

‘A cut woman is the pride of all her relatives’: a situation analysis of female genital mutilation in Mali

Executive Summary

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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.

Executive summary

Reducing the prevalence of female genital mutilation (FGM) is a major global challenge. While awareness of the physical and mental health consequences of FGM has increased, the practice persists, for reasons that vary between regions and over time. Understanding context, including the role of decision-makers and other influencers, as well as the factors that drive or hinder FGM is key to designing effective interventions to eliminate the practice.

This study offers a situation analysis of FGM in Mali, where 89% of females aged 15 to 49 years old have undergone FGM and where support for the practice is widespread. In 2018, just 17% of females favoured discontinuing the practice compared to 13% of men (DHS, 2018). The practice is conducted with differing levels of severity: in 2018, 25% of circumcised females had undergone Type 1 (clitoridectomy, where a small part of the clitoris is cut); 41% of this group underwent Type 2 (ablation, or removal of the whole clitoris); and 8% underwent Type 3 (infibulation).¹

The study describes trends in FGM in Mali and the factors that lead FGM to persist or to be abandoned. It focuses on six study sites of interventions run by the EU-funded Spotlight Initiative² and UNFPA-UNICEF Joint Programme: Kayes (Yelimane), Koulikoro (Kolokani and Dioila), Sikasso (Sikasso), Segou (Bla) and the District of Bamako (Commune VI). The study also identifies and explores the attitudes and role of the main

stakeholders who decide upon and/or shape attitudes towards the practice, and examines programming strategies and approaches to challenging FGM in the study sites.

This study uses two methodologies: i) a *quantitative analysis* illustrating trends in Demographic Health Survey (DHS) data from 2001 onward, coupled with multivariate analysis of the 2018 microdata; and ii) a *qualitative analysis* based on interactions with 92 respondents across the six study sites. The quantitative analysis used regression models to identify how key outcomes relating to education, employment, and sexual and reproductive health differ for women who have undergone FGM compared with those who have not; the factors that predict whether a young girl aged 0 to 4 years will be cut; and characteristics that are associated with opposition to FGM. Qualitative tools included in-depth interviews (IDIs), focus group discussions (FGDs), inter-generational trios (IGTs) or family case studies and key informant interviews (KIIs). As well as capturing the perspectives of adolescent girls and boys, the data collection sought to explore the views of other key stakeholders such as elders, parents, religious and community leaders, traditional circumcisers and health providers. Our analysis also draws on a literature review conducted for this study (Leon-Himmelstine et al., 2022a), which explores the drivers of FGM, the policy and legal landscape and interventions that have been implemented in Mali, reporting on their

¹ For the remaining 26% of females, the type was not known or not reported.

² The Spotlight Initiative is a global, multi-year partnership between the European Union and the United Nations that seeks to eliminate all forms of violence against women. Mali has received funding, in partnership with the government and civil society, aimed at contributing to the elimination of gender-based violence, harmful practices and barriers to accessing reproductive services.

effectiveness where results are available. Findings from this report have assisted the next stage of this work programme which involved designing behavioural change tools to shift social norms towards abandoning FGM and child marriage

(see Leon-Himmelstine et al., 2022b). They also contributed to the design and development of a baseline survey aiming to measure social norms related to FGM and child marriage across the intervention sites.

Findings

Legal and policy landscape

Mali has no specific national law banning FGM nor any provisions against its medicalisation. Circular No. 99-00197, issued in 1999 by the Minister of Health, the Elderly and Solidarity, contained an administrative instruction to hospital directors prohibiting FGM in health facilities. In July 2017, a draft law to address gender-based violence (including a ban on FGM) was presented to the Ministry for the Advancement of Women, Children and the Family by the National Programme for the Fight against Excision (PNLE) with support from international partners. However, high-profile religious leaders who favoured the practice voiced objections and have prevented the law from being passed. In April 2021, the NGO EqualityNow and the Institute for Human Rights and Development in Africa (IHRDA), together with two other local organisations, filed a case against the Government of Mali in the Economic Community of West African States' (ECOWAS) court of justice in Abuja, Nigeria, to challenge Mali's failure to prohibit FGM by adopting a legal and policy framework that would criminalise the practice. This case had yet to be heard by the court at the time this report was written.

Overview, trends and perceptions of female genital mutilation

Overview and trends in FGM

FGM rates have remained uniformly high in Mali since 2001: the prevalence was estimated at 92% of women aged 15 to 49 years in 2001 and at 89% in 2018 (DHS, 2018). There is some evidence of decreasing severity over the two-decade period – namely an increase in Type 1 excision and a decline

in Type 2 excision. However, non-response to questions about FGM is high, social desirability may condition responses and the phrasing of these questions across DHS surveys has improved, all of which may induce measurement errors. The main differences are between survey waves: the FGM rate differs only slightly across five-year age groups over time, suggesting substantial continuity in the practice.

Analysing 2018 DHS data, we found that FGM has only a weak or non-statistically significant impact on a woman's years of education, whether she undertakes paid work, child mortality, her age at marriage and number of sexual partners. The only robust effect we identified is that being cut positively predicts whether a woman will agree it is ever justifiable for a husband to beat his wife. It appears that women who are cut may be more accepting of violence against women in their later lives, possibly due to tighter gender norms.

Perceptions and knowledge of FGM

In all locations, participants in the qualitative research agreed that FGM was practised to some degree in their respective communities, corroborating DHS data suggesting substantial continuity in the practice. Participants noted that nowadays girls are cut at a much younger age than their mothers or grandmothers were (from around a few days after birth (2 to 40 days) to three months after birth); this was also supported by quantitative analysis. Regarding the type of cutting, the descriptions of girls in Sikasso, Bamako and Dioila indicate their communities practise Type 1 cutting, corroborating the quantitative analysis that points to an increase in Type 1 from 2001 (2% of circumcised women) to 2018 (25% of circumcised

women). In Segou and Kayes, girls indicated that the community practises Type 2. Cutting is often undertaken by traditional cutters, however cutters from other ethnicities (participants did not mention which ones), with no knowledge or experience, have become popular in recent times. Some participants also noted the recent role of health workers performing the practice (especially in Bamako). Most respondents observed that no ceremony takes place during FGM as it is conducted individually, or as observed by key informants, '*in secret*' owing to increased awareness of its negative consequences or a perception that FGM is illegal. Most respondents observed that talking about FGM remains taboo, although information about the practice circulates regularly through different channels (e.g. close female relatives, community discussions, interventions to address FGM, radio).

Our quantitative findings suggest that region matters to girls' cutting status. Girls are much less likely to be cut in all regions except for Kayes, while in the DHS sample, not a single girl aged 0 to 4 was cut in Gao or Kidal (predominantly populated by the Tuareg, who have not, historically, practised FGM). Respondents in Bamako are much less likely (17 percentage points) to report having daughters who are cut than those living elsewhere, though residing in an urban or rural zone itself was not a meaningful predictor. Participants in the qualitative research shared significantly contrasting perceptions regarding the persistence of FGM in their respective regions and locations. This could reflect some social desirability bias, conflicting opinions or indeed, nuanced geographic difference.

Those who indicated that FGM has reduced or is no longer practised in their respective communities attributed the change to the past 5 to 10 years, mainly due to awareness-raising activities and approaches challenging the practice.

Decision-makers and other stakeholders shaping FGM and attitudes towards the practice

Participants across sites (apart from Sikasso) shared that those who support, advise and take decisions regarding FGM are the 'older women' or female elders, particularly paternal grandmothers. This is because the child is perceived to belong to the paternal (rather than maternal) lineage and paternal grandmothers occupy the highest position in the hierarchy when it comes to making decisions about children and women's health. However, grandmothers shared differing perceptions: some favoured the practice, while others opposed it.

The FGM decision is not taken in isolation: a wide variety of actors influence and/or support the grandmother as decision-maker. Our own analysis of the 2018 DHS data suggests that mothers' FGM status is hugely important: if the mother is cut, the daughter is 37 to 51 percentage points more likely to be cut herself. Moreover, girls of mothers who report opposition to the practice are much less likely to be cut (by about 20 percentage points). However, the DHS survey does not provide information on who takes decisions regarding FGM nor on the attitudes of others within the household or extended family – factors that the qualitative work suggests may take precedence.

Our participants suggested that mothers have limited authority regarding FGM. Mothers are supposed to 'naturally agree' with the 'old women' (usually their mothers-in-law). Participants across sites observed that even if mothers opposed FGM, they would need to respect their husband's and in-laws' decision. As with grandmothers, several mothers indicated that they did not want the practice to continue, while others supported

the practice. Young women in our sample confirmed that they have no say in the decision, which is the preserve of their grandmothers.

Most men across the study locations considered that FGM is ‘a women’s issue’, noting that paternal grandmothers and aunts are the main decision-makers, with some also mentioning mothers. Sikasso is the only location where respondents (including grandmothers) indicated that ‘excision is men’s business’, with older men holding decision-making authority over cutting, as heads of households. Most adolescent boys indicated that they did not wish FGM to continue due to its negative health consequences, but equally, that they would not challenge any decisions in its favour because these were taken by their elders, whom they should respect.

Some participants in our study, particularly males, observed that although religious leaders are not decision-makers they can exert an important influence on the views of the community regarding FGM. In turn, the religious leaders in our qualitative study held mixed attitudes, including Imams. Participants of different ages and gender across study locations perceived healthcare workers as influencers, due to the information and health knowledge they possess, with the ability to persuade families and community leaders (imams, elders) to abandon FGM. Our findings suggest that healthcare staff can also perform FGM, as noted by some mothers who indicated having taken their daughters to a health facility to undergo the procedure. Traditional cutters (all female in our sample) do not act as decision-makers, but they are performers and may have a role as influencers, due to their position in Malian society. Former traditional cutters in our sample indicated financial motives for those who perform the practice. In addition, they may also receive desirable items such as soaps, cereals, shea butter or loincloths.

What factors enable or hinder the persistence of FGM?

Drivers and factors leading to the persistence of FGM

Social norms, beliefs and expectations: Our analysis of 2018 DHS data affirms the importance of social norms, given that peer effects – in this case, the share of girls who are cut and live in the same community as the respondent – is one of the strongest predictors of whether a young girl will herself be cut. Every 10% increase in the prevalence of FGM among girls aged 0 to 9 in a region or urban/rural area is associated with an increase of about 8 percentage points in the likelihood that a girl aged 0 to 4 years is also cut. As mentioned, whether the mother herself is cut is also hugely important, as is whether or not she opposes FGM. However, the share of the population opposed to FGM in a community is not a meaningful predictor. It could be that respondents are understating their opposition to FGM (e.g. social desirability bias) or alternatively that attitudes, on average, are not decisive – it is the attitudes of ‘key decision-makers’ that count.

The qualitative findings also highlight the importance of social norms and collective expectations. Participants across study sites highlighted that one important cultural meaning attributed to FGM is the importance of preserving culture and tradition relating to collective identity. Although FGM is performed on girls from a very young age, some participants in our study associated FGM with rites of passage and initiation. Adolescent girls pointed to an uncut girl as being not completely a girl nor a boy, but someone in between; while boys indicated that an unexcised girl would be referred to as *bogotigui*, meaning a girl who is not yet a woman. Another norm that drives FGM in Mali is a desire for

social acceptance. Several participants observed that FGM is done because all members of the community practise it, and if a family goes against the norm they will be questioned. Norms around premarital sex, faithfulness and good sexual relationships were also noted by respondents. For example, some indicated that a high sexual desire was problematic because it could lead to early sexual activity and early or unwanted pregnancies. Others had the impression that the reduction of sexual desire was aligned too with norms around faithfulness and having good sexual relationships. Participants also highlighted the relationship between FGM and norms around marriageability, with the perception that FGM improves girls' marriage prospects.

If honour, pride, acceptance, belonging, well-being and security are the rewards for conforming to the social norms described above, stigma is the price that people pay for not conforming, as observed by study participants. A non-excised girl can be laughed at, pointed out, marginalised and excluded. Our study participants indicated that uncut girls and women can face stigma from peers, family members and other women in the community, including co-wives and mothers-in-law. Other key factors that may help to explain the persistence of (and in some cases, increases in) FGM were the following:

Ethnicity: Our quantitative analysis shows that girls aged from birth to four years among the Sarakole/ Soninke/ Marka ethnic groups are more likely to be cut, though that effect dissipates nearly entirely once peer effects are included in our modelling. Similarly, study participants observed that the Malinke, the Baman, the Peulh and the Bambara ethnic groups in Bamako are more likely to support FGM. In contrast, participants who identified themselves as Minianka observed that their ethnic group did not practise it.

Age: Several participants in all regions observed that older people (women and men) tend to support the continuation of FGM because they are the 'guardians of traditional practices' and consider FGM a 'duty that must be carried on'. Our DHS analysis, in contrast, found no strong link between age and opposition to FGM.

Education and wealth: Adolescents in Segou and Bamako suggested that more educated people are more likely to understand the harmful consequences of FGM. However, our DHS analysis found that education is only very weakly associated with FGM incidence, suggesting that additional years within the current educational system are unlikely to bring about meaningful reductions in the practice. Though household wealth is also positively associated with the likelihood of being cut, the relationship is weak.

Perceptions regarding health and childbirth: Some study participants observed that FGM has health benefits. Some girls and women reported that FGM brings good health and protects girls and women from a variety of illnesses and health issues such as 'internal wounds', stomach aches and menstrual pain. Other participants noted that FGM was important to ease childbirth. Our analysis of DHS data found that FGM predicted child mortality, but only negligibly. There is no data in the DHS about maternal death and FGM, so this study did not analyse this relationship.

Religion and symbolic representations: Our study participants, males and females, observed that FGM was important from a religious point of view because it purified the girl, including her soul. The clitoris is believed to be an 'evil organ' (*kéré*) that needs to be removed so the girl is no longer 'impure'. In our DHS analysis, Muslims were much more likely to report support for the practice than adherents to other religions.

Drivers and factors supporting the elimination of FGM

Our analysis of 2018 DHS data suggests that respondents who are female and older are more likely to oppose the practice, as are those with additional years of education (although this latter relationship, as indicated, is weak). For example, women are, on average, 7 percentage points more likely to report that FGM should stop and older people, on average, are slightly more likely to report that FGM should stop. Muslims are much less likely to oppose the practice than respondents with other religions. Neither wealth, rural-urban residence, region nor ethnicity show statistically significant relationships, once peer effects – defined as the share of people around the respondent who oppose FGM – are included in the modelling.

Our qualitative fieldwork adds some nuance to these trends. For example, it uncovered mixed evidence across sites regarding whether women or men are more likely to challenge FGM. Moreover, while our DHS analysis found no strong link between age and opposition to FGM, our informants held a general perception that young people (by which some indicated that they meant people under 30) are more likely to support the elimination of FGM due to increased awareness of its negative health effects. Other factors mentioned by participants included:

Returnee migrants: In Kolokani and Kayes, respondents observed that returnee migrants play an important role in making people aware of the harmful consequences of FGM, as they learn from ‘outside’ the community about the negative consequences of FGM and raise awareness upon their return.

Awareness of health consequences: Several respondents across sites indicated that excision

should be abandoned due to its negative health consequences and dangers. There is also considerable knowledge of the health effects caused by FGM.

Practice against religious beliefs: Some participants indicated that FGM was not related to religion, and others, that it was condemned by their religion. Our quantitative findings revealed a potential paradox – while a mother’s religion had no bearing on the likelihood of her young daughter being cut, it was strongly associated with whether or not she was likely to report opposition to the practice. It may be that communal norms trump individual attitudes in determining whether a young girl is cut, again underlining the need for a focus on norms.

Marriageability: A few respondents explicitly indicated that being uncut does not affect marriageability.

Programming strategies and approaches to challenge FGM

Approaches and programmes to challenge FGM in study sites

The six implementing partners of the Spotlight Initiative and UNFPA-UNICEF Joint Programme in the study locations are Tostan (Dioila), MPDL (Kayes), ASSAFE (Segou), APSEF (Bamako, Tagne (Kolokani) and CAEB (Sikasso). FGM activities and related services (e.g. health, education, gender-based violence) are delivered through a multisectoral / stakeholder approach involving NGO staff, local government (health and education staff), local radio stations, and local and religious leaders. Funding of activities is mainly through UN agencies such as UNICEF and UNFPA, but the government (particularly the Ministry for the Promotion of Women, Children,

and the Family) is crucial in providing technical assistance and accessing communities. According to study key informants, NGOs employ multiple interventions to provide information and raise awareness. These include trainings; debates and conversations (with testimonies of traditional cutters or women affected by FGM, health staff, religious leaders); audiovisuals such as laminated photos, drawings or diagrams; public declarations (particularly used by Tostan); intergenerational dialogues; training of trainers; role models; drafting and distributing pitches for religious leaders; social media (Facebook); booklets to explain FGM at school; and the arts (theatre play, poems, dancing, songs, screening of films and sketches).

Effectiveness of interventions to challenge FGM in study sites

According to participants, conversations were helpful to raise awareness of the consequences of FGM, to reduce stigma and to improve communication between generations. Other participants mentioned the utility of disseminating information (at health centres, community events, schools) to raise awareness of the health consequences of the practice or its lack of connection to religion. Public declarations were an approach particularly mentioned in Dioila where the NGO Tostan was active. There were contrasting perceptions regarding the success of Tostan's interventions to challenge FGM in Dioila. In the case of public awareness-raising initiatives recalled by participants, these included radio, film screenings, theatre plays and pictures displaying the consequences of FGM. There is mixed evidence regarding the effectiveness of these other approaches. While some participants observed that they had gained knowledge and awareness, this does not necessarily translate into changes in practice.

Approaches and interventions that can help to change attitudes and behaviours from a community perspective

Participants considered the best approaches to challenge FGM should be those that:

- engage with communities continuously and build long-term relationships with them
- engage all community stakeholders (e.g., community members, state services, local governments, traditional authorities, religious leaders) to facilitate access and buy-in
- are designed and agreed by community members
- engage role models or local influencers to share information
- take into account the role of authority and respect (with parents and elders at the top)
- understand the importance of preserving culture and ancestral practices.

Conclusions and recommendations

In Mali, most girls – and indeed, fully 89% of all girls and women aged 15 to 49 – have undergone FGM. This finding is echoed among participants in our qualitative work – nearly all girls in our sample had undergone FGM – but the practice has evolved over the years. Most girls are now cut a few days or months after birth, compared to their mothers or grandmothers who were cut at ages ranging from eight years old till after puberty. In our analysis of DHS data by region, Segou stood out as having the largest reduction in FGM prevalence since 2001, whereas the other regions saw only limited reductions. Qualitative data from specific sites adds nuance to this finding. Participants in Dioila reported that FGM has reduced in prevalence in the past 5 to 10 years, whereas in contrast, in Kayes and Sikasso, participants observed that it is practised by nearly all community members. In

Segou, Kolokani and Bamako participants noted that the practice persists, but held mixed views as to whether it had reduced or not in recent years. It may be that regional trends mask more nuanced differences at lower geographic levels.

Our qualitative research shows that the main decision-maker regarding whether a girl undergoes FGM is the paternal grandmother. For a mother to challenge her mother-in-law's decision regarding her granddaughter's FGM would be disrespectful and would send the message that the child does not belong to the father's household. Our analysis of national DHS 2018 data is possibly at odds with this finding, suggesting that the mother's attitude towards the continuation of FGM was an important predictor of whether her daughter is circumcised. However, the DHS does not provide information on who takes decisions regarding FGM nor on the attitudes of others within the household or extended family; it could be that mothers' attitudes are correlated with those of decision-makers (grandmothers) who are also shifting their attitudes regarding FGM. Adolescent girls, we observed, are not decision-makers and held mixed attitudes regarding the continuation of the practice.

Our research highlights the importance of social and gender norms in shaping decisions around FGM (e.g. norms around social acceptance, premarital sex, faithfulness and good sexual relationships or around marriageability). Our DHS 2018 analysis singles out one important component – peer effects, notably the share of young girls in a community who are cut.

The study also identified drivers supporting the elimination of FGM. There was a general

perception that young people are more likely to support the elimination of FGM and some adolescents considered the practice 'archaic' or 'old-fashioned', although our analysis of 2018 DHS data found no association between age and support for FGM. Indeed, the only measurable effect was among women, with older women appearing slightly more likely to oppose FGM than younger women. Our analysis also suggested that men are less likely to oppose FGM than women.

Our evidence of factors that support or challenge decisions around FGM have important implications for FGM programming. We found that the decision whether or not to cut a girl is highly influenced by social norms that appear to take precedence over individual attitudes. Thus, rather than focusing on knowledge, attitudes and practices of individuals or clusters of groups (e.g. adolescent girls, men and boys), it is important to focus on shifting collective norms based on community systems. Our findings also suggest that the various stages of a community gaining knowledge, shifting attitudes and changing practices (KAP theory) is not necessarily linear. It seems plausible that changes in collective social norms (rather than individual knowledge and attitudes) lead to shifts in practices or behaviour. Furthermore, these norms are enforced by influential community actors and family members. It follows that particular attention needs to be paid to those who yield decision-making power to enforce a norm – in the case of FGM in Mali, the parental grandmothers and to some extent the mothers.

Based on these findings, policymaking and programming priorities should include the following actions.

Measuring change and tracking performance

- Develop and operationalise MERL (monitoring, evaluation, research, learning) systems which are appropriately human and financially resourced and involve an assessment during all stages of an intervention.
- MERL systems should involve mixed methods studies. Combining qualitative and quantitative research can show whether and why knowledge, attitudes and practices around FGM are changing, as the processes can be slow. These systems should consider that the outcomes of some initiatives may only be visible years later or after more consistent, long-term support for the abandonment of FGM.
- Studies need to be conducted at least during baseline and endline, collecting data on KAP indicators, and taking into account adaptive planning and programming. Understanding which programmes have led to, or catalysed long-term behavioural change and which have seen reversion is crucial.
- Gender norm change takes time. This means strategies need to include long-term interventions with programming horizons which engage different stakeholder groups in a succession of activities and reinforce messages through different channels.
- Community participation is key to achieve buy-in and steady change. Involve communities at every stage, from the start of a situation analysis to the design of an intervention, including in the sharing of progress, challenges and adaptation of activities, among other stages. This can help not only to gain support, but also to inspire others to change their attitudes or practices once others in the community have done so. Accountability to communities is important to validate data, to

involve community members in decision-making processes around social norms change, and to avoid community distrust of implementers. Sharing the findings of MERL systems and further studies can support accountability processes. It is also important to support feedback mechanisms from community members to adapt activities, approaches and programming.

- Initiatives need to take into account stakeholders at all levels including grandmothers, local authorities, and district and government departments working on FGM topics. Also, the involvement of different sectors (health, education) can ensure holistic interventions that lead to sustainable change.

Address gender norms through context-specific approaches

- Design approaches that address harmful social norms. Social norms are context-specific, even varying at site level. Implementers should pay attention to these and understand the drivers of, and benefits and sanctions associated with FGM to design effective programming.
- Identify the main context-specific decision-makers and reference groups relevant to FGM and involve them respectfully and at each stage, as reaching these will be crucial to change gender norms and practices. In our study sites, the main decision-makers were grandmothers. Interventions therefore need to involve grandmothers in intervention design, implementation and follow-up.
- Identify influencers, community and government authorities as key stakeholders to work with in efforts to eliminate FGM. Work with these stakeholders as key allies in promoting new norms.

Design features to consider for programming/approaches to challenge FGM

- Work with a wide range of community members rather than focusing on individuals or particular groups as a strategy to create ownership and ensure that all community members are involved in the process of abandoning FGM.
- Work with key individuals and role models in the community who are inspiring, have the skills to transmit knowledge and can push for change. In the context of our study sites, grandmothers can identify other grandmothers who can lead on implementing approaches with proper training and support from partners.
- It is desirable to build up trust and dialogue within peer groups based on age and gender primarily, with a view to obtaining consensus within those groups, before moving to inter-peer group / intergenerational / community-level dialogues.
- Highlight the positive aspects of culture, tradition, customs and religious beliefs that characterise communities. This approach can be helpful to build rapport and trust before talking about FGM (Newman and 28toomany, 2019), and to highlight the strengths of communities rather than framing FGM as an archaic or harmful tradition.
- Community-led activities or dialogues between people from different genders and generations can substitute the initiation rituals that were part of FGM. For example, gatherings organised and led by grandmothers (supported by other community members such as parents or local leaders) can teach girls about communities' traditions and positive values.³
- Implement approaches that lead to reflection and critical thinking rather than directive messaging which tells people what to think or do. For example, although our FGDs were not

designed to change FGM perspectives but to gather information, we found some indication that the Grandmother Project's 'Stories without an Ending' could be a fruitful way to begin discussions around FGM and allow participants to reflect on their decisions.

- Avoid the use of images and/or anatomically explicit diagrams or models when working with community members (and test whether this is pertinent with health and protection staff). Making use of dummies or anatomical models may be more suitable to show, for example, the different kinds of FGM cuts to health staff. Images tend to focus attention on the cutting, and therefore on cultural or community 'deficits' rather than strengths (Newman and 28toomany, 2019). If images are needed, practitioners should use those that are non-judgmental and neutral rather than those that explicitly show physical harm.

New information and discussion materials around FGM

- Use the community's own terminology for describing the type of FGM it practices. Language is important and evidence suggests that 'the more neutral the better' (Newman and 28toomany, 2019). Avoid negative and judgemental language that can make women and community members feel ashamed or uncomfortable.
- Phrasing messages in a manner attuned to local contexts and cultures can increase their chances of being accepted and acted on. Current interventions mainly focus on transmitting messages conveying the consequences of excision and that FGM is not required by religion. Messages can be effective if they resonate with community values, such as their culture, beliefs and overall well-being.

3 See Musoko et al. (2012) for more guidance based on the Grandmother Project.

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- Information is more likely to be absorbed if it reflects direct experiences of community members, those close to the community (e.g. midwives), and/or people highly respected by community members. Creating spaces for dialogue where people can share their experiences is important. It is equally important to support communities to reflect on their individual and collective beliefs around FGM. Information that tackles stigma, taboos or the role of gender norms can lead to critical thinking and a shift in attitudes and potentially behaviours.
 - New information and information that challenges misconceptions need to be tailored to target different community stakeholders. Information and discussion prompts tailored to grandmothers may differ from those best suited to fathers or boys and girls. For example, the Saleema campaign⁴ in Sudan challenged stigma against uncut girls using a variety of channels (public campaigns, community dialogues, public pledges to abandon FGM) tailored to different members of a household and the community as a whole.
 - Identify who is the best stakeholder to transmit information and/or discussion prompts in a certain group. Some information may be better transmitted by religious leaders, others by grandmothers and others by young men, in a way that encourages group dialogue and motivates people to share the outcomes with their peers and the wider community. Annex 7 from the report provides a summary of best ways to transmit information and prompt community discussions based on the *Communications for Social Change Model* (CSCM) by Figueroa et al. (2002).
 - Some information can be transmitted by radio but needs to be tailored to community contexts.

4 The norm to be changed is that a girl remaining uncut is associated with the word *Saleema*, which connotes remaining whole and as God given. See Evans et al. (2019) for evaluation results of the initiative.

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