ODI Literature Review

Social norms related to female genital mutilation/cutting (FGM/C) and behaviour change approaches to challenge FGM/C and child marriage in Mali

Summary of the literature review

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Cover: Bogolan is a traditional fabric from Mali. Bogolan means 'made with earth' and is a dyeing technique originating in Mali in the 12th century. Credit: Leonova Elena /Shutterstock.com.

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1 Introduction

This literature review was produced as a resource for the study on social norms related to Female Genital Mutilation/Cutting (FGM/C) and child marriage in the five Spotlight Initiative intervention zones in Mali (Kayes, Koulikoro, Sikasso, Ségou and District of Bamako). The Spotlight Initiative is an initiative of the United Nations (UN) system and the European Union, in partnership with the government and civil society of Mali, to contribute to the elimination of gender-based violence, harmful practices and barriers to accessing reproductive services. UNICEF is responsible for Pillar 3 on prevention of harmful practices and changing social norms.

Female Genital Mutilation (FGM) is defined by the World Health Organization (WHO) as all procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons (WHO, 2020). Some UN agencies use the term 'Female Genital Mutilation/Cutting' (FGM/C), wherein the additional term 'cutting' is intended to reflect the importance of using non-judgemental terminology with practising communities (WHO, 2008). The term 'cutting' is also preferred in some academic and organisational literature (e.g. Bellemare et al., 2015; Cetorelli et al., 2020; Diop et al., 2007). In countries where FGM/C is practised, it is referred to as circumcision (Smolak, 2014) or the French equivalent 'excision'. As such, this literature review describes the practice as FGM/C or excision, as it is referred to in Mali.

At least 200 million females across 30 countries in Africa, the Middle East and Asia were circumcised in 2016 (UNICEF Data, 2022a). In Africa alone, around 92 million females aged 10 years and older had undergone the practice by 2019 (Ameyaw et al., 2020). If current trends continue globally, it is estimated that 68 million girls are or will be at risk of FGM/C in the period between 2015 and 2030 (UNFPA and UNICEF, 2019). In Mali, nearly 8 million girls and women had undergone FGM/C by 2019 (UNICEF, 2022). Mali has one of the highest FGM/C prevalence rates in the world, at 89% for women aged 15 to 49 years in 2018 according to the Demographic and Health Survey (DHS) (DHS, 2018). Of the 19 countries in the UNICEF Female Genital Mutilation Global Database (2021), FGM/C prevalence rates among girls and women aged 15 to 49 years ranged from 99.2% in Somalia (2020) to no more than 1% in Uganda (2016) (UNICEF Data, 2022b). With its 89% rate, Mali ranks third in this list of 19 countries, behind Somalia and Guinea, and well above the sub-Saharan average of 35%.

This literature review brings together existing evidence on the drivers that explain the persistence of FGM/C, including the role of social norms, and the behaviour change programmes/approaches to challenge FGM/C and child marriage. This review does not explore the drivers of child marriage in Mali as these have been studied by another UNICEF study (Bicchieri et al., 2019) but looks instead at the interventions to challenge it. We focus on children and youth (aged 0 to 19) as they transition from childhood to adolescence and into adulthood. We paid particular attention to existing studies on our five regions of interest in Mali (Kayes, Koulikoro, Sikasso, Ségou and Bamako), but also on regional and global literature. The literature review informed the qualitative and quantitative primary research conducted by ODI and Plan International in Mali as part of the broader study which explores the following research questions:

- What factors and/or drivers perpetuate and/or favour the approval and/or persistence of – or challenge the continuation of – FGM/C?
- What social behaviour change materials/ interventions have been implemented in Mali and similar contexts to address harmful gender norms relevant to FGM/C and child marriage?
- What has worked and what has not worked to address harmful gender norms relevant to FGM/C and child marriage?

This review also assisted the next stage of this work programme which involved designing behavioural change tools to be used at the community, municipal, local and/or regional levels to shift social norms towards the abandonment of FGM/C and child marriage (see Leon-Himmelstine et al., 2022).

2 Overview and current trends of FGM/C in Mali

Mali has one of the highest FGM/C prevalence rates in the world. Data from 2018 showed that 89% of women aged 15 to 49 years old had undergone the practice (DHS, 2018). According to the DHS (2018), the type of FGM/C most widely practised in Mali (affecting 41% of women and girls aged 15 to 49 years) is type II or excision (this is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva). This is followed by type I (affecting 25% of women and girls aged 15–49), which is a clitoridectomy or a 'cut, no flesh removed' in the terminology of the DHS, and 8% who suffered infibulation (the seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans).

Although activism by Malian feminists to combat FGM/C started in the early 1960s, interventions to reduce FGM/C such as preventive and information campaigns only really began in the 1980s and increased in the 1990s and 2000s (Diabate and Mesplé-Somps, 2019). In the 1970s, national associations and non-governmental organisations (NGOs) recommended the practice be undertaken at health facilities, which contributed to the medicalisation of FGM/C (when FGM/C is performed by any category of healthcare provider). The objective at that time was to promote a more moderate FGM/C practice (type I) in a sterile environment to reduce health risks. The medicalisation of FGM/C is seen as an unintended outcome of anti-FGM/C campaigns, as Malians began to demand safer operations (Gosselin, 2000). Training sessions in Mali with traditional practitioners were also organised by national and international NGOs to improve health conditions and provide appropriate equipment (Diop et al., 2007). To date, Mali has no legal provisions nor legal sanctions against the medicalisation of FGM/C (28 Too Many, 2018; Orchid Project and 28 Too Many, 2022).

Table 1 summaries key indicators in relation to FGM/C in Mali from a variety of sources.

Table 1 FGM/C indicators in Mali

Indicator		Source
FGM/C prevalence	National 89%; Sikasso 96%; Koulikoro 96%; Kayes 95%; Ségou 92%; Bamako 91%; Mopti 82%; Tombouctou 50%.	DHS (2018)
	Prevalence is between 80% and 90% in the south, 50% in Tombouctou (the north-west), and less than 2% in the north-east.	Orchid Project and 28 Too Many (2022)
Number of girls and women (15–49 years) who have undergone FGM/C	7.9 million as of 2019.	UNICEF (2022)
FGM/C age	Most girls (76%) are cut before the age of 5.	DHS (2018)
	The precise age depends on the ethnic group and region. For example, in Sikasso, the share of girls cut by age is: 67% before the age of 5; 23% between 5 and 9 years; and 6% between 10 and 14 years. In Ségou: 77% before the age of 5; 15% between 5 and 9 years; and 3.5% between 10 and 14 years (DHS, 2018). In Bamako, FGM/C takes place after baptism, a week after birth.	DHS (2018); 28 Too Many (2020)
	FGM prevalence among girls increases substantially with age; 56% of girls under age 5 have undergone FGM/C compared to 86% of girls aged 10 to 14 years.	UNICEF (2022)
	There appears to be a slight trend towards earlier cutting in Mali, with adolescents (15–19 years) more likely than older women (45–49 years) to have experienced FGM/C before age 5 (82% and 70% respectively).	UNICEF (2022)
Attitudes	Three-quarters of women and men (75%) (aged 15–49) think that FGM/C should continue, compared to 18% of women and 13% of men who think it should not. Moreover, 81% of circumcised girls and women (15–49 years) think that FGM/C should continue, compared to 12% of non-circumcised girls and women (15–49 years).	DHS (2018)
	74% of adolescents aged 14–19 in the regions of Gao (Gounzoureye), Kayes (Kéniéba), Ségou (Niono), Sikasso (Koutiala), Mopti (Taga), and six communes of Bamako are unaware of the negative consequences of FGM/C and want to continue the practice. An even higher proportion of girls (85%) than boys (74%) were unaware of the consequences and wished it to continue.	Traoré et al. (2020)
	58% of girls who have been cut are daughters of mothers (aged 15–49) who oppose the practice, pointing to the mother's relatively limited ability to take decisions regarding this practice, as observed by other studies in Mali (Cappa et al., 2020; Diagne, 2008) and our qualitative findings. However, our analysis of the 2018 DHS data suggests that a mother's opinions have a bearing whether or not a girl is cut (see section 4.3, decision-makers).	UNICEF (2013)

Indicator		Source
How	Type I (clitoridectomy): cut, no flesh removed (25%)	DHS (2018)
	Type II (excision): cut, flesh removed (41%)	
	Type III (infibulation): sewn closed (8%)	
	Type not determined (26%).	
By whom	Traditional practitioners (traditional circumcisers or traditional birth attendants who are mostly females) perform most of the procedures (92%).	DHS (2018)
	However, in recent years, there has been an increase in the proportion of FGM/C carried out by healthcare providers (trained medical doctors, nurses and midwives).	Gosselin (2000); Konte (2007)
	Indeed, families are increasingly requesting that healthcare providers perform FGM/C, based on the belief that it would prevent health consequences for girls.	Doucet et al. (2017)
Where	The operation can take place in a toilet, in a room in the compound, in the shade of a large tree outside the village, or at a traditional practitioner's house. This last place appears to be the most common location (50%).	BERFAD (2020)
Decision-making process	The role of traditional FGM/C practitioner is assigned to post-menopausal women. The decision and preparations for the rituals are carried out by the paternal grandmother and/or aunt, because the child is perceived to belong to the father's family.	Konte (2007); Diagne (2008); Gosselin (2000)
Why	Girls and women aged 15–49 most frequently cite social acceptance (37%) as their reason for supporting the continuation of the practice, followed by religion (24%), and cleanliness/hygiene (22%).	UNICEF (2013)
	70% of women and 69% of men aged 15–49 report that FGM/C is a religious requirement.	DHS (2018)
Ethnicity	FGM/C is practised more among certain ethnic groups – it is much more common among the Bambara, Soninke, Malinke, Senufo and Fulani ethnic groups (more than 90% of girls) than among the Bobo (71%), the Sonraï (32%) and Touareg/Bélla (24%).	Diabate and Mesplé-Somps (2019); UNICEF (2022)
Education	Whether girls are circumcised or not does not differ according to the level of education of their mothers. 72% of girls (0–14 years) whose mothers are uneducated were circumcised compared to 71% of girls whose mothers studied secondary or higher education.	DHS (2018)
	However, women and girls (aged 15–49) with higher education (54%) are much more likely to report that FGM/C should be discontinued, compared to those with no education or primary education (15% and 17% respectively).	UNICEF (2022)
Economic status	Adolescent girls (15–19) in the poorest quintile of households (73%) support the continuation of FGM/C as much as girls from households in the richest quintile (70%).	Dalal et al. (2018) Dalal et al. (2018)
Urban vs rural location	The FGM/C rate is similar in cities and in rural areas, at 89.2% and 88.4% respectively.	Orchid Project and 28 Too Many (2022)

3 The Malian policy environment

Mali has ratified several international resolutions relevant to FGM/C. For example, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was ratified in 1985; the United Nations Convention on the Rights of the Child (UNCRC) was ratified in 1990; and the Maputo Protocol was ratified in 2005 (Cetorelli et al., 2020).

The Malian government department responsible for gender issues, including the elimination of FGM/C, is the Ministry for the Advancement of Women, Children and the Family (Ministère de la Promotion de la Femme, de l'Enfant et de la Famille, MPFEF). The coordination of work to eliminate FGM/C is the responsibility of both the National Action Committee for the Abandonment of Harmful Practices (Comité National d'Action pour l'Abandon des Pratiques Néfastes, CNAPN) to the health of women and children, and the National Programme for the Abandonment of Gender-Based Violence (Programme National pour l'Abandon des Violences Basées sur le Genre, PNVBG), created in 2019. The PNVBG replaces the previous National Programme for the Fight against Excision (Programme National de Lutte pour l'Abandon de l'Excision, PNLE), established in 2002. The PNVBG aims to prevent, coordinate, monitor and evaluate all government actions around gender-based violence (GBV), including FGM/C as well as the continuation of goals set by the PNLE to combat FGM/C (Ministère de l'Economie et des Finances, 2019).

The Ministry for the Advancement of Women, Children and Families also developed a holistic national communication strategy on gender-based violence for 2018–2027, which includes the issue of FGM/C (CEDAW, 2019). The most recent National Action Plan adopted by the Malian government to address FGM/C covers the period 2015–2019 (28 Too Many, 2018).

Despite FGM/C being included in the National Action Plan, Mali still has no specific national law that bans FGM/C and no provisions against its medicalisation (28 Too Many, 2018). Circular No. 99-00197, issued in 1999 by the Minister of Health, the Elderly and Solidarity, contained an administrative instruction to hospital directors that prohibits FGM/C in health facilities; however, it does not contain sanctions in the event of non-compliance and does not have the power of a law that has passed through parliament (28 Too Many, 2018). There have been many attempts to ban FGM/C and government departments and NGOs have tried to introduce various draft laws, but these have failed to be agreed and passed through parliament (ibid.). This failure has also been driven by objections from various groups including high-profile religious leaders, and others in positions of authority such as doctors, members of the judiciary and the police (ibid.). As a result, FGM/C persists in Mali.

In April 2021, the NGO EqualityNow and the Institute for Human Rights and Development in Africa (IHRDA),[1] together with two local organisations, filed a case against the Government of Mali in the Economic Community of West African States' court of justice in Abuja, Nigeria, to challenge Mali's failure to prohibit FGM/C by adopting a legal and policy framework that would

1 The case was filed on 6 April 2021 by the Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT) and the Association pour le Progrès et la Défense des Droits des Femmes Maliennes (APDF), represented by IHRDA and Equality Now (IHRDA, 2021).

criminalise the practice (IHRDA, 2021). This case has not yet been heard by the court at the time this report was written, but IHRDA said the case 'had the potential to establish a landmark in women's and girls' rights jurisprudence in Africa' (Bhalla, 2021).

4 Drivers and factors explaining the persistence of FGM/C in Mali

The drivers and factors that explain the persistence of FGM/C in Mali are related to gender norms and attitudes; beliefs around hygiene, aesthetics and health; religion and symbolic systems; and stigma. Whether educational level is a factor behind the persistence is also explored. Table 2 summarises these drivers.

Table 2 Evidence on drivers of FGM/C in Mali

Driver/factor	Evidence in the Malian context
Education	Whether girls are circumcised or not does not differ according to the level of education of their mothers (DHS, 2018). Daughters of women with primary or higher education still experienced FGM/C (Hayford et al., 2020). Nevertheless, the DHS (2018) indicates that the more education a person has, the more likely he or she is to think that FGM/C should not continue: 25% of women with secondary or higher education compared to 14% of women with no education considered FGM/C should not continue. Among men, 17% of those with secondary school or higher education compared to 9% with no education thought it should not continue.
Hygiene, aesthetics and health related factors	Some evidence indicates parents requesting that FGM/C be performed on their daughters at health facilities to prevent risks of accidents or future health problems related to the practice. Some evidence shows that from a hygienic and aesthetic point of view, some in Mali consider that the external female genitalia are perceived as dirty and ugly (Diop et al., 2007). In other cases, FGM/C is regarded as protective against HIV infection because it is believed to help women resist 'illicit' sexual acts (see below gender norms). However, there is no evidence that FGM/C protects women from HIV infection, or that it leads to a decrease in risky sexual behaviour (Smolak, 2014).
Gender norms, beliefs and expectations	The reasons why FGM/C persists in Mali differ according to the available literature but explanations include the following: • alignment to social norms around the value of culture and tradition (BERFAD, 2020) • as a rite of passage (from a girl to a mature woman, from a prepubescent to an accomplished woman) and initiation (Diallo, 1997; 1999) • social acceptance to conform to social norms around marriageability, purity as well as belonging to the household of their in-laws (Diop et al., 2007) • beliefs around premarital sex and pregnancy (Gosselin, 2000) • marriageability and links to understanding the roles of wives and mothers (Desrumaux and Ballo, 2014; Diop et al., 2007) • to reduce the sexual desire of women, to keep wives faithful to their husbands and to have a good sexual relationship (BERFAD, 2020).

Driver/factor	Evidence in the Malian context
Gender norms, beliefs and expectations (continued)	Regarding the ritual around FGM/C, the period of retreat (isolating the young initiates from two weeks to three months) and the initiatory songs have practically disappeared from usage (Diallo, 1999). The ritual has also turned from a collective celebration to an individualised and medicalised practice, particularly in urban areas, partly due to the declining age of FGM/C (ibid.). In rural areas, ceremonies are maintained but simplified to the point that the seclusion period is disappearing in many locations (Diallo, 1997). However, an alternative form of celebration emerged, consisting of bringing together girls circumcised at different times and in different villages to organise ceremonies that were postponed after the procedure with the purpose of minimising costs (Diallo, 1997). Nowadays, most youths seem still to approve the rite of passage around FGM/C; 55% of adolescents (aged 14–19) in the study by Traoré et al. (2020) indicated their wish to safeguard the practice of initiation rites.
Stigma	FGM/C is practised to avoid ridicule or rejection by the community or by future in-laws (BERFAD, 2020; Diop et al., 2007; Konte, 2007). Some evidence suggests that an uncircumcised woman might be stigmatised as *bilakoro* or 'uncircumcised', which carries connotations of being immature, irresponsible, weak, generally unworthy, and sometimes also of being dirty and oversexed (Gosselin, 2000). In another study, an uncircumcised girl could be considered as 'immature, childish, impure, dirty, unlucky, unfaithful and without social consideration' (Plan International, 2004: 26).
Religion and symbolic systems	Among the Mande ethnic group, FGM/C is not only a puberty ritual but connected with a purified version of Islam (Gosselin, 2000). However, imams in the same study indicated that FGM/C was not mandatory and only recommended. Religion and other beliefs explain its persistence among certain ethnic groups including in relation to fertility, survival of future offspring, or purification (Diop et al., 2007). A survey (BERFAD, 2020) covering 30 villages across Kayes, Diéma and Yélimané districts found that 49% of respondents considered religion as the main reason to continue the practice. Participants of the same study indicated that the prayers of an uncut woman are not accepted because she is 'unclean', and in society she is criticised and frowned upon by peers.

5 Decision-makers and the role of other key stakeholders shaping FGM/C in Mali

Sources of decision-making power around when and if FGM/C is carried out must be considered for interventions to be successful (Johansen et al., 2013). The decision to cut a girl is rarely taken by an individual; instead, it is taken collectively, and a wide variety of actors influence the decision. It is essential to understand that due to age and gender hierarchies, individuals have widely divergent degrees of decision-making capacity in relation to their own bodies or those of the girls in their family, or the authority to influence others in their community. Table 3 below summarises findings on different decision-makers and stakeholders in Mali, including their attitudes and their decision-making capacity and authority.

Table 3 Decision-makers and the role of other key stakeholders shaping FGM/C in Mali

Decision-makers / key stakeholders shaping FGM/C	Evidence on attitudes	Evidence on decision-making capacity and authority
Grandmothers	Grandmothers are generally in favour of FGM/C as they want to protect their granddaughters against the consequences of not respecting tradition (BERFAD, 2020).	Female elders (or grandmothers) play key roles as ultimate decision-makers and influencers as the child is perceived to be part of the paternal lineage – rather than the maternal lineage. Grandmothers are in the highest position in the family and community hierarchy when it comes to making decisions about children's and women's health (Diagne, 2008; Gosselin, 2000; Konte, 2007).
Mothers (women of reproductive age)	Women who reported having undergone FGM/C in the West African region (including Mali) are more likely to be in favour of FGM/C (Bellemare et al., 2015; Tokinndang and Diallo, 1997).	FGM/C is more prevalent among daughters whose mothers want the practice to continue, even if their fathers are opposed or undecided (Cappa et al., 2020). This suggests that, in the context of this example, mothers have more decision-making influence than fathers.
Female adolescents and young women	Young women aged 15–19 mostly agreed (73%) that FGM/C should continue (Dalal et al., 2018; DHS, 2018).	Based on a wide review of anthropological accounts, female adolescents are rarely influencers, decision-makers or performers of FGM/C (Newman and 28 Too Many, 2019).
Male members of the community	Younger generations of men seem less supportive of FGM/C (BERFAD, 2020; DHS, 2018).	Fathers and other male family members are becoming increasingly relevant, and in some cases play a dominant role, both in favour of and against the practice (Cappa et al., 2020). In one study, educated men in positions of power were the most vocal against the practice (Gosselin, 2000).

Decision-makers / key stakeholders shaping FGM/C	Evidence on attitudes	Evidence on decision-making capacity and authority
Chiefs and religious leaders	Religious leaders in Mali have a wide range of views on FGM/C. Some religious leaders have spoken out at national level in favour of the practice, as a marker of Muslim identity and an act of resistance against Western cultural and political influence (Amselle, 2018). The survey conducted by BERFAD (2020) in Kayes, Diéma and Yélimané including village chiefs and traditional leaders found that 75% of them were not in favour of passing a law to end FGM/C. Qualitative findings of the same study found that some village chiefs agreed with the continuation of FGM/C as a religious requirement. However, other evidence from Koulikoro, Sikasso, Ségou and Kayes suggests that some religious leaders do not consider FGM/C a religious requirement and are important stakeholders when persuading local communities (Diagne et al., 2008).	Religious leaders (male or female) have a strong role as influencers, as they can adhere to or distance themselves from beliefs that FGM/C is a religious requirement (Newman and 28 Too Many, 2019). In some villages, it has been observed that the chief and religious leaders decided about the timing of the cutting and informed the circumciser (Diagne et al., 2008). BERFAD (2020) indicated that some participants mentioned that they practise FGM/C as recommended by their religious leaders.
Healthcare providers	Some evidence suggests that some health professionals think that FGM/C is safe if done in a health facility and that FGM/C keeps the sexuality of girls and women under control (Diop et al., 2007). However, male providers seemed slightly more open to change practices in relation to FGM/C than female providers (ibid.).	Health professionals do not play a role as decision-makers, but they may play a role as influencers, both in favour of or against the practice, since they are generally respected members of the community (Diop et al., 2007).
Traditional cutters	Some traditional cutters believe that if they refuse to practise their function, they will receive punishment from the ancestors (Plan International, 2014).	Traditional cutters do not have a role as decision-makers, but they are performers of FGM/C and may have a role as influencers, due to their position in Malian society. Although they are considered inferior to other castes in Malian society, they are believed to possess mystical powers and they inspire fear and caution (Donahoe, 2016). Almost all women are cut by a woman of this caste (Konte, 2007).
Return migrants	Adults living in localities with return migrants are shown to be more informed about FGM/C and in favour of legislation (Diabate and Mesplé-Somps, 2019).	Some evidence suggests that return migrants can have a significant influence on convincing locals to abandon their FGM/C practices (Diabate and Mesplé-Somps, 2019).

6 The linkages between FGM/C and child marriage

Evidence suggests that too often discussion about the links between FGM/C and child marriage is over-simplified, by presenting these practices chiefly in terms of a transition from childhood into adulthood, when the two distinct phenomena have many different causes and drivers.

There is, however, evidence showing that the two practices share some of the same drivers, including:

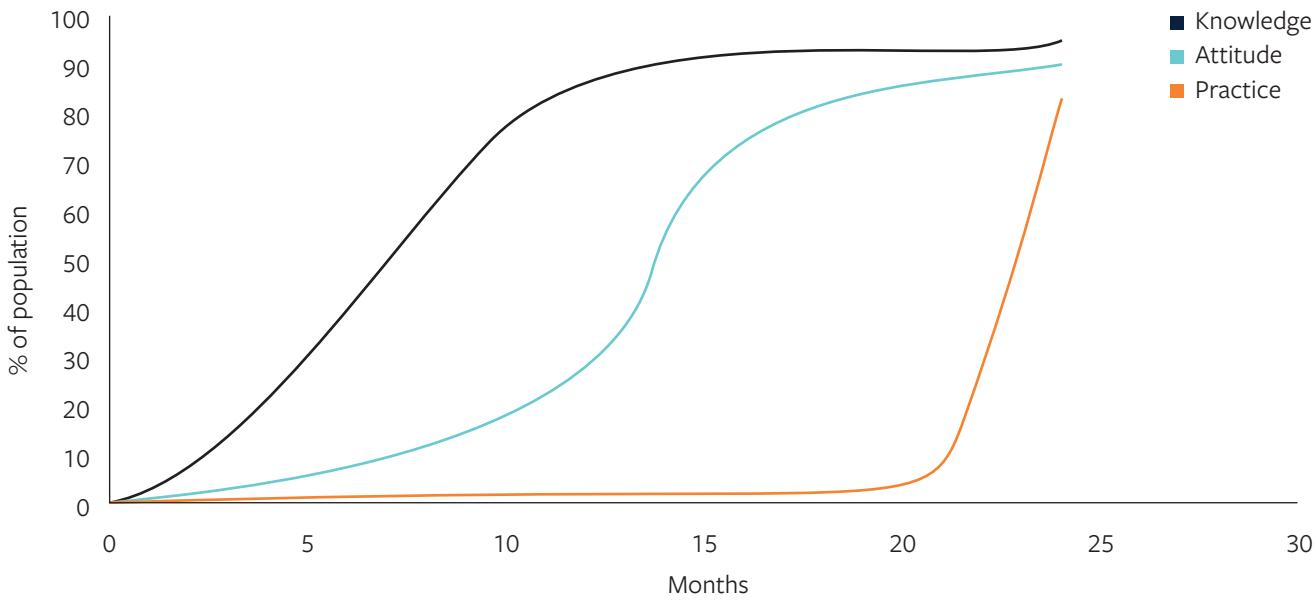
- families' wishes to secure a stable future for daughters through marriage
- fears about adolescent pregnancy
- understandings of female sexuality
- the importance of girls' virginity, including from a religious perspective.

The implications of these findings are that, while it is important to avoid conflating FGM/C and child marriage, or over-simplifying their respective causes, there are, however, common points of entry that may contribute to reducing the prevalence of both practices. This could be approaches that address the socioeconomic drivers behind child marriage; address gaps in sexual and reproductive health education and services; or engage religious leaders in reinterpretation of religious texts to demonstrate the lack of religious justification behind both practices. Similarly, unintended negative impacts of programming on FGM/C and child marriage should be considered, namely the stigmatisation and marginalisation of girls and women who are impacted by changing social norms in their community.

7 Behaviour change approaches to challenge FGM/C and child marriage

A key element of developing a behaviour change strategy is understanding the temporal interaction between the various stages of a community gaining knowledge, shifting attitudes and changing practices (known as KAP). As Figure 1 shows, changes in practice come much later in the timeline than gains in knowledge and shifts in attitudes, highlighting the importance of sustained communication and dissemination of knowledge required to influence attitudes until a community reaches a crucial 'tipping point'.

Figure 1 Stages of knowledge, attitudes and practice (KAP)



Source: UNFPA (2020)

7.1 Approaches to challenge and/or eliminate FGM/C

This section presents findings of evaluations of programmes that aim to reduce or eliminate the practice of FGM/C. It focuses on seven interventions implemented in Mali (12 are in the full report) with some complementary insights from other contexts within the West African and sub-Saharan African regions. Table 5 provides further details of the interventions.

The interventions reviewed used a range of indicators to try to identify evidence of shifts in knowledge, attitudes and practices related to FGM/C in the target population. Notably, just three studies of interventions provided comparative data on prevalence of the practice before and after implementation. Prevalence is the strongest indicator of behaviour change. Table 4 outlines the indicators of change used by each intervention.

Table 4 Indicators of change used for FGM/C programmes

Indicator/measure	Target group	Studies/evaluations
Prevalence (measured by community member reporting on full or partial prevalence, or perception of prevalence in the community, i.e. high, medium, low)	Community as a whole, girls, women, traditional circumcisers, health practitioners	Diagne (2008); Rainbo (2005); Desrumaux and Ballo (2014)
Public declaration of abandonment, sometimes including signed letter	District mayor, village chief, traditional leaders, religious leaders, community as a whole	Desrumaux and Ballo (2014); Nielssen and Coulibaly (2014); Diagne (2008)
FGM/C openly discussed and therefore no longer regarded as taboo	Community as a whole	Diagne (2008); Nielssen and Coulibaly (2014); NCA (2009)
FGM/C no longer viewed as a religious requirement	Community as a whole, religious leaders	Diagne (2008); Nielssen and Coulibaly (2014); NCA (2009)
Intention to have daughters circumcised	Men, women, youth, village leaders	Diop (2004); PMC (2010); UNICEF Mali (2020a)
Beliefs and attitudes: for example, 'female circumcision is dangerous for the health of the girl/woman'	All community members, including traditional circumcisers and health practitioners	PMC (2010); Easton (2002) in Diop and Askew (2006); Diagne (2008); Population Council and CNRST (1998)
Reported demand for FGM/C	Traditional circumcisers or health practitioners	Diagne (2008)
Community organising, including monitoring of adherence to declarations, monitoring of births	Community organisers (committee members, community mobilisers, ex-circumcisers, volunteers, women's groups), wider community	Diagne (2008); Nielssen and Coulibaly (2014)
Dissemination of information to communities not directly involved in intervention	Members of other communities (women, men, youth, village leaders)	Easton (2002) in Diop and Askew (2006); Monkman et al. (2007); Diagne (2008)
Reported stigma (e.g. of uncircumcised girls, individuals working to stop the practice etc.)	Circumcisers, uncut girls and women, cut girls and women, programme volunteers and staff	Diagne (2008)

7.1.1 Some key features of the FGM/C strategies and learning from other contexts

All of the anti-FGM/C strategies reviewed in the study framed activities around one or more of the following:

- health – the negative impacts of FGM/C
- human rights – women's rights and children's rights
- religion – addressing the religious justifications for FGM/C.

Successful or promising interventions engaged a range of stakeholders, including:

- community leaders (village chiefs and other traditional leaders)
- religious leaders
- women and existing women's groups
- service providers, including healthcare providers
- former circumcisers
- children and school-age adolescents.

Activities included:

- training and capacity-building of key actors, including community 'champions'
- education and sensitisation of key groups
- community discussions/dialogue between social groups
- committees and community-led monitoring and reporting
- intergenerational dialogue
- use of radio and other social media for community mobilisation and sensitisation
- public declarations.

Lessons from other comparable contexts included:

- The importance of strengthening intergenerational communication, community cohesion and increasing community capacities to take collective action.
- Developing a process around participatory communication and education methods to involve grandmothers and other community elders to promote dialogue and problem-solving.
- Involving religious leaders and teachers in programme activities focused on intergenerational dialogue, cultural and religious identity.

Table 5 Summary of FGM/C interventions implemented in Mali

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Diagne (2008) Centre Djoliba Programme Population Council and Save the Children Sweden Funder: Population Council and Save the Children Sweden	Koulikoro, Sikasso, Ségou and Kayes Village chiefs, religious leaders, traditional circumcisers, women, men, youth, children, women's groups	The evaluation does not specify the duration of implementation. Centre Djoliba had been using this approach since 2004 and appears still to be doing so. IEC tools, theatre, community mobilisers, community discussion, slow progressive approach for dissemination of knowledge, health and child rights framework.	Recruiting and training community mobilisers (including children and youth). Awareness-raising/sensitisation activities on harmful effects of FGM/C (childbirth, infertility, risks of contracting HIV) placing emphasis on children's rights to good health, physical integrity and protection from violence, sexual and reproductive health and rights (SRHR), child marriage. Local radio used to mobilise population. Development of relationships and dialogue between circumcised and uncircumcised women and girls of the community to share experiences Training and supporting organisation of ex-circumcisers to sensitise and monitor community.	Slow progressive approach used to avoid causing backlash. Access of key groups in community to complete, exhaustive information campaign about harmful effects of FGM/C reinforced by hearing experiences of circumcised and uncircumcised women, girls (and their partners). Deconstruction of *raison d'être* of the practice (religious justification, link to mysticism, link to fertility, male sexual pleasure).	FGM/C no longer a taboo subject and talk of abandonment discussed openly in villages. Involvement of Muslim leaders in anti-FGM/C movement after establishing that circumcision is not a requirement of Islamic scripture. Improved knowledge of the harmful effects of circumcision among community members. Total abandonment or sharp decline in practice of FGM/C in almost all villages targeted. All categories of community members report that the practice is in decline. In villages where abandonment is widespread, villagers have set up ad hoc committees for monitoring adherence to declaration of abandonment. FGM/C services no longer being solicited in certain villages (reported by traditional circumcisers). Study / evaluation: Diagne (2008)

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Desrumaux and Ballo (2014) Protéger la prochaine génération: promouvoir l'abandon des mutilations génitales féminines dans le district sanitaire de Kayes au Mali Equilibres & Populations and AMSOPT Funder: unclear	Kayes district Implemented in 99 villages. All members of community targeted: women, men, youth, village leaders.	New villages are integrated into project in phases, phase one started 2006, evaluation took place in 2013 in third phase. Unclear if still being implemented. Facilitated community dialogue. Public declarations of abandoning the practice reported via local and national media to show other communities that social change is possible.	Pilot project: One facilitator per 10 villages, community discussions on topics of: health, including sexual and reproductive health, human rights, harmful traditional practices, gender roles. Recruitment and training of four community mobilisers per village (two women, two men). Collaboration with local committees set up by PNLE (CLAPN). Strengthening healthcare response to FGM/C in Kayes.	Behaviour change strategy (pp.53–54): • Promotion of behaviour change through a non-directive and non-coercive approach, based on Thomas Schelling's theory of social convention; the choice made by a family to carry out FGM/C is interdependent on the practices of other families. Organised dissemination of change among communities linked by marital ties. • An integrated framework of women's health and human rights at core of education and sensitisation activities. The higher the status of women in the community, the stronger and more longer lasting the decision to abandon will be. • Political mobilisation and strengthened collaboration between actors (PNLE, committees of health and social actors, NGOs). • Involvement of migrants from relevant villages in Mali now living in France to help influence attitudes and behaviours.	99 of the 250 villages in the district of Kayes declared abandonment of the practice (signed letter). Of which: 61 considered to have fully abandoned the practice 19 considered to have partially abandoned the practice 14 moving towards abandonment 6 villages resistant, village chiefs refuse to be involved, similarly to most men and women in community. Study / evaluation: Desrumaux and Ballo (2014)

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Nielssen and Coulibaly (2014) Development programme of the region of Mopti (PDRM-MELM) The Evangelical Lutheran Mission in Mali in cooperation with the Norwegian Missionary Society (NMS) Funder: unclear	Mali: Mopti and Konna, 30 villages Women's groups, religious leaders, traditional circumcisers, men, women, school teachers, members of municipal council.	2009–2015 Training, sensitisation and mobilisation of key actors to break taboos. Accompanied by women's economic empowerment activities.	Participative approach: emphasis on local initiatives, mobilisation, participation and ownership at all levels. Sensitisation activities, training and capacity-building of local actors (committee members, municipal council, school teachers, voluntary animators, circumcisers). Mobilisation of village leaders, religious leaders, existing women's organisations in movement against FGM/C. Large events organised for mobilisation and sensitisation (football cup, film performances, public meetings).	Three-fold strategy: combines sensitisation and training at ground level with structures developed by PNLE and stimulation of social and economic development of communities.	Established a local discourse on FGM/C (no longer a taboo topic). Led two-thirds of communities involved to officially declare their abandonment of FGM/C with a signed declaration. All circumcisers claim they no longer practise in their village and instead are active members of anti-FGM/C groups. The leading imam in Konna explained to the team how he had gathered all the imams in his area in a workshop, where they together had studied the Koran and other holy scriptures in order to discuss the relationship between Islam and FGM/C; the meeting concluded that FGM/C is not a religious obligation. Study / evaluation: Nielssen and Coulibaly (2014)

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Rainbo (2005) Norwegian Church Aid FGM/C Programme APAF/Muso Dambe; Centre Djoliba; Pose Ton Couteau; Musewjigi; Médecins du Monde Funder: NORAD	Mali, Kenya, Ethiopia, Eritrea In Mali: Ségou, Bamako, Koulikoro, Kita, Kayes, Mopti	Three-year FGM/C Programme (2001–2004) Mainly focused on awareness-raising and transfer of information. Health consequences approach; human rights approach regarded as unsuitable for the Malian context.	Theatre and film followed by community discussion, local radio broadcasts, school interventions, training of medical practitioners, engagement of religious leaders to address and disprove the religious justification of the practice.	No objectives or outcome indicators were developed for the programme or individual projects. The link between the activities and the overall programme objective was remote and based on assumptions. It was assumed that the passing on of information would result in behavioural change.	Of the 59 villages where Norwegian Church Aid partner Centre Djoliba is working, 21 have not practised circumcision since 2000. Families such as that of a Nousamma patriarch in Mali have decided not to circumcise their girls and have maintained that for the last two years. Increased knowledge on female physiology and the health consequences of FGM/C. Decreased use of health facilities for FGM/C. Qualitative evidence that community members have started to question the religious justification for the practice. Study / evaluation: Rainbo (2005)

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Norwegian Church Aid GBV Programme in Mali (2009) Bamako: Réseau Malien de Lutte Contre les MGF; Pose ton couteau; WILDAF/Mali Segou: APAF/Muso Dambe Mopti: Médecins du Monde Gao: GREFFA Funder: NORAD	Mali: Bamako, Ségou, Mopti, Gao Religious leaders, male and female community members, municipal councillors	Three-year GBV programme as part of five-year plan (2005–2009) Awareness-raising, engaging leaders to address and disprove religious justification.	Organising and training: of religious leaders on relationship between Islam and excision; of municipal councillors on reproductive health and FGM/C; of peer educators; of radio presenters; of women's groups and circumcisers. Distribution of texts: Cairo fatwa; Additional Protocol of Maputo. Theatre presentations including anti-FGM/C topics; radio broadcasts; creation/ distribution of CDs on FGM/C and fistula. Creation of support group (11 members) and development of a framework for dialogue between mayor and support group. Meeting of mayors of municipalities and neighbourhood communities to raise awareness. Drafting of a convention against FGM/C in municipality of Moribila and Kassorola.	Strategic framework (FGM/C and early marriage): Inform people who can influence decisions in the area of FGM/C and early marriage, such as parents, men in general, community and religious leaders. Work for a reduced social acceptance of harmful traditional practices through advocacy and to develop a national legal framework in compliance with conventions ratified by Mali (CEDAW, UNCRC and Additional Protocol of Maputo).	Greater involvement of religious leaders in the fight against excision and more leaders who understand and accept that FGM/C is not a requirement of Islam. Declaration of Ségou on FGM/C by religious leaders. Greater interest among community members in understanding the relationship between Islam and FGM/C. Greater awareness in community about the harm of excision. In intervention zones, excision is no longer a taboo topic. Study / evaluation: NCA (2009)

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
UNICEF Mali (2020a) Spotlight Initiative GBV Programme in Mali – Promotion of norms and protective social values against all forms of GBV against girls and women including harmful traditional practices UNICEF and NGO TAGNE Funder: Spotlight Initiative	142 villages in Kolokani, region of Koulikoro May 2020 – April 2021	May 2020 – July 2021 Promotion of gender equality and positive social norms and behaviours through sensitisation and community dialogue.	Sessions for teachers and students on norms, attitudes and behaviours linked to gender equality. Identification and training of community focal points/ facilitators, half of whom were men and young men, and half women and young women. Strengthening capacities of journalists on dissemination of information on GBV, harmful traditional practices, women's and child rights, sexual and reproductive health (SRH), and positive social norms. Traditional communicators were also engaged on these issues, to strengthen their capacity to disseminate these messages, including religious leaders.	Community advocacy platforms are established or strengthened to promote norms, attitudes and behaviours favourable to gender equality, reproductive rights for women and girls, positive masculinity, strengthening of confidence and self-esteem. Decision-makers from relevant non-state institutions and leaders. Opinion leaders are better equipped to advocate for the implementation of the legislation and policies to end violence against women / GBV / harmful practices and to promote SRH rights of women and girls.	15 girls aged 5 to 9 were not circumcised due to the intervention. There were no cases of child marriage during the intervention period. Community facilitators sensitised families and village authorities, creating an environment open to change. Intergenerational dialogue took place between young people and village leaders. Study / evaluation: UNICEF Mali (2020a)

Author, year, name, implementers and funder	Target groups/ areas	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
UNICEF Mali (2020b) Spotlight Initiative GBV programme – Promotion of community approaches to the prevention and transformation of social norms linked to FGM/C, child marriage and other forms of GBV APSEF (L'Association pour la promotion des droits et le bien-être de la famille) Funder: Spotlight Initiative	102 villages in Kati and 21 areas in District of Bamako Men, women, youth	May 2020 – July 2021 Promotion of gender equality and positive social norms, attitudes, and behaviours at the community level and advocacy for FGM/C and SRHR legislation.	Radio programmes Strengthening capacities of focal points on GBV, SRHR, positive masculinity, school for model husbands, clubs for model husbands and future model husbands, positive femininity, to make them agents for change. Workshops run on SRH, human rights with a focus on child rights, harmful traditional practices, and the concept of gender.	Theory of change (from 2019 Mali Country Programme Document) IF multiple strategies such as community mobilisation, engagement of key stakeholders and education strategies are carried out in an integrated, coordinated manner, based on a common understanding and approach consistent with international standard and evidence on prevention of GBV, including harmful traditional practices and promotion of SRHR of women and girls, THEN positive social norms, attitudes and behaviours will be promoted at community and individual level, BECAUSE multi-faceted prevention initiatives that are mutually reinforcing can effectively change individual and sociocultural norms, including those affecting women's sexuality and reproduction.	Evidence of individual shifts in attitudes on other topics related to gender equality but continued silence on child marriage and circumcision in group discussions. Study / evaluation: UNICEF Mali (2020b)

7.2 Approaches to challenge and/or eliminate child marriage

This section presents findings from evaluations of programmes that aim to reduce or eliminate the practice of child marriage. It focuses on five interventions in Mali (six are in the full report), with some complementary insights from other contexts within the West African and sub-Saharan African regions. Table 6 provides more detailed information about the interventions.

7.2.1 Some key features of child marriage strategies and learning from other contexts

The six child marriage programmes were framed by one or more of the following thematic areas:

- education and empowerment of girls (Diarra et al., 2019; Melnikas et al., 2019)
- GBV and the application of anti-GBV law, and children's rights to be protected from violence (Care Mali, 2017; Monkman, 2007; IFRC, 2019; UNICEF, 2020a; 2020b)
- girls' and women's sexual and reproductive health (Care Mali, 2017; Melnikas et al., 2019; UNICEF Mali, 2020a; 2020b)
- promotion of gender equality (all six programmes included this theme).
- Most of the programmes framed awareness-raising activities around the harmful effects of child marriage, including on girls' health, and community responsibility to protect children and their rights to be protected from all forms of violence.

All six programmes targeted a range of stakeholders with activities, including village chiefs, community leaders, religious leaders, women including mothers, men including fathers, youth/students, and teachers.

- The Spotlight Initiative (UNICEF, 2020a; 2020b) also targeted journalists (with training), radio stations, and healthcare providers.
- The TEMPS programme (Care Mali, 2017) targeted staff in social promotion centres (CPS) with training.
- A number of programmes engaged relevant government ministries at the local and national level with sensitisation, capacity-building and advocacy activities (Care Mali, 2017; IFRC, 2019; Melnikas et al., 2019).

Activity types included:

- community sensitisation
- facilitating dialogue
- engaging men and boys
- public declarations
- training a range of key stakeholders
- income-generation activities

7.3 Wider learnings for both FGM/C and child marriage

Design and implementation recommendations included the following:

- Programmes should be based on formative research to ensure framing, content, activities and target groups are relevant to a specific context.
- Communities should take part in programme design as well as monitoring to create community ownership which can also affect sustainability of change.

- Effective coordination and collaboration between organisations (NGOs, CSOs, government) working on reducing child marriage is important in order to avoid mixed messaging, among other things.
- Long-term engagement of more than one to two years is critical in order to achieve change.

Learning from other contexts

- Also critical are intergenerational dialogue and education, as well as targeting of religious leaders and engaging men and boys.

Table 6 Summary of child marriage interventions implemented in Mali

Author, year, name, implementers and funder	Target groups	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Care Mali (2017) TEMPS - Travaillons ensemble contre les mariages précoces Care Mali, Care Benin/Togo and the Government of Canada Funder: Care Mali and the Government of Canada	Mali and Benin Mali: eight areas in regions of Mopti and Tombouctou Community leaders, 'protectors of tradition', religious leaders, women, men, students, teachers, social promotion centres Also worked with government: Ministries of Women, Children, and the Family; Health; Education	Community awareness-raising about the harms of child marriage; rehabilitation of survivors of child marriage; advocacy for application of laws that guarantee rights of the child.	2.5-year programme (March 2015 –September 2017) Mass awareness-raising and advocacy activities through radio, film, documentary, comic book and music video on harms of child marriage; community dialogues, group sessions, training and mobilisation of community mobilisers/ focal points (to influence social norms and promote healthy masculinity); development of community action plans and prevention committees; organised exchange of learning and best practices between communities; training of teachers to facilitate student clubs on gender, GBV, SRHR, community theatre, art etc.; student clubs; capacity-building for social promotion centres (CPS) to support survivors; economic support, education and training for survivors.	Promotion of gender equality, improved understanding of the harms of child marriage among community leaders, men, women and children to develop attitudes in favour of preventing child marriage and protect children's rights in their community.	These various activities have significantly improved beneficiaries' knowledge of the harms of child marriage and have laid the groundwork for prevention. Challenges still remain – raising legal age of marriage and psychosocial care for survivors. Number of child marriages prevented not measured. Improved knowledge of child protection, child rights (socioeconomic, health and education) among women's groups. Improved understanding of relevant laws and texts on the rights and protections of girls, gender and child marriage among civil society organisations (CSOs). Improved CSO capacity to apply anti-GBV law and child rights law. Study / evaluation: Care Mali (2017)

Author, year, name, implementers and funder	Target groups	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Diarra et al. (2019) Lutter contre les mariages précoces par l'autonomisation des filles en Afrique de l'Ouest, Mali, Niger, Togo WILDAF-AO and CRDI (Centre de Récherches pour le Développement International, and the Canadian Government) Funder: Canadian Government	Mali, Niger, Togo Mali: Kayes region, N'Di and Nioro du Sahel	Girls' empowerment and advocacy with key stakeholders	Three-year programme (2016–2019) Education/training of groups of girls and boys identified for intervention to increase knowledge of child marriage and to develop skills necessary to fight against child marriage (how to sensitise, advocate, influence) Trained youth take part in sensitisation and advocacy activities such as community discussions, intergenerational dialogues, meetings with local authorities and religious leaders WILDAF advocacy with same stakeholders WILDAF provided assistance to families: legal assistance, support finding SRH services, and directing them to NGOs working on economic activities	Theory of change: Empower girls with education about their rights and child marriage, and training in communication, advocacy and debating skills to sensitise and influence their (male and female) peers, families, communities and local authorities, and advocate against child marriage. Sensitise community and regional leaders and traditional and religious leaders. This will create an environment where a decline in child marriage is possible, and families, community members and local authorities will decide to stop practising child marriage.	Qualitative data provided Increased knowledge of the negative impacts of child marriage, human rights, gender, GBV among girls and boys. Shifts in relationships between boys and girls – collaborative dynamic developed. Improved relationships between youth and community elders. Change in attitudes towards child marriage among community members and traditional and religious leaders, local authorities, police. Perceived prevalence of the practice measured among community members (medium), unclear what it was at baseline (very high, high, medium, low, very low). Study / evaluation: Diarra et al. (2019)

Author, year, name, implementers and funder	Target groups	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
Monkman et al. (2007); Girls Not Brides and Tostan (2017) Tostan Community Empowerment Programme (CEP) Government of Mali, Project Muso, Sini Sanuman, NORAD, UNFPA Funder: Unclear	Mali, Mauritania, Guinea, Guinea-Bissau	30-month, participant-centred human rights education programme	Three-year programme currently under way; six-month pilot implemented in 2000 Two classes of 24–30 participants (one for adults and one for adolescents) three times a week. Participant-centred sessions. Curriculum includes: creating a shared vision for the future of the community; implications and meaning of human rights to survival, education, being free from violence, marrying the person of one's choice, and children's rights; responsibilities of the community to ensure rights are respected; critical thinking, research skills, and problem-solving skills to address issues in own communities (such as child marriage or FGM/C). Training of Community Management Committees (CMCs): 17 democratically selected community members, 9 of whom must be women. Training includes Child Protection Module and focuses on building capacity to address harmful norms and practices, and to intervene in cases on child abuse.	Tostan CEP: Kobi phase: 'Prepare field for planting' – discussion of human rights, promotion of positive traditions and practices. Aawde phase: 'to plant the seed' – training on project management and income-generating activities. Community Management Committees responsible for implementing development programme designed by the community. Organised dissemination to help spread information through connected communities, or social networks.	Increase in percentage of participants who knew their human rights: 20% to 63% Number of participants in Tostan villages who could name at least two harmful consequences of child marriage: 90%, compared with 37% in non-participant villages Increase in percentage of community members who felt it would be unreasonable to stop sending a girl to school at any age: from 60% to 78% Increase in shared parent decision-making, as opposed to one parent alone, as to whether children would be given away for marriage: from 3% to 29% Study / evaluation: Monkman et al. (2007); Girls Not Brides and Tostan (2017).

Author, year, name, implementers and funder	Target groups	Tool or intervention	Description	Behaviour change theory	Reported outcomes (knowledge, beliefs, attitudes, behaviour, etc.) Studies and evaluations
UNICEF Mali (2020a; 2020b) Spotlight Initiative GBV Programme in Mali – Promotion of norms and protective social values against all forms of GBV against girls and women including harmful traditional practices UNICEF Mali, TAGNE (Koulikoro) and APSEF (Kati and Bamako) Funder: Spotlight Initiative	With TAGNE NGO: 142 villages in Kolokani (Koulikoro) With APSEF: 102 villages in Kati and 21 areas of District of Bamako Community mobilisers (men, women, youth); students; teachers; village leaders; religious leaders, healthcare providers, journalists	Sensitisation of community via community mobilisers on prevention of GBV and the rights of women and girls including SRHR GRAAP method used by APSEF	This project May 2020–2021; broader SI project 2018–2022 School-based interventions, curriculum includes: promotion of norms, attitudes and behaviours linked to gender equality; how to exercise their rights, including SRHR; risks of GBV linked to Covid-19 and prevention strategies. Identification of community mobilisers/change agents (adults and youth, 50:50 male–female) and training on prevention of GBV and existing cases of GBV in their communities. Community mobilisers carried out sensitisation activities (group and individual sessions) with their families, village leaders and religious leaders, promoting attitude and behaviour change, and creating a protective environment for women and girls (promoting their rights). Training of journalists on communication of information on GBV, harmful traditional practices, the rights of women and girls, and positive social norms. Partnerships set up with local radio stations, and radio programmes broadcast (Kati and Bamako). Partnerships set up with healthcare providers (Kati and Bamako).	Theory of change (from 2019 Mali Country Programme Document): IF multiple strategies such as community mobilisation, engagement of key stakeholders and education strategies are carried out in an integrated and coordinated manner, based on a common understanding and approach consistent with international standards and evidence on prevention of GBV, including harmful traditional practices, and promotion of SRHR of women and girls, THEN positive social norms, attitudes and behaviours will be promoted at community and individual level, BECAUSE multi-faceted prevention initiatives that are mutually reinforcing can effectively change individual and sociocultural norms, including those affecting women's sexuality and reproduction.	Zero cases of child marriage reported in implementation period (May–July 2020) Cancellation of a marriage (14-year-old girl) reported by a community mobiliser. Study / evaluations : UNICEF Mali (2020a; 2020b)

8 Gaps and recommendations for further research

8.1 Drivers and factors explaining the persistence of FGM/C in Mali

A key gap in the literature is the lack of qualitative studies. Most studies on the drivers of FGM/C in Mali and the West Africa region (for example, Ameyaw et al., 2020; Bellemare et al., 2020) have used quantitative methods. These studies are useful for describing trends and prevalence (Bellemare et al., 2020; Cetorelli et al., 2020) and drawing correlations between certain demographic factors such as education, wealth or religion (Dalal et al., 2019) and the practice. However, quantitative studies do not explain causal pathways, and context-specific relationships between drivers and decision-making processes within households and communities, which lead to trends in prevalence. One exception to the dominance of quantitative approaches is BERFAD (2020), which explored the drivers of FGM/C using mixed methods and noted some of the perceptions around FGM/C among youths and adults. Furthermore, we identified gaps and further research questions on the following topics.

Perceptions of adolescent girls

One of the main gaps in the literature on social norms and FGM/C in Mali concerns adolescent girls and young women, as the focus has been on women in general. Looking at the qualitative studies, a few of them include young women in their sample (such as Gosselin (2000), with women over 15 and older; Konte (2007) with a few women in their 20s) but these did not disaggregate the findings between older and younger women. The mixed methods study of BERFAD (2020), which surveyed and interviewed adolescent girls aged 10 to 15 years old, found that 44% of their sample expressed being against FGM/C, but more insights about their perceptions and the challenges they may face if they are not in favour of the practice are unknown. In contrast, DHS data (2018) suggests that a majority of adolescent girls aged 15 to 19 support the practice, but there is a gap related to the drivers of such perceptions. Dalal et al. (2019) also identified linkages between the sociodemographic characteristics (for instance, levels of education, economic status) of adolescent girls (aged 15 to 19) and their support for the continuation of FGM/C, but the study did not collect qualitative data to explain such linkages.

Appropriate qualitative studies among adolescent girls exploring the reasons for such support could lead to more effective and targeted interventions to eradicate FGM/C.

The role of grandmothers, mothers and other women of reproductive age

The existing evidence suggests that grandmothers play important roles as decision-makers, influencers and executors of FGM/C. However, there is a gap in the literature regarding the discussions and negotiations around FGM/C that take place in the household, and regarding how and if these are initiated by grandmothers. More research on grandmothers' views and authority within families and communities is crucial to understand the important role that they play in driving FGM/C decisions. Similarly, the role of mothers and other women of reproductive

age, such as co-wives, aunts or other maternal family members, is unclear. The authority of older women relative to men in their household also merits more investigation. The literature also suggests that most mothers are in favour of continuing FGM/C due to social norms and to avoid stigma. However, whether they can voice their opinion and their role in the decision-making process is unclear.

Involvement of male relatives and members of the community

There is some evidence that male family members play an important role as influencers either in favour of or against FGM/C (Cappa et al., 2020), but their involvement in family decision-making is unclear. Also, the attitudes of male relatives may differ according to age, other characteristics such as education or their position in the household, which need to be explored in more depth. It is unclear whether the attitudes of young men may be shifting, particularly with regard to whether and how they still expect a potential wife to be circumcised, and other expectations that they may have of their female partners.

Role models

Some evidence suggests that return migrants play an important part as role models, influencing the decision around not circumcising a young girl (Diabate and Mesplé-Somps, 2019). Similarly, other existing studies have found that men with higher levels of formal education seem to be more against the practice (Gosselin, 2000). Improved understanding of which members of the community are respected and wield authority, and are more likely to support abandonment of FGM/C, can better inform potential interventions to reduce FGM/C.

Social norms

Although there is some evidence on the role of social norms as drivers of FGM/C, these need to be explored in more depth. The evidence suggests that social norms around marriageability and purity play an important role. But norms are fluid over space and time and further research on the specific roles of social and gender norms in specific contexts is needed. Furthermore, social norms around being accepted by the husband's family and the community are mentioned in some Mali literature but little is known on how these norms are experienced, what are the clear expectations that families and society have of women in relation to men, and what exact sanctions stem from not conforming. Indeed, a few studies (Diop et al., 2007) suggest that a few women have not been cut and have managed to continue being part of their households and communities. Further research is needed about what is different about them, what factors played a role in them being still accepted or further stigmatised in their communities and their perceptions.

Religion

Although the DHS (2018) suggests that a majority of men and women consider that FGM/C is a religious requirement, it is unclear what the precise role of religion is and what the perceptions are of individuals belonging to different denominations beyond Islam who may associate the practice with other beliefs or symbolic systems. Moreover, there is very limited literature (for example, Gosselin, 2000) on the perceptions of religious leaders regarding FGM/C and whether they consider it a religious requirement or not.

Covid-19

Evidence from West and East Africa suggests that Covid-19 is leading to increased incidence of FGM/C. However, whether Covid-19 is increasing or decreasing FGM/C in Mali is unknown, as are the factors in the lives of women and girls that can lead to different outcomes. Understanding the effects of Covid-19 on child marriage in the country is another topic that needs further research.

8.2 Behaviour change approaches to challenge FGM/C and child marriage

Engaging male community members

Studies reported challenges in engaging men in intervention activities (Desrumaux and Ballo, 2014; Nielssen and Coulibaly, 2014) and high levels of drop-out among men who began participating (Easton, 2002, in Diop and Askew, 2006). Evaluations of interventions that reported successfully engaging men in programme activities provide limited information on the extent to which this impacted programme outcomes. The Population Media Center (2009) found that their radio programme influenced male attitudes towards FGM/C in terms of the percentage of male listeners who said they would not circumcise their daughters, and who regarded FGM/C as a health risk to women and girls and as a practice that needs to stop. Male understanding, beliefs and expectations relating to female sexuality and marriage appear to be key factors in their support for or against both FGM/C and child marriage. The literature shows that male household heads can be important decision-makers and influencers; however, more insight is needed into how behaviour change strategies targeted at men help to influence change. It is also important to consider that interventions seeking to shift male attitudes towards FGM/C by encouraging men to marry uncircumcised women can lead to the stigmatisation and marginalisation of circumcised women and girls.

Engaging female elders, including grandmothers and mothers

It is unclear whether grandmothers and older women are involved in programme activities. The age of participants in women's groups is rarely provided and where the age of female participants is given by studies, the interventions in question have targeted younger women in the 15–49 age range (Easton, 2002 in Diop and Askew, 2006). Analysis of the decision-making dynamics and influencers in the Malian context identifies older women as important figures, often in ensuring the continuation of the practice, and they often have greater influence over whether a girl will be circumcised than her parents. More insight is therefore needed into the impact that programme activities targeted at older women would have on collective behaviour change.

Sustained behaviour change

Evidence of sustained behaviour change over a long-term period represents a significant gap in the literature. There are concerns that shifts in attitudes and reductions in the prevalence of FGM/C or child marriage are dependent on the continuation of programme activities over several years, and is undermined by short-term programming lasting two years or less. Similarly, criticisms have been raised that public community declarations to abandon practices are made for the benefit of NGOs rather than being representative of community intentions. It is crucial to understand which programmes have led to, or catalysed a process leading to, long-term behaviour change, and which have seen communities revert once the NGO departs.

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