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# POLICY AND ADVOCACY INITIATIVES TO SUPPORT ELIMINATION OF FEMALE GENITAL CUTTING IN MALI

**JULY 2010**

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



# TABLE OF CONTENTS

- Acknowledgments .....iv**
- Executive Summary ..... v**
- Abbreviations ..... vii**
- Introduction..... 1**
  - Overview of the Problem..... 1
  - FGC in Mali..... 2
  - Responses to Female Genital Cutting in Mali ..... 4
  - Strengthening the Policy and Advocacy Response to Female Genital Cutting in Mali ..... 7
- Methodology ..... 8**
  - Desk-based Policy Review and Situation Analysis ..... 8
  - Development and Validation of Advocacy Tools..... 8
  - Capacity Building of Religious Leaders..... 10
- Findings and Results..... 10**
  - Responding to Changes in the Policy Environment: The Family Code ..... 10
  - Commitments by Religious Leaders..... 11
  - Impact on Policy Environment ..... 11
  - Multisectoral Collaboration..... 12
- Conclusions..... 12**
  - Lessons Learned ..... 12
  - Next Steps for Addressing FGC in Mali..... 12
- Appendix A. Advocacy Tools ..... 14**
- Appendix B. Key Stakeholders ..... 30**
- References..... 31**

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## EXECUTIVE SUMMARY

Many people believe that the practice of female genital cutting (FGC) is a violation of human rights and an act of gender-based violence. Because FGC has severe consequences for girls' and women's reproductive health, as well as for maternal and child health, the practice is increasingly seen as an important public health issue. Many health sector FGC interventions take the form of awareness-raising and behavior change communication activities or provision of clinical services to respond to the practice's negative health consequences. Policy, however, is an important dimension of changing the environment that allows FGC to continue. While legal measures are not the only means to stop the practice, 17 countries in which FGC is prevalent have passed laws banning it.

To contribute to the elimination of FGC, the USAID | Health Policy Initiative, Task Order 1 implemented an advocacy activity to address FGC in Mali, a country in which 85 percent of all girls and women have undergone FGC. Mali has a strong community of stakeholders committed to advocacy for reproductive health and gender issues, and the project staff have worked with local public and private organizations on reproductive health issues for nearly a decade.

To inform the design of the activity, the team conducted a desk review of global FGC interventions, a local situational analysis to assess advocacy needs, and interviews to identify and solicit input from key stakeholders about the FGC policy environment. Based on the information gathered, the team coordinated a participatory process to develop two advocacy tools that use evidence to argue for the elimination of FGC in Mali through policy change. The tools are custom-designed to give stakeholders a unified, evidence-based argument against FGC.

The first advocacy tool is a PowerPoint presentation, "Female Genital Mutilation/Cutting: A Major Public Health and Human Rights Concern," which is directed toward decisionmakers, including community leaders and Parliamentarians. This tool discusses the harmful health, social, and human rights consequences of FGC. It was created through a series of meetings with Malian stakeholders and was finalized at a 2008 workshop attended by more than 60 stakeholders.

The second tool is another PowerPoint presentation, "Islam and Female Genital Cutting," which encourages religious leaders to engage in dialogue about FGC with their fellow religious leaders, congregations, and policymakers. It focuses on separating the tenets of Islam from the practice of FGC and represents a particularly important step in the elimination of this practice, as religion is a significant barrier to changing attitudes that support the practice at the community level. Religious leaders and other stakeholders participated in drafting this tool, and more than 60 stakeholders approved it at a 2009 workshop.

To build the capacity of approximately 30 Islamic religious leaders, the project team held a 2009 workshop on use of the religion-focused FGC advocacy tool and advocacy techniques in general.

The participatory process of developing the advocacy tools also increased stakeholder collaboration and commitment to advocating for an end to FGC. The activity contributed to the ongoing process of improving the policy environment for FGC, particularly by providing a forum for open dialogue about the practice, its consequences, and health- and religion-based arguments against FGC.

During the time of the advocacy activity, a separate, controversial policy discussion about women's and men's equality in marriage changed the policy environment and made it difficult to discuss gender issues, including FGC. This shift shows the importance of recognizing how the broader political context may open or close "policy windows" for complex issues such as FGC. While the policy window for FGC may have closed temporarily, stakeholders insist that advocacy against the practice, especially at the policy

level, can and must continue. It is also important to sustain support for religious leaders, who remain committed to advocating for an end to the practice. With such sustained advocacy and continued discussion, the stakeholder community will be successful in setting the stage for change and taking advantage of open policy windows in the future.

## ABBREVIATIONS

|        |   |
|--------|---|
| AMSOPT | <i>Association Malienne Pour la Suive et l'Orientation des Pratiques Traditionnelles</i> (Malian Association for the Monitoring and Orientation of Traditional Practices) |
| CPS    | <i>Cellule de Planification et de Statistique</i> (Cell Planning and Statistics)  |
| CRC    | Convention on the Rights of the Child   |
| DHS    | Demographic and Health Survey   |
| DNSI   | <i>Direction Nationale de la Statistique et de L'Informatique</i> (National Directorate of Statistics and Informatics)  |
| FGC    | female genital cutting  |
| IEC    | information, education, and communication   |
| MOH    | Ministry of Health  |
| NGO    | nongovernmental organization  |
| PNLE   | <i>Programme National de Lutte Contre l'Excision</i> (National Program to End the Practice of FGC)  |
| PSI    | Population Services International   |
| RIPOD  | <i>Réseau Islam Population et Développement</i> (Islamic Network for Population Development)  |
| UNAFEM | <i>Union Nationale des Associations de Femmes Musulmanes du Mali</i> (National Union of Muslim Women Associations)  |
| UNAIDS | Joint United Nations Program on HIV/AIDS  |
| UNDP   | United Nations Development Program  |
| UNECA  | United Nations Economic Commission for Africa   |
| UNESCO | United Nations Educational, Scientific and Cultural Organization  |
| UNFPA  | United Nations Population Fund  |
| UNHCR  | United Nations High Commissioner for Refugees   |
| UNICEF | United Nations Children's Fund  |
| UNIFEM | United Nations Development Fund for Women   |
| USAID  | United States Agency for International Development  |
| WHO    | World Health Organization   |



## INTRODUCTION

In 2008, the USAID | Health Policy Initiative, Task Order 1 began an advocacy activity to address female genital cutting (FGC) in Mali. The project team selected Mali because of the country's high prevalence of the practice of FGC, the project's strong country presence and local staff, and the project's previous success in working on health policy issues related to gender equity through advocacy. The project team based in Washington, D.C., partnered with in-country staff and a local consultant to begin activity implementation in February 2008. Initially, the project team conducted a desk review of global interventions to eradicate FGC. The team also conducted a situational analysis at the local level to better understand the political and legal contexts surrounding FGC in Mali and to identify needs, opportunities, and potential partners for a policy and advocacy intervention toward ending the practice of FGC.

Based on the contextual information and recommendations gathered in the desk review and situational analysis, the project team coordinated a participatory process to develop two advocacy tools for stakeholders to use in advocating for FGC elimination in Mali. The first advocacy tool is a PowerPoint presentation that targets myriad decisionmakers at all levels—from community leaders to Parliamentarians—with evidence regarding the health consequences of FGC. The second tool is another presentation that focuses on separating the practice of FGC from Islamic beliefs and practices. Key Malian stakeholders created and reviewed the tools.

To encourage use of the tools, the project team trained a group of Islamic religious leaders in advocacy skills and, using the religious-focused advocacy tool, built their capacity to advocate against FGC from a religious perspective.

## Overview of the Problem

Also called female circumcision, FGC is defined as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether [or not] for non-medical reasons” (UNAIDS et al., 2008, p. 1). Some advocates for FGC eradication refer to the procedure as female genital mutilation because of the extent of damage it can cause to a woman's reproductive organs. Box 1 defines the four classifications of FGC that have been established by international agencies.

### Box 1. Classification of Types of FGC

*Type I:* Partial or total removal of the clitoris and/or prepuce (clitoridectomy).

*Type II:* Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision).

*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 cauterization.

Source: UNAIDS et al., 2008.

Many people consider FGC a violation of human rights because it is performed on girls and young women who are not yet adults and so are unable to make informed decisions for themselves. Many also see it as an act of gender-based violence because it causes lifelong harm to females (UNAIDS et al., 2008). The practice of FGC is problematic at both individual and societal levels. As a sociocultural practice, FGC is both a manifestation of and a contributing mechanism to the larger system of inequitable gender relations between men and women (Lewnes, 2005). For instance, FGC responds to gender norms

that say women should be sexually pure. This norm is enforced through measures that endanger girls' and women's health and cause needless suffering.

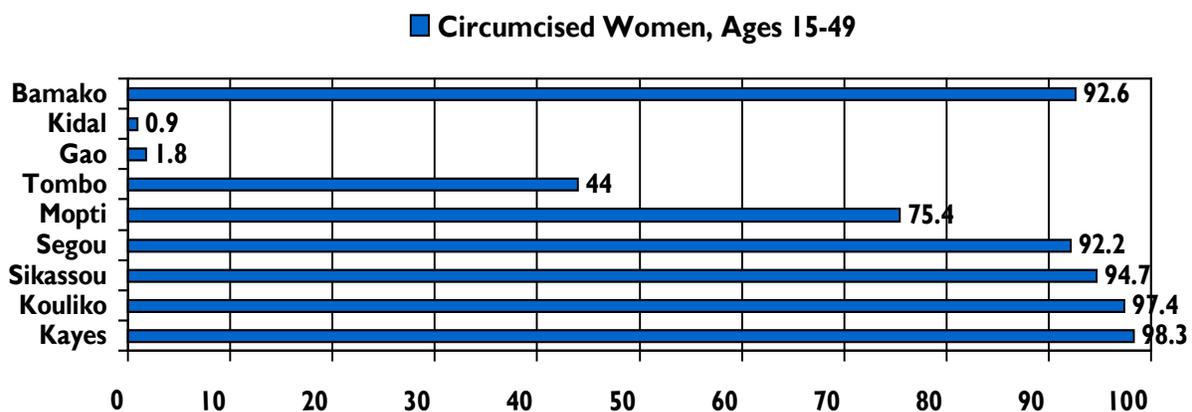
The consequences of FGC for individual women are particularly relevant in the context of health programs. Immediate consequences of FGC can include acute pain, severe bleeding, shock, psychological trauma, infection (including tetanus), and death (WHO, 2000). The long-term health consequences also can be severe, including obstetric complications; gynecological problems, such as menstrual disruption, infertility, and painful intercourse; urinary blockage and retention; sexual dysfunction due to fear and pain; and psychological conditions, such as depression (WHO, 2000). Moreover, as recent data from a World Health Organization (WHO) multi-country study shows, women who have undergone FGC are significantly more likely than those who have not to experience adverse childbirth outcomes, including post-labor hemorrhage, episiotomy, extended hospital stays, resuscitation of the infant, and inpatient perinatal death.

Furthermore, there is clinical evidence from Mali of cases of Type II FGC that resulted in infant mortality, urinary incontinuity, sexual dysfunction, and inability to release menstruation, particularly in cases of female cutting that turned into Type III FGC due to scarring. Given that Mali's maternal and child health indicators are among the worst in the world, the serious and sometimes fatal effects of FGC must not be taken lightly.

## FGC in Mali

FGC prevalence in Mali is among the highest in the world. According to the 2006 Demographic and Health Survey (DHS), 85 percent of women and girls ages 15–49 have undergone FGC. This proportion varies little among age groups, indicating that the practice of FGC has not changed, at least for women ages 15 and older. FGC rates do vary according to region, but the practice is most common in Kayes, Koulikoro, Sikasso, and Bamako, with FGC prevalence between 93 and 97 percent in these regions (see Figure 1). The lowest prevalence is in Kidal at 0.9 percent and Gao at 1.8 percent (CPS et al., 2006).

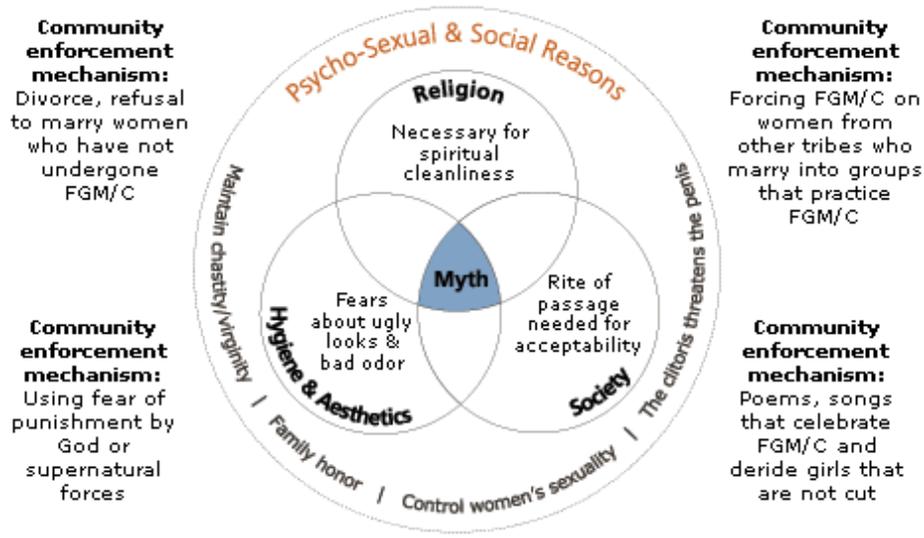
**Figure 1. Percentage of Malian Women Who Have Undergone FGC, by Region**



Source: CPS et al., 2006.

In Mali, girls ranging from infancy to adolescence undergo FGC. However, Mali's DHS data show that FGC is being practiced increasingly on younger girls and infants, whereas previously, it had been performed on girls reaching adolescence. The 2006 DHS found that 77 percent of girls who had recently undergone FGC were under 5 years old at the time of the procedure (CPS et al., 2006).

**Figure 2. Why Female Genital Cutting Continues: A Mental Map**



Source: adapted from: Asha Mohamud, Nancy Ali, Nancy Yinger, World Health Organization and Program for Appropriate Technology in Health (WHO/PATH), FGM Programs to Date: What Works and What Doesn't (Geneva: WHO, 1999): 7.

Globally, FGC is practiced across all educational and social levels and across varying religions (Feldman-Jacobs and Clifton, 2010). There appear to be three types of overlapping rationales for the practice—sociological, spiritual and religious, and hygienic and aesthetic.

1. **Social rationale.** Complex social norms and beliefs perpetuate the practice of FGC. Some people believe that the clitoris prevents women from reaching maturity and having the right to identify with their age group, the ancestors, and the human race (WHO, 1999). Some women and men feel it is their duty to cut their daughters so that they will be prepared for adulthood and marriage (Lewnes, 2005). Many people also believe that women who have undergone FGC are less likely to have sexual relationships outside of marriage. In some areas, an “uncut” clitoris is believed to cause a woman to become promiscuous by growing so big that she cannot control her sexual desires. As such, the uncut clitoris is perceived as a threat to the entire community (WHO, 1999). FGC is thus seen as a way to control a young woman’s sexuality, ensuring that she does not become over-sexed and lose her virginity, thereby disgracing her family and endangering her chance for marriage.
2. **Spiritual and religious rationale.** Some religious groups support the removal of the clitoris and external genitalia, which sometimes are said to make women spiritually unclean. This reasoning is particularly relevant in the Malian context, where many people use Islamic texts to justify FGC, even though many religious leaders say that Islam “found” FGC when the religion arrived in the region through the Saharan trade routes. In other words, the practice preceded the adoption of the Islamic faith in the region. Religious norms of chastity and sexual purity, which are important dimensions of the religious motivations for FGC, are closely linked to social norms that underpin the practice. Religious justification for FGC, however, is fiercely contested in Mali and elsewhere. Increasingly, religious scholars and leaders argue that Islamic texts do not support FGC and that in fact, its practice runs contrary to Islamic religious principles.

- 3. Hygienic and aesthetic rationale.** One line of reasoning for FGC relates to perceptions in some areas that “uncut” female anatomy is ugly or dirty. In these areas, FGC is seen as a hygienic or aesthetic practice. For instance, the Bambara in Mali sometimes call the practice of FGC *Seli ji*, meaning ablution or ceremonial washing (Lewnes, 2005).

These rationales are related to the fact that FGC is a manifestation of gender inequality meant to reinforce inequitable gender norms related to women’s sexuality and social status. Even though those who support and perpetuate the practice may not explicitly address or even acknowledge this dimension (Lewnes, 2005), it is important to recognize this larger context to fully understand why FGC persists.

In Mali, all three lines of reasoning are relevant. According to the 2006 Mali DHS, 37 percent of women ages 15–49 who were surveyed believed that FGC is a social obligation, 24 percent thought that it is a religious obligation, 22 percent believed that it is a practice of good hygiene, and 10 percent felt that the practice makes a woman more marriageable (CPS et al., 2006). The same survey reports that 61 percent of women believe that FGC poses no disadvantage to women, whereas 17 percent of women believe the practice has no advantage (CPS et al., 2006).

The practice of FGC in Mali also persists because of complex gender dynamics. As is true in some other countries, in Mali FGC is performed most often by female elders, who may do this work for prestige and power in the community, but who also may rely on the financial compensation that sometimes comes with performing FGC procedures. This tradition contributes to social pressure to continue the practice and makes it difficult to persuade traditional excisors to find another source of income.

## **Responses to Female Genital Cutting in Mali**

### **Government response**

While the practice of FGC is not explicitly prohibited by Malian law, there are several laws and agreements that advocates cite when arguing that the country’s laws do not support the practice. For example, Article 166 of the Penal Code prohibits voluntarily cutting, injuring, or committing any violence against a person. Moreover, Article 171 states that anyone who willingly administers any procedure or substance to an individual without consent, causing illness or disability, can be punished with six months to three years of imprisonment. The power of this policy in relation to FGC is more rhetorical than practical—there is no evidence that anyone has ever tried to prosecute a case of FGC using this law. Further, because the individuals performing FGC on girls typically are grandmothers or elderly women, prosecution of these women under the penal code is perceived as socially unacceptable. Moreover, prosecution is nearly impossible because there are no prison facilities for female inmates.

Another policy—the Ministry of Health’s (MOH) Circular Letter N° 0019 MSPAS-SG, January 7, 1999—prohibits the practice of FGC in public health clinics. However, this policy is not strictly enforced. In fact, the 2006 DHS reports that health professionals—including doctors, nurses, and midwives—perform only 4.3 percent of all FGC procedures (CPS et al., 2006); better enforcement would have limited impact on the prevalence of FGC, as traditional excisors carry out 92 percent of FGC procedures (CPS et al., 2006).

Advocates also cite international laws and agreements to which Mali is party (see Box 2) to articulate the government’s obligations to work toward ending the practice of FGC.

## **Box 2. International Agreements Related to FGC**

**Convention on the Rights of the Child (CRC)**—defines a child as 18 years or younger, unless the age of majority is reached earlier; forbids all forms of violence against children, including child abuse and exploitation and discrimination based on gender.

**The African Charter on the Rights and Welfare of the Child**—sets many of the rights in the CRC within an African context; prohibits customs and practices that compromise the health of the child and/or are discriminatory to the child on the grounds of sex.

**Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment**—prohibits the infliction of physical or mental pain or suffering on women.

**General Recommendation No.19 of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**—obligates states under international law to prevent, investigate, and punish violence against women.

**The UN Declaration on the Elimination of Violence Against Women**—provides that states should not invoke any custom, tradition, or religious consideration to avoid their obligation to eliminate violence against women; further, that they must exhibit due diligence in investigating and imposing penalties for violence and establishing effective protective measures.

**Universal Declaration of Human Rights**—establishes the equal rights of all people, as well as the right to be free from torture and mistreatment.

In June 1997, the Malian Government committed itself to the eradication of FGC through the creation of a National Committee for the Eradication of Traditional Practices Harmful to the Health of Women within the Ministry for the Promotion of Women, Children, and the Family. This body comprises representatives of government ministries, public institutions, and nongovernmental organizations (NGOs). The committee has developed a five-year plan of action for 1999–2003; and in June 2002, the government created the *Programme National de Lutte Contre l'Excision* (PNLE) to coordinate the national response. The PNLE's mission is to

- Coordinate all actions of the fight against FGC;
- Undertake studies and research on the phenomenon of FGC;
- Develop an information, education, and communication (IEC) strategy targeting individuals, social groups, and communities to advocate for the abandonment of FGC;
- Develop nationwide programs with the cooperation of partners;
- Monitor and evaluate grassroots activities that address FGC;
- Create a database on FGC; and
- Support the development of curricula and introduce them into training programs for health professionals and educators (CPS et al., 2006).

While the PNLE coordinates all FGC activities, the MOH actually is responsible for treating the medical consequences of female cutting. Some stakeholders report that, because the PNLE is part of a separate ministry, weak coordination between the PNLE and the MOH presents a key policy barrier to addressing FGC.

### **Box 3. History of Anti-FGC Legislation in Mali**

The Health Policy Initiative is not the first organization to advocate against FGC at the policy level. In the early 2000s, a group of advocates, including representatives from Parliament, NGOs [Centre Djoliba and Association Malienne Pour la Suive et l'Orientation des Pratiques Traditionnelles (AMSOPT)] and the PNLE formed a working group that developed an action plan to sensitize members of Parliament about FGC and its health and human rights consequences. The action plan also sought to bring members of Parliament together with NGO representatives and lawyers to sensitize the broader community about FGC.

This working group drafted a law and submitted it to the National Assembly in 2002. At the time, President Alpha Konare was amenable to passing the law. However, the legislation drew such strong opposition from religious leaders that President Konare removed its passage from his final agenda.

In a separate attempt, an NGO called Sini Sanuma (Healthy Tomorrow) gathered 30,000 signatures in Mali to a Pledge Against Excision. The pledge states an individual's commitment to never have a girl undergo FGC and to work toward an end to the practice. In addition, the pledge card allows signers the option of agreeing to a statement that a national law should be passed against FGC; 95 percent of those who signed the pledge also agreed with this statement. Sini Sanuma presented the 30,000 signed pledges to the National Assembly in 2007 to demonstrate that many Malians support outlawing the practice of FGC.

Although these efforts have not yet led to formal debates on the floor of Parliament about a law against FGC, this history shows that support for such a policy exists—both within government and civil society.

### **Programmatic response**

Several NGOs have been working against FGC in Mali for decades, with some important signs of progress. Most notably, Malians increasingly discuss the subject of FGC openly, while just a decade ago the issue was taboo and rarely discussed.

Most of the programmatic work against the practice of FGC in Mali has taken the form of community mobilization and awareness raising. Sometimes groups employ traditional communicators, such as storytellers or actors, to share information about the negative consequences of FGC. Other groups combine messages about FGC with other services, such as literacy and vocational training or reproductive and maternal health information. Organizations such as Centre Djoliba, Sini Sanuma, and AMSOPT have followed awareness-raising and community mobilization activities with a process in which communities sign contracts or statements that declare the abandonment of FGC in that community. In a way, such contracts can be seen along a continuum of anti-FGC policy. All of these interventions share a common thread of the intervening organization's continued presence in the community to build trust and steadily influence attitudes and behaviors.

Some awareness-raising interventions have occurred at the national level, such as television and radio programs supported by Population Services International (PSI). However, the issue of FGC is so controversial that these interventions have had limited success. For example, PSI/Mali produced a month-long television show that aimed to de-bunk myths about non-circumcised women. The program aired for only one day before being cancelled by the national television station. In another intervention, PSI/Mali staff videotaped several religious leaders denouncing the practice of FGC, but the leaders quickly withdrew their consent for the videos to be televised for fear of reprisal by fellow religious leaders and followers. One religious leader who did agree to denounce FGC in a radio broadcast experienced threats, harassment, and accusations of accepting payment from Westerners for speaking out against FGC.

Other programmatic responses include outreach to women who experience health problems as a result of FGC, offering them medical treatment and reproductive health information.

## **Using policy to diminish the practice of FGC**

Currently, 17 African countries have laws prohibiting the practice of FGC, including all countries that border Mali (UNFPA, n.d.; Folsom, 2003). While laws at the national level provide a legal platform for activities aimed at eliminating FGC and act as state-sanctioned rejections of the practice, they are less likely to change deeply-entrenched cultural practices, primarily because of the difficulty of large-scale enforcement (Bodiang, 2003). Rather, when outlawed, the practice often persists in secrecy (Bodiang, 2003). Project partners in Mali note that, because the practice is so prevalent, a law criminalizing FGC will not end the practice but may in fact have perverse outcomes, such as driving it underground, encouraging families to send girls abroad to undergo the procedure, or even resulting in communities organizing mass FGC procedures in protest of the new law.

It is important to note, however, that criminalization is not the only possible policy response to FGC. Governments can support a range of policy efforts across multiple sectors to encourage a change in attitudes, discourage the practice at the community level, and ensure that public health practitioners are trained to treat FGC-related injuries and health problems. Other types of anti-FGC law include (1) community-level contracts (whether formal law or informal agreements) in which community members agree to stop practicing FGC; (2) laws that create programs to raise awareness about FGC and its consequences in order to start changing attitudes and reduce support for the practice (some key informants in Mali called these “pedagogical” laws); and (3) laws that allocate resources to educate healthcare providers so that they will advocate with parents against the practice and train providers to treat FGC-related health problems. As noted above, policy that improves coordination among bodies such as the PNLE and other government ministries, especially ministries of health, may increase the efficiency and effectiveness of government response to FGC. Furthermore, while they may not directly address FGC, laws that promote gender equality more broadly also may help to create an enabling environment for eliminating FGC by changing the inequitable norms and attitudes that support the practice.

## **Strengthening the Policy and Advocacy Response to Female Genital Cutting in Mali**

This section of this report describes the rationales and objectives for strengthening the policy and advocacy response to FGC, as well as the methodology and findings of this initiative in Mali.

### **Rationales**

As described earlier, the practice of FGC is a complicated religious, cultural, and societal phenomenon based on deeply embedded cultural practices, spiritual and religious beliefs, social and gender norms, and hygienic and aesthetic perceptions. The majority of Mali’s population identifies themselves as Muslim, and Islamic religious leaders enjoy tremendous influence at the community level. Consequently, Islamic religious leaders in Mali can influence elected officials, such as Parliamentarians, because of their strong link to the electorate. In its efforts to promote public health policy, the Health Policy Initiative in Mali has recognized this critical advocacy group and has collaborated effectively with Islamic and other religious leaders for many years. To address policy issues for FGC in Mali, the project team identified Islamic religious leaders as key collaborators for implementing this activity.

### **Objectives**

This activity aimed to collaborate with local partners in the government, civil society, religious, health, and social sectors to identify and overcome barriers to addressing FGC. The project sought to

- Increase multisectoral collaboration to prevent FGC;
- Facilitate the development of advocacy tools; and
- Conduct advocacy that targets religious and government leaders to improve the policy environment for the abandonment of FGC.

## **METHODOLOGY**

### **Desk-based Policy Review and Situation Analysis**

In February and March 2008, Health Policy Initiative staff in Washington, D.C., conducted a desk review of global interventions to abandon FGC, with an emphasis on the development and implementation of FGC policies and laws.

In May 2008, a Health Policy Initiative team consisting of two technical experts from Washington, DC, one local staff member, and a local consultant conducted a local-level situation analysis through interviews with key Malian FGC stakeholders to (1) understand the political and legal contexts surrounding FGC in Mali, including relevant laws, policies, and programs; (2) identify needs and opportunities in the fight against FGC; and (3) identify key partners to carry out a policy and advocacy intervention toward ending the practice of FGC. The team conducted approximately 30 key informant interviews with the ministries of health (Division of Reproductive Health), justice, and promotion of the woman, child, and family; Parliamentarians; governmental bodies working against FGC; NGOs and NGO networks; religious leaders and religious organizations; and public health clinicians.

While the objective of this activity was not explicitly to advocate for a national law in Mali prohibiting the practice of FGC, this initial assessment revealed that stakeholders had mixed opinions about the timing and the country's readiness for a national law against this practice. Some argued that the consequences of FGC are so severe that a law was warranted and that, without legislation, there was no protection for people who wished to not practice FGC. However, other stakeholders argued that the practice is so prevalent and so closely linked with cultural and religious beliefs and norms that a law would have little effect, would drive the practice underground, or would be extremely difficult to enforce on a large scale.

With this feedback, the team identified multiple opportunities for targeted advocacy to change attitudes at the national level and improve the environment for policies that diminish the practice of FGC. In particular, the project team decided that advocacy activities needed to target

- Elected officials, many of whom do not support FGC yet fear speaking out against it in the interest of being re-elected by an electorate highly influenced by Islamic religious leaders;
- Doctors and midwives who still believe there are no major health problems related to FGC or do not make the connection between obstetric complications and this practice; and
- Religious leaders and their constituencies who believe that FGC is a practice sanctioned by Islam.

The team identified two key components of an intervention to help partners meet these advocacy needs:

1. Advocacy tools using data on health and economic consequences of FGC, as well as text from the Qur'an and Islamic teachings to conduct advocacy among policymakers, health personnel, religious leaders, and Parliamentarians
2. Capacity building among networks of religious leaders to target high-level decisionmakers, such as Parliamentarians to further champion eradication of FGC in Mali

### **Development and Validation of Advocacy Tools**

The project team hired a local consultant—a former Parliamentarian who had been instrumental in earlier efforts in Mali to advocate against FGC—to facilitate implementation of the two intervention components described above. The team intended to develop one advocacy tool targeting decisionmakers at all levels, including policymakers and community and religious leaders, and a second tool specifically tailored for

Islamic religious leaders to use in advocacy activities with Parliamentarians—this second tool would help to separate the practice of FGC from Islam using passages from the Koran and interpretation of teachings from the Hadiths.<sup>1</sup>

Through a series of more than 20 formal and informal meetings, representatives of the PNLE, NGOs, gynecologists, religious leaders, and the project team drafted the first, more generic advocacy tool. This tool, “Female Genital Mutilation/Cutting: A Major Public Health and Human Rights Concern,” lays out arguments against FGC based on the health, social, and human rights consequences. The presentation makes recommendations for working against FGC at the national level through multisectoral engagement, capacity building, and legal reform (including legislation to outlaw FGC, monitoring and enforcement of existing laws that could protect girls against the practice, and policy-driven advocacy and behavior change interventions). It also recommends community-level responses, such as promoting open dialogue about FGC—including presenting IEC materials about its consequences—and engaging men and community leaders in the process of eliminating the practice. Once this tool had been drafted, the project team validated it at a November 2008 stakeholder workshop attended by more than 60 representatives of government and civil society, including the ministries of health, youth and sports, and culture; members of Parliament; and NGOs and religious leaders.

Next, the project team continued to coordinate multiple formal and informal meetings among networks of male and female Muslim religious leaders to develop the second advocacy tool, a presentation titled “Islam and Female Genital Cutting.” In Mali, religious leaders influence both policymakers and individuals in communities and therefore they are important in the process of policy change. Almost a decade ago, the USAID-funded POLICY Project approached religious leaders to involve them in the fight against HIV and AIDS and in addressing high levels of maternal and infant mortality in Mali. The POLICY Project and subsequent Health Policy Initiative strengthened the capacity of Muslim and Christian leaders for policy dialogue and advocacy and supported the creation and expansion of networks such as the *Réseau Islam Population et Développement* (RIPOD) and the *Union Nationale des Associations de Femmes Musulmanes du Mali* (UNAFEM). These networks and their leaders were instrumental in helping to pass national HIV and AIDS and Reproductive Health laws in Mali because of their engagement in these issues at the highest levels. The Health Policy Initiative believed that these same religious leaders could also be critical in influencing the policy dialogue concerning FGC in Mali.

The focus of the second advocacy tool was to separate Islam from the practice of FGC and show that Islam does not sanction or require its followers to practice FGC. The leaders of several networks—including RIPOD, UNAFEM, and the *Haute Conseil Islamique*—researched Islamic texts, especially the Qur’an and teachings in the Hadiths, to support the tool’s basic arguments. This collaborative group of the project team and Islamic religious leaders drew on these texts in the presentation to dispel the myth that FGC is supported or obligated by Islam and to lay out arguments that the practice is in fact contrary to Islamic customs and values.

Although religion, especially Islam, often is used to justify the continuation of FGC, the practice preceded the adoption of the Islamic faith in Mali and other countries in West Africa. Contemporary Muslim authorities increasingly argue that FGC is not sanctioned by Islamic discourse. The following verse from the Holy Koran is often quoted to justify circumcision for both males and females:

*“Then, We have shown you (O Prophet!) the inspired (Message), ‘Follow the ways of Abraham, the (one) True in Faith, and he did not join Gods (with Allah).’”* Sura 16, Verse 123.

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<sup>1</sup> Hadiths are Islamic texts originating from the words and deeds of the Prophet Muhammad.

This verse has been interpreted to mean that everyone should be circumcised, even though circumcision is not directly addressed in any of the 114 Suras of the Koran.

Likewise, the Sunnah (statements and laws attributed to the Prophet Muhammad) contains some passages that could be interpreted as supporting FGC/circumcision:

*“Touch gently and do not abuse because that makes the face more radiant and increases satisfaction of the husband.”* Instructions for circumcisers, as narrated by Abou Daoud

*“Circumcision is a praiseworthy tradition (sunnah) for men and an honor (makrumah) for women.”* Narrated by Ahmad

Prominent Muslim leaders, however, have denied that these oral texts and others cited as referring to FGC are authentic. Aside from the issue of credibility, Islamic scholars argue that the texts simply acknowledge FGC, especially as an historical practice, but in no way imply that the practice is obligatory. On the contrary, religious advocates against FGC quote the following statements from the Sura, maintaining that FGC impairs the body’s faculties:

*“We have truly created man in the best of forms”* Sura 95, Verse 4.

*“Allah intends every facility for you; He does not want to put you to difficulties ...”* Sura 2, Verse 185.

The conclusion of the advocacy tool reinforces that Islam in no way obligates girls to undergo FGC and that, in fact, because the practice is so harmful to women, it violates Islamic principles. Religious leaders are encouraged to engage in dialogue about FGC with their fellow religious leaders, congregations, and policymakers, and raise awareness of religious arguments against FGC in their communities.

The project team and members of the Islamic leaders networks validated the second advocacy tool at a February 2009 stakeholder workshop, attended by 63 male and female religious leaders, PNLE representatives and other governmental and NGO partners, and journalists.

## **Capacity Building of Religious Leaders**

For the next phase of the activity, the project team trained approximately 30 Islamic religious leaders to understand and use the religious-focused tool to advocate against FGC with decisionmakers at the national level. Participants became well-versed in use of the tool and advocacy methods more broadly.

## **FINDINGS AND RESULTS**

### **Responding to Changes in the Policy Environment: The Family Code**

In August 2009, the Parliament ended a long debate and passed a new Family Code—one portion of which stated that husbands and wives have equal rights in marriage. This language was highly controversial and was publicly protested, especially by religious leaders, who staged highly visible and organized protests against the Code in the capital of Bamako. As a result, Malian President Amadou Toumani Touré refused to sign the Family Code into law and sent it back to members of Parliament to vote on revised language.

While the Family Code did not mention the FGC specifically, the project team recognized that this highly politicized event was linked to the policy environment for FGC and might mean that decisionmakers would be less supportive of issues related to gender equity, including the elimination of the practice of FGC. Over the subsequent months, it became difficult for elected politicians in Bamako to speak about FGC or any other women's rights issue for fear of being accused of supporting the Family Code and potentially losing their constituents' support. Stakeholders advised not to move forward with the Parliamentary-level meeting to present the FGC advocacy tool until the tumult over the Family Code had passed.

## **Commitments by Religious Leaders**

Although the trained religious leaders were not able to present their advocacy materials to Parliament, their participation in the development of the two advocacy tools raised awareness and support among other leaders about the need for a policy to end the practice of FGC and helped to clarify the stance of Islam on FGC in Mali. The advocacy tool addressing FGC from the Islamic perspective powerfully separates cultural obligations to practice FGC from Islamic beliefs. This separation alone—if supported by further dissemination activities—could have a significant impact on the policy environment for FGC and the practice itself.

Even though some religious leaders in Mali were vocal in their protest against the Family Code, there is still support for advocacy against FGC within religious networks, including RIPOD and UNAFEM. In follow-up interviews, religious leaders in these organizations stated their commitment to advocating for the elimination of FGC in Mali, but felt the need to de-couple the issue of FGC from the Family Code. The leaders recognized that change in the FGC policy environment is likely to take place slowly over time (*"petit à petit"*) and that advocacy activities against FGC must come from multiple sectors and at multiple levels, especially at the community level.

In February 2010, several Protestant leaders approached the Health Policy Initiative/Mali team to request training on ways to address FGC issues in their communities. The pastors had heard about the collaboration with Islamic religious leaders in creating advocacy tools against the practice. The project team conducted a two-day training with approximately 40 Protestant leaders—a group that included both men and women. After the training, the pastors agreed that collectively they would report back on sessions they held with their congregations regarding the abandonment of FGC. This experience demonstrates the power of creating an environment for addressing sensitive cultural issues through community leaders, such as religious leaders.

## **Impact on Policy Environment**

The activity's impact on the policy environment is limited by tensions introduced by the Family Code. However, it is important to recognize that broad support for FGC eradication still exists in government ministries and in religious and NGO communities. This activity solidified that support through its national-level participatory and collaborative process to develop and validate the advocacy tools. Many stakeholders stated in follow-up interviews that they had even conducted informal awareness raising among their staff and partner organizations to raise support for the development and use of the advocacy tools. Although it remains difficult to speak publicly about FGC in Mali, stakeholders commented that the subject is slowly becoming less taboo. When asked about the future of FGC advocacy in light of the Family Code turmoil, stakeholders responded nearly unanimously that advocacy against FGC can and must continue, if cautiously, despite the setback caused by response to the code.

## **Multisectoral Collaboration**

In follow-up interviews, several stakeholders said that the most important contribution is that the advocacy tools unify the multiple messages the government and NGO community have been using to advocate against FGC. The stakeholders commented that previously, groups had used inconsistent terminology and focused on different aspects of the problem of FGC. Stakeholders expressed their appreciation for a consistent, consensus-derived, evidence-based, and well-articulated tool with which all stakeholders can discuss FGC and its health consequences.

They also stressed the importance of having a tool that powerfully uses the language of the Qur'an and Hadiths to separate the practice of FGC from Islamic beliefs and practices.

The process of meeting to develop and validate the tools gave multiple ministries, NGOs, and religious leaders opportunities to collaborate and ensured input into and ownership of the tools. This multisectoral collaboration also increases the likelihood that future efforts to advocate against FGC will be coordinated and unified.

## **CONCLUSIONS**

### **Lessons Learned**

This activity is an excellent example of how complex it is to influence through policy those behaviors driven by deeply held beliefs, especially those related to gender. While the initial situational analysis found that the policy environment was quite sensitive and that the activity should not specifically push for a national law against FGC, the team did not anticipate the setback caused in August 2009 by the reaction to the Family Code. FGC does not exist in isolation; it is underscored by complex social and gender norms. Several stakeholders in Mali expressed frustration that the Family Code is not related to FGC but affected FGC advocacy nonetheless. Perhaps, however, it is useful to acknowledge the link between anti-FGC policy dialogue and the Family Code, as both seek to change deeply embedded gender norms and roles. Framing FGC as a health issue may have blinded actors to other dimensions of the policy environment, possibly reducing the intervention's effectiveness. Even though this activity carefully considered many factors and identified other existing initiatives that suggested the policy "window" for FGC was open, it may have been useful to examine the broader gender policy environment in Mali as part of the initial assessment.

Health sector policy responses to end FGC cannot stand alone in any country; they are likely to be more successful in the context of other policies supportive of gender equality. The activity is also a good reminder that gender norms do not change quickly. The more organizations and agencies discuss FGC and the better informed the messages are, the more people will begin to take notice. Stakeholders are right to recommend that advocacy initiatives continue—slowly, carefully, and consistently—after this activity has ended.

### **Next Steps for Addressing FGC in Mali**

In follow-up interviews, stakeholders participating in the advocacy activity recommended the following next steps toward eradication of FGC in Mali:

- Continue to advocate for an end to FGC supported by national policy. Stakeholders recognized that the norms underpinning FGC are slowly changing. They stressed that continuous, consistent advocacy at the community level is necessary to change beliefs around FGC. Although this work is slow, it is necessary to strive for consensus at multiple levels and in multiple sectors.

- Disseminate the advocacy tools in several formats (e.g., on brochures and cassette tapes). Several stakeholders recommended that the advocacy tools be adapted for use at the community level, in local languages, and through oral channels, such as storytelling and skits.
- Continue to support religious leaders as they forge ahead with the process of separating FGC and the tenets of Islam. This is likely to be a long process, and it is important to ensure that religious leaders remain dedicated to and have the tools and skills to continue advocacy against FGC.
- Frame FGC as a health and human rights problem but also as part of a larger goal of gender equality. The health sector is a crucial actor in the fight against FGC. However, the practice of FGC is sustained by a complex system of institutionalized gender inequality. Anti-FGC efforts must be supported by promotion of gender equality more broadly.

# APPENDIX A. ADVOCACY TOOLS<sup>2</sup>

## Female Genital Cutting: A Major Public Health and Human Rights Concern



**FEMALE GENITAL CUTTING:**

**A MAJOR PUBLIC HEALTH AND HUMAN RIGHTS CONCERN**

Editorial Note: This version has been translated from the French version used in Mali and revised to correspond to USAID language and formatting guidelines.

**COORDINATION**

**Ministry for the Promotion of Woman, Child, and Family**

**Ministry of Health  
National Program to Combat Excision  
National Health Directorate**

**FUNDING AND TECHNICAL SUPPORT**

**USAID | Health Policy Initiative, Task Order 1  
Futures Group**

**Presentation Overview**

- **Definition of female genital cutting (FGC)**
- **Classification of FGC**
- **Extent of the problem**
- **Change in the practice based on Demographic Health Surveys (DHS) III and IV**
- **Stated reasons**
- **Consequences of FGC**
- **Legal and legislative aspects**
- **Actions to take**

**Definition of FGC**

“Female genital mutilation [cutting] comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for **cultural and** non-medical reasons.”

– World Health Organization, 2008

**Classification of FGC**

- **Type I:**
  - **Circumcision** of the prepuce, with or without **circumcision** of part or all of the clitoris
- **Type II:**
  - **Circumcision of the prepuce and** the clitoris with partial or total removal of the labia minora

**Classification of FGC (continued)**

- **Type III:**
  - **Circumcision** of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation)
- **Type IV:**
  - **Non-classified interventions:**
    - Pricking, piercing, or incising of the clitoris and/or the labia minora or labia majora
    - Stretching of the clitoris and/or labia
    - Cauterization by burning of the clitoris and surrounding tissue

<sup>2</sup> These PowerPoint presentations can be downloaded at <http://www.healthpolicyinitiative.com> and are also available in French.

### Classification of FGC (Type IV continued)

- Scraping the vaginal opening or cutting of the vagina
- Introduction of corrosive substances into the vagina to cause bleeding or introduction of herbs into the vagina for the purpose of tightening or narrowing it
- Any other procedure that falls under the broad definition of genital mutilation described above

### Extent of the Problem in Mali

- Types I and II are the most widespread; infibulation (Type III) remains low.
- Prevalence: 85 percent (DHS IV) among women ages 15 to 49 years
- High prevalence in all except the northern regions of Mali

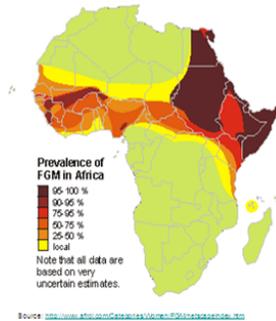
### Extent of the Problem

#### Worldwide:

- 132 million circumcisions
- 2 million girls cut per year
- All continents (immigration)

#### In Africa:

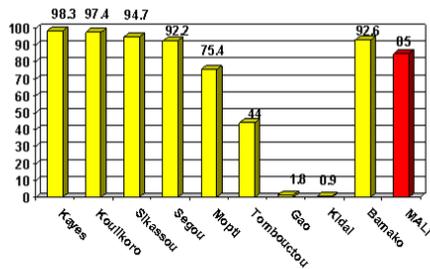
- More than 90 percent of world's cases
- 28 countries



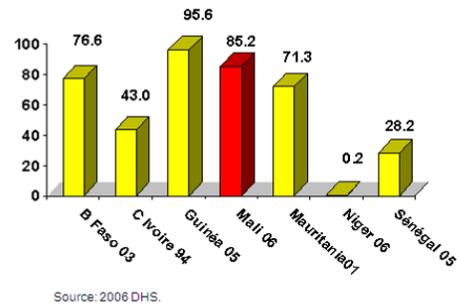
### Change in the Practice Based on the DHS III and IV

| Regions               | Prevalence of FGC DHS III, 2001 | Prevalence of FGC DHS IV, 2006 |
|-----------------------|---------------------------------|--------------------------------|
| Bamako                | 92.8%                           | 92.6%                          |
| Kayes                 | 97.7%                           | 98.3%                          |
| Koulikoro             | 99.0%                           | 97.4%                          |
| Sikasso               | 96.6%                           | 94.7%                          |
| Ségou                 | 94.6%                           | 92.2%                          |
| Mopti                 | 87.5%                           | 75.4%                          |
| Gao, Tbtou, Kidal     | 33.6%                           | 15.6%                          |
| <b>Average – Mali</b> | <b>92%</b>                      | <b>85%</b>                     |

### Percent of Women Ages 15 to 49 Who Are Circumcised in Mali



### Percent of Women Ages 15 to 49 Who Are Circumcised in **Several** West African Countries



### The Practice of Female Genital Cutting

#### How?

- By traditional circumcisers and sometimes healthcare professionals (2.5% of cases, based on the 2006 DHS)
- Equipment used: special knives, scissors, and razor blades in Mali. Elsewhere, shards of glass bottles, split millet twigs, sharpened stones, and scalpels are also used.

### The Practice of Female Genital Cutting (continued)

- Generally, no anesthesia or antiseptic is used; a mixture of herbs, mud, and cattle excrement sometimes rubbed on the wound to stop bleeding.

#### When?

- Very early: 77 percent of girls are excised before the age of 5 years (2006 DHS).

### Stated Reasons for FGC

#### Some stated reasons to justify FGC:

- Increased fertility and chances for marriage
- Eradication of the evil power of the clitoris
- Hygienic and aesthetic considerations
- Passage from the status of "blakoro" child to adult

### Stated Reasons for FGC (continued)

- Reducing the woman's sexual desire
- Protecting the woman's chastity and virginity
- Religious considerations: practiced in the name of Islam, as some think it is recommended by its holy scriptures
- Social conformity

### In Reality

- Far from increasing fertility, FGC may make women sterile.
- The practice of FGC cannot fundamentally change a woman's sexual behavior and conduct, which depend more on her individual characteristics.

### In Reality (continued)

- **FGC can cause**
  - Major complications during childbirth (fistulas, infant and/or maternal mortality)
  - Severe sexual and psychosocial difficulties
- **FGC is a customary practice that existed before Islam.**

## Consequences of Female Genital Cutting

### I. Immediate Physical Complications

- Pain
- Trauma
- Hemorrhage (bleeding)
- Urine retention

#### Pain

**Severe pain for the young girl—the clitoris contains many nerve endings.**



#### Trauma

- Combination of neurological shock and hemorrhagic shock, possibly resulting in death.
- Other possible traumas: lesions of neighboring organs, fracture or dislocation of the child's limbs.

#### Hemorrhage

- Bleeding occurs at the section of blood vessels (especially the clitoral artery).
- The young girl can lose a lot of blood, which can result in death.

#### Urine Retention

- Due to swelling of the perimeter of the wound, the girl is afraid to urinate.
- Urine retention is very common and can last several hours or days.
- Retention can cause infections spreading up from the urethra to the bladder and even further (kidneys).

**Kidney Failure**

**Photo on left:** A newborn, a few months old, presenting a vesicle globe/urinary retention with complete closure – infibulation of the vaginal opening at the beginning of the procedure after catheterization (introduction of a catheter). Note the urinary jet. Without treatment: renal insufficiency/death.

**Photo on right:** Case of kidney failure.



*Photos: Dr Moustaphe Touré, Chief Physician, CSRefCIV*

## II. Long-Term Complications

- Infections
- Problems related to scarring
- Fistulas
- Urinary problems
- Gynecological problems
- Obstetric outcomes
- Sexual consequences
- Social consequences
- Economic consequences

### Infections

- Increased risk of tetanus
- **Abscess:** Isolated infection, sometimes requiring surgical incision
- **Vaginal infections:** Odorous vaginal discharge; increased risk of Hepatitis B and HIV transmission

### Scarring

- **Keloids:**  
Abnormal production of excess tissue during scarring
- **Retractions:**  
Contraction of the vaginal opening and tears in the pelvic, anal, and vaginal areas

### Case of a Cyst Due to FGC

- Cyst appeared on the scar over time after circumcision. It became increasingly large despite traditional treatments (without success).
- This cyst caused psychological trauma to the spouse, resulting in legal separation.



*Photo: Dr Moustaphe Touré, Chief Physician, CSRefCIV*

### Fistulas

**Fistulas can cause:**

- Abnormal connections between either the
  - Vagina and bladder (Vesico-vaginal/VVF)
  - Vagina and rectum (Recto-vaginal/RVF)
  - Vagina, bladder, and rectum, or double fistula
- Secondary: difficult deliveries or accidental wounds (e.g., violent sexual relations)
- Urinary or fecal incontinence can last a lifetime, with severe psychological, sociological, and economic repercussions

## Urinary Problems

- **Dysuria**, or difficult urination, is due to an infection of the urethra (**urethritis**) and its opening (**urinary meatus**), which causes an irritation or secondary contraction.

## Gynecological Problems

- **Dysmenorrhea**
  - Painful menstruation
- **Amenorrhea or retention of menstrual blood with:**
  - Sterility
  - Hematometra: Retention of blood in the uterus
  - Hematocolpos: Retention of blood in the vagina

## Levels of Gynecological Complications

According to the DHS IV 2006:

Nearly one-third of excised girls (28%) have had at least one gynecological complication and, for 12 percent of cases, the girls have had at least two complications, **according to statements from mothers.**

## Blood Retention

- Retention of menstrual blood (two liters) after infibulation (stitching)
- Resulted in conflict with the family, who believed an unmarried girl presenting increased volume in her abdominal area to be pregnant.



Photos: Dr/Moustaphe Touré, Chief Physician, CSRef C/IV

## Obstetric Outcomes

- Difficulties in conducting some gynecological exams
- During delivery:
  - Rigidity of the perineum, causing multiple tears
  - Difficult expulsion of the fetus with risk of
    - Fetal suffering
    - Stillborn fetus
    - Obstetrical fistulas
    - Death of the woman

## Stillborn Baby

- Girl circumcised at age 12 and married at age 15.

- **Difficult delivery:** blockage of the head of the fetus, which could not come out due to infibulation.

- 72-hour labor; stillborn baby; vesico-vaginal, recto-vaginal fistulas.

- Three surgical procedures were necessary.

- Psychological problems for the mother.



Photos: Dr Moustaphe Touré, Chief Physician, CSRef C/IV in collaboration with AMSOPT

## Sexual Consequences

- **Frigidity:**  
Dissatisfaction for the woman during sexual relations, who in many cases does not experience orgasm
- **Dyspareunia:**  
Pain during sexual relations that becomes traumatizing for the woman
- **Sexual Dysfunction:**  
For the partners, thus creating discord in the relationship, and even divorce

## Sexual Consequences

- This woman was divorced after her wedding night due to the impossibility of consummating the marriage.
- She was taken to the health center by a relative who participated in a workshop on circumcision.



Photo: Health Policy Initiative/Mali

## Social Consequences

- School **absenteeism**/drop-out
- Difficulty/impossibility of consummating marriage
- Marital disagreements
- Rejection and stigmatization of women with fistulas

## Economic Consequences

- Costs related to the practice of **circumcision**:
  - The cost of treatment for complications for the family and the State
  - Lost work days for patients and the family
  - Lowered productivity and its impact on development

## Female Genital Cutting: Legal and Legislative Aspects

### Laws Applicable to the Eradication of FGC in Mali

#### The law protects all citizens (male and female)

- The 1992 Constitution of Mali provides, in Article 1: "The human person is sacred and inviolable. Every individual has the right to life, liberty, security, and integrity of person."
- The Penal Code of Mali includes articles that could curb the practice of FGC (Art. 166, 207, 213).
- The Circular Letter N° 0019 MSPAS-SG of 07 Jan 1999 prohibits **circumcision** in health clinics.

## Child Protection Law

The Child Protection Law (notably Articles 50 and 66) guarantees and protects the rights of the child:

### Article 50 (Line k):

Considers as particularly difficult situations threatening the child's health, his or her development or physical and moral integrity: "Exposure of the child to practices that have a harmful effect on his or her health."

### Article 66:

"A Delegate for childhood protection is appointed for the Governor of each region and the district of Bamako."

## Countries That Have Adopted Laws against FGC

|                          |                   |
|--------------------------|-------------------|
| Benin                    | Kenya             |
| <b>Burkina Faso</b>      | <b>Mauritania</b> |
| Central African Republic | <b>Niger</b>      |
| <b>Côte d'Ivoire</b>     | Nigeria           |
| Cameroon                 | <b>Senegal</b>    |
| Djibouti                 | Sierra Leone      |
| Egypt                    | Togo              |
| Ghana                    | Tanzania          |
| <b>Guinea</b>            |                   |

## International FGC Treaties Ratified by Mali

- Universal Declaration of Human Rights (1948)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW in 1979)
- African Charter on Human and Peoples' Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)

## International FGC Treaties Ratified by Mali (continued)

- Protocol to the African Charter on the Rights of Women in Africa, Article 5 (2003)
- Convention on the Rights of the Child (CRC, 1989)
- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

## Mali's Response to FGC

National Program to Combat Excision (PNLE) 2002, which has a policy and a national action plan (2008–2012):

National Action Committee for the Eradication of Harmful Practices (CNAPN):

- Chaired by the Minister for the Promotion of Women, Children and Families in 1999

Regional Action Committees for the Eradication of Harmful Practices (CRAPN):

- Chaired by the Regional Governors

Local Action Committees for the Eradication of Harmful Practices (CLAPN):

- Chaired by the Prefects

## Mali's Response to FGC (continued)

The contribution of civil society organizations, notably nongovernmental organizations/associations:

- Advocacy at the national policy level to
  - Improve the legal and policy environment on FGC
  - Allocate resources to the fight against FGC
- Information, education, and communication campaigns in communities
- Sensitization and training of health providers on the negative effects of FGC and health complications

## Next Steps

### What to Do?

#### The Importance of a Multisectoral Response

- Advocate for the allocation of more resources to eradicate FGC
- Increase support of the National Program to End the Practice of FGC (PNLE) and strengthen its decentralization and leadership
- Support structures in the Ministry of Health for treatment and those in the Ministry of Justice for the promotion of human rights
- Encourage and strengthen the involvement of other ministries
- Further empower actors in civil society and strengthen their capacities

### What to Do?

#### At the Community Level

- Promote dialogue about FGC between women and men
- Discuss negative outcomes and alternatives for FGC with women
- Intensify information, education, and communication campaigns in communities
- Engage more men and religious and community leaders in dialogue about FGC
- Engage more elected officials in eradicating the practice of FGC
- Obtain the support of territorial communities and other community actors

### What to Do?

#### Improvements in Healthcare

- Pursue awareness raising and training for healthcare providers about the adverse effects of FGC and in treating complications
- Use healthcare providers as educators and activists for the eradication of FGC

### What to Do?

#### Legal and Political Reforms

- Ensure the application of laws that are in force
- Conduct an evaluation of the impact of Circular Letter N° 0019 MSPAS-SG of 07 Jan 1999 prohibiting the practice of circumcision in health structures
- Adopt a specific law against the practice of circumcision and monitor its effective implementation
- Pursue ongoing advocacy and behavior change communication campaigns before and after adoption of the law

### IN CONCLUSION

#### FGC is

- A major public health concern
- An act of violence toward the woman and child
- A threat to the woman and child's health
- An attack on women's sexuality

*To truly confront this issue, an ongoing, coordinated, and multisectoral response supported by visible political will is essential. Education efforts will fail without the support of policy decisionmakers.*

# Islam and Female Genital Cutting

**THANK YOU  
FOR YOUR ATTENTION**

 **USAID** | HEALTH POLICY INITIATIVE  
FROM THE AMERICAN PEOPLE

**Islam and Female Genital Cutting**



**COORDINATION**

**National Program to Combat Circumcision**  
National Health Directorate  
**National Union of Associations of Muslim Women**  
Islamic Network for Population and Development

**FUNDING AND TECHNICAL SUPPORT:**  
USAID | Health Policy Initiative, Task Order 1  
**Futures Group**

- Presentation Overview**
- Definition of female genital cutting (FGC)
  - Classification
  - Extent of the problem
  - Change in the practice based on the Demographic and Health Survey (DHS)
  - Stated reasons; the reality
  - Religious arguments in favor of circumcision
  - Observations
  - Conference recommendations
  - Consequences of FGC
  - Conclusion

**Definition of Female Genital Cutting (FGC)**

"Female genital mutilation [cutting] comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for **cultural** or non-medical reasons."

– World Health Organization, 2008

**Extent of the Problem**

**Worldwide:**

- 132 million women circumcised
- 2 million girls cut per year
- All continents (immigration)

**In Africa:**

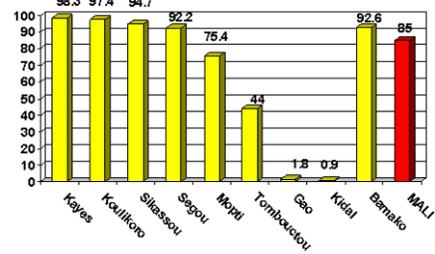
- More than 90% of world's cases
- 28 countries

http://www.afro.who.com/ceborates/Women/FGM/pressrelease.nsf" data-bbox="704 604 868 731"/>

### Extent of the Problem in Mali

- Types I and II are the most widespread; infibulation (Type III) remains low.
- Prevalence: 85 percent among women ages 15 to 49 years (2006 DHS)
- High prevalence in all except the northern regions of Mali

### Percent of Women Ages 15 to 49 Who Are Circumcised, Based on the 2006 DHS



Source: 2006 DHS.

### Change in the Practice Based on the DHS III and IV

| Regions               | Prevalence of FGC DHS III, 2001 | Prevalence of FGC DHS IV, 2006 |
|-----------------------|---------------------------------|--------------------------------|
| Bamako                | 92.8%                           | 92.6%                          |
| Kayes                 | 97.7%                           | 98.3%                          |
| Koulikoro             | 99.0%                           | 97.4%                          |
| Sikasso               | 96.6%                           | 94.7%                          |
| Ségou                 | 94.6%                           | 92.2%                          |
| Mopti                 | 87.5%                           | 75.4%                          |
| Gao, Tbtou, Kidal     | 33.6%                           | 15.6%                          |
| <b>Average – Mali</b> | <b>92%</b>                      | <b>85%</b>                     |

### Stated Reasons for FGC

- Reducing the woman's sexual desire
- Protecting the woman's chastity and virginity
- Religious considerations
- Social conformity

### In Reality

- Circumcision can cause
  - Major complications during childbirth (fistulas, infant and/or maternal mortality)
  - Severe sexual and psychosocial difficulties
- Circumcision is a practice that existed before Islam.

## Consequences of Female Genital Cutting

### Immediate Physical Complications

- Pain
- Trauma
- Hemorrhage (bleeding)
- Urine retention

### Long-Term Complications

- Infections
- Fistulas
- Gynecological problems
- Obstetric outcomes
- Sexual consequences
- Social consequences

### Infections

- Increased risk of **tetanus**
- **Abscess**: Isolated infection, sometimes requiring surgical incision
- **Vaginal infections**: Odorous vaginal discharge and increased risk of Hepatitis B and HIV transmission

### Fistulas

#### Fistulas can cause:

- Abnormal connections between either the
  - Vagina and bladder (Vesico-vaginal/VVF)
  - Vagina and rectum (Recto-vaginal/RVF)
  - Vagina, bladder, and rectum, or double fistula
- Secondary: difficult deliveries or accidental wounds (e.g., violent sexual relations)
- Urinary or fecal incontinence that can last a lifetime, with severe psychological, sociological, and economic repercussions

### Gynecological Complications

According to the DHS IV 2006:

- One-third of circumcised girls (28%) have had at least one gynecological complication.
- 12 percent of girls circumcised have had at least two complications.

### Obstetric Outcomes

- Difficulties in conducting some gynecological exams
- During delivery:
  - Rigidity of the perineum, causing multiple tears
  - Difficult expulsion of the fetus with risks
    - o Fetal suffering
    - o Stillborn fetus
    - o Obstetrical fistulas
    - o Death of the woman

## Sexual Consequences

- **Frigidity:**  
Dissatisfaction for the woman during sexual relations, who in many cases does not experience orgasm
- **Dyspareunia:**  
Pain during sexual relations that becomes traumatizing for the woman
- **Sexual Dysfunction:**  
For the partners, thus creating discord in the relationship, and even divorce

## Social Consequences

- School absenteeism/drop-out
- Difficulty/impossibility of consummating marriage
- Marital discord
- Rejection and stigmatization of women with fistulas

## Religious Arguments

## Evidence Based on Islamic Jurisprudence

- The Sharia is based on the Holy Koran and the Sunnah.
- Next are the consensus (Al-Ijmâ) and analogy (Al-Qiyâs).

## The Holy Koran

- It is known by its authority over Muslims and its priority over all other sources.
- Three categories of instructions are found in the Koran:
  - Those that reveal a belief
  - Those that reveal a moral
  - Those that reveal cultural (Ibâdât) and social (Mu'âmalât) practices. Circumcision falls within this framework

## What Does the Holy Koran Say?

- Examination of the Holy Koran reveals that circumcision has not been directly addressed in any of the 114 suras.
- Nevertheless, the chafeite and hambalite jurisconsults who believe that circumcision is an obligation for both males and females cite, among others, the following verse:  
*"Then, We have taught you (O Prophet!) the inspired (Message), 'Follow the ways of Ibrahim (Abraham), the (one) True in Faith, and he did not join Gods (with Allah).'" Sura 16, Verse 123.*

## The Sunnah

- From a religious perspective, speaking about the Sunnah indicates:
  - All of the Prophet Muhammad's (pbuh) authentic statements
  - All of His authentic acts
  - All authentic acts that He explicitly approved
  - The authentic acts that He saw achieved by others or that were reported to Him and that He did not disapprove
- The Sunnah must be reliable and certain to have legal authority.
- Only the Sunnah would include the Hadiths taken by scholars as a basis for the various viewpoints on this issue.

## What Does the Sunnah Say?

The main Hadiths cited regarding circumcision are

- First Hadith (authentic): "If two khitân (circumcised parts) come into contact, ritual bathing is required." Narrated by a Muslim
- Second Hadith (not authentic): From Umm 'Atiyah based on what the Prophet (PBUH) said to the circumciser: "Touch lightly and do not abuse because that makes the face more radiant and more satisfying to the husband." Narrated by Abou Daoud

## What Does the Sunnah Say?

The Prophet (PBUH) prohibits the circumciser from excess in the circumcision. The Malérites and the Hanafites often use this Hadith to point out the superfluous character of the practice.

Third Hadith (not authentic):

"Circumcision is a praiseworthy tradition (Sunnah) for men and an honor (makrumah) for women." Narrated by Ahmad.

"And no one can tell you (the Truth) like Him (one Allah), Who is all Informed of all things," (Sura 35, Verse 14) and "Then ask Him as the All Aware and informed" (Sura 25, Verse 59).

"Allah intends every facility for you; He does not want to put you to difficulties ..." (Sura 2, Verse 185).

## Consensus and Analogical Reasoning

- The Ijmâ' consensus of Ulemas: Consensus is obtained by specialists in Muslim law on a legal case.
- Analogical reasoning is an analytical process that allows for judgment on a case for which no instructions are found in the texts. It uses other similar cases for which a legal precedent is found.

## Observations

- Examination of the Koran, the Sunnah, the consensus of scholars, and analogical reasoning have demonstrated that no proof can be drawn to justify the obligatory or recommended nature of circumcision, any more than their application to its odious or illicit nature.
- This practice also is observed in animist regions and is justified by several cosmogonies.

## Recommendations from the Religious Leaders' Forum on the Link between Islam and Circumcision, Ségou 5-7 Nov. 2007

- The practice of circumcision is not an absolute obligation in Islam. Any Muslim woman, excised or not, can legitimately carry out her obligations to Islam.
- Given the various scientific data, particularly in medicine, that stipulate that circumcision can harm a woman's health, the Ulemas are open to learning about the consequences of the practice.

**Recommendations from the Religious Leaders' Forum on the Link between Islam and Circumcision, Ségou 5-7 Nov. 2007**

- Since Islam encourages all Muslims to be polite and respectful of others, the Ulemas urge their brothers to have constructive dialogue on the issue of circumcision.
- The Ulemas reaffirm their willingness to increase dialogue with other actors (state structures, civil society, and technical support and funding partners) about the issue of circumcision.

**Circumcision Is Subject to Debate**

- Circumcision is a debatable practice in Islam. "We have truly created man in the best of forms" Sura 95, Verse 4.
- Allah, the Most High, wants well-being for humans, not restriction: "Allah intends every facility for you; He does not want to put you to difficulties ..." Sura 2, Verse 185.

**Tragedies Related to Circumcision Experienced by Individuals and Families**

**Testimonies Given by Religious Women**

- Three deaths of young girls following hemorrhaging caused by circumcision have been reported at two neighboring communes in the Cercle de Kayes.
- A circumciser acknowledged having destroyed the sexuality of a young girl at marriage age by circumcision to satisfy the demands of her future co-wife, who wanted to prevent her husband from marrying the girl. She used these words to address the lecturer, a UNAFEM member: "Can I receive God's forgiveness after this act?"

**Testimonies Given by Religious Women**

- A little girl, the child of a religious association member, underwent three procedures performed by a circumciser who claimed that the initial procedures were unsuccessful.
- In addition to these testimonies from religious women, scores of cases of complications due to circumcision at the only Reference Health Center in Commune IV are reported in the book by Doctor Moustaphe Touré: *Qu'en est-il à l'intérieur du Pays ?* (What Is Going on Inside the Country?)

**Next Steps**

### What Can Religious Leaders Do?

- Promote political dialogue about circumcision between women and men
- Facilitate debates between religious leaders, including those who are opposed to FGC
- Promote dialogue between religious leaders and policy decisionmakers

### What Can Religious Leaders Do?

- Conduct advocacy on and political dialogue about circumcision with religious and community leaders
- Conduct information, education, and communication campaigns in communities
- Promote greater involvement of men, religious and community leaders, youth, and female elders in consciousness raising and discussion

### In Conclusion

- Circumcision is a major concern for society.
- The religious leader has an important role to play in raising awareness in communities.
- The religious leader also has a key role in promoting policy dialogue about circumcision.

“ Everyone among us is a shepherd, everyone will be asked to give an account of his activities over his herd. The Imam is a shepherd, and he will be asked to give explanation ...” Narrated by Bukhari.

**The Republic of Mali**  
**One People—One Goal—One Faith**

**Thank you for your attention!**

## APPENDIX B. KEY STAKEHOLDERS

1. Honorable Daouda Touré, former Malian Parliamentarian and consultant on the FGC elimination activity of the Health Policy Initiative
2. Dr. Lamine Boubacar Traoré, Socio-Anthropologist, Monitoring and Evaluation Program Analyst, UNFPA
3. Mme. Virginie Moukoro, Program Coordinator, Centre Djoliba
4. M. Jean de Dieu Dakouo, General Director, Centre Djoliba
5. Dr. Moustaphe Touré, Gynecologist, Referral Health Center Commune IV, Bamako
6. Mme. Assétou Kourouma, Organization Coordinator, UNAFEM
7. Mme. Mafouné Sangaré, Head of Administration, UNAFEM
8. M. Zeydi Dramé, President, RIPOD
9. M. Souleymane Keita, Member, RIPOD
10. El Hadj Thierno Hady Boubacar Thiam, former President of *Haut Conseil Islamique*, Mali
11. Mme. Assa Diallo, Editor-in-Chief, Africable
12. Mme. Mariam Fofana Diallo, FGC Program Coordinator, Population Services International
13. Mme. Josephine Traore Keita, Director, PNLE
14. Mr. Bob de Wolfe, Deputy Team Leader, USAID
15. Honorable Safiatou Traoré Touré, President, Commission for Health, Social Development and Solidarity, National Assembly
16. Mme. Fatoumata Touré Traoré, President, ASDAP (*Association De Soutien au Développement des Activités de Population*)
17. Hon. Fanta Manchini Diarra Sissoko, Deputy and Vice President, Mali National Assembly
18. Mme. Kadidia Aoudou Sidibé, President, AMSOPT
19. M. Abu Amel Camara, Program Coordinator, Tostan
20. Dr. Binta Keita, Chief, Division of Reproductive Health, Ministry of Health
21. Mr. Souleymane Dolo, Executive Director, Groupe Pivot Santé Population
22. Association Pour le Progrès et la Défense des Droits des Femmes Maliennes (APDF)
23. Plan International/Mali

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