they undermine eradication efforts.³

Though many religious leaders in Mali believe that FGM is not part of any religious mandate and should not be practised, **some religious leaders do support its continuation**. Religious beliefs in witchcraft (often part of animist religions) explain FGM complications as supernatural punishments. Wahabia Islam teaches that anti-FGM discourse is part of imperial Western ideas, which are counter to Islam and African tradition. Moreover, it has been reported that 'low levels of education and literacy among the Imams, especially in rural areas, hampered drawing them into health promotion programmes.'⁴

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- 1 United Nations Periodic Review.
 - 2 The World Bank (2013) [website]. Available at <https://www.worldbank.org/>.
 - 3 Plan (undated) *Project to support and promote initiatives in favour of the abandonment of excision in Mali*. See also <https://plan-international.org/mali>.
 - 4 Schmid et al. (2008) *The Contribution of Religious Entities to Health in Sub-Saharan Africa*. [Unpublished report.]

Conclusions and Strategies for Moving Forward

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. We propose the following general conclusions, many of which are applicable within the wider scope of international policy and regulation and some that are specific to Mali.

Adopting Culturally Relevant Programmes

FGM is a social norm and an ancestral tradition. In order to create successful programmes, organisations need to be mindful of the patriarchal and age-based hierarchical structure of Malian society. Programmes that are solely targeted at girls, young mothers or men will not be effective, as elders (including mothers-in-law) have greater authority on health matters and decide whether to have a girl cut. It is of the utmost importance to include community authority figures in dialogues around FGM. Islamic leaders are important gatekeepers to educating on faith and FGM. *Griots* (community storytellers) can also play an important role in communicating health knowledge, particularly as literacy rates remain low in Mali. Each community group has various reasons why they practise FGM and different ways of practising it; therefore, regional and community programmes need to be mindful of the needs and beliefs of their target audiences.

Sustainable Funding

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. Continued publicity of current FGM practices at a global level, particularly through the UN and the WHO, is crucial for ensuring that NGOs and charities are given support and resources long term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as is discussed in this report, FGM is a focal issue connected to these crises and directly relates to several of the MDGs. In Mali, funding has been especially challenging due to the 2012 coup and its aftermath.

FGM and The Millennium Development Goals

Considering FGM within the larger framework of the MDGs conveys the significant negative impact that FGM makes on humanity. The abandonment of FGM is connected to the eradication of extreme poverty and hunger, the promotion of universal primary education, gender equality, reducing child mortality, improving maternal health and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience, because it highlights the need for funding anti-FGM programmes in the fight for broader social change. There has been momentum for change, with the UN global ban on FGM in December 2012 and the UN CSW 57 focusing on violence against women and girls, which includes FGM. We

hope that this momentum is continued and that violence against women and FGM are reflected in the post-MDGs agenda.

FGM and Education

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause of the perpetuation of social stigmas surrounding FGM as they relate to health, sexuality and women's rights. The lack of education also directly relates to child marriage. We recommend that organisations continue to provide programming related to education for boys and girls.

FGM, Medical Care and Health Education

We commend the Malian Government for recognising FGM as a public health problem in 2011. The efforts of PNLE and other organisations in Mali to train medical professionals on how to recognise, educate and treat issues related to FGM has shown encouraging results. 28 Too Many hopes that the Government and all NGOs working on health issues (such as the Fistula Care Project) continue to make positive changes with their work.



*Gender equality is a means to improving maternal and child health
(© globalgender currents)*

FGM, Advocacy and Lobbying

Advocacy and lobbying are essential to ensure that the Government continues to be challenged on its hesitancy to criminalise FGM and to support programmes that tackle the practice.

FGM and the Law

We encourage NGOs to continue their fight for legislation criminalising FGM in Mali. The Government's recent efforts with PNLE are to be commended, and we encourage the Malian Government to renew its efforts by enacting an anti-FGM law. Furthermore, efforts should be made to enforce the Penal Code in matters concerning FGM. With respect to Islamic law, 28 Too Many supports those committed to clarifying that bodily harm (including FGM) is in violation of their laws and beliefs.

FGM in the Media

Media has proven to be a useful tool for fighting against FGM and advocating for women's rights. 28 Too Many supports the work that has been done on FGM using media and encourages these projects to continue. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level.

FGM and Faith-Based Organisations

As more than 80% of the population of Africa attends a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are major agents of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision. They can also work with global bodies such as the UN and its agencies. Good work has been done in Mali on networking with Islamic leaders to dispel the myth of FGM being a required practice. It is hoped that organisations and the Government will continue to work with faith leaders to educate on the complications of FGM and the fact that it has no validity as a faith-based practice.

Communication and Collaborative Projects

There are a number of successful anti-FGM programmes currently operating in Mali, at the international, national and grassroots levels. We recommend a continued effort to communicate this work more publicly and encourage collaborative projects. A coalition against FGM would be a stronger voice in terms of lobbying and more effective in obtaining sustainable funding and achieving programme success, and efforts in Mali are headed in this direction, particularly with PNLE.

The fight against FGM will be intensified by the strengthening of such networks of organisations working against FGM and, more broadly, on women's and girls' rights; the integration of anti-FGM messages into other development programmes; sharing best practice and success stories; researching operations; publishing training manuals, support materials and advocacy tools; and providing links/referrals to other organisations.

Further Research

There is a need for further research and up-to-date data on the prevalence of FGM in Mali that includes infants and girls under 15 years of age, so as to capture recent trends. The reported rise in Type III FGM (infibulation) needs urgent further study to confirm data and stop the trend towards this most extreme form of FGM.

APPENDIX I

List of International and National Organisations Contributing to Development Goals and Women's and Children's Rights in Mali (as at 2014)

Please note that this list was current as at September 2014; it has not been updated. Additionally, 28 Too Many does not claim that this is an exhaustive list; we recognise that there are many more organisations working on women's and children's issues and to eradicate FGM in Mali.

Aid for the Development of Traditional Medicine (Aidemet)
Aide de l'Eglise Norvégienne (AEN)
Association des Juristes de Mali (AJM)
Association Malienne pour la Protection et la Promotion de la Famille (AMPPF)
Association Malienne de Suivi et d'Appui à la Femme et l'Enfant (AMSAFE)
Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT)
ANDANSOVI
ANIMALI
Appui à la Promotion des Aides Familiales (APAF)
Association pour le progrès et la défense des droits des femmes Maliennes (APDF)
ASCAM
Association of Support in the Development of Activities of the Population (ASDAP)
ASISDCE
Association des Sages Femmes du Mali (ASFM)
Projet d'Appui aux Jeunes Entrepreneurs (PAJE-Nièta)
Association for the Promotion and Empowerment of Women of Mali (ASSOPROFEN)
Ben Kadi
Cabinet Médical Kénéyasou
Comité d'Action pour les Droits de l'Enfant et de la Femme (CADEF)
Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA)
Caritas Mali
Centre Djoliba
Cadre National de Pilotage du Curriculum de la formation du Parajuriste (CNPCP)
Coopérative des Femmes pour l'Education à la Santé Familiale et l'Assainissement (COFESFA)
Croix Rouge Mali
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Développement Holistique Africa (DHA)
Division Sante Reproductive
DNANGR
ELS GANDAL
Equilibres & Populations

Fotè Mogoban

Groupe De Recherche, D'étude, De Formation Femme Action (GREFFA)

Groupe de Recherche Action Formation (GRAF)

Groupe Presse Nyeleni

IAMANEH Suisse

Inter-African Committee

HELVETAS Swiss Intercooperation (HIS)

Musko – JIGI

Muso Cesirilen

Muso Kunkan

Nyeta-Sira

Organisation pour l'Aide et Assistance au Développement de l'Environnement (OAADE)

Observatoire des Droits de l'Enfant et de la Femme (ODEF)

Plan International - Mali

Pose ton Couteau

Promotion des Femmes de Sabalibougou (PROFESAB)

Project EVT/EMT GADEF

Programme National De Lutte Contre La Pratique De L'excision (government programme)

Population Services International (PSI)

RADECO

Réseau des Communicateurs

Réseau Malien de Lutte Contre les Mutilation Génitales Feminines

Save the Children - Sweden

Service de Développement Intégré (Ségou)

Sini Sanuman

Syndicat Libre et Démocratique de l'Enseignement Fondamental (SYLDEF)

TAGNE

Tolérance

Tostan

USAID

United Nations Children's Fund (UNICEF) - Mali

United Nations Development Programme (UNDP)

United Nations Women

United Nations Population Fund (UNFPA)

Wildaf Mali

Woïyo Kondeye

World Health Organization

World Vision



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