



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 'lack of adequate documentation and research on violence against women and girls (VAWAG) (D.120)'. Since I began humanitarian aid work in 2001 and anti-female genital mutilation (FGM) work in 2005 that has been my experience and the 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', 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, with 3 million predicted to be affected in this next year – one girl being cut every ten seconds. Whilst 28 Too Many's initial focus is the 28 countries in Africa where certain communities still practise FGM, increasingly knowledge is also 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 (15-49 years) in 2013 was 91.4%. This is reported as an increase from 85.2% in 2006 but the 2013 survey did not include three northern regions and, when adjusted for a direct comparison, the prevalence rate is not significantly different at 92.0% in 2006 and 91.4% in 2013. The prevalence rate by faith shows a Muslim rate of 92.8% and Christian rate of 65.2%. Over 60% perceive FGM as a religious requirement, although it is not a requirement of either faith.

73% of girls in Mali have FGM at age five years or younger and the age of cutting is decreasing. There also seems to be a worrying trend that some women without FGM have had their daughters cut, and 38% of these are 'sewn closed' (Type III). There is no Malian law specifically criminalising FGM; a major challenge is that 69.5% (men) and 76.0% (women) felt no benefits of NOT performing FGM, seeing it as a cultural practice that is traditionally justified.

FGM is 'known about' by over 98% of men and women, and yet patriarchy gives authority to older men and women over younger women who cannot question the 'authority of wisdom or age' and have little voice to stand against FGM. Older women also feel resentment to men's involvement in anti-FGM work as it reduces their already limited authority.

FGM has serious immediate and long term physical consequences, with 52% of Malian women who suffered a complication from FGM suffering a haemorrhage. 34% of Mali's maternal deaths are due to haemorrhage. Higher neonatal death, maternal death and fistula (incontinence) often follow FGM, which can also be linked with child marriage. In Mali, child marriage can happen from age ten.

FGM in Mali is performed for complex reasons, entrenched with historical diversity, including caste, ethnicity and age. I have visited twelve 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 who are seeing progress 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 NGO Sini Sanuman, where nine villages signed a community declaration against FGM in 2005.

As the impact of the unrest in 2011-13 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 NGO 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 read:

'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.'

This declaration was signed by:

President of the women of Moussala (Djénéba Traoré)

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

Wife of the Imam of Moussala (Madina Doumbia)

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

Village chief of Moussala (Fasoko Samaké)

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

President of the Committee of Moussala (Bréhima Traoré)

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



Fig. 1: Grand Boubou signing a certificate, 2014 (Sini Sanuman)

BACKGROUND

28 Too Many is an anti-female genital mutilation (FGM) charity, created to end 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, where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We hope to build an information base, including the provision of detailed Country Profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop a network of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and to support community programmes to end FGM.

PURPOSE

The prime purpose of this Country Profile is to provide improved 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. Whilst 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 to 28 Too Many. We invite comments on the content, suggestions as to how the report could be improved as an information tool, and seek updates on the data and contact details.

ACKNOWLEDGEMENTS

28 Too Many is extremely grateful to all the FGM practising communities, local NGOs, CBOs, FBOs and international organisations who have assisted us in accessing information to produce this Country Profile. We thank you, as it would not have been possible without your assistance and collaboration. 28 Too Many carried 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.

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

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Mark Smith creates the custom maps used in 28 Too Many's Country Profiles.

Rooted Support Ltd donated time through its Director Nich Bull in the design and layout 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.

Photograph on front cover: Bozo girl in Bamako, 2007 ©Ferdinand Reus

Please note the use of the photograph of the girl on the front cover does not imply she has, nor has not, had FGM.

LIST OF ABBREVIATIONS

AACE Cable - African Coast to Europe Cable
 AIDS - Acquired Immunodeficiency Syndrome
 ARP - Alternative Rites of Passage
 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 Health Survey
 ECOWAS – Economic Community of West African States
 FBO - Faith Based Organisation
 FC - Female Circumcision
 FGC - Female Genital Cutting
 FGM - Female Genital Mutilation

GBV - Gender Based Violence
 GDP - Gross Domestic Product
 GPI - Gender Parity Index
 HIV - Human Immunodeficiency Virus
 HTP - Harmful Traditional Practice
 IAC - Inter-African Committee
 IAMANEH - International Association for Maternal and Neonatal Health
 ICCPR - International Covenant on Civil and Political Rights
 ICESCR - International Covenant on Economic, Social and Cultural Rights
 ICT- Information and Communication Technology
 INGO - International Non-Governmental Organisation
 LGBT - Lesbian, Gay, Bisexual, Transgender
 MCH - Maternal and Child Health
 MDG - Millennium Development Goal
 MICS - Multiple Indicator Cluster Survey
 MNLA - National Movement for the Liberation of Azawad
 NGO - Non-Governmental Organisation
 OECD - Organisation for Economic Co-operation and Development
 PNLE - Portant Code Des Personnes et de la Famille (Personal and Family Code)
 SIGI - Social Institutions and Gender Index
 STI - Sexually Transmitted Infection
 TBA - Traditional Birth Attendant
 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
 US - United States
 USAID - US Agency for International Development
 VAWG - Violence against Women and Girls
 WFP - World Food Programme
 WHO - World Health Organisation

EXECUTIVE SUMMARY

This Country Profile provides comprehensive information on FGM in Mali. The report 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. The purpose of this report is to enable those committed to ending FGM to shape their own policies and practice to create positive, sustainable change.

In Mali the percentage of girls and women who have undergone FGM is 91.4% (DHS, 2013). This rate has increased from 85.2% in the DHS 2006 survey, though the northern regions were not included in the 2013 report. The adjusted figure for 2006 showing prevalence excluding the northern regions to make it comparable to 2013 is 92%. Thus, when only comparing the regions surveyed in both reports, the rate of FGM has declined slightly. Prevalence of FGM is only marginally higher among those residing in rural areas (91.8%) than in urban areas (90.5%) (DHS, 2013). Rates of FGM are highest in the western and southern regions of Kayes, Sikasso, Koulikoro and Bamako, and lowest in the north eastern regions of Kidal and Gao. FGM in Mali is a social norm. Reasons for practising FGM include: social recognition, hygiene, more pleasure for the man, better marriage opportunity, belief that it is a religious requirement, ensuring virginity and 'other' reasons. FGM is practised by religious and non-religious Malians. The country has a large Muslim majority, who have a prevalence rate of 92.8%. Christians practise FGM at 65.2%, Animists 77.2%, and non-religious Malians at 91% (though these last two groups are minorities).

The DHS surveys for Mali do not use the WHO defined Types (I, II, III, IV) of FGM for classification. Instead, women aged 15-49 reported 'cut flesh removed' at 48.9%, 'nick, no flesh removed' at 14.6%, 'sewn closed' 10.6% and 'don't know/missing' at 25.9%. 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 daughters aged 0-14 is highest in the Sikasso region at 23%, and the Kayes region is lowest at 10%. There is also worrying data that women without FGM themselves have had 15% of their daughters cut, and 38% of those were sewn closed (DHS, 2013). FGM is carried out primarily by a traditional excisor. Most girls and women with FGM in Mali are cut under the age of 5 (73%). The age group 5-9 is 14.6%, ages 10-14 6.7%, 15+ 0.4% and 'unknown' is 5.3%.

The majority of Malians have knowledge of FGM; 98.3% of women are aware of the practice and 98.8% of men (DHS, 2013). On continuing the practice of FGM, 76.0%

of women were in favour, and 69.5% of men (DHS, 2006). When surveyed, most 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 in and of itself.

There are numerous INGOs and NGOs working to eradicate FGM using a variety of strategies, including: a harmful traditional practices (HTP) approach, addressing health risks of FGM, educating excisors and offering alternative income, rights-based approach and media campaigns. A comprehensive overview of these organisations is included in this report. To highlight a few success stories, the NGO Tagne visits villages with an anatomical model, teaching community members about female reproductive health and the dangers of FGM. Sini Sanuman works with excisors 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 theatres, TV, radio, and publications. Media campaigns appear to prove 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 (Portant Code Des Personnes et de la Famille, 2011(PNLE)) declared that FGM should be prohibited under the Penal Code, though enforcement remains an issue. The 2011 Personal and Family Code should also cover harmful traditional practices. NGOs including RML/MGF and Plan-Mali are working to produce petitions for new legislation.

We propose measures relating to:

- 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 girl's lives.
- Sustainable funding. This is an issue across the third sector; for Mali, maintaining funding is a particular challenge as the government continues to deal with 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 is low in Mali; by gaining an education, Malians are better able to understand health information, and the consequences of FGM. Education changes their views of continuing FGM.
- Improving access to health facilities and in managing 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.
- 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 FBOs to act as agents of change and be proactive in ending FGM
- Increased collaborative projects and networking, with support from the PNLE
- Further research

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 Nations, 2009).

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the WHO as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Over 125 million girls and women alive today have had FGM in the 28 African countries and Yemen where FGM is practised and 3 million girls are estimated to be at risk of undergoing FGM annually (UNICEF, 2013).

HISTORY OF FGM

FGM has been practised for over 2000 years (Slack, 1988). Although it has obscure origins, there has been anthropological and historical research conducted on 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 pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th Century BC Egypt, with infibulations being referred to as

'Pharaonic circumcision' (Slack, 1988). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983).

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 wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids and traded through the Red Sea to the Persian Gulf (Mackie, 1996) (Sources referred to by Wilson, 2012/2013).

GLOBAL FGM PREVALENCE AND

PRACTICES

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North 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.

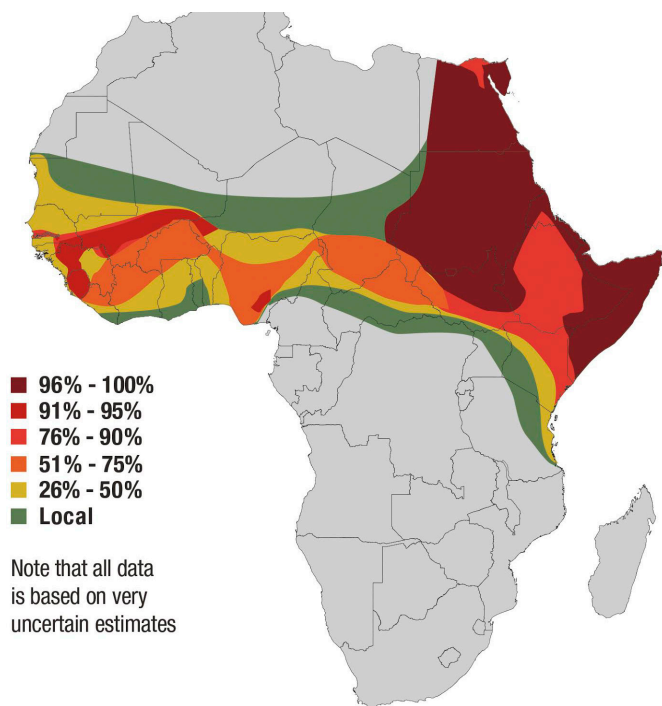


Fig. 2: Prevalence of FGM in Africa (Afrol News)

The WHO classifies FGM into four types (WHO, 2008):

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
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 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, piercing, incising, scraping and cauterisation.

This report follows the categories of FGM used in the DHS surveys. For Mali, these are: cut, flesh removed; nick, no flesh removed; sewn closed; don't know/missing. FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, 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 scripts require the practice, practitioners often believe that the practice 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 (UNICEF, 2005). 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, cysts, infertility, an increased risk of childbirth complications and new born deaths and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

The eradication of FGM is pertinent to the achievement of six Millennium Development Goals (MDGs): MDG 1 – eradicate extreme poverty and hunger, MDG 2 – achieve universal primary education, MDG 3 - promote gender equality and empower women, MDG 4 - reduce child mortality, MDG 5 – improve maternal health and MDG 6 - combat HIV/AIDS, malaria and other diseases. The post-MDG agenda is currently under discussion and it is hoped that it will include renewed efforts to improve the lives of women.

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM. A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well

as providing more general information relating to the political, anthropological and sociological environments in the country to offer a contextual background within which FGM occurs. This can also be of use regarding diaspora communities that migrate and maintain their commitment to FGM.

The Profile also offers some analysis 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 knowledge base from which to determine the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research we have met many anti-FGM campaigners, CBOs, policy makers and key influencers. We wish to help facilitate in-country networking to enable information sharing, education and increased awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

NATIONAL STATISTICS

GENERAL STATISTICS

POPULATION

15,704,199 (9 September 2014) (Countrymeters)

Median age: 16 years (2014 est.)

Growth Rate: 3.0% (2014 est.)

Human Development Index

Rank: 176 out of 187 in 2014 (UNDP)

Health

Life expectancy at birth (years): 54.6 years (UNICEF, 2012)

Infant mortality rate (per 1,000 live births): 80 (UNICEF, 2012)

Child mortality rate (per 1,000): 128 (UNICEF, 2012)

Maternal mortality rate: 540 deaths/100,000 live births; country comparison to the world: 2 (UNICEF, 2008-2012)

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

HIV/AIDS – adult prevalence rate: 0.9% (2012 est.)

HIV/AIDS – people living with HIV/AIDS: 100,300 (2012 est.); country comparison to the world: 44

HIV/AIDS – deaths: 4,900 (2012 est.)

Literacy (age 15 and over who can read and write): Total: 33.4% Female: 24.6% Male: 43.1% (2011 est.)

Youth (15-24 years): Female 38%; Male: 56% (UNESCO, 2012)

GDP (in US dollars)

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

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

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

Urbanisation

Urban population: 34.9% of total population (2011)

Rate of urbanisation: 4.77% annual rate of change (2010-15 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 the Mali's total urban population lived in Bamako in 2010.

Ethnic Groups

Mande 50% (Bambara, Malinke, Soninke), Peul 17%, Voltaic 12%, Songhai 6%, Tamachek and Moor 10%, other 5%

Religions

Muslim 94.8%, Christian 2.4%, Animist 2.0%, none 0.5%, unspecified 0.3% (2009 Census)

Languages

French (official), Bambara 46.3%, Peulh/foul-foulbe 9.4%, Dogon 7.2%, Maraka/Soninke 6.4%, Malinke 5.6%, Sonrai/djerma 5.6%, Minianka 4.3%, Tamachek 3.5%, Senoufo 2.6%, unspecified 0.6%, other 8.5%

Unless otherwise stated, all citations are from World Factbook.

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.



Fig. 3: Millennium Development Goals

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 (UN website). 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. These results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).

Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's sixteen 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 (Harper, 2013).

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.

POLITICAL BACKGROUND

HISTORICAL

The first Mali Empire was formed by the Soninke people in the 8th Century. In the 11th Century, Almoravids arrived from the north, defeated the Empire, and converted the Soninke to Islam. The Keita people, resisting Islam, split off and became the Dogon people. Soninke 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 European so-called '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 re-joined 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 percent 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 as 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 (Minority Rights website).

CURRENT POLITICAL CONDITIONS

In 2002 Amadou Toumani Touré was elected President of Mali, and 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 January 12th to July 6th (US Dept. of State, 2013). Mediation efforts were led by the Economic Community of West African States (ECOWAS), 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 disappearance of civilians with connections to rebels (US Dept. of State, 2013). 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. This was preceded by an exchange of prisoners. The Malian government is currently refusing to discuss demands for full autonomy (*Reuters*, 2014). French forces remain in Mali in an effort to combat jihadist extremist groups. The UN also retains their peacekeeping force in the country (*The New York Times*, 2014).

Unless otherwise cited, all information is from World Factbook and Wikipedia.

ANTHROPOLOGICAL BACKGROUND

The DHS (2006) collected FGM data on the 10 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. Mande people comprise 50% of the population and are predominately sedentary farmers, including: Bambara, Malinke, Soninke, Dioula, Bobo and Khassonke groups. Sonrai (6%) and the Dogon 4%, the Voltaic people making 12% of the population, include the Senoufo, Bwa, Minianka and Mossi.

Traditionally herders, the Peulh/Fulani make up 17%, Tamachek and Maure 10% and others 5%. With the exception of a large proportion of the Sonrai and Tamachek ethnic groups, FGM is practised among all the other ethnic groups. The ethnic classifications, however, are not as rigid as the figures above imply and have been historically fluid. 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. The Mande peoples, who make up 50% of the population, share many of the social structures which are significant in keeping FGM in

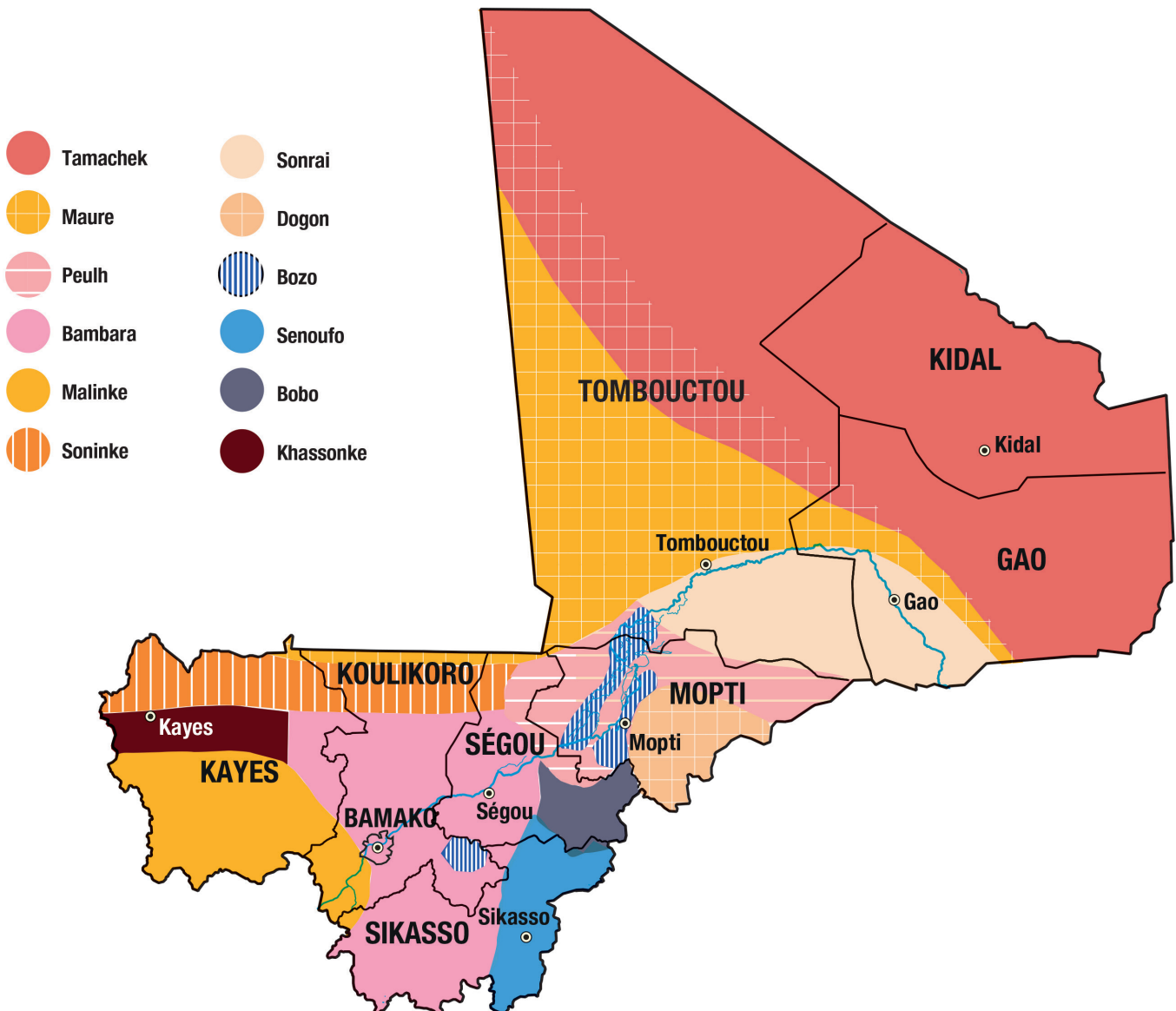


Fig. 4: Geographical distribution of ethnic groups within Mali and the district boundaries in which they live

place. The structures of social division of caste and class as well as many social norms are also shared with the Fulani people.

The 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 all men in general, and age structure gives older women authority over younger women's behaviour and sexuality. Given the limited sphere of power bestowed to 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 where to question one's elders is unthinkable.

There is a fundamental importance in understanding this social power structure of Malian society in order to understand the reasons that keep FGM in place, contrary to many years of government and NGO campaigns for the abandonment of this practice. The Mande and the Fulani (together about 67% of the population) are patriarchal and gerontocratic, meaning authority is in the hands of men and society is structured on 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. 40% of married women are in polygamous marriages, including 20% of married girls aged 15-19. The percentages vary in rural (45%) and urban (27%) locations, but also with the education of the woman: 42% of women with

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.

Case study taken from **Gosselin, 2001**.



Fig. 5: Songhay women (KweeKudee, Trip down memory lane)

no education compared to 19% with secondary education (SIGI website). 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 (Gosselin, 2001). 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.

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 (Gosselin, 2001). Women's power is felt and expressed as mothers (a highly respected role in society (Gosselin, 2001)), 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 (Dettwyler, 1994).

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 (Everyculture website). 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) can voice opinions outside of the norms 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 different crops they grow 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 and when added to the perception of political and economic exclusion of the northern areas and peoples, has created resentment between ethnic groups. The Tamachek have always felt marginalised and this surfaced into violent conflict in the 1990's 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 (Minority Rights website, 2013).

Looting and incidents of rape by the MNLA and Arab militias were reported by Amnesty International in April 2012. 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. Ongoing violence has created further ethnic tensions and prejudice as light-skinned Malians are now being associated with Islamist extremists (IRIN, 2013). 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 ability 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 (US Dept. of State, 2013).

ETHNIC GROUPS

BAMBARA (BAMANA)

The Bambara are a Mande speaking group of settled agriculturalists living mainly in the south and west of Mali. They make up the largest part of the Mande 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. 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.

Bambara is the *lingua franca* for 80% of the Malian population. They live within a gerocratic society, and, like all Malian groups, are deeply unequal in gender parity. 95% of the women and girls aged 15-49 have had FGM (DHS, 2013).

BOBO

There are an estimated 110,000 Bobo Fing living in Mali and Burkina Faso, the majority in the latter. They speak a Mande language and are known in Bambara as Bobo Fing to differentiate them from the Bobo Oule (Bwa). Among the Bobo the FGM prevalence is 63.5% (DHS 2013), of whom 68.7% are cut before the age of 5. They 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, headed by the eldest male. They are seen as conservative and resistant to change, and guard their traditions (Roy, undated).

BOZO

The Bozo are often referred to as fishers of the middle Niger River, and number around 132,000 in Mali (2000 census). They are believed to be descendants of Soninke (Saracole). The various Bozo along the Niger speak four recognised distinct languages, the closest related language is Soninke. They took possession of the banks of the Niger in the 10th Century where they came to dominate fishing and river transport, a role they still hold as 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+ during the dry season (Gosselin, 2000). There is no direct data on age of FGM now for this group specifically but given the very low numbers cut after age 10, it is not clear that it still is 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'.

BWA (BOBO)

The Bwa live in the San and Tominian districts (cercles) in the Segou region of Mali with an estimated population of 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, and means Red Bobo, to distinguish the Bwa from the Bobo, whom the Dioula called Black Bobo. Bwa farmers have retained traditional beliefs and customs although many have become Christians (Minority Rights, Directory of Minorities). They are descendants of the Soninke diaspora and speak a Voltaic language they call Bwamu, as opposed to the Mande language spoken by the Bobo. 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' (Roy, undated). Openness is an important distinction between these two Bobo groups when looking at interventions and changing social norms. There are no published figures of FGM prevalence for the Bwa.

DIAWARA

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

DOGON

The Dogon live 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, 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 circumcision 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 cliterodectomies (Gosselin, 2001). The first peoples created were twins and the Dogon still believe that children contain both male and female aspects, which are removed through circumcision (Machacek and Wilcox, 2003).



Fig 6: Dogon circumcision artwork. Red and white are the colours associated with FGM for the Dogon. Although the painting's subject may be publically known, the symbolism remains a closely guarded secret, known only to the initiated (150-days-ghana.blogspot.com).

MALINKE/MANDINGO/MANDINKA

The Malinke also speak a Mande language and live in the south-west and west of Mali, and 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 Malinke 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 age 12. The preferred marriage pattern is for the daughters to marry the mother's brother's son (Everyculture.com). FGM was traditionally a rite of passage to adulthood, but in Mali has become performed earlier than puberty with the majority of the girls cut (72%) before the age of five (DHS, 2006).

MAURE (MOORS)

The Maure are a Berber population living in northern Mali, who migrate between 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 peoples groups, 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. The Peulh also tend the cattle of the agricultural Bambara people, who also consider cows as a sign of wealth and status.

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.



Fig 7: Fulani woman dressed in traditional blue to mourn the death of her husband (moroccanmaryan.typepad.com)

Peulh women wear their wealth as gold jewellery including distinctive nose rings, as worn by the woman in figure 7. She also has the indigo lip dying/tattooing, which is a sign of beauty among the Peulh and some Bambara women. Child marriage is common among some Peulh groups with girls married at 12-13 years of age (Wing, 2008). FGM prevalence is 93.1% among Peulh women aged 15-49 (DHS, 2013).

SENOUFO/MINIANKA/SUPYIRE

The Senoufo (of which Minianka and Supyire are sub-groups) are found in south-east Mali, Burkina Faso and the Ivory Coast. Most are sedentary farmers. Many Senoufo have also migrated to urban areas in Mali. Senoufo resisted Islam more than other peoples, and many continue to adhere to traditional beliefs. Inheritance is matrilineal, via the mother's brother. After the Peuhl, the Senoufo are the next largest group remaining in Mali who perform FGM on or after the age of 10. This accounted for 10.3% of women aged 15-49 cut. Another 21.8% were cut between the ages of 5-9 years. Overall, they have an FGM prevalence among girls and women 15-49 years of 87%, of which 9.7% are infibulated (DHS, 2013).

'The people in the village have understood that there was nothing in the traditions of the Senoufo 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 Senoufo world.'

Mr. Mélégué Traoré (ipu.org, 2001)

There are many branches from the main Senoufo people who all speak related Gur languages, including the Minianka and Supyire. 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.

SONINKE/MARKA

The Soninke, or Saracole, live in north-west Mali, in the Sahelian zone along the Senegal River. They have lived in the region for thousands of years. Traditional Soninke society is characterised by a rigid caste system similar to the Mande 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 Soninke now are merchants and travel throughout West Africa and beyond. They are one of the few ethnic groups in Mali that had traditionally practised FGM on infants. They have an FGM prevalence of 96% (DHS, 2013).

SONRAI /SONGHAI/SONGHAY

The Sonrai are mostly settled subsistence farmers in south-eastern Mali in the Niger valley from Djenne to Ansongo, although some nomadic groups are dispersed across Mali, Niger, and into Algeria. They are descendants of the 15th and 16th Century Sonrai Empire of Gao, which was destroyed by the Moroccans in 1591. The Sonrai were converted to Islam in the 13th Century. Sonrai families tend to be large. In rural areas, brothers 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 whilst 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 (Everyculture website, Songhay).

The majority of Sonrai do not perform FGM. However, the DHS (2006) reported 28.4% prevalence, and this number rose in the latest DHS to 59.5% but it is based on only 101 women living in southern regions of Mali. Female initiation in the past did not involve genital mutilation, but was a ritual purification prior to marriage called Gosi. Boys were circumcised at a late age by travelling specialists, but now are cut as toddlers by physicians in a medical setting (Worldmark Encyclopedia, 2009).

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 are charged with the education of the children into the traditions, music, and poetry of their group. Being nomadic herders and traders, the men often travel 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 (Aboucacrine, 2014). In 1995, the DHS reported the FGM prevalence among the Tamachek as 16.5%, this worryingly doubled in 10 years to 31.6% by 2006 and further research is needed to understand why this shift has occurred. Figures from the 2013 DHS survey do not include a large enough population sample size to make a comparison.

Case Study - The Supyire

There are around 300,000 (1991 data) Supyire living in southern Mali, within a 40 km radius of the town of Sikasso. They speak a Senoufo family language. The Supyire in Jemphrey's ethnography lived 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. Yet, the words for marriage still means 'woman cutting' *cikwoore*. On their wedding day, women are still ritually washed as they would have been after being cut.

According to FGM rituals the girls are undressed before the operation, removing 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 the child still while she is excised. Each cut is made with a fresh razor blade to limit infection. The cut flesh is dropped into a prepared hole covered by a stone, which will later be filled in and continued to be marked by the stone.

Immediately after cutting the girls are washed in liquid prepared with ebony tree leaves and then 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 with strips of cotton between the legs and tied on a strip round the waist. All materials are provided by the mothers. In addition, they bring soap for the washing of the wound for the two weeks it takes to heal, conducted by the excisor 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 excisor's saliva and secret incantations before application.

Traditionally among the Supyire, the excisors were a guild of women who knew the secret incantations and treatment for the excision and used a small iron knife. The practitioner watched in the above account was not a Supyire, as the last traditional excisor in the village had died 50 years previously.

The ethnography of the Supyire, gave several reasons for FGM. The first is that it is not possible to give birth without FGM as the opening would be blocked. Another reason is to control a woman's sexual pleasure so she would not be unfaithful to her husband. The third is that it is tradition and impossible to conceive of women who are not cut (Jemphrey, 1997).

OVERVIEW OF FGM PRACTICES IN MALI

This section gives a broad picture of the status of FGM in Mali. The following sections of the report give a more detailed analysis of FGM prevalence set within their sociological and anthropological framework, as well as efforts at eradication.

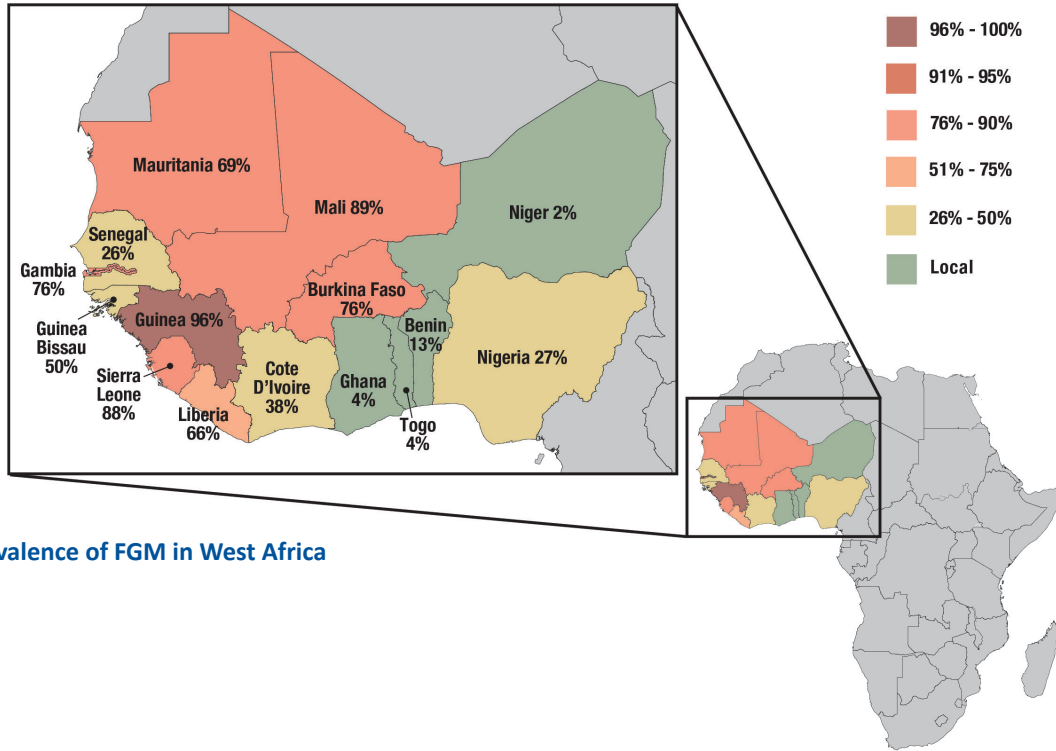


Fig. 8: Prevalence of FGM in West Africa

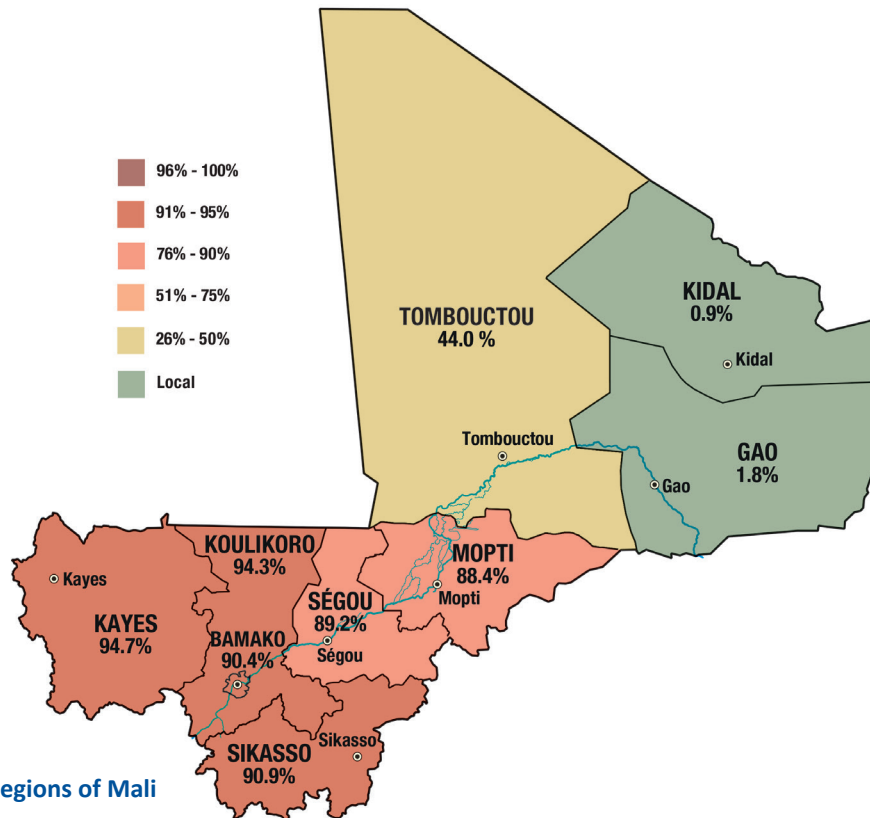


Fig. 9: Districts and Regions of Mali

A note on data

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.

The DHS makes the following statement:

‘Comparing the proportion of circumcised women in DHS 2006 and 2013 should be interpreted with caution. Indeed, since the current survey was not conducted in the three northern regions which are less populous areas (Timbuktu, Gao and Kidal represent only about 10% of the total population) and also those where the prevalence of circumcision is lowest (it does not exceed 23% according to the results DHS IV of 2006). To have two comparable indicators prevalence must be recalculated for the previous survey, excluding the three northern regions. The results then show a prevalence of 92% (2006) against 91.4% for the present investigation, virtually no change between the two surveys. If the northern regions previous results are included and both surveys are compared, then prevalence has declined slightly’ (DHS, 2013).

NATIONAL STATISTICS RELATING TO FGM

The estimated prevalence of FGM in girls and women (15-49 years) is 91.4%. The prevalence is therefore reported as increased from 85.2% (DHS, 2006). Mali is classified as a group one country, according to the UNICEF classification (a country with a prevalence of over 80%).

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS). For Mali they are DHS 2006 and DHS 2013 (which does not include data for the northern regions) and MICS 2010 (which has not been released in full). There is limited data on the reasons for FGM in the 2013 report so data is used from 2006 to explore this aspect. DHS reports do not use WHO FGM typology, the categories of FGM

used in the DHS surveys for Mali, are: cut, flesh removed; nick, no flesh removed; sewn closed; don't know/missing.

PREVALENCE OF FGM IN MALI BY PLACE OF RESIDENCE

Mali has significant regional variations in FGM, with prevalence ranging from 2% up to 98%. These regional differences reflect the diverse ethnic communities. Prevalence of FGM within individual communities is discussed below in the section on FGM in Mali by ethnicity. As shown in Figure 10, rates of FGM are highest in the western and southern regions of Kayes, Sikasso, Koulikoro and Bamako and lowest in the north eastern regions of Kidal and Gao. Figure 4 shows the ethnic groups and their distribution across the regions.

Percent distribution of women aged 15-49 with FGM by regional residence

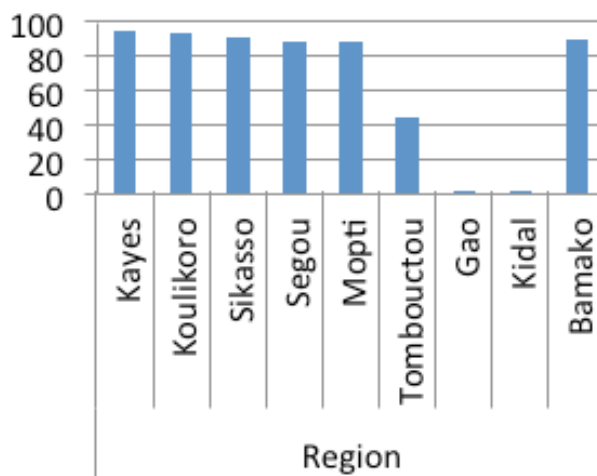


Fig 10: Percent distribution of women aged 15-49 with FGM by regional residence (DHS, 2013) (Figures for Tombouctou, Gao and Kidal are from DHS 2006 as these are the last available)

There is hardly a difference in the prevalence of FGM DHS (2013) between those who reside in urban areas (90.5%) as opposed to rural locations (91.8%). These figures have changed significantly since the 2006 DHS where prevalence rates for Bamako (92.6%) masked the lower rates in all other urban centres combined. This was 72.2% and

shows a marked difference from rural residences at 87.4%. The total population living in rural areas in 2010 was 66% (Worldbank/Trading Economics).

Percent distribution of women aged 15-49 with FGM by urban/rural residence

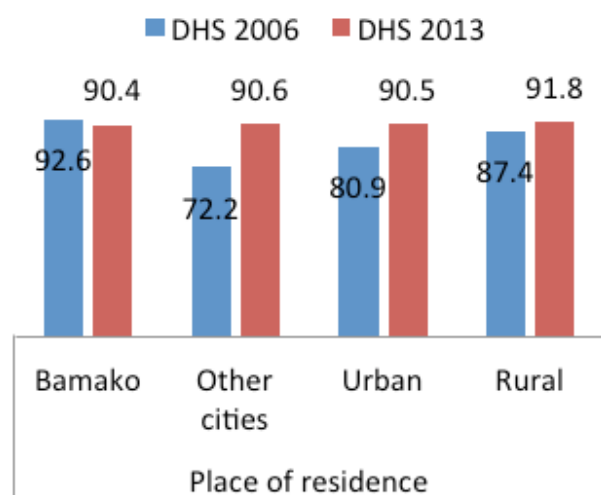


Fig 11: Percent distribution of women aged 15-49 with FGM by urban/rural residence (DHS, 2006 and 2013)

PREVALENCE OF FGM IN MALI BY HOUSEHOLD WEALTH %

MICS and DHS break down the population into quintiles from the richest to the poorest, using information such as household ownership of certain consumer items and dwelling characteristics.

Findings between DHS 2013 and MICS 2010 differ. Whereas the UNICEF data indicates that richer, urban residences are slightly more likely to practise FGM, which is an exception to the norm (UNICEF, 2013), the DHS data shows that the richest and poorest quintiles are equal. The richest families though are more likely to have cut their daughters (0-14 years), with 74.8% of richest mothers and 64.3% of the poorest.

Percent distribution of women aged 15-49 and daughters 0-14 with FGM according to their wealth

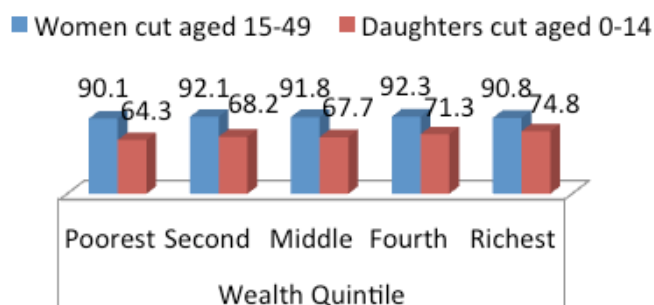


Fig. 12: Percent distribution of women aged 15-49 and daughters 0-14 with FGM according to their wealth (DHS, 2013)

TYPE OF FGM AND PRACTITIONERS

As can be seen in figure 13, the practice of FGM is variable among ethnic groups and the type of procedure also varies. Even though the Sonrai cut the lowest proportion of their women, they perform sewn closed FGM (which is defined by WHO as Type III) on a larger proportion of them than any other ethnic group. Type III is found in over 10% of all women cut in all groups except the Dogon, Senoufo, Tamacheck and the Bobo. The majority of women are excised with both the clitoris and inner labia removed.

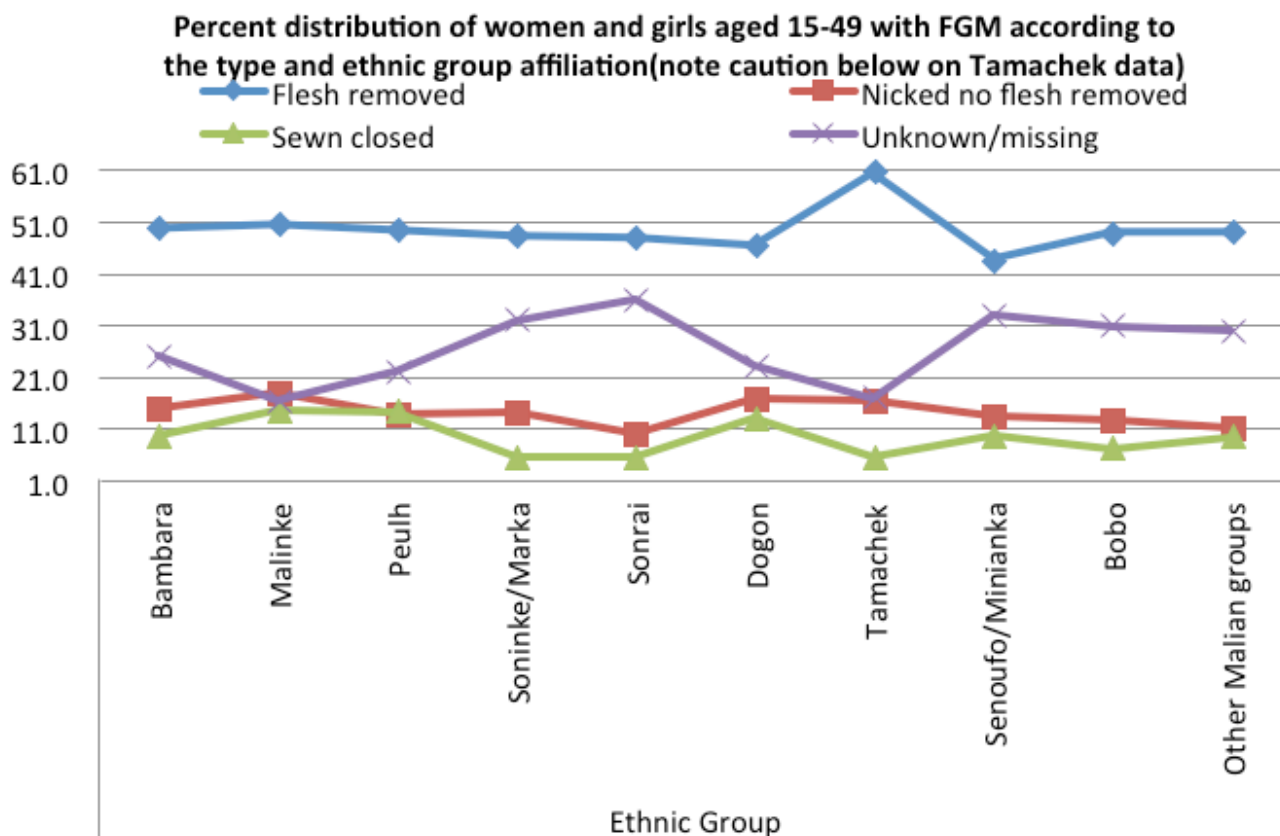


Fig. 13: Percent distribution of women and girls aged 15-49 according to their type of FGM and ethnic group affiliation (DHS, 2013)

The figures for the Tamachek are based on only 61 interviews, and not taken from regions where they traditionally live, which were excluded from this report. These figures should be read with caution, for although it is noted in this report that the numbers of Tamachek women with FGM is rising they are one of the two groups that practise FGM the least. The other is the Sonrai and the figures shown here relate to only 101 women currently residing in the southern half of the country.

Table 1 does show that a large percentage of women either do not know the type of FGM they had, or the data is missing. For the rest, cut flesh

removed forms the largest proportion of FGM in Mali, but a worryingly large proportion of women were infibulated.

Cut, flesh removed	48.9%
Nick, no flesh removed	14.6%
Sewn closed	10.6%
Don't Know/missing	25.9%

Table 1: Percent distribution of type of FGM procedure carried out in Mali on women aged 15-49 years (DHS, 2013)

Percent distribution of daughter's type of FGM according to her mother's FGM status

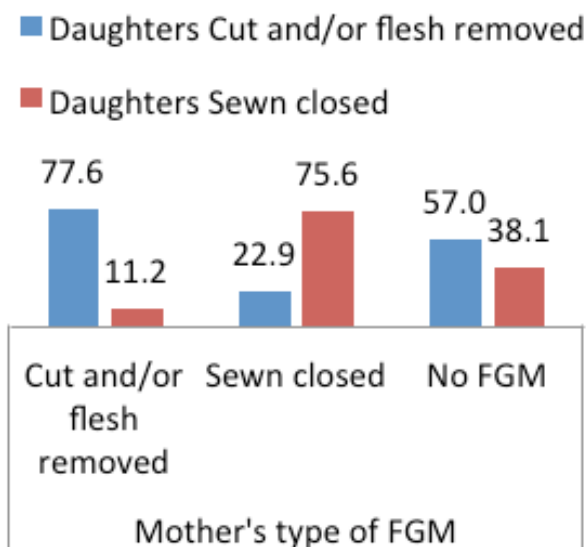


Fig. 14: Percent distribution of daughter's type of FGM according to her mother's FGM status (DHS, 2013)

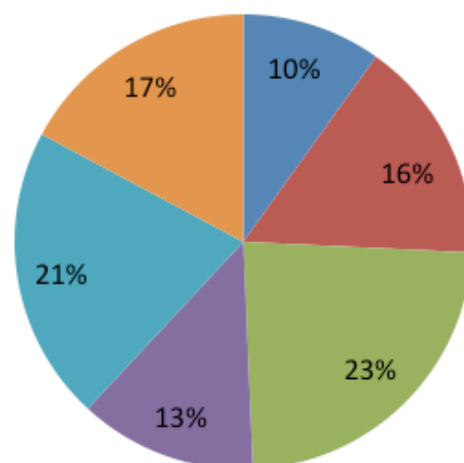
Figure 14 shows that the type of FGM that daughters have is to a large part dependent on the type of procedure the mother had, though 22.9% of girls were not infibulated, while their mothers were. A worrying trend is that women without FGM themselves have had their daughters cut, and 38% of those were sewn closed (DHS, 2013).

In the DHS 2013 a section of data was released on the number of daughters aged 0-14 who were sewn closed and by the practitioner who performed the procedure. Figure 15 shows the distribution by region of daughters sewn closed and Figure 16 the practitioners who sewed the daughters closed.

There is a strong regional variation in the numbers of daughters who have been infibulated, with twice as many in Mopti (21%) than in Kayes (10%). Sikasso has the highest proportion with almost a quarter of their girls sewn closed during FGM.

Percent distribution of daughters aged 0-14 sewn closed by region

- Region Kayes
- Region Koulikoro
- Region Sikasso
- Region Segou
- Region Mopti
- Region Bamako



Percent distribution of those who infibulated daughters age 0-14

- Traditional excisor
- Traditional birth attendant
- Other traditional
- Doctor
- Nurse/Midwife

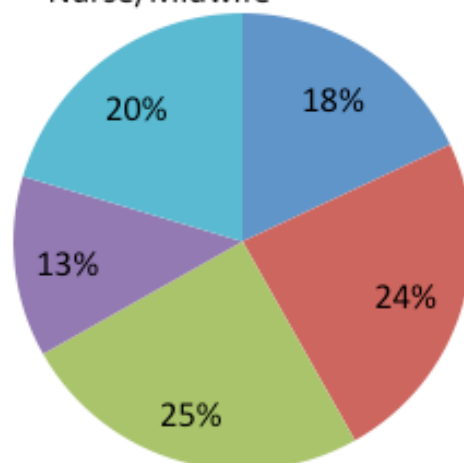


Fig. 15 shows the distribution by region of daughters sewn closed and Fig. 16 the practitioners who sewed the daughters closed (DHS, 2013)

PRACTITIONERS OF FGM

Though the figures are high (Fig. 16 above) for medical practitioners performing infibulations (33%), the figures for medicalisation of FGM as a whole throughout the regions covered by DHS 2013 is very low; 2% of girls aged 0-14 cut by medical staff and only 0.7% of girls and women aged 15-49. The majority of these professionals are nurses/midwives (1.1%) and (0.9%) doctors (for aged 0-14) and 0.2% and 0.5% for nurse/midwives and doctors respectively for the group aged 15-49.

FGM is 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 (ACDI, 2011). Table 2 show this has not changed over the years. Performing FGM can be a valuable income to support a practitioner's livelihood. According to IAMANEH Suisse (2013), current excisors must be offered an alternative source of income before they are willing to abandon their profession. They note that about half of the former excisors they surveyed today work as midwives.

Practitioners of FGM	Aged 0-14	Aged 15-49
Traditional excisor	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
Missing/don't know	0.2	8.4

Table 2: Percentage of women and girls cut by which practitioner of FGM (DHS, 2013)

PREVALENCE OF FGM IN MALI BY AGE

The estimated prevalence of FGM in girls and women (15-49 years) is 91.4% (DHS, 2013). This has remained virtually unchanged from 91.6% in 2001 (DHS, 1998) and 93.7% in 1995-6 though it jumped from 85.4% in 2006 (DHS, 2006). The MICS 2010 survey data puts the figure lower at 89% overall prevalence. 83% of daughters currently aged 14 have been excised compared to the figure for women 15-49 at 91.4% (unadjusted figure).

Percent distribution of women with FGM by age at when FGM occurred over 4 DHS

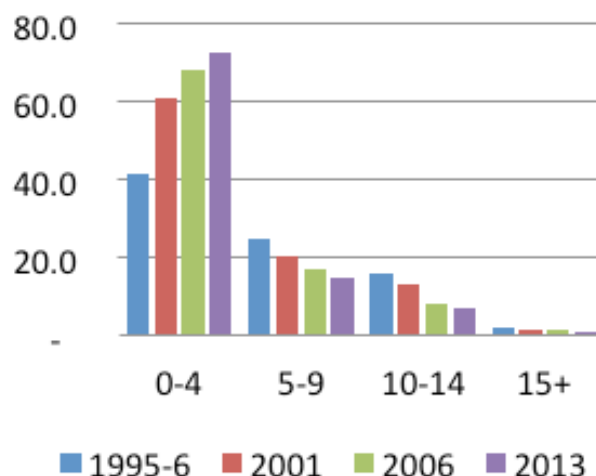


Fig. 17: Percent distribution of women with FGM by age when FGM occurred (DHS, 1995-6; 2001; 2006; 2013)

The prevalence of FGM in all daughters currently aged 0-14 is 69.2%. Many of these girls may still be at risk of FGM.

The age of performing FGM has changed significantly. Shifts can be seen in the DHS figures over the four consecutive reports. Figure 17 shows that in 2013 73% of women aged 15-49 were cut by the age of 4, with a further 14.6% by the age of 9. In 1995, the figures were 41% and 24% respectively. The risk of being cut after age 9 is low at 7% compared to 17.3% in 1995. Figure 18 shows the percent of daughters with FGM within current age cohorts and by ethnicity. It cannot be

Percent distribution of FGM in cohorts of daughters and the total for all daughters 0 -14 according to the mother's ethnic affiliation

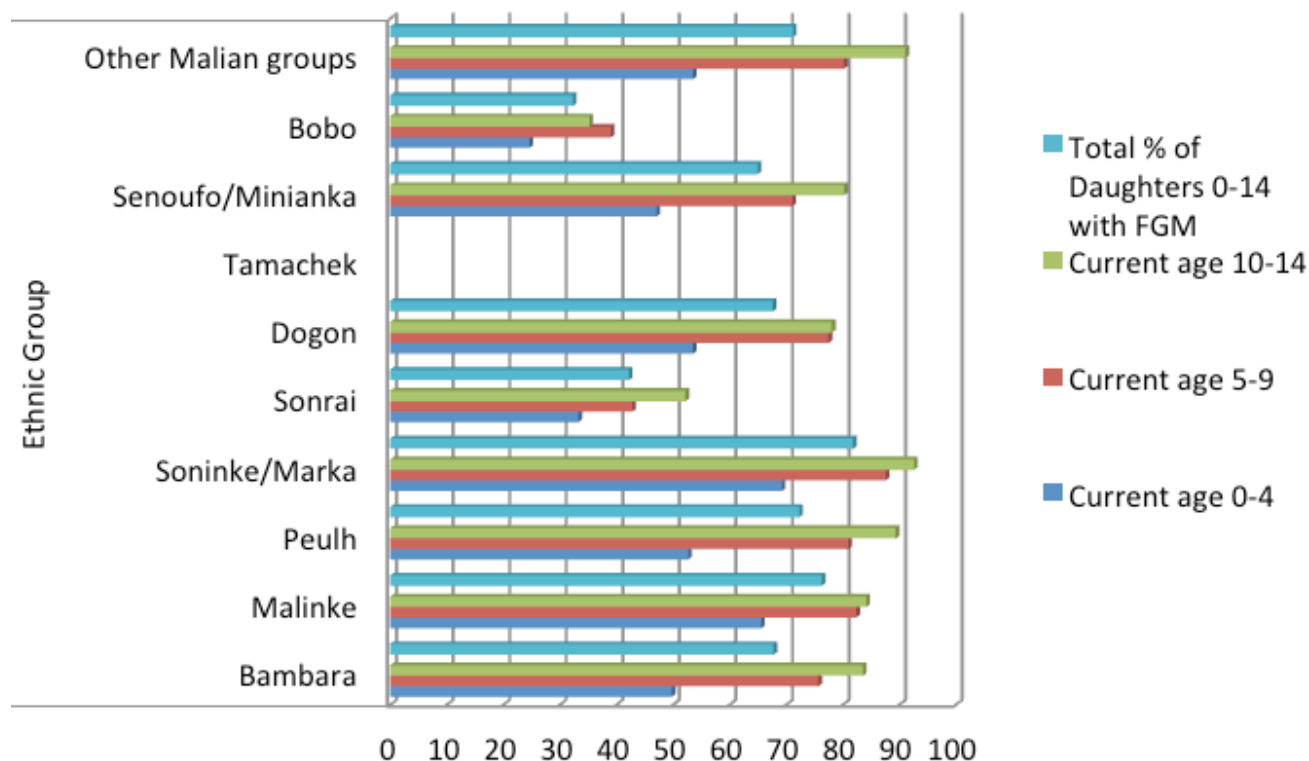


Fig. 18: Percent distribution of FGM in cohorts of daughters and the total for all daughters aged 0 -14 according to the mother's ethnic affiliation (DHS, 2013)

extrapolated from this that girls currently aged 0-4 will be cut to the same level as girls currently aged 10-14.

The reasons given for the reduction in age are variable but centre on 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 the procedure on a very young girl (Poricho, 2006). Figure 19 shows the age of FGM among all ethnic groups and highlights which groups still practise FGM on girls over age 5. This later age of performing FGM may correspond with coming of age rites, which include FGM.

Percent distribution among all daughters with FGM at the age they were cut according to ethnic group

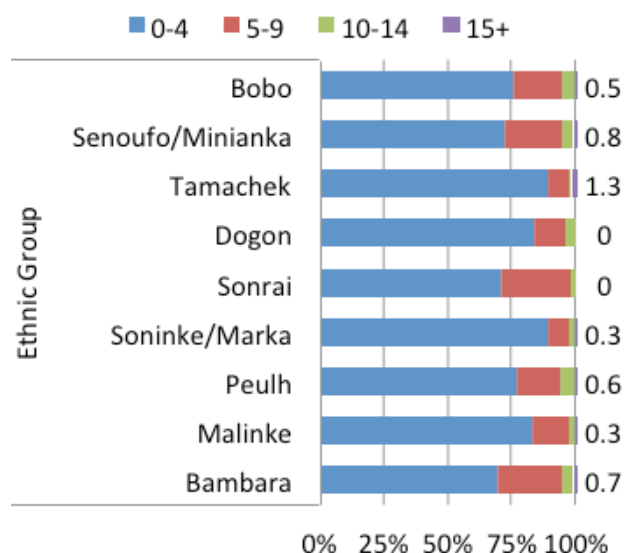


Fig. 19: Percent distribution among all daughters with FGM at the age they were cut according to ethnic group (DHS, 2006, there are no comparable figures for 2013). The figures on the right of the graph show the percentage of daughter cut after 15, which are so low they do not show graphically.

COUNTRYWIDE TABOOS AND MORES

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.

All references cited within **Ogunyemi, 2008**.

Traditionally in Malian society, menstruation, pregnancy and sex are taboo subjects, and are often a source of embarrassment for women. For example, menstruation in Dogon is believed to make women impure. Women are kept separate in 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 predicted by the religion of the husband, not by the religion of the wife. Women who had animist husbands used the huts; women whose husbands were not animists did not (Lost Womyn's Space). It is also believed that in the Dogon religion, FGM is a procedure thought to spiritually cleanse women. This is because the first incident of FGM was said to have been performed on Mother Earth (Shell-Duncan and Hernlund, 2001). 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 (Snow, undated). Today FGM is performed on girls under the age of four, whereas historically it was practised on teenagers as a rite of passage (Grosselin, 2001). A study from the 1950s on FGM amongst the Bamanan discussed male circumcision and FGM 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 round their waists (Poricho, 2006).

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 amongst 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 and triggering a caring protective reaction from 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 surrounding maternal health and remarkably 85% of respondents who were uninvolved with coordinating the project, communicated the concept (Clemmons & Coulibaly, 1999). This use of traditional symbols and communication was effective in changing behaviour and could lend itself to other behaviour change interventions concerning sexual health and FGM.

Breastfeeding is the norm in Mali. Breast milk is thought to both produce strong and healthy offspring and to 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 which will cause a breastfeeding child to become ill (DHS, 1995-6). In Malian culture breast milk is sacred; if two children have been breastfed by the same women, regardless of whether they are biologically related or not, they are considered milk siblings and cannot marry (Virginia Friends of Mali website).

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 isolate themselves and keep their sexual identity hidden. Violence (including mob violence) has been reported against LGBT individuals where the police do 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.

Unless otherwise stated, all information is from US Dept. of State, 2013.

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

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 (SIGI website). In the overall distribution of costs by sector for the MDGs, the promotion of gender and the empowerment of women is only 1% (Plan project, undated).

Rogaia Abushara explains that 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' (Althaus, 1997). 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 the stipulation that a wife should obey her husband (Portant Code Des Personnes et de la Famille, 2011).

In Mande culture, singing is considered a feminine activity and, 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 Mande society (Duran, 2000).



Fig. 20: 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 (Portant Code Des Personnes et de la Famille, 2011). Underage marriage is a problem throughout the country. In some regions, girls marry as young as age 10. It is common practice for a girl who is age 14 to marry a man twice her age (US Dept. of State, 2013).

DHS data from 2012-13 shows that among women aged 25-49 years, 20% were married before the age of 15 years and 50% before the age of 18 years. The first marriage of women aged 25-49 is estimated to have been at the median age of 18.0 years. The median is slightly lower amongst those aged 20-49 at 17.8 years. 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 aged 25-49 differs from one place of residence to another. Rural women marry earlier than those in urban areas namely 17.7 years against 19.0 years (DHS, 2013). 35% of women who are currently married are in a polygamous marriage (DHS, 2013). The levels of polygamy decreased with

education 35 % to 15% respectively (DHS, 2013). 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 (CEDAW, 2004).

Under the Personal and Family Code, wives are legally obliged to obey their husbands, and the husband has sole family and parental authority (FIDH, 2011). Husbands decide where the family will live and their wives are obliged to obey (CEDAW, 2004). Legally, either spouse may petition for divorce, but in rural areas women rarely initiate proceedings because of strong social pressure (CEDAW, 2004). 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 (US Dept. of State, 2013).

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 (Jones-Casey *et. al.*, 2011). A further discrimination is that women can inherit only poor quality land that is not very fertile (CEDAW, 2004). 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 Senoufu, Peulh and Soninke communities (Commission de l'immigration et du Statut de refuge du Canada); (CEDAW, 2004). 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* (CEDAW, 2004).

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 (\$1,030 USD) or, if premeditated, up to ten years' imprisonment (US Dept. of State, 2013). Public opinion generally accepts that men have a 'right' to beat their wives. Three in four (76%) of women think a man has a right to beat a woman (DHS, 2013). 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, they would be unable to support themselves financially, and so they seek to avoid social stigma or fear further ostracism. The government's planning and statistics unit, established to track prosecutions, is not operational (US Dept. of State, 2013).

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, 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 (US Dept. of State, 2013).

RESOURCES AND ENTITLEMENTS

Civil law provides for equal property rights, but ignorance of the law prevent women from taking full advantage of their rights (US Dept. of State, 2013). While legally men and women have the same access to land, in reality, many other obstacles prevent women from exercising their rights, including 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 (US Dept. of State, 2013).

CIVIL LIBERTIES

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 women are not free to move in order to work (CEDAW, 2004). On a day-



Fig. 21: Girls returning from bathing in the Senegal River (28 Too Many in-country researcher)

to-day basis, 61.6% of women reported that they could not go and visit female friends and relatives without their husband's permission, indicating considerable restrictions on women's freedom of movement (UNICEF, 2007).

HEALTHCARE SYSTEM

Mali has some of the lowest health indicators in the world with life expectancy currently standing at around 57 years (WHO, 2012). Malaria is the leading cause of morbidity and mortality. Although the use of mosquito nets is high (84% of households own a net), the disease is still prevalent with 52% of children carrying malaria parasites during the high transmission period (USAID, 2013).

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 (USAID, 2013).

According to WHO (2012) there are just 0.8 physicians to serve each 10,000 people and 4.3 nurses and midwives per 10,000 people (compared to regional averages of 2.6 and 12 respectively). The total expenditure on health per capita is \$74 USD, which is higher than the WHO estimate of minimum spending per person per year needed to provide basic, life-saving services (\$44) (WHO, 2012) and the total expenditure on health as a percent of GDP is 5.8% (WHO, 2012a).

Since the 2012 crisis, Mali's health infrastructure has been compromised. With Jihadist rebels controlling northern Mali, most of the health facilities were destroyed or damaged, health workers fled and many health care services stopped functioning (USAID, 2013).

In addition, WHO (2014) reports problems arising from the conflict including:

- 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
- Large influx of people to services in southern regions which were not prepared and became overwhelmed

HEALTH AND THE MDGS

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 with the adoption of their 2006-2015 plan. This strategy focuses on poverty reduction and socio-economic development (particularly agriculture, food security, education and health) (UN, 2010).

USAID stated in 2009 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 (2009) highlighted the importance of strengthening FP services in Mali in order to slow population growth and make MDGs more achievable. The costs of achieving five MDGs, both with the unmet need for FP remaining constant and being gradually met by 2020 were calculated and clear evidence was found to show that reducing the unmet need for FP would significantly reduce the costs of meeting the following MDGs:

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

USAID estimated that the costs that would be saved in meeting these 5 MDGs through increased FP services would outweigh the additional costs of FP by a factor of almost 2 to 1.

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 (UNICEF) .

Child mortality rates fell from 253 per 1,000 children (1990) under 5 years to 128 in 2012 (UNICEF).

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 (WHO, 2013 ref by Worldbank).

The UNDP MDG Report for Mali projects that it 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 rate fell from 1.7% in 2001 to 0.9% in 2012 (UNICEF).

The UNDP progress report for Mali stated that meeting this MDG target is dependent on rapid governmental change and the development of affordable vaccines and medications.

Unless otherwise cited, all references from UNDP MDG Report on Mali, 2004.

WOMEN'S HEALTH AND INFANT

MORTALITY

WOMEN'S HEALTH

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

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

There has been little research into the impact of FGM on general health and complications in childbirth in Mali. Jones *et. al.* (1999) 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) (Fig. 22). Those found to have undergone FGM were asked to report complications they had experienced. 94% of women examined in Malian clinics had undergone FGM, most (74%) had Type II FGM.

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. Of the 1,468 Malian

women who attended the clinics to give birth, 24% experienced complications (episiotomies were the most common complication at 12%). There was, however, a significant disparity between cut and uncut women's experiences; while only 5% of Type II and 36% of women with Type III did face complications.

FGM TREATMENT

Mali has taken positive steps in creating a national programme to accelerate FGM abandonment. Programme National de Lutte contre 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 which arise from FGM. This led to the additional FGM-related treatment of 864 women and girls

in 19 community health centres assessed by a 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 (UNFPA, 2013).

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 (DHS, 2013). This rate has decreased since the 2006 DHS survey; prior to this it had remained static at 6.6 since 1996 (Worldbank, 2011). The 2006 survey 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

FGM Complications - percentage of sample affected

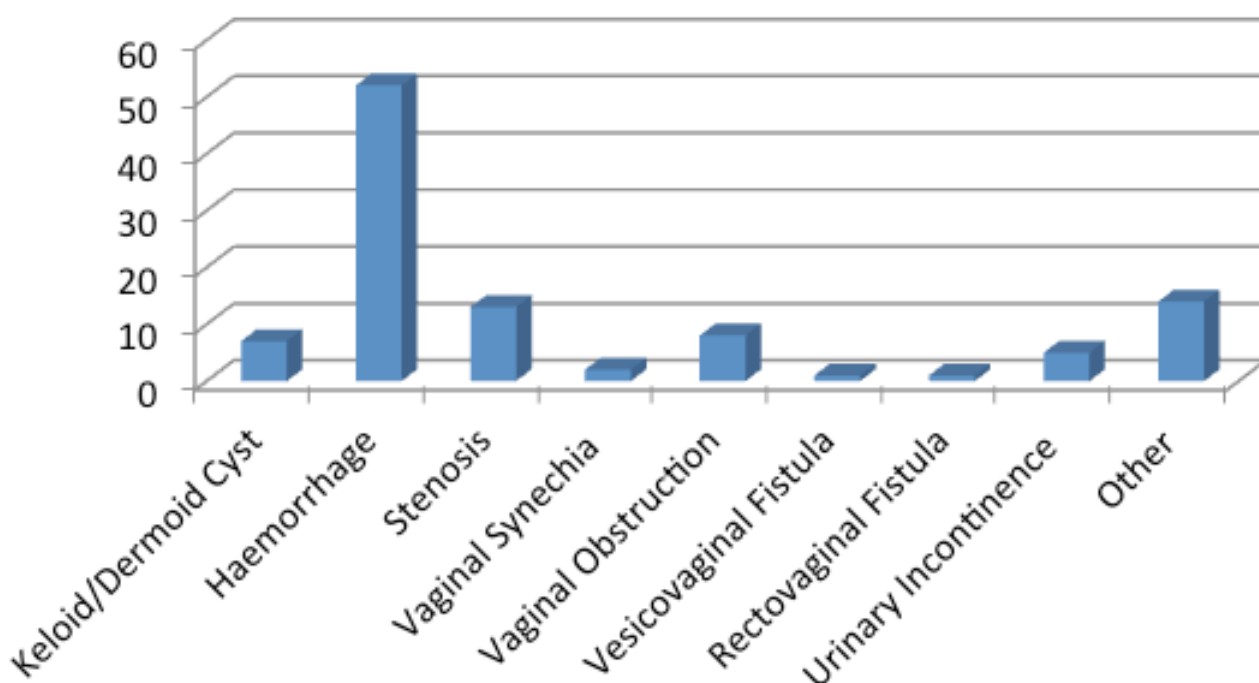


Fig. 22: Distribution of all cut women with at least one gynaecological complication, by type of complication, 1998 (Jones et. al. 1999)

no education could expect to give birth 7 times, whereas women with secondary education or higher could expect 3.8 births (Worldbank, 2011). In the 2012-13 survey the same trends remain, but rates were 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.

Contraception use is low in Mali, with less than one in ten women using modern contraceptives. While this rate is slightly higher in 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 (31%). Those most likely to complain of an unmet contraceptive need were women with secondary or higher education, women in the wealthiest quintile, women aged between 40 and 44 and women living in Bamako. Reasons commonly given for not using modern contraceptive methods were: opposition to modern methods (36%), wanting more children (13%) and lack of knowledge of modern contraceptives, or where to acquire them (13%). Concerns regarding contraceptive costs and access are not ranked as highly and the Worldbank (2011) suggests these findings indicate a need to strengthen family planning services.

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 (UNICEF, 2013).

Almost 74% of women accessed some form of medical care during their most recent pregnancy. Women in urban areas were more likely to access care during their pregnancy (93%) than women in rural areas (69%). Educational attainment was also a factor in whether or not a woman would access antenatal care, with only 71% of women who had

no education accessing antenatal care compared to 95% of women with secondary level education or higher (DHS, 2013).

Despite Mali having a high total fertility rate, the number of women accessing maternal health services is low. In 2006 35% of women reported attending the four or more antenatal appointments recommended by the WHO and only 22% received healthcare in the 48 hours following delivery. The likelihood of women accessing all recommended antenatal appointments, delivering in a healthcare facility and receiving adequate postnatal care greatly increased when their mothers-in-law believed in the efficacy of these treatments, and decreased when mothers-in-laws favoured traditional methods (White *et. al.*, 2013).

REPRODUCTIVE HEALTH COMPLICATIONS

Mali's maternal mortality rate is 540 per 100,000 births (UNICEF). 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 1000 live births (UNFPA, 2011). Haemorrhage is a known birth complication for women who have had FGM of all types due to the inelasticity of the scar tissue, which leads to tearing during delivery and potential excessive loss of blood. 26% of maternal deaths in sub-Saharan Africa are due to haemorrhage and 34% are in Mali; even births conducted in a health facility may not receive proper treatment as there is a shortage of donated blood throughout Mali (UNICEF, 2012).

Physicians for Peace (2014) assert that the primary cause of new mothers dying from haemorrhage is the inadequate access to clean, safe blood transfusions. This reflects numerous studies which 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 and, due to the lack of facilities to collect,

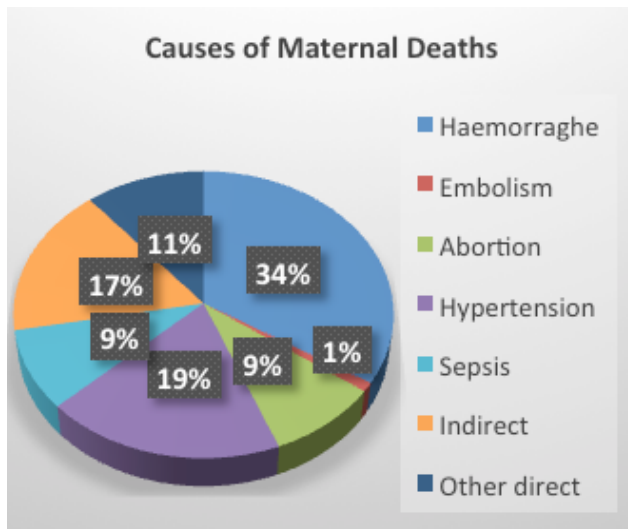


Fig. 23: Percent distribution of causes of maternal deaths in Mali (UNICEF, 2012)

Complication	Type 1	Type 2	Type 3
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 3: Relative risk of a complication for women with FGM giving birth by type of FGM. 1 represents the relative risk for a woman without FGM (WHO, 2006)

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 the patient to transmittable infections. Plans are currently in place to introduce a second blood bank to the country in Segou.

A WHO (2006) multi country study 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 was estimated to be US \$3.7 million and ranged from 0.1% to 1% of government spending on health for women aged 15-45 years (WHO, 2011). Table 3 shows relative risk of a complication for a cut or uncut woman giving birth as 1.0. Numbers larger than 1 show an increased risk of problems for women with FGM (depending on type) compared to uncut women, conversely numbers smaller than 1 indicate a decreased risk.

FGM was 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 is a debilitating condition which causes embarrassment and discomfort to those affected and 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 (UNFPA, 2012), and in Mali there are around 1,800 women at risk of obstetric fistulas every year and 1,000 new cases annually (Brugière, 2012).

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 family planning (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: 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 (Intrahealth, 2013).

PLACE OF DELIVERY

55% of births took place in a healthcare facility. As with antenatal care, the likelihood of accessing medical care during delivery was strongly linked with both location and educational attainment. In rural areas only 46% of deliveries took place in a healthcare facility, compared to 91% of births in urban areas.

DHS YEAR	1987	1995	2001	2006	2013
Percentage of live births attended by health care professional	32	40	41	49	55

Table 4: Percentage of live births attended by a skilled healthcare professional 1987-2013 (DHS, 2013)

While 91% of women with a secondary education or higher gave birth in healthcare facilities, only 73% of women with a primary education and 50% of women with no education did (DHS, 2013). Less than 1 in 2 births took place in a health facility in the regions of Kayes (47%), Segou (41%) and Mopti (26%), compared to 1 in 2 or more in the regions of Koulikoro (63%), Sikasso (63%) and Bamako (98%) (DHS, 2013).

INFANT MORTALITY

The under age 5 mortality rate currently stands at 128 deaths to every 1000 births, and Infant mortality (under 1 year) 80 per 1000 children (UNICEF, 2013) The WHO (2006) demonstrated that death rates among new-born babies are higher in mothers who have had FGM (in a multi-country study). There was an increased need to resuscitate babies whose mothers had had FGM (66% higher in women with Type III). The death rate among babies during and immediately after

birth was also much higher for those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.

Maternal and newborn health referenced from Countdown to 2015 (2010).

EDUCATION

Literacy rates are low in Mali at 56% and 38.8% for men and women aged 15-24 respectively, and 33% for the general population (UNICEF, 2012). School lessons are taught in French, often 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 (approx. 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 (DEF) at the end of grade 9, and the baccalauréat at the end of grade 12. The academic year lasts about 24 weeks (UNESCO IBE, World Data on Education, 2010/11).

Table 5 shows a steady drop off as pupils move from enrolment to completion of primary 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 (UNESCO IBE, World Data on Education 2010/11).

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 their 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 (Oxfam, 2009).

	Male	Female
Youth literacy rate (15-24 years)(%) 2008-2012	56.0	38.8
Pre-primary school participation, Gross enrolment ratio (%) 2008-2012	3.3	3.5
Primary school participation, Gross enrolment ratio (%) 2008-2012	86.7	76.4
Primary school participation, Net enrolment ratio (%) 2008-2012	71.6	62.6
Primary school participation, Net attendance ratio (%) 2008-2012	60.2	54.6
	Admin Data	Survey Data
Primary school participation, Survival rate to last primary grade (%) 2008-2012	75.5	90.0
	Male	Female
Secondary school participation, Net enrolment ratio (%) 2008-2012	35.9	25.2
Secondary school participation, Net attendance ratio (%) 2008-2012	36.0	23.1

Table 5: Latest education participation statistics relating to the years 2008-2012 (UNESCO)

Mali faces a shortage of basic educational resources, forcing multiple pupils to share seats and textbooks. The budget for books and materials from the government amounts to between \$0.50 and \$1 USD 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, rather than having them working, can also seem high, particularly for girls expected to help with domestic duties. Children from rich households are between two and three times more likely to attend primary school than are children from low income households.

There is also a serious lack of schools and classrooms. Nearly 7% of pupils have to walk more than 5km to reach their primary school, and less than one in five schools have a separate classroom for each year group (Oxfam, 2009). The absence of separate toilets for boys and girls in the majority of schools is a significant factor deterring girls from attending class. Since the 2012 northern conflict, schools in the regions of Timbuktu, Gao and Kindal are barely operational or are closed (UNESCO, 2013).

The number of teachers at primary level is as little as one teacher for 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, both the 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 in trained teachers. The quality and level of training for teachers has also been sacrificed in an effort to boost numbers. Oxfam (2009) 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.

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 their 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 (Oxfam, 2009).

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. Their aim was to train 3,000 teachers. Workshops to promote programmes such as the 'Every Child Needs a Teacher' were also held in Ségou in 2012. The availability of basic necessities has also 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 (Plan website, 2014).

EDUCATION AND THE MDGS

The African Development Bank Group has described Mali as a 'trailblazer' on the African continent for achieving Millennium Development Goal (MDG) targets, one of which includes achieving universal primary education by 2015. However, as has already been discussed, Mali is still struggling to achieve most of its targets for the MDGs. As of 2012, the total net enrolment ratio in primary education of both sexes in Mali was 73.3% (MDGs website), a significant increase from the estimated net enrolment of 47.2% in 1999. There are three MDGs which 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 and 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 (Burchi and Muro, 2007). 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 in 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 with the target to ensure that by 2015 all boys and girls complete a full course of primary schooling. 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 their public expenditure on education, Mali is thus 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% (Oxfam, 2009).

GOAL 3: PROMOTE GENDER EQUALITY

AND EMPOWER WOMEN

The aim of this MDG is to eliminate all gender disparity in primary and secondary education 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 (MDGs website). 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 (Oxfam, 2009).

Marriage can possibly be considered to be 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 (Population Council, 2004). It is likely that early marriage and dropping out of school results in women's literacy rates lagging behind those of men. The high adolescent birth rate, at 190 per 1000 births, which is linked to early marriage, also supports the disparity between literacy rates.

EDUCATION AND FGM

It has been shown in 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' (UNICEF, 2008). 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 pressure and engage with information about the harm of FGM and their rights (UNICEF, 2008).



Fig. 24: Education campaign by Oxfam that reads 'My protection starts with my education'

The desire to continue the practice of FGM decreases in accordance with the level of women's and men's education attained as shown in Figure 25. The figures have changed since 2006 when there was a 20 percentage point difference between the desire of the non-educated women and those with secondary plus education. This has narrowed to only 10% in part because more women with higher education now think it should continue. As with all figures on abandoning FGM, men have in the newest data less interest in stopping FGM. Access to secondary education is mainly found in urban centres, and may influence some of the differences in FGM statistics between urban and rural. For instance, the age of cutting daughters is younger in mothers with secondary plus education, but also in urban areas. The highest level of education is no protection against the most severe form of FGM; girls with mothers

educated to secondary plus level are more likely to be infibulated (22.4%) than those with primary education (19.1%) or no education (18.4%). These figures could again reflect the uneven access to education of differing ethnic groups depending on whether their main residence is rural or urban. Further research is needed to investigate these trends (DHS, 2013).

Percent distribution of women's and men's attitudes towards continuing the practice of FGM

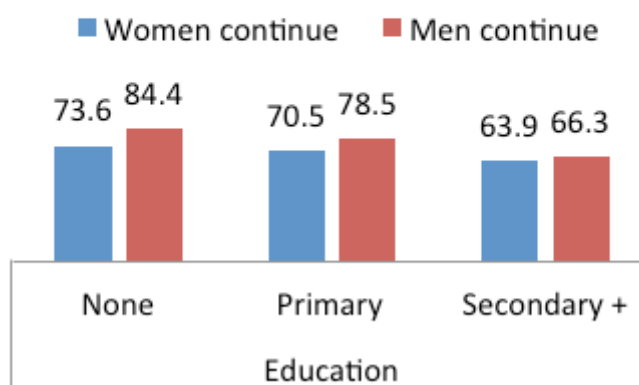


Fig. 25: Percent distribution of women's and men's opinions on whether the practice should continue according to their level of education (DHS, 2013)

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 education, or only primary level education.

More benefits of NOT performing FGM were recognised by both men and women with secondary education than those with less education. Still, only 22% of men and 23% of women recognised the increased health benefits of NOT being cut. 41% of men and 44% of women with the highest levels of education still believed that there were no benefits to be had from not having FGM (DHS, 2006).

RELIGION

Over 90% of Malians are Muslim and mosques form an important part of cultural and social life. Most are Sunni Muslims who belong to one of two main Sufi brotherhoods: i) the Quadiriya, who came to West Africa in the 15th Century and ii) the Tijaniya, founded in the 18th Century and popularised in Mali during the 19th Century. Sufism is a mystical movement within the Islamic faith, where 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 form 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.



Fig. 26: Djenne Mosque, Mopti with women standing outside (kjoyran.blogspot.com)

In Mali, there are Christian minorities making up around 4% of the population, of whom approximately two-thirds are Roman Catholic and one-third 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 (Pew Forum on Religion and Public Life).

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 all of 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.

The Malian High Council of Islam (HCIM), an umbrella organisation representing all significant Muslim groups, serves as the main liaison between the government and these 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

'Circumcision is a "sunna" whereas excision is an optional practice in the Muslim religion. It is just a traditional custom.'

- Ousmane Chérif Haidara, Malian teacher and preacher (the leading Muslim leader in Bamako)

Sunna is a term applied to FGM but has varied meanings. As an FGM typology it means the removal of the tip of the clitoris or the clitoral hood. In the context of the quote above it means required by the Koran. FGM predates the major religions and is not exclusive to one religious group. It has been justified under Islam, yet many Muslims do not practise FGM and many agree it is not in the Koran, though there is disagreement as to whether it is referred to in genuine hadiths (sayings of the Prophet) or only weak ones (not attributable to the Prophet).

'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' (Munir, 2013).

Wahabia Islam in Mali 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 (Gosselin, 2000).

Within Christianity, the Bible does not mention FGM, meaning that Christians in Mali who practise FGM do so because of a social norm.

'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

Prevalence rates vary according to religious affiliation: Muslims at 92.8%, Animists at 77.2% and Christianity lower at 65.2%. Figure 27 shows that there is a discrepancy between the numbers of women with FGM and both their beliefs and men's, that it is a religious requirement to perform FGM. The smallest discrepancy is found among the Muslims, while the largest divide is among the Christian community, followed by the Animists. In all cases it is clear that religion is not the sole driver for the practice or the figures would be lower. A change in the beliefs and practise of Muslims

Percent distribution of women with FGM and women's and men's beliefs that it is a religious requirement

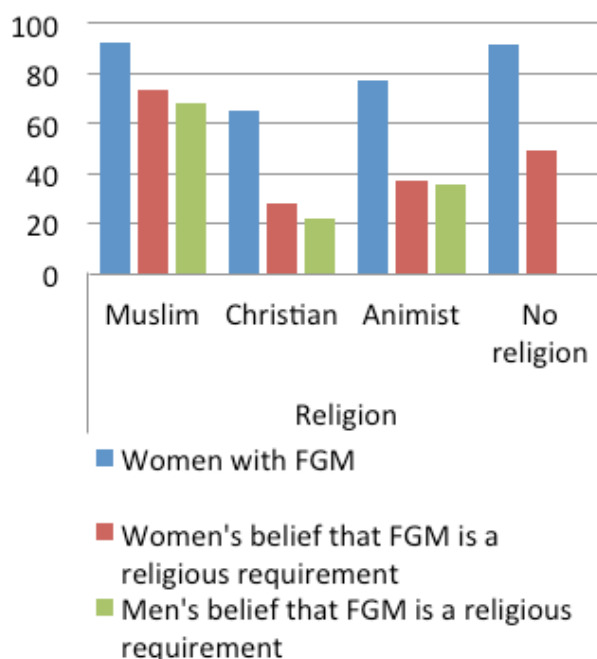


Fig. 27: Percent distribution of women with FGM and women's and men's beliefs that it is a religious requirement (DHS, 2013)

Percent distribution of women's and men's answers to 'Is FGM a religious requirement?' by age

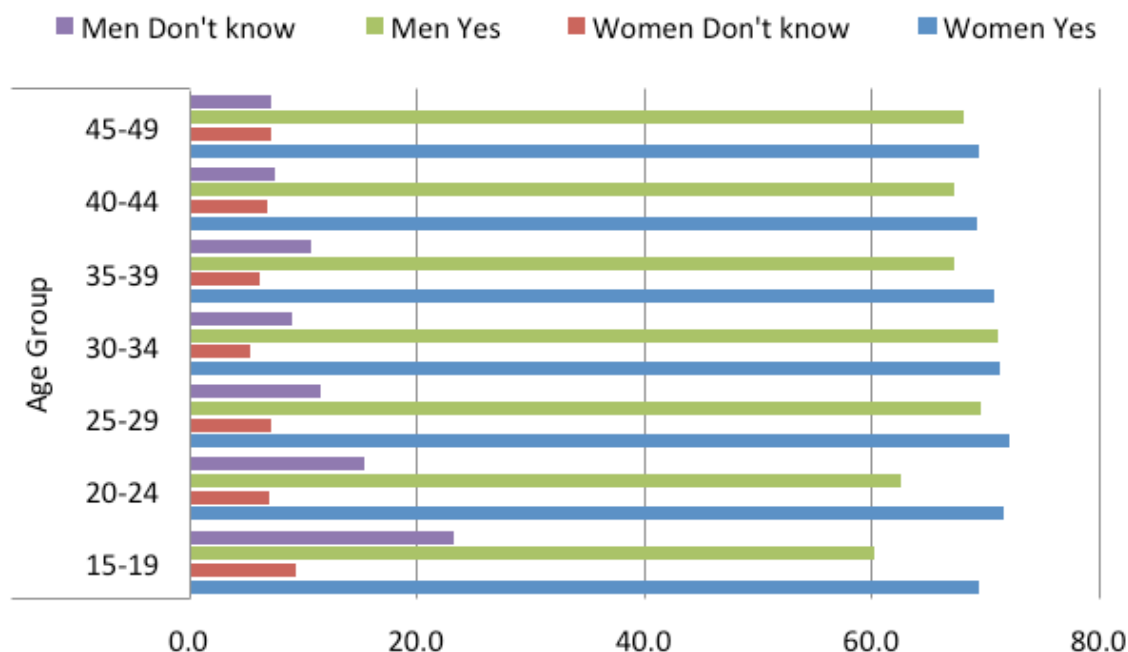


Fig. 28: Percent distribution of women's and men's answers to 'Is FGM a religious requirement?' by age (DHS, 2013)

for FGM would have the biggest impact on the numbers of girls mutilated, because Muslims make up over 90% of the total population.

Figure 28 shows that more men than women across all ages are unsure if FGM is required by religion. More women than men of all ages believed that it is required. Younger men between the ages of 15 and 25 believe (average of 61%) that it is required by religion, a higher rate than any other age of either sex. An average of 70.5% of women and girls of that age group believe that it is required by religion.

Data from DHS 2013 shows a little variation in response of the different ethnic groups on whether FGM is a religious practice. In all religious groups women said that they believed FGM was required by religion more than men, with the exception of the Bobo and Sonrai women. The Peulh women and men held the highest belief in this with 77.8% and 74.4% respectively believing that FGM is a religious requirement.

More men than women attend Mosques, and it is mainly older women who attend Friday prayers. Historically, sermons were delivered in Arabic, limiting attendees 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 and hear Imams preach against FGM and deny the religious connections (Diouf and Leichtman, 2009).

The UN joint programme has worked in Mali in the last few years on programmes addressing and educating religious leaders on the harmful effects of FGM and 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.

MEDIA

PRESS FREEDOM

The Malian constitution provides freedom of speech and press, but in recent years the government has restricted press freedom (US Dept. of State, 2013). Since 2012, journalists have had difficulty accessing information concerning the northern conflict. Journalists have been detained and assaulted, and 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 (Aljazeera website, 2014).

MAIN NEWSPAPERS IN MALI

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

L'Essor - state-owned national daily; *Le Republicain* - national daily; *L'Independent* - privately-owned; *Info Matin* - privately-owned daily; *Les Echos* - daily; *MaliWeb* - online news portal; *Malikounda* - online news portal; *Malijet* - online news website; *aBamako* - online news website

ACCESS TO MEDIA

Media exposure at least once a week	Female	Male
Reads a newspaper	5.5%	11.6%
Watches television	32.8%	46.5%
Listens to radio	46.9%	72.1%
All three media	4.2%	9.6%
No media	45.8%	21.0%

Table 6: Media exposure for men and women (DHS, 2013)

Exposure to media in Mali is dependent on residence. 54% of rural women and 25% of rural men were not exposed to media, whereas the rates are less in urban areas at 21% and 9% for women and men respectively (DHS, 2013).

Radio is Mali's most popular medium, possibly due to low literacy rates. The Media Foundation for West Africa said in 2012 that 369 private stations were on the air. The BBC broadcasts in Bamako (88.9 FM) and Radio France Internationale is widely available on FM. Television was introduced in 1983. There is the Office de la Radiodiffusion Television du Mali (ORTM) which operates public channels (ORTM TV and TM2), with programmes in French and local languages. Another station is Africable TV (private).

The government does not restrict access to the internet. Bamako has many internet cafes, but home internet remains limited due to costs (US Dept. of State, 2013). The International Telecommunication Union estimates that, in 2013, internet use was 2.7% (4.7% according to BuddeComm). Socialbakers claims that Facebook had a 1.6% penetration rate in 2013. Despite the northern conflict, information and communication technology (ICT) is progressing in Mali.

In 2012, 89.5% of the population used mobile phones. Though ITC was affected by the 2012 coup, most infrastructures are based in Bamako, and are not heavily affected by the northern conflict. At the end of 2014, it is expected that the ACE cable will be launched, along with a third mobile operator, and this should lower internet costs (OAFrica website).

MEDIA AND ANTI-FGM CAMPAIGNS

Mali celebrated International Day of Girls in ICT with an open house at Orange Mali on April 26, 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 which read that a girl's body

is sacred, 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.

Unless otherwise cited, information is from BBC Mali profile, 2013.



Fig. 29: Anti-FGM campaign poster from Sini Sanuman

ATTITUDES AND KNOWLEDGE RELATING TO FGM

Knowledge of FGM in Mali is near universal, with 98.3% of women being aware of FGM and 98.8% of men (DHS, 2013). Social norms theory can help explain why the practice of FGM continues. FGM is a regular facet of society and individuals believe that even if they wanted to stop, other community members do not want them to stop, and that they would face ostracism if they do not follow custom. Moreover, because FGM is a taboo subject, there is no dialogue to express views on the practice. Individuals are forced by societal custom to continue, even though many community members might want the practice to be abolished.

The figures from 2006 show that there is a marked difference in views on the advantages of FGM between men and women, depending on their locales. For men in all areas, the three largest categories in Figure 30 of FGM advantages are 'ensuring virginity', FGM being a 'religious requirement' and 'no advantage'. Again, the advantages are highest in Bamako and the 'no advantage' category is lowest. Social recognition

Percent distribution of perceived advantages among women and men aged 15-49 of FGM according to residence

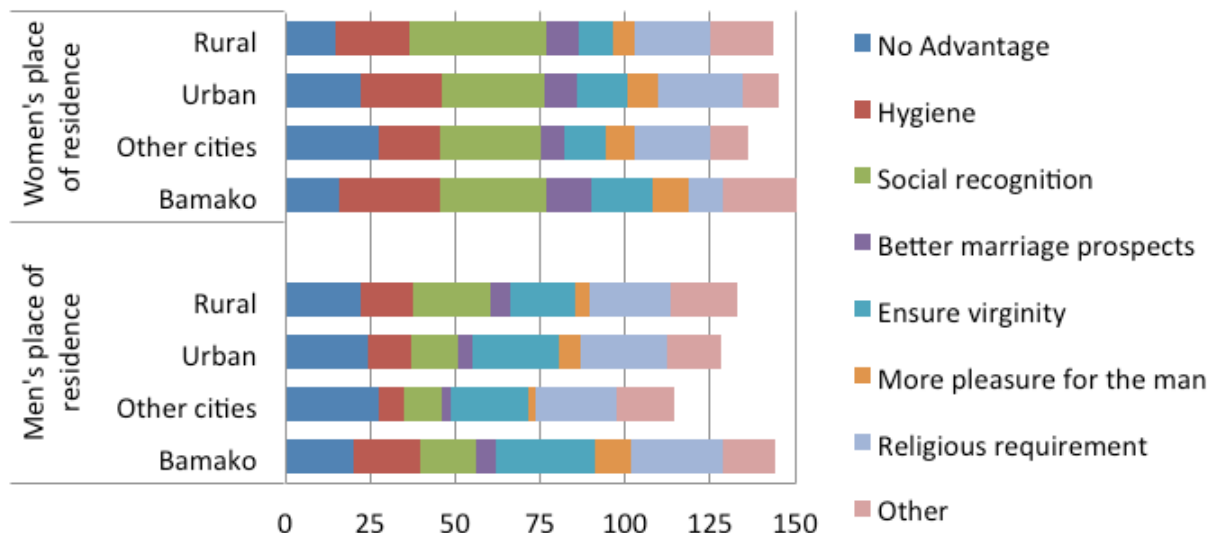


Fig. 30: Percent distribution of perceived advantages among women and men aged 15-49 of FGM according to residence (numbers do not add to 100 as respondents could choose multiple advantages) (DHS, 2006)

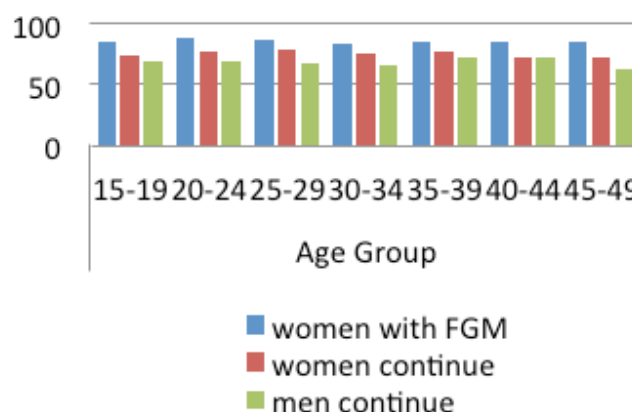
is the largest category of advantage across all rural and urban locations for women, but more important for rural populations and for those with no education (data not shown). Among those with a secondary education, as opposed to no education, ensuring virginity was seen as a benefit of FGM and it was seen to provide more pleasure for a man during intercourse. More positively, higher levels of education also resulted in higher proportions of those who see no advantage to FGM. Among both sexes the 'other' category is chosen more often than most other categories, but it is unclear what the parameters of this category are from the literature.

Figures 31 and 32 show that in 2006, as opposed to 2013, across all ages more women have had FGM than believe that the practice should continue. However, the opinions of both men and women varied little, although more women than men wanted the practice to continue. In 2013 the attitudes to abandoning the practice reversed and more men than women across all ages thought it should continue. Among women, the desire to continue FGM fell when compared to men, but also fell with respect to women's previous attitudes (to a low of 70% in the youngest age cohort).

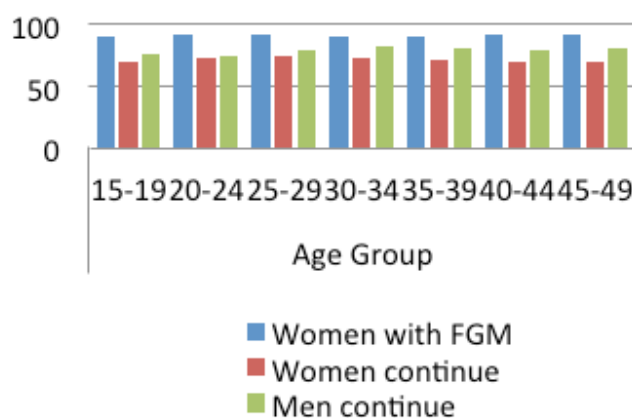
Figure 33 offers an interesting perspective on the population's views of FGM. Instead of asking questions about the reasons for continuing FGM, with the defined categories of why people cut their daughters, the data below is based on questions about the benefits of NOT cutting the girls. Using the urban/rural residence categories, and divided by sex to demonstrate the attitudes, it is possible to see who the intervention programmes had reached by 2006 and affected. Unfortunately this data was not released in the latest DHS 2013. Detailed information on the NGOs who work in Mali and their intervention strategies is included towards the end of the report.

The vast majority of respondents surveyed saw no benefit in NOT performing FGM (meaning FGM is considered beneficial). Even ethnic groups that do not traditionally practise FGM saw little benefit

Percent distribution of women with FGM and the opinion of both women and men on whether the practice should continue according to their ages DHS 2006



Percent distribution of women with FGM and the opinion of both women and men on whether the practice should continue according to their ages DHS 2013



Figs. 31 and 32: Percent distribution of women with FGM and the opinion of both women and men on whether the practice should continue according to their ages (DHS 2006 and 2013)

in not doing so. Urban residents saw more benefits to not cutting girls than rural counterparts, except in the 'other benefits' category, which is recognised by more rural residents. The religious message that FGM is not part of any religion, and that to NOT cut your daughters accords to religious belief, appears to have reached more urban men (excluding Bamako), but is still low at 18%. The figure for Bamako is 4.6%.

Figures 34 and 35 show the benefits of not performing FGM by ethnic group and gender. The coloured bands' heights above each group's name represent the percentage that each benefit was chosen.

For example, the wide red band above the Sonrai, represents the 30.8% of Sonrai women that recognised less health problems as a benefit of NO FGM. In terms of intervention, recognition

of the health problems of FGM appears to have positively influenced marginally more men than women. However, on average less than 15% of each gender believe that women will have fewer health problems if they do not have FGM. More women than men believe that there are no benefits to NOT having FGM, which is consistent across all ages at about 60%. Little regard is given by both men and women to saving women from the suffering from FGM, though higher regard is given by ethnic groups that do not universally practise FGM. The pain of FGM was part of the rites for older girls and suffering with fortitude is a value for Malian women. More men than women see increased sexual pleasure for the women as a benefit of no FGM, and more men believe that no FGM accords with their religious beliefs (DHS, 2006).

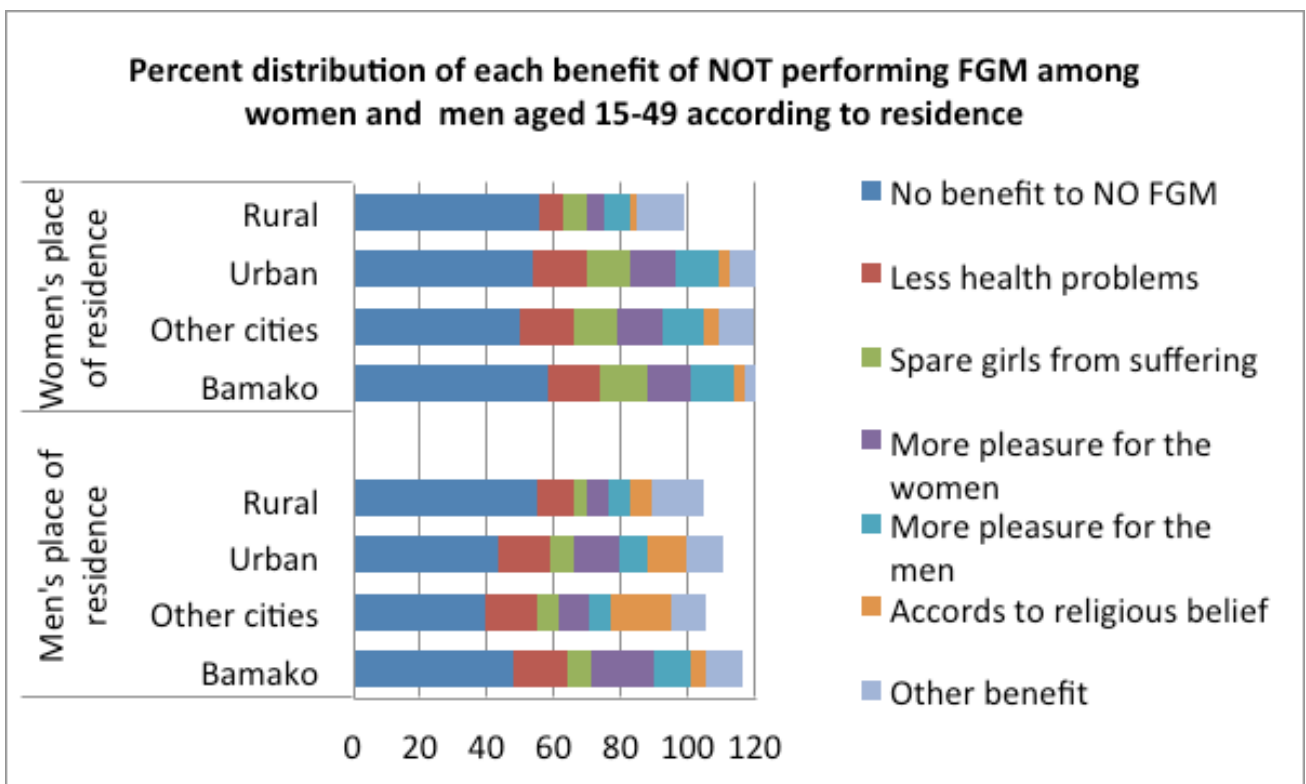
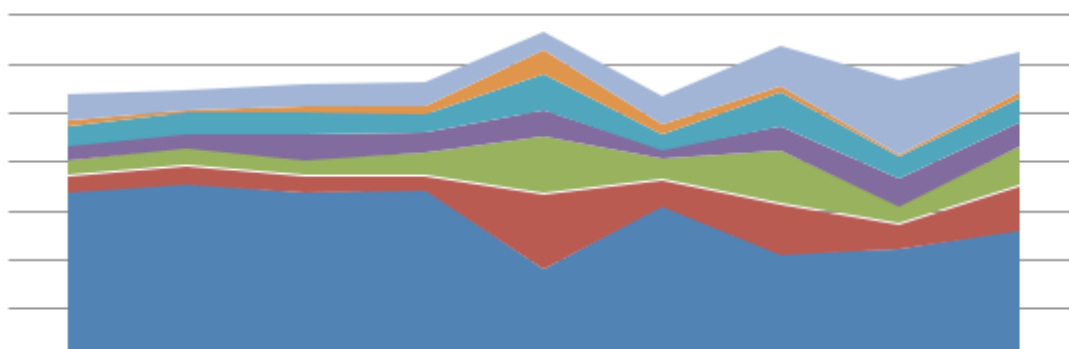


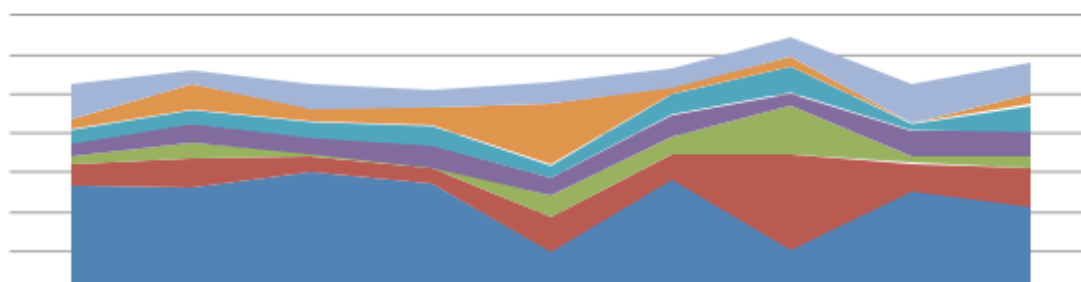
Fig. 33: Percent distribution of each benefit of NOT performing FGM among women and men aged 15-49 according to residence (numbers do not add to 100 as respondents could choose multiple benefits (DHS, 2006)

Benefits of NOT performing FGM according to women aged 15-59 by ethnic group



	Barbara	Mainle	Paulh	Soninke/ Marle	Sonrai	Dogon	Tamachek	Senoufo/ Minianle	Bobo
Other benefit	107	78	8.6	9.9	7.3	121	159	30.7	16.6
Accords to religious belief	2.2	11	25	2.7	9.9	38	25	1.1	2.0
More pleasure for the men	8.1	8.4	9.4	8.1	15.0	6.2	14.4	9.2	10.4
More pleasure for the women	6.3	6.1	10.4	8.4	11.0	4.1	10.2	11.0	10.3
Spare girls from suffering	5.9	7.2	6.3	9.1	23.4	8.0	21.1	7.3	15.5
Less health problems	6.8	7.3	7.2	5.8	30.8	11.0	21.1	10.2	18.3
No benefit to NDFGM	678	71.2	67.4	68.6	36.0	621	421	44.4	52.2

Benefits of NOT performing FGM according to men aged 15-59 by ethnic group



	Barbara	Mainle	Paulh	Soninke/ Marle	Sonrai	Dogon	Tamachek	Senoufo/ Minianle	Bobo
Other benefit	17.2	7.3	12.6	9.0	11.1	9.4	10.1	20.0	15.3
Accords to religious belief	5.4	13.1	6.8	9.1	30.5	3.7	4.8	0.3	5.7
More pleasure for the men	6.5	6.1	7.4	9.6	6.3	9.7	13.3	3.4	12.8
More pleasure for the women	6.9	9.8	8.0	11.2	8.9	11.6	6.2	13.2	12.5
Spare girls from suffering	3.6	8.2	1.8	0.6	10.8	8.5	24.4	3.1	6.6
Less health problems	10.8	14.6	7.9	7.9	17.8	12.6	48.7	14.0	18.8
No benefit to NDFGM	54.0	52.9	60.5	54.7	20.4	57.2	21.1	51.3	43.6

Figs. 34 and 35: Benefits of NOT performing FGM according to men aged 15-59 by ethnic group according to women and men (DHS, 2006)

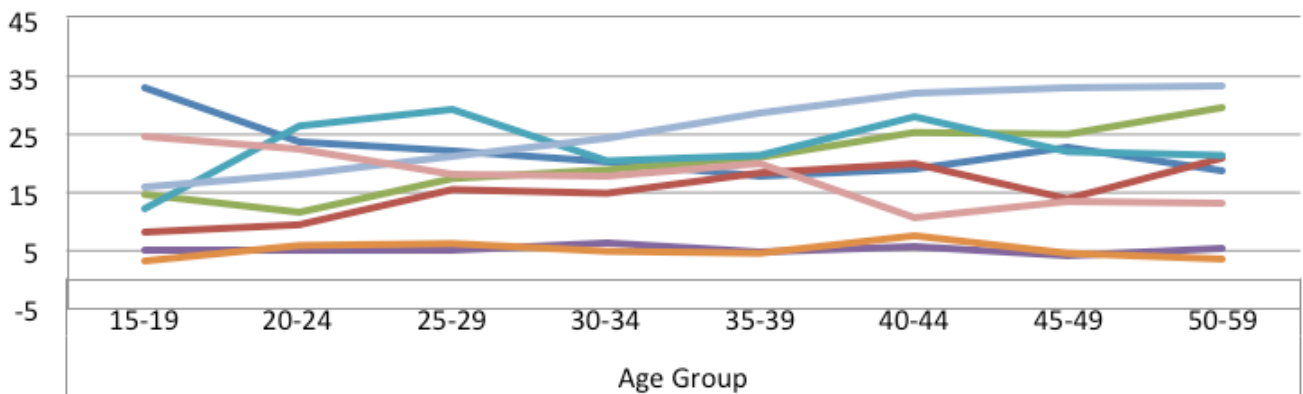
REASONS FOR PRACTISING FGM AND ITS

PERCEIVED BENEFITS

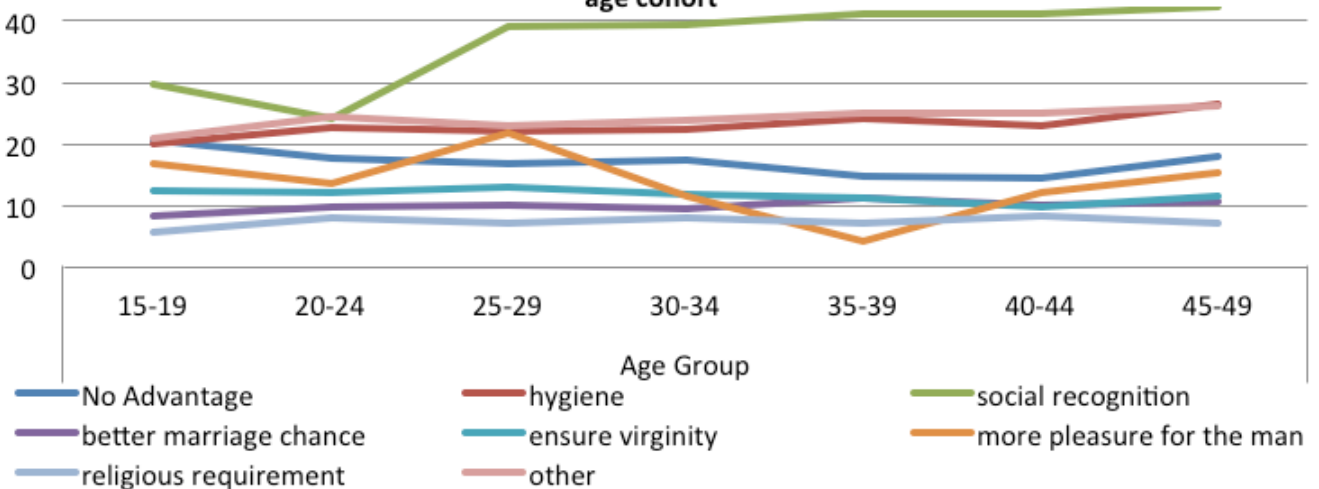
FGM is a social norm tradition, often enforced by community pressure and the threat of stigma. Although communities in which FGM is found in Mali may have different specifics around the practice, within each practising community it manifests deeply entrenched gender inequality. The Figures in this section highlight that the reasons given for practising FGM vary according to the age, ethnicity, gender and place of residence, and any intervention programmes must be tailored with these specificities in mind.

Figures 36 and 37 show the choices made as to the advantages of FGM out of eight categories according to age. When asked directly if FGM was a religious requirement in 2013, the percentages were much higher (see religion and FGM section). Figure 37 below shows that for women the perceived advantages have changed little over time as the tradition is passed through the generations. The exception to this is seen in younger women's view of social recognition, and the changing view of FGM giving more pleasure to the man. This is in contrast to figure 36 for men, where the perceived advantages have changed over time.

Percent distribution of each perceived advantages of FGM expressed by men by age cohort (legend as above for women)



Percent distribution of each perceived advantages of FGM expressed by women by age cohort



Figs. 36 and 37: Perceived advantages of FGM as expressed by women and men according to their age cohorts (DHS, 2006)

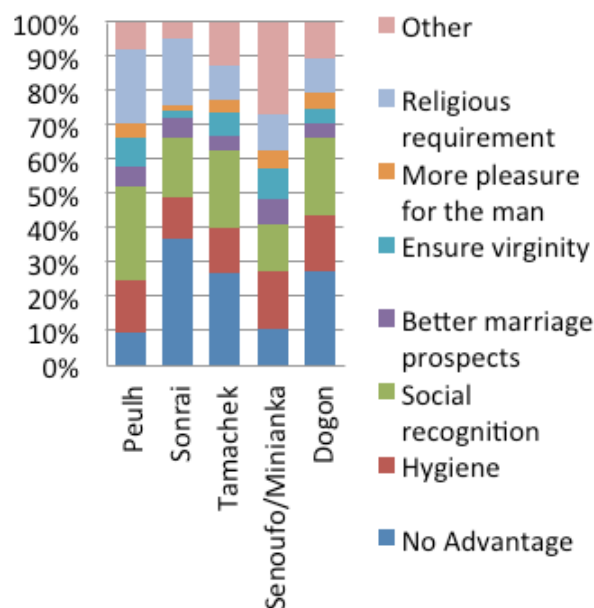
The 2006 data shows the advantage of FGM as fulfilling a religious requirement has dropped progressively from 33% of the oldest men (note age 50-59 unlike the women's data which only goes to 49) to 18% of boys aged 15-19. The 'other' category has risen in importance in the younger men, whereas social recognition has fallen in line with religious requirements.

A comparison can be made between the original Mande peoples and the other ethnic groups in terms of perceived advantages of FGM. The Peulh reasons for FGM are closely matched with the Mande peoples with social recognition and hygiene scoring highly, but more Peulh view FGM as a religious obligation than any other group. What can be seen in figures 38 and 39 is that the relative importance of each perceived advantage of FGM depends on ethnicity and interventions need to be addressed accordingly.

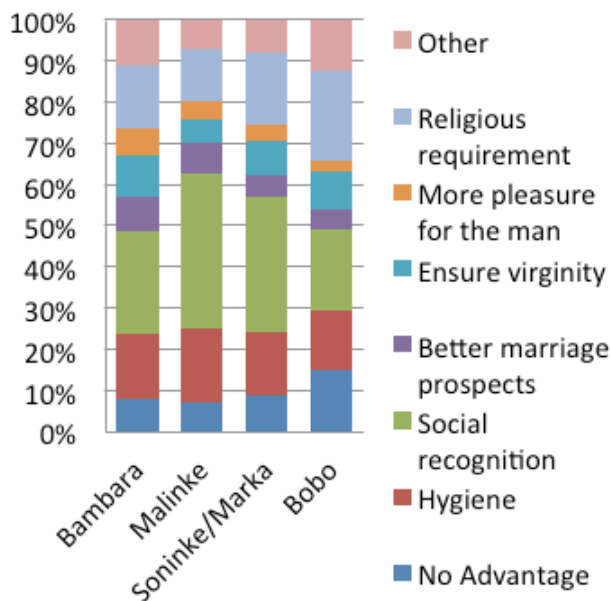
In figures 38, 39 and 40 the numbers do not total 100, therefore the colours are representative of the proportion of the whole that viewed different reasons for FGM favourably, rather than a percent distribution of the ethnic group for each reason.

More detailed work is needed with each ethnic group to ascertain the perceived advantages grouped together as 'other' in the DHS survey to understand all drivers that keep FGM in place. Among the Senoufo/Minianka women, 'other' is the largest recorded category at 37.5% for these women. In many of the groups, 'other' is documented as more important than better marriage prospects, ensuring virginity, or more pleasure for the men during sex.

Perceived advantages of FGM among the Non-Mande women in Mali



Perceived advantages of FGM among the Mande women in Mali



Figs. 38 and 39: Perceived advantages of FGM among the Mande and the non-Mande women in Mali (DHS, 2006)

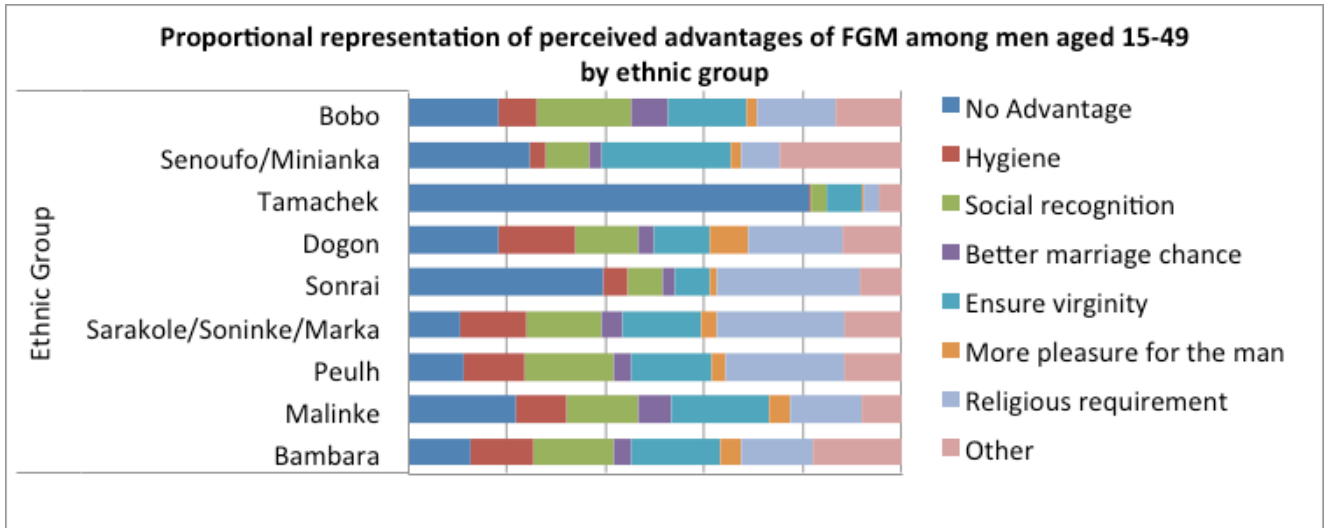


Fig. 40: Proportional representation of perceived advantages of FGM among men aged 15-49 by ethnic group (DHS, 2006)

‘Other’ is still an important category for the men surveyed on their perceived advantages of FGM. Ensuring virginity, however, is more important in all ethnic groups, apart from the Tamacheck and the Dogon. This is in stark contrast to the data gathered for the women. Similarly, FGM viewed as a religious requirement is significantly higher for the men of most ethnic groups than the women. This data is important in its differences as it highlights specific intervention requirements for the two genders.

SOCIAL ACCEPTANCE /CULTURAL IDENTITY

The biggest reason to continue FGM for all groups and both genders is social acceptance. This reason in data based on ethnic groups points to the control of women’s sexuality before and after marriage as of huge import to a family’s honour and social standing (Gosselin, 2001). This is why it is not an individual choice whether to perform FGM, as the reflection is on the family as a whole. There are many cases of children cut against their parents’ wishes by grandmothers or other female relatives (Poricho, 2006).

FOR CLEANLINESS/HYGIENIC REASONS

This category is seen as an advantage by more women than men in most ethnic groups. The women of the Dogon, Tamacheck and Sonrai who

perform the least FGM see it as less important than other groups. Senoufu (3.4%) and Tamacheck (0.1%) men see it as the least important, though women in both groups register 23.8% and 16.7% respectively. Among the wealthiest quintile of women hygiene is seen as more important than poorer women, but the figures are the same for men in all quintiles. Only 3% of animist and Christians state hygiene is an advantage, whereas Muslims scored 15%. More research and education is needed to counteract this false belief.

BETTER MARRIAGE PROSPECTS

Less than 10% of women and 5% of men on average from all ethnic groups see FGM as a route to better marriage prospects.

PRESERVE VIRGINITY

Unsurprisingly, in a patriarchal society, more men than women believe that FGM acts as a method of ensuring women’s virginity (DHS, 2006). The literature indicated that they believe it makes a woman more faithful in marriage. 29% of men in Bamako, compared to 19% in rural locations, believe that FGM will ensure a girl’s virginity. For example, a father of 12 girls in Kayes interviewed believes it reduces their arousal, stopping debauchery and preserving their virginity. 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-excising communities behave well (Gosselin, 2001).

RELIGIOUS REQUIREMENT

Wahabism preaches that without FGM, women will be sexually promiscuous and their prayers not recognised (Gosselin, 2001). 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.

The figures above show the percentage of Malians who chose religious requirement as one of many advantages of FGM. The figures for whether FGM is a religious requirement on its own shows much higher levels of people who believe it is a requirement. See 'religion and FGM' section.

OTHER BENEFITS

It is not clear from the literature if the reasons given in this category form some, or all, of the 'other' category in the DHS reports because they are chosen by all ethnic groups in varying degrees. Some Bambara and Dogon believe that if the clitoris comes in contact with the baby's head during birth, the child will die (Chambers, 2008). Among the Dogon, it is their 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 (Machacek and Wilcox, 2003). Another extreme belief of the Bambara men is that upon entering an uncut woman, a man could be killed by the secretion of a poison from the clitoris upon its contact with the penis. This folk belief acts as a rationale for clitoral excision (US Dept. of State, 2001).

NO BENEFIT

Among the Mande and Peulh people (the majority of the population), only a small proportion of women see no benefits to FGM. Malinke men saw no benefit at 28% but only 10% of women. FGM being non-beneficial was recognised more by the non-practising peoples, but even here it was not universally recognised with 83% of Tamachek men noting no advantage of FGM, but only 33% of the women. Among the Sonrai the gender positions were reversed with 39% of the men and 45% of the women recognising no advantage.

LAWS RELATING TO FGM

INTERNATIONAL AND REGIONAL TREATIES

Mali has signed and ratified several international human rights conventions, which 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 10th September 1985
- Convention on the Rights of the Child (CRC), which was ratified on 20th 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 16th July 1974
- International Covenant on Economic, Social and Cultural Rights (ICESR), which Mali acceded to on 16th July 1974
- African Charter on the Rights and Welfare of the Child, which was ratified on 3rd 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 13th January 2005
- African Charter on Human and People's Rights (the 'Banjul Charter'), which Mali ratified on 21st December 1981

The African Union declared the years from 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 (UN, 2012). 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 inclusive 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 that, '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 (Centre for Reproductive Rights, 2006).

Under the ICESCR, FGM is a violation of the right to health. Article 12(2) provides that ‘[t]he 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’ above.

Article 4(1) of The African Charter on the Rights and Welfare of the Child requires that the ‘best interests’ of the child are paramount in any decision concerning a child. Article 5(1&2) stress 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.

Unless otherwise stated, all references in this sub-section are to Mgbako *et. al.*, 2010.

NATIONAL LAWS

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

Under Article 281 of the Personal and Family Code, the legal minimum age for women to marry is 16 years. However they can be married when at least aged 15 with a civil judge’s permission and parental consent (Government of Mali official website). 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 United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which prohibit FGM. In light of this, Mali is not only in violation of its international obligations as signatories of these instruments, but it is also 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 3 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 (Personal and Family Code).

As a result of the recommendations made at the June 1997 national seminar, the government charged the National Action Committee to submit draft legislation making these practices illegal in Mali to the National Assembly. 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 (Refworld website).

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 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' (UNICEF-UNFPA Joint Programme, 2011).

INTERVENTIONS AND ATTEMPTS TO

ERADICATE FGM

BACKGROUND

NGOs have been working on eradicating FGM in Mali since the 1960s. NGOs and other organisations are facing sustainability issues in part 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 8 years older at the time of this report, it 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 aimed at school-age children to resist the practice. Anecdotally, mothers-in-law and grandmothers are generally implicated in deciding on FGM. Evidence from White *et. al.'s* (2013) study show 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.

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

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, though they face difficulties in applying for tax exemptions and government tenders (USAID, 2009).

In Mali, 25,965 leaders have pledged in favour

of abandoning FGM, with 200 of them making public statements (UNJP, 2012).

PROGRAMME NATIONAL DE LUTTE CONTRE LA PRATIQUE DE L'EXCISION (PNLE)

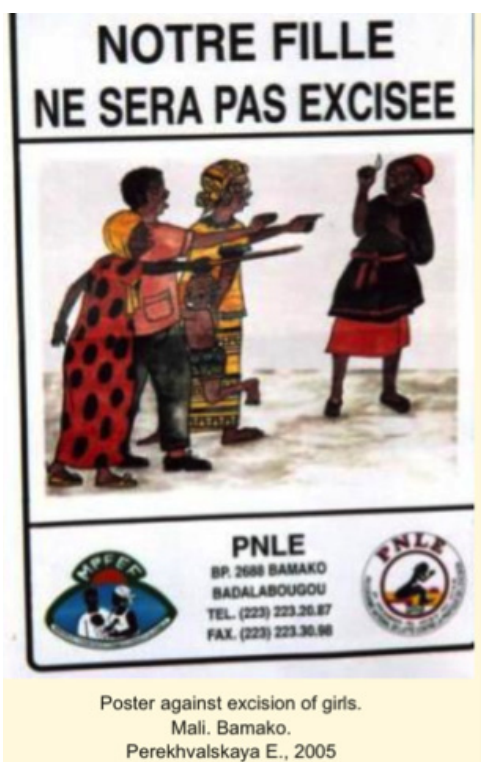
The PNLE was established in 2002 by the government as part of the Ministry of Woman Promotion, Child and Family. It is in charge of coordinating programming related to eradicating FGM. Their action plan 2010-14 has a strategic outcome of reducing FGM from 85% to 65% by the end of 2014. The roles of PNLE 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
- 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 (Ministère de la Promotion de la Femme, de l'Enfant et de la Famille, 2008).

PSI's 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% (Population Services International, 2007). 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.



Poster against excision of girls. Mali. Bamako. Perekhvalskaya E., 2005

Fig. 41: A poster against FGM by PNLE, 2005

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-oriented 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 FGM, 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 (Winterbottom, 2009). In Mali, many of the complications are explained in terms of magic and taboos.

In a 2006 study (Poricho) most interviewees were able to list direct and indirect complications related to FGM, according to their own beliefs and superstitions. 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 with medical knowledge.

ASDAP is an NGO that works with local health centres and recruits women to talk about the health consequences of FGM with men and women in their communities. 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 and, until then, government health workers showed little interest in the issue. Therefore PNLE and other partners, including the Joint Programme (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 UNFPA, 63 cases of complications resulting from FGM were treated in 2011 and a further 864 women and girls in 2012. They report 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 (Norwegian Church Aid Country plan 2011-2015). They regularly speak with local authorities and traditional and religious leaders, who play a significant role in FGM intervention (IRIN, 2012). Their 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 on prevention.

EDUCATING TRADITIONAL EXCISORS AND OFFERING ALTERNATIVE INCOME

'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

Population Council and CNRST evaluated three NGO programmes and found that traditional practitioners continue to perform FGM, despite making statements that they had abandoned the practice (Diop and Askew, 2007). More positively, Sini Sanuman has recorded 150 excisors who have stopped practising, many of whom have joined their anti-FGM initiatives (Sini Sanuman website).



Fig. 42: Excisors who have abandoned their practice (Sini Sanuman)

RELIGIOUS-ORIENTED APPROACH

A religious-oriented approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour. 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' (Poricho, 2006).

USAID's Health Policy Initiative identified three main audiences for their 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; (3) religious leaders and their constituents who believe that FGM is a practice endorsed by Islam. They 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 Joint Programme (UNJP), four regional forums brought together 150 religious leaders to discuss the practice in the context of Islam. Save the Children Sweden believes that

'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)

religious leaders are the gatekeepers for change and their project with Centre Djoliba focuses on dialogue with these individuals.

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 of achieving a law passed against FGM, involving regional councils and regional health directorates. Plan – Mali has also declared that they aim 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 decision 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 (Wilson, 2012/13). This approach was pioneered by Tostan in Senegal (UNICEF, 2005). 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 (GIZ, 2011).

The difference in 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 (Gosselin, 2001).

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, covering 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 they work. 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 which provides counselling and shelter for women suffering from domestic violence (including FGM).

MEDIA AND COMMUNICATION

In 2009 the integrated mass communication strategy was started, which includes theatres, forums, travelling cinemas, local and national radio and TV stations. Since then, a number of workshops were 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 Joint Programme 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 UN JP counted 3500 + press releases, radio and TV programmes in 2012, up from around 500 in the previous year (UNJP, 2012).

Sini Sanuman uses popular media such as theatre, songs and **music videos** to spread its anti-FGM initiative. They work in collaboration with famous singers and traditional song writers 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 without being influenced. They work with many NGOs, the government, and other organisations on various anti-FGM projects. AMSOPT also hold discussions with men on general health and reproduction.

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. They aim to promote sustainable development through improved living conditions and status of women, and they focus on health, sexual and reproductive rights. Partners include other organisations and CBOs, traditional leaders, women's groups, health personnel, researchers, journalists, and political figures. They have 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 they initiated a programme named Soutien aux initiatives locales de lutte contre l'excision (SILE), and aim 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.

Their most effective activities have included theatre, 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. They evaluate their progress not only through the number of girls who have not gone through FGM in villages, but also through village consultations at the end of each project phase. However, they maintain that changing mind-sets 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 which include UNICEF, United Nations Population Fund, Aide de l'Eglise Norvégienne (AEN), 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. They provide psychosocial counselling and shelters for women, and work on fighting FGM. Their project 'Lutte contre les mutilations génitales féminines' attempts to get people to understand excision as an act of violation, with negative consequences for women's health including haemorrhages and potentially the spread of AIDS. They also have a programme which aims to reduce mortality and maternal morbidity due to fistula, a common complication of FGM.

Their 2013 report states that, with the help of their partner SDI, they have successfully persuaded 27 villages in Segou region to abandon FGM, with a further 8 expected to sign agreements in 2014. Part of their objective is to provide a source of alternative income for excisors. Another co-project teaches health information in schools in an effort to teach about the dangers of FGM. In 2013 they also supported a regional meeting on FGM in Segou in order to identify all locales where organisations are working so as to 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 below).

PLAN INTERNATIONAL- MALI

Plan's Project to support and promote initiatives in favour of the abandonment of excision in Mali is based at the Kangaba, Kati, Kita and Baroulé programme units. The project's time frame is April 2010-March 2016 with a budget of \$3,714,600 US. Their overall aim is to reduce the prevalence of FGM among girls aged 0-14 by 10% by June 2016. Plan also hopes to increase the number of village FGM abandonments from 25 to 65 in the project area. They advocate 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 TBAs, 18 community leaders, 200 religious leaders, 180 CBOs, 90 child organisations and 4 NGOs. Their approach is rooted in community ownership and they encourage community leaders to create their own abandonment plans. At a national level they meet and train 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 and other CBOs and organisations in the FGC network on issues of FGM and violence against women and children. Also train members of the legal and media communities to push for the criminalisation of FGM.
- Advocacy- hosting advocacy forums and community dialogues. Work with MPs and the High Islamic Council and other groups to create a draft bill criminalising FGM.
- Monitoring/Evaluation/Research- host regular meetings and conduct inspections to measure actions and support local initiatives
- Communication for Behaviour Change- contents for best 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 their policy on FGM and creating their national strategy against the practice.

POPULATION SERVICES INTERNATIONAL (PSI) - MALI

The Mali branch of PSI was founded in 2001, with their aim being to focus on improving reproductive health and child survival. In 2007 they introduced programmes to reduce the incidence of FGM. They are currently working with the Malian government on mass media campaigns to dispel myths that FGM is an obligatory Islamic practice. They have 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. They focus on a rights-based approach, particularly child rights, and recommend the continued advocacy for national legislation against FGM. Save the Children/Sweden believe that dialogue with religious leaders, who are gatekeepers, is key for social and cultural change. Their 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 works through a human rights approach, building the capacity of communities to form long-lasting social change. They work mainly with people who have never had an education, teaching skills in human rights, problem solving, health and sanitation. They also regularly appear

on the radio.

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

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

Tostan is a member of CNAPN (Comité National d'Abandon des Pratiques Néfastes), 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. Their objectives include reducing the prevalence of FGM to 65% by 2014.

UNICEF MALI

UNICEF seeks to tackle FGM by encouraging a multi-sector approach including access to medical care, psychological aid, and help with accessing judicial support. UNICEF also invests in changing social norms through challenging individual and group behaviour. They work with civil society and financial partners in their work towards FGM abandonment; they also work closely with the government of Mali. Their work is funded by the Ministère de la Promotion de la Famille de la Femme et de l'Enfant (MPFFE) via the PNLE programme. They work with the nine Directions Régionales Promotion Femme Enfant Famille (DRPFEE), which are decentralised organisations of the MPFEE. They also work with National NGOs; AMSOPT in Kayes, Tagne in Koulikoro, Family

Care International in Mopti and Sini Sanuman in Bamako.

UNICEF works to build capacity of partners by providing resources, 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: UNICEF targets large groups of people with theatre and with Cinéma Numérique Ambulant on the theme of excision to begin a dialogue about FGM, alongside home visits for families and community leaders.

Response: Build capacity of communities seeking to tackle FGM, health workers, educational bodies, elected officials and those in positions to communicate, such as the media. Their work is reinforced by theatre and cinema productions. They also ensure medical, socioeconomic and psychological structures are in place for survivors of FGM. They aim 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 the 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 their various partners.

UNICEF has achieved a number of successes in Mali including having effective aid in place for survivors of FGM. By providing medical help with complications, for instance, this helps to gather support for anti-FGM activities. Women who have

been helped at these centres are more likely to become advocates in their communities.

UNICEF and 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, and 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 be able to effectively identify and treat FGM complications. They 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 their work has shown success, with the percentage of women favouring the abandonment of FGM rising from 15% to 62%. The percentage who intended to cut their daughters reportedly fell from 81% to 33% from the participants surveyed.

WORLD VISION – MALI

World Vision Mali has the Sourountouna Program, which works in 58 villages in an effort to encourage FGM abandonment. World Vision has partnerships with other organisations and community leaders in Mali. They have 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 excision 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. They work extensively with traditional healers and midwives, and through this are able to mobilise against FGM. In 2011 they 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 and works to defend women's health, sexual and reproductive rights. Part of their work is a phased action plan against FGM, during which they meet with community authorities and villagers to ensure their help with projects. Each village they work with is required to nominate two male and two female volunteers to work alongside AMSOPT while they are 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. They rarely speak directly on FGM but incorporate it into general health and reproductive education. AMSOPT are providers of information only, and do not use a direct approach of asking villagers

outright to abandon FGM. Through asking strategic questions during workshops, conducting mass awareness campaigns and providing aid to those experiencing complications from FGM, they seek to change the minds of people and 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 work 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 they are 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. They host training sessions and meetings to teach girls about the health risks of FGM (and other health issues). By teaching girls, 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 partner with Save the Children Canada, UNICEF, 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. Their 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 to protect them. The services they offer include:

- Training and education
- Information and sensitisation
- Lobbying and advocacy
- Micro finance
- Legal advice and assistance

Some of their 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. They have 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 works to end FGM across Mali, working closely with the Ministry of Health to increase their access to towns and villages. Targeting women over 30, they work to spread information about the damaging effects of FGM and promote the rights of women and girls to have healthy births. They focus on five main strategies:

- Advocacy
- Behaviour change
- Capacity building
- Managing complications that arise due to FGM
- Research

Within these strategies they then use different

techniques including the use of pictures, film, theatre productions and posters, often using a health approach and 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 their most successful work has come through 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 their work to create a strong resource base such as reference manuals, films and data sheets.

ASDAP is a founding member of the Comité National pour l'Abandon des Pratiques Néfastes (CNAPN), coordinated by the PNLE. ASDAP is also a member of Réseau Malien de Lutte contre les Mutilations Génitales Féminines (RML/MGF), du Réseau Malien pour l'Élimination de la Fistule Obstétricale (REMAEFO) and sits on the administrative council of the 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 DEL 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 they also use radio to reach people. They target strategic groups such as community and religious leaders, and they also ensure every village has a surveillance committee to ensure 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 strategy.

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 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 their website, using case studies and inviting guest bloggers to share expertise. They 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, it includes teachers, excisors, religious leaders and local authorities, to offer training on the complications of FGM. In villages, the organisation manages clubs against FGM in schools and universities and uses theatre to increase awareness amongst the public.

DÉVELOPPEMENT HOSITIQUE AFRICA AU MALI (DHA)

The DHA was established in Bamako in 1998, and focuses on ethical human welfare. Currently, they operate in Bamako, Kati and Dogon. They work with other grassroots associations in communities to improve living conditions and their vision is to foster physical, social, cultural, economic and spiritual development. The aims of DHA are: promote access to education for disadvantaged children; foster literacy for young and disadvantaged women; promote maternal and child health, including fighting against FGM; encourage self-promotion through mobilising local resources. They are financial partners with 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 their 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 they carry out radio broadcasts on FGM and fistula and train obstetric staff. They also work to help communities to openly discuss sensitive topics, with the aim of enabling them to seek more easily treatment in hospital. They target 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 their other developmental programmes, which include women and child health and education. Their activities are based in Kayes, Segou and Bamako where they have 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. They use 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 their main target group, and they enact revenue-generating activities and awareness campaigns to achieve their goals. They also target young girls with reproductive health education and have a listening centre which 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 their successful campaigning was in the town of Benena, where Nyeta-Sira's work contributed to abandonment after an official communal proclamation which 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 their organisations and develop tools to help them. They organise 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. They further carried out a comparative study on Burkina Faso, a country which had passed a law against excision. Together, these actions helped raise the profile of the organisation, and consequently, of the fight against FGM.

SINI SANUMAN

Sini Sanuman, an NGO based in Bamako and the surrounding areas, mainly uses media to get their message across to the public. Their album, **Stop Excision**, was released in 2000 and has eight songs in five local languages, sung by top Malian musicians. They have also produced TV clips and posters picturing Malian celebrities with messages against FGM. They estimate that 4 million people have seen or heard their message through radio or television.

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

As a result of their public discussions, 11 villages have abandoned FGM and 150 excisors have renounced the practice. They have worked extensively in Bamako with local authorities to ensure that all newly married couples are spoken to about not cutting their daughters.

Sini Sanuman are members of the Comité National de Lutte contre l'Excision.



Fig. 43: NGO Sini Sanuman use 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 reproductive health of women and girls. A member of RML-MGF and PNLE and funded by UNICEF and Oxfam DE, they work closely with networks across Mali to provide support to women and to advocate for change.

TAGNE is based in Kati, Koulikoro, and provides free psycho-social support to survivors of FGM and conducts awareness and mobilisation activities in villages, targeting 10 villages every year. Of the 10 districts in Kati, two have declared total abandonment. They have also been successful in providing survivors of FGM with training and economic empowerment activities to help them regain confidence and independence. Examples of their awareness-raising work include a football tournament with words 'We must abandon FGC' on the kit, and talks with village members and using a model of a woman's body. They stated: '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.'

CHALLENGES FACED BY ANTI-FGM

INITIATIVES

A UN periodic review stated ‘in 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’ (United Nations Periodic Review). That said, because FGM is a social norm and ancestral tradition, a community-wide (and society-wide) change of attitude is needed before FGM can be abandoned. Given that there are varying perceptions of the practice (gender, age, religion, ethnicity), 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 road systems to rural communities can also be an obstacle for organisations. As in most countries, 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 a particular hindrance for 28 Too Many, when trying to contact organisations. Unavailability and out-of-date information on organisation websites was also a challenge when profiling 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 Worldbank 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’ (Worldbank, 2013). 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 already undergone FGM.

With respect to educating communities on the health risks of FGM, lack of education (especially in the older population) is a major challenge. There has also been an increase of new practitioners who are not ‘experts’ carrying out FGM. These new practitioners are motivated by the financial benefits. Hence, these changeovers to women unknown in the community are even more dangerous, and they undermine eradication efforts (Plan – Mali).

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 punishment. 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’ (Schmid *et. al.*, 2008).

CONCLUSIONS

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 specific to Mali.

ADOPTING CULTURALLY RELEVANT PROGRAMMES

FGM is a social norm and 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 on deciding whether to have a girl cut. It is of the utmost importance to include community authority figures in dialogues concerning 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 variations in why and how they practise FGM and therefore regional and community-based 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 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 aftermath.

FGM AND THE MILLENNIUM DEVELOPMENT GOALS

Considering FGM within the larger framework of the MDGs conveys the significant negative impact FGM makes on humanity. Stopping FGM is connected to promoting 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 and research for broader social change. There has been a 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, including 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 for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women's rights. Lack of education also directly relates to issues surrounding 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.



Fig: 44: Gender equality is a means to improve maternal and child health (globalgender currents, 2014)

FGM, ADVOCACY AND LOBBYING

Advocacy and lobbying is essential to ensure that the government continues to be challenged on its hesitancy to criminalise FGM, and to support programmes that tackle FGM.

FGM AND THE LAW

We encourage NGOs to continue their fight for legislation criminalising FGM in Mali. The government's recent efforts with the PNLE are to be commended, and we encourage the Malian government to renew its efforts in enacting an anti-FGM law. Furthermore, more effort 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 against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on FGM 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

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision regarding issues such as FGM. 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 myths of FGM being a required practice. It is hoped that organisations and the government will continue to work with all faith leaders to educate on the complications of FGM and that it has no role 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 continued effort to communicate their work more publicly and encourage collaborative projects. A coalition against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success, and efforts in Mali are headed in this direction, particularly with the PNLE.

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

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 old, so as to capture recent trends. The reported rise in Type III (infibulations) needs urgent further study to confirm the data and stop the trend towards the 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

Aid for the Development of Traditional Medicine (Aidemet)	Cadre National de Pilotage du Curriculum de la formation du Parajuriste (CNPCP)	Programme National De Lutte Contre La Pratique De L'excision (government programme)
Aide de l'Eglise Norvégienne (AEN)	Coopérative des Femmes pour l'Education à la Santé Familiale et l'Assainissement (COFESFA)	Population Services International (PSI)
Association des Juristes de Mali (AJM)	Croix Rouge Mali	RADECO
Association Malienne pour la Protection et la Promotion de la Famille (AMPPF)	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Réseau des Communicateurs
Association Malienne de Suivi et d'Appui à la Femme et l'Enfant (AMSAFE)	Développement Holistique Africa (DHA)	Réseau Malien de Lutte Contre les Mutilation Génitales Feminines
Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT)	Division Sante Reproductive	Save the Children - Sweden
ANDANSOVI	DNANGR	Service de Développement Intégré (Ségou)
ANIMALI	ELS GANDAL	Sini Sanuman
Appui à la Promotion des Aides Familiales (APAF)	Equilibres & Populations	Syndicat Libre et Démocratique de l'Enseignement Fondamental (SYLDEF)
Association pour le progrès et la défense des droits des femmes Maliennes (APDF)	Fotè Mogoban	TAGNE
ASCAM	Groupe De Recherche, D'étude, De Formation Femme Action (GREFFA)	Tolérance
Association of Support in the Development of Activities of the Population (ASDAP)	Groupe de Recherche Action Formation (GRAF)	Tostan
ASISDCE	Groupe Presse Nyeleni	USAID
Association des Sages Femmes du Mali (ASFM)	IAMANEH Suisse	United Nations Children's Fund (UNICEF) - Mali
Projet d'Appui aux Jeunes Entrepreneurs (PAJE-Nièta)	Inter-African Committee	United Nations Development Programme (UNDP)
Association for the Promotion and Empowerment of Women of Mali (ASSOPROFEN)	HELVETAS Swiss Intercooperation (HIS)	United Nations Women
Ben Kadi	Musko - JIGI	United Nations Population Fund (UNFPA)
Cabinet Médical Kénéyaso	Muso Cesirilen	Wildaf Mali
Comité d'Action pour les Droits de l'Enfant et de la Femme (CADEF)	Muso Kunkan	Woïyo Kondeye
Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA)	Nyeta-Sira	World Health Organization
Caritas Mali	Organisation pour l'Aide et Assistance au Développement de l'Environnement (OAADE)	World Vision
Centre Djoliba	Observatoire des Droits de l'Enfant et de la Femme (ODEF)	
	Plan International - Mali	
	Pose ton Couteau	
	Promotion des Femmes de Sabali-bougou (PROFESAB)	
	Projet EVT/EMT GADEF	

APPENDIX II - REFERENCES

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