FACTORS AFFECTING THE PRACTICE OF FEMALE GENITAL MUTILATION IN SIERRA LEONE

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By

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Sierra Leone

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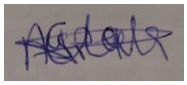
X 

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ABSTRACT

Background: Sierra Leone (SL) is a country in west Africa that borders the Atlantic Ocean. Female Genital Mutilation (FGM) is widespread in SL with 9 out 10 women who have undergone the practice. SL has one of the highest FGM prevalence rates in the world (approximately 90%). The government of SL banned FGM in 2019. However, the efforts put in place to ensure the implementation of the ban have not been effective in creating a major gap in care. Parents, influenced by social norms and community expectations, believe that FGM secures social and economic security for their daughters.

Methods: A review of the literature was done using the conceptual framework developed by Berg and Denison (2013). The framework was used to provide an understanding of factors promoting and factors hindering FGM in Sierra Leone.

Results: The findings from the study establish an understanding of factors influencing FGM in SL. Law, gender, and socio-cultural factors have been essential in promoting FGM. The practice of FGM in SL remains high because it is considered a tradition. Being part of the Bondo society as it is referred to in SL brings honor and respect to women as the society believes. Even though the government put a ban on FGM, the practice continues because there is no legislative law prohibiting the practice and the political class has retained the support of the Bondo society through supporting their activities to gain political mileage. Health consequences of FGM can range from immediate/ short term such as severe pain, and hemorrhage, to long-term psychological and psychosexual effects. The socio-economic and cultural factors that influence the practice in SL include cultural traditions, marriageability, religion, and educational level with cultural tradition the major/ greatest influencing factor. The health sector does not play many roles in preventing FGM in the country nor does it have quality care in place in managing its health complications.

Conclusion: cultural norms, values, and principles are identified as major factors influencing the practice of FGM in SL along with other socioeconomic factors.

Recommendations: Government through the Ministry of Health and Sanitation (MOHS), and related stakeholders need to engage actively to develop strategic health sector plans that address FGM. These plans need to be informed by contextual factors specific to each setting, including the epidemiology of the practice, the specific drivers as well as the health system profile and readiness to address it. to institute anti-FGM laws. Community engagement to educate the community about the misconceptions surrounding the practice as well as the negative and long-lasting complications it has on women and young girls. Empower women by educating them.

Key Words: FGM, Culture, Traditions, Factors, Sierra Leone.

Word count: 9753

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List of abbreviations:

ADRA	Adventist Development Relief Agency
CEDAW	Convention on the Elimination of Discrimination against Women
CEP	Community Empowerment programs
CHCs	Community Health Centers
CHOs	Community Health Officers
CRC	Convention of the Right of Child
DHS	Demographic Health Survey
FAHP	Forum Against Harmful Practices
FGM	Female Genital Mutilation
FGM/C	Female genital Mutilation /Cutting
HCPs	Health Care Practitioners
MH	Maternal Health
MOHS	Ministry of Health and Sanitation
NGOs	Non-governmental Organizations
PHUs	Peripheral Health Units
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
SDG	Sustainable Development Goal
SL	Sierra Leone
SRHR	Sexual Reproductive Health and Rights
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

Key terms:

Female genital mutilation: (FGM) also referred to as female genital mutilation and cutting (FGM/C), is a procedure that involves the alteration of female genitalia without a medical or therapeutic reason (1).

Culture: is the collective training of the mind that separates one group or category of people from one another (2).

Factor: a situation, information, or anything that has an impact on the outcome (3).

Sierra Leone: is a country in West Africa that borders the Atlantic Ocean (4).

West Africa: is the western part of the continent of Africa (5).

Acknowledgment

Firstly, I would like to thank the Almighty God for bringing me this far. Only by His Grace and strength, I was able to go through the many challenges and be able to reach this successful ending.

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Finally, thanks to my course mates, it has been an incredible experience studying with you all.

Introduction:

Female genital mutilation (FGM), also known as female circumcision or cutting (FGM/C, is one of the world's oldest and most harmful practices (6). It is defined as a procedure in which the external female genitalia is partially or completely removed or otherwise harmed in some way for non-medical purposes (1). FGM is widely acknowledged as a violation of girls and women's human rights, as well as an utmost form of gender discrimination, revealing deep-seated gender inequity. Notwithstanding, at least 200 million women and girls worldwide are affected by FGM (6). Moreover, according to WHO, over 4.6 million girls are at risk of undergoing FGM per annum (1), and more girls will be harmed if the current trend continues in the coming years, with an estimated 68 million girls being exposed to FGM by 2030 (1).

In more than 28 nations on the continent, FGM is a widespread practice that has been deep-rooted in most African societies. Although there is evidence that FGM is practiced in other parts of the world, such as the Middle East and Asia (7). It is also performed in the United Kingdom, Europe, and Australia because the people who migrated to these regions practiced it in their home countries (8). In Africa, an estimated 92 million girls 10 years and older have undergone the practice (9).

FGM leads to lifetime pain for girls and women who have undergone the procedure, as well as health inequity, without providing them any health benefit, also causing long-term physical, mental and sexual difficulties for them (1). The government of Sierra Leone (SL) is working to curb the spread of FGM in the nation. The government outlawed FGM in the nation in 2014. However, no legislation to outlaw FGM has been achieved, giving the FGM ban little success. To limit FGM in the nation, organizations from all over the world, such as the United Nations Population Fund (UNFPA), have been working to adopt legislation by emphasizing the immediate and long-term consequences of FGM (10).

My interest in this study has been drawn to fewer efforts in eradicating FGM in the country despite the associated complications. I gained personal interest in the topic when I realized that my own biological sister went through the procedure on her own without the knowledge or consent of our parents, even though my mother who also went through it, never wished for any of her children to go through it or suffer what she suffered. I have observed my sister suffer in silence from complications of the procedure but have not been able to openly talk about it. Also, working as a medical officer and a clinician at the main maternal hospital in SL, I get to see the challenges women who have been cut go through with the various effects of FGM ranging from obstetric complications to psychological and psychosexual effects. And this has enabled me to understand the extent of the problem and why despite strong cultural inclinations, FGM needs to be controlled to improve health outcomes and self-dignity. I have also been able to observe that the input of different organizations is fundamental to the attainment of the needed change. The study's findings will help understand the key factors affecting the practice of FGM in SL as well as the role of efforts that are currently in use and how to improve health systems to achieve better health outcomes.

Structure of the thesis:

Chapter 1 presents the general information on SL, including an overview of FGM in SL, and information about the structure of the SL health system, and the classification of FGM. In chapter two, the problem statement, justification, and study objectives are presented. Chapter three will explain the methodology of this study to achieve the study objectives. Chapters 4, 5 and 6 will present the findings of the study analysis of factors affecting the practice of female genital mutilation/cutting in Sierra Leone to inform programs aimed at reducing and preventing the practice. Chapter 7 explores the best practices addressing FGM in West Africa and beyond to apply in Sierra Leone. Chapter 8 consists of the discussion including the limitations of the applied framework of the study. To conclude chapter 9 presents the conclusion and recommendations.

1.0. CHAPTER ONE: BACKGROUND ON SIERRA LEONE

This chapter presents information on SL, and an overview of background information including facts and figures about FGM in the country. The general classification of FGM will also be presented in this chapter.

1.1.1 General information on Sierra Leone

SL is a country on the west coast of Africa that borders the Atlantic Ocean. Additionally, it is well renowned for the Freetown Peninsula's white sand beaches (4) The name originated from a harbor figure from the 15th century, Pedro Sintra. Its capital Freetown has one of the highest natural resources in the world (11).

Figure 1: The map of Sierra Leone (4).

Sierra Leone is a mining hub, though most of its population depends on subsistence agriculture. Its territory contains rutile, bauxite, gold, and diamonds (titanium dioxide). The nation was ripped apart by internal conflict starting in the late 1980s, which sparked a violent civil war that lasted from 1991 to 2002 (12). Since the conflict finished, the country's administration has had to put in a lot of effort to restore the nation's economic and social infrastructure while simultaneously attempting to unite its citizens (13).

Around 18 different cultures coexist in the nation: they all practice FGM as a means of preparing girls for adulthood. These cultures share traits including secret societies, chieftaincy, patrilineal descent, and farming techniques (13). Mende, who inhabit the east and south, and Temne, who inhabit the center and northwest, are the two largest ethnic groupings. The Limba, Kuranko, Susu, Yalunka, and Loko are people who live in the north. There are the Kono and Kisi in the east and southwest, and the Sherbro in the southwest. Smaller ethnic groups include the Fulani and Malinke, who originated in Guinea and primarily inhabit the north and east, as well as the Bullom, Vai, and Krim, who reside near the coast. Near Freetown, the majority of Creoles reside. They are the offspring of former slaves who moved to the coast between the late 18th and the middle of the 19th century (13). During the 19th century, SL was also home to black people from the United States and the West Indies (14) Lebanese and Indian traders who work in cities add to the mix of different ethnic groups. Muslims make up around two-thirds of the population, while Christians make up about one-fourth. A number of traditional religions are practiced by less than 10 percent of the population. These religions have had no restrictions to the FGM practice (4).

The population density in SL is 111 per Km2 (286 people per mi2). The median age in SL is 19.4 years. There are approximately 7.7 million people in the country with a 15.4% growth rate. The birth rate in the country is approximately 37.40 births per 1,000 inhabitants while the death rate is 11.03 deaths per 1,000 inhabitants. Life expectancy in the country is 57 years with the female having 60 years compared to men with 55 years. The fertility rate stands at approximately 4.2 children born per woman (4).

The level of literacy in the country is low. According to Sierra Leone Demographic Health surveys (DHS) (2019), 29% of males and 39% of females above 18 years have no education. Further, urban residents are highly likely to be educated compared to rural residents with statistics showing that 25% of women in urban areas have no education compared to 50% in rural areas. There are 16% of men in urban areas with no education compared to 38% in rural areas (13).

Education is affected by one's level of wealth; among women in the wealthiest quintile, just 10 percent have completed secondary school or above, while 18 percent have not completed secondary school or higher (12). In addition, 57 percent of women whose wealth is in the lowest quintile have not completed secondary school. Literacy rates for young adolescents (defined as those aged 10 and older) are much higher among young male adolescents (59.4 percent) than they are among young female adolescents (43.9 percent). The general literacy rate in the country is greater among men, at 62 percent, in comparison to the women, who have a literacy rate of 43 percent (15). The official age of marriage in Sierra Leone is 18 years. Nevertheless, Sierra Leone still has a high rate of child marriage, with 13% of girls getting married before they turn 15 and 30% getting married before they turn 18 years of age. Amongst boys, 7% get married before they turn 18 years of age, making Sierra Leone one of the top 20 nations with the highest rates of child marriages (16).

1.1.2. Overview of FGM in Sierra Leone

FGM has been widespread in SL (17). It is considered a requirement for entry into the women's secret societies (18,19). All the ethnic groups in the country are known to practice except the Creoles who are normally the only ethnic groups that are not involved in the practice. But

regardless of the name of the group, the initiation process takes the same form. The discussion of everything related to the Bondo society is forbidden among all men and those women who have not gone through the procedure (18,19). The majority of women in SL mostly undergo Type I and II forms of FGM (18).

The prevalence of FGM in SL is among the highest globally and it is the only country in Southwestern Africa that has high rates of FGM(17). Until now, there is strong political will or engagement to prohibit FGM in the country. The traditional FGM practitioners, locally known as Soweis, influence females' votes and serve as the link between some communities and the central government. The practice is considered a social norm (20). Females who refuse it are sometimes ostracized and labeled as ill-mannered or unready for marriage and forfeit the public recognition earned by those who comply (17).

The names of the FGM practice or secret societies, the excisors (The heads of the society), the initiates and non-initiates are called differently depending on the ethnic groups (19), as shown in table 1, but for the purpose of this study, the practice of secret societies, that is the practice of FGM, is generally referred to as "The Bondo society" and the name of the excisors are referred to as "Soweis", this is because regardless of the ethnic groups or languages, these names are generally known and understand nationwide, and when mentioned, it can easily be related to the practice of FGM.

Table 1: Names of aspects of Bondo society in the main Sierra Leonean Languages

Ethnic Group	Name of Bondo Society	Name of Head of Society/Excisor	Name of Iintiate	Name of Non-Initiate
Fulah	Baytee	Barajelli	Betijor	Jiwor
Limba	Bondo	Baregba	Banka	Gboroka
Loko	Bondona	Ligba	Bondofayra	Gborrga
Mende	Sande	Sowei/Majo/Digba	Morgbinie	Kpowei
Susu	Ganyee	Yongoyelie	Ganyee Gineh	Amoogaangeh
Temne	Bondo	Digba	Bonka	Gurka
Kono	Sandeneh	Soko	Seinama	Dumisuuneh
Kissi	Fangabondo	Sokonoh	Sumunoh	Kwehdenoh
Kuranko	Sayere	Biriyele/nu		

Age of circumcision

According to World Health Organization (WHO), FGM is most prevalent in children below 15 years of age. The majority of female circumcisions in Sierra Leone take place betweenK the ages of 10 and 14, and 71 percent of women aged 15 to 49 had undergone the practice before the age of 15 (13). In a study conducted in seven African countries, it was suggested that young girls who are from countries with a high prevalence of FGM are more likely to support the practice. In this same study, it was discovered that 50% of adolescents15-19 years think that FGM should continue (21).

Attitude and Knowledge about FGM

The knowledge of FGM in SL is almost universal. 98% of all women 15-45 years know about the practice of FGM and 48% of these women think it is not a requirement of their religion and 34% think it must be stopped (13). The acceptance of FGM varies according to wealth status, religion, and education. Christians generally think it should be stopped while Muslims think it should be continued, and the wealthy and more educated have less support for its continuation (18).

1.1.3. Classification of FGM

Based on the severity of injury done to the external genitalia, WHO has identified four main types of FGM/C, with subtypes (22) . These are.

- **Type 1:** This is when part of or all the clitoral glans or the hood of the clitoris is removed.
    - Type 1a: only the prepuce/hood of the clitoris is removed.
    - Type 1b: the clitoral glans is removed together with the prepuce/hood of the clitoris.
- **Type 2**: constitutes the partial or complete elimination of the clitoris and the inner lips (labia minora), with/without eliminating the outer lips (labia majora).
    - Type 2a: only the labia minora is removed.
    - Type 2b: partially or completely removing the clitoris and the labia minora.
    - Type 2c: partially or completely removing the clitoris, together with the labia minora and majora.
- **Type 3**: here, the formation of a covering seal narrows the vaginal aperture. The seal is created by cutting and relocating the inner or outer lips. The vaginal aperture is covered with or without removing the hood of the clitoris and the clitoral glans. This type is also known as infibulation, and it is the most severe form of FGM/C.
    - Type 3a: eliminating and relocating the labia minora.
    - Type 3b: eliminating and relocating the labia majora.
- **Type 4:** This category includes many different practices. It is anything that is done to the external genitalia for non-medical purposes that is not the first three types. For example, small pricks to the clitoris or the lips, stretching the lips, scraping, and/or cauterization.
- **De- infibulation:** is the process of cutting open a woman's sealed vaginal entrance after she has been infibulated. It is frequently performed to enable sexual intercourse or to promote childbirth, and it is also required to improve the health and well-being of the woman.

1.1.4. Prevalence and distribution of FGM in Sierra Leone

83% of women in SL have undergone FGM (23). SL is classified under group one by UNICEF among countries where FGM/C is practiced, because of the prevalence which is above 80% (24). The prevalence of FGM in SL rises with age. Among women aged 10-19, 61% have been cut compared to 95% of those aged 45-49 years. By religion, FGM is more common among Muslims (87%) compared to Christians 69%. It is more practiced in the rural region (89%) than the urban region (76%), the north-western province has the highest prevalence (953%) while the southern province has the lowest (74%). By district, Karene has the highest prevalence (98%) while Bo has the lowest prevalence (65% (13).

1.1.5. Health system and structures in Sierra Leone

The Sierra Leonean healthcare system is divided into two tiers of care: primary care, which is provided by Peripheral Healthcare Units (PHUs) with an extended community health program, and secondary care, which is provided by 21 district hospitals and three referral hospitals. In addition, there are 45 private clinics and 27 private hospitals, the majority of which are located in the Freetown area(25). In delivery of health care within the country, the health system is divided into maternal and child units which serve approximately 500 – 5000 people, community units which serve 5000 – 10,000 people and community health centers which are located in chiefdom level and serve a population of around 10,000 – 30,000 people (15). Community health centers (CHCs) are managed by community health officers (CHOs) and are considered as first responders to emergency in care. They have first-hand engagement with patients presenting with FGM complications. Some of them (the CHOs) have also been involved in FGM practice as contracted by the community (26).

2.0. CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION, AND OBJECTIVES

This chapter presents a detailed focus on the problem statement and the objectives.

2.1. Problem statement

The practice is common in SL because it is not considered a violation of girls' and women's rights but a regular cultural practice that is commonly accepted in society (27). Whilst some feminists and other academics say that FGM is used to gain power and control over women, the case of SL is different as women themselves arrange and make sure that the practice is performed without interruption (27,28)The issue is so critical that those who do not practice FGM are victimized (29). Being a member of the "Bondo Society" as the practice of FGM is referred to in SL, is an honor, Women who undergo the procedure gain respect and are considered to have good manners, suitable for marriage (wife material), and are highly recognized in society(28,30). It is thought that the physical suffering undergone by the girls who are jointly initiated helps to develop a lifelong friendship (31) 79% of those who have undergone FGM in SL underwent it before the age of 15 years(15), this proves that they go through the procedure even before they are mature to make decisions on their own and without any knowledge of the immediate or long-term effects the practice will have on them (13).

SL has been part of many global human rights organizations that considers FGM/C as a human rights violation (30), yet FGM is still not prohibited in the country, and there is no specific legislation against it (18). Even though the Child Rights Acts overrule every other government legislation that protects the rights of children, the FGM clause was omitted from the final report during the congressional debate (32).

Efforts to prevent FGM in SL have been implemented although with minimal success based on the existing status quo and the strong influence of culture (33). In 2014, the SL government instituted a ban against the practice of FGM. The success of this ban has been minimal considering the high rates of FGM among young women in the country. But while national legislation should be advocated, it is not sufficient. Despite SL being a signatory to international treaties aimed at preventing FGM, less effort within the country has been made to initiate measures to abandon the practice (30) The practice is respected in the country and few people including the political class are willing to condemn it publicly (14,24). The efforts by international organizations such as United Nations in the country have been trivialized with the assertion that they do not respect the values and culture of the natives (24).

Despite the challenges associated with FGM in the country, it is still revered as a strong cultural practice that continues to be practiced unabated. There has been no clear multi-agency commitment to help fight this problem. The government has offered less help pertaining to coming up with local agencies and structures to help prevent FGM. Factors hindering and those promoting FGM in SL have not been fully investigated which has presented a major gap in developing structures and policies to improve on the current efforts to end this vice.

2.2. Justification

Limiting the practice of FGM requires multisectoral commitment which has been effectively lacking in Sierra Leone. There is a need to develop a strong linkage between the government and

all stakeholders in the fight to end FGM (27). Controlling the FGM practice with urgency must be done with respect to culture and harnessing it for change. There is overarching fear across the community for anyone who publicly condemns FGM because of the high influence of the secret Bondo society. Politicians have in the past participated in Bondo society activities including holding fundraisers as well as sponsoring their activities to gain political mileage(27). Such activities have strengthened the resolve of this secret society and its continued practice of this outdated cultural practice without necessarily evaluating its impact on its victims. Despite all these efforts to eliminate FGM, it continues to be a major public health concern in Sierra Leone. Attaining this requires a high collaborative level across different sectors. Thus, this study reviews factors promoting and hindering the practice of female genital mutilation in Sierra Leone.

2.3. Objectives

2.3.1. General objective

The general objective is to explore promoting and hindering factors affecting the practice of female genital mutilation in Sierra Leone to inform programs aimed at reducing and preventing the practice.

2.3.2. Specific objectives

1) To explore the practice of FGM in Sierra Leone and its health consequences.

2) To explore the socio-economic, and cultural related factors affecting the practice of FGM in Sierra Leone.

3) To identify the role of the health system related to FGM in Sierra Leone.

4) To identify successful or best practices addressing FGM in West Africa and beyond to apply in Sierra Leone.

5) To make recommendations to inform the health and social sector targeting FGM in Sierra Leone.

3.0. CHAPTER THREE: METHODOLOGY, STUDY TYPE, SEARCH STRATEGIES

This chapter presents an overall description of the study, study type, search strategies, introduction of the framework, limitations of the study methodology, search terms presented in a table as well inclusion & exclusion criteria.

3.1. Study Type

This study will be done by a literature review. The researcher will search for relevant literature on factors affecting the practice of FGM in SL. This study will adopt a review of literature. The review focused on peer-reviewed articles, grey documents, annual national reports, and publications from various organizations that are engaged in efforts to reduce FGM. Fact sheets, National policy documents and research briefs on FGM in Sierra Leone. The study seeks to identify factors that perpetuate FGM and factors that hinder FGM practice with key emphasis on reducing and preventing the practice.

3.2. Search Strategies

Google Scholar, PubMed, and the Vrije University Library database will be used to conduct a purposeful literature search. The search will obtain Peer-reviewed papers, official documents, and publications including grey literature from the Ministry of Health and Sanitation (MOHS) Sierra Leone, archives and websites, and publications from the World Health Organization (WHO), The DHS, and the UNFPA will also be included. Additional articles will be found using the snowballing technique from in-text citations and references from the selected pair-reviewed publications and grey literature.

The search will make use of a collection of keywords and terms, including, 'FGM', 'FGM/C', 'female circumcision', 'clitoridectomy', 'infibulation', 'socioeconomic factors', 'cultural factors', 'health consequences', 'Culture', 'Factor' 'FGM interventions', 'FGM program', 'low-income settings', 'impacts', 'family role', 'community role', 'health sector', 'Sierra Leone', 'West Africa', 'Africa', etc. The search terms and combination will be the Boolean operators 'AND' ;OR'as shown in the search table in Table 2.

Table 2: Search Table

AND			
	Factors	Female genital mutilation	Sierra Leone
	Hindering factors	Female genital cutting	West Africa
	Perpetuating factors	Female circumcision	Africa
	Promoting factors	Clitorectomy	Sub-Sahara Africa
	Socioeconomic factors	Infibulation	Low middle-income countries
	Culture		
	Traditions		
	Values		

OR	Norms		
	Marriageability		
	Religion		
	Education		
	Gender		
	Age		
	Sexual norms		
	Health consequences		
	Health sector		
	Community role		
	Impacts		
	Marriageability		
	Health system		
	Role of health sector		
	Efforts to prevent		
	Prevention programs		
	Interventions		
	Best practices		
	Successful practices		
	Preventions efforts		
	Prevention		

3.3. Inclusion and Exclusion Criteria

The study will include studies examining factors associated with FGM in SL and other regions where the practice is performed. It will include literature published in English only.

The study will exclude any research on FGM that does not provide focus on factors associated with FGM, and that are not published in English. It will exclude articles that do not provide access to the complete article.

3.4. Conceptual Framework

The present study will utilize the model developed by Berg and Denison 2013 (figure 2). The model explores the factors perpetuating and hindering FGM in the Sub-Saharan Africa context. Key drivers prolonging FGM have been documented the most fundamental factor is cultural tradition (34). This model was chosen because it was considered fit for achieving the overall objective of this study.

While searching for conceptual frameworks for this study, the ACT framework (35) developed by the UNFPA-JOINT Program on the elimination of Female Genital Mutilation was primarily considered, but the model developed by Berg and Danison was preferred because, the ACT framework focuses mainly on the social norms contributing to the practice of FGM. While social norms are important for my study, it only addresses one of the objectives of the study, leaving out other objectives dealing with health consequences, role of the health sector and best practices. The Berg and Danison model on the other have addressed all aspects of this study, analyzing holistically the factors perpetuating and hindering the practice of FGM hence make more suitable.

The conceptual model for factor perpetuating and hindering FGM by Berg & Danison 2013 consists of an upper part that represents the main perpetuating factors and a lower part that represents the hindering factors.

3.4.1. Factors promoting FGM

From the findings of Berg and Denison, the perpetuating factors include Religion, cultural tradition, Marriageability, Sexual morals, Health benefits, male sexual enjoyment, social identity, ideal girl, honor, and avoiding pain (34).

3.4.2. Factors hindering the practice

These are: Health consequences, not religious requirement, illegal, and no need according to the findings of Berg and Danison (34).

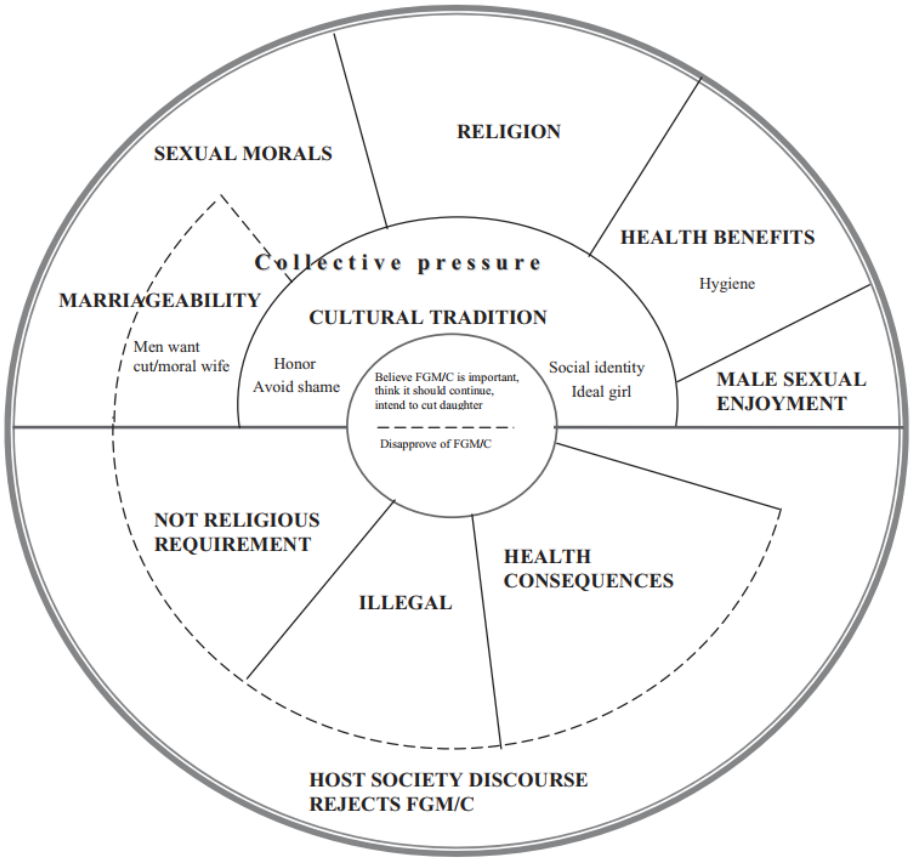

Figure 2:Conceptual framework of factors perpetuating and hindering FGM (Berg and Danison 2013) (34).

3.5. Limitations to study

Literature search focuses on making conclusions from published literature. The study will only focus on studies that have been done in English language hence studies published in other languages will be excluded. There is a lot written about FGM but are not evidence informed, so they could not be included in the study.

4.0. CHAPTER FOUR: THE PRACTICE OF FGM IN SIERRA LEONE AND ITS HEALTH CONSEQUENCES

This section presents a review of the practice of FGM in Sierra Leone and its associated health consequences. The consequences that are investigated in this context relate to the physical, mental, and psychological implications of FGM.

4.1. The practice of FGM in Sierra Leone

FGM practice in SL remains as we have seen above highly prevalent with nine in ten women have undergone the practice. The two main procedures done in SL are: sunna, the removal of the hood of the clitoris with the body intact, and clitoridectomy or excision, removing the clitoris and all or some of the labia (20). The Bondo society has been a significant proponent of FGM in SL. It is a secret society that has spearheaded the practice. The Bondo is governed by "powerful" women known as "digba" or "Sowei," who have constantly asserted their cultural expertise in relation to the practice. Excised women and girls are automatically admitted to the Bondo. The membership aspect implies that the society goes beyond cutting but cutting nonetheless plays a significant role in its rituals (17,33). Bosire claims that the Bondo is a "store of gendered knowledge that bequeaths members with privileges and authority preserved by secret." Initiates used to be frightened to discuss the ritual in public because of the oath of secrecy, but this taboo has now been broken. Additionally, soweis stated that the initiation only involves cutting lately, the traditional teachings of the Bondo are being forgotten (27) and the commercialization of the practice has diminished the customary symbolic authority (20).

Culturally, FGM is viewed as the procedure as an essential step on the path to adult femininity, purity, and marriageability (24). Despite the fact that this view is completely at odds with reality, proponents of FGM view the Bondo bush as a setting in which initiates are instructed in the art of home keeping, healthy social relations with in-laws, sex education, childbearing, and aspects of motherhood and traditional medicine. The Bondo society has a public presence through the formation of Sowei council, which was established in 1993. It has headquarters in Freetown but also has branches in all of the districts. Since its establishment, its members have been formally invited to various conferences and workshops and have been allowed to engage the media in order to campaign on their own behalf. They became more defiant as they acquired more publicity, and they became more emboldened as the political wind blew in their favor (27,36).

The political elite has continued to promote the practice by funding their activities despite the government's ban on FGM, in order to advance their political interests. Leaders of the society have also been chosen for leadership roles (19). The Soweis are aware that many supporters are people who have not had formal education and who reside in rural villages. For the people of Sierra Leone, the festive rites provide a moment of relief and excitement amid their otherwise monotonous life (20).

Figure 3: The Mende Sande Mask (Indianapolis Museum of Arts)

The Bondo engage in a masquerade during the ceremony, which includes dances and masks with ritualistic significance. Given the symbolism carved into the Bondo mask, it is believed to represent the spirit of the Bondo societies (18)

There are 5 main stages of the Bondo initiation ceremony.

1) Entering into the Bondo bush.

2) FGM

3) Other initiation rites

4) Teachings of the society

5) Rituals for coming out of the Bondo bush (27).

The Bondo drums are used to signal the beginning of the ceremony. The Soweis arrive in the community to gather the kids and any other community members who choose to participate, then take them several kilometers away to a separate location in the bush (18)/

The ritualistic cutting off of the girls' genitalia serves as the first step in their initiation, after which they are taught the social customs, dances, and songs, as well as how to care for their husbands domestically and sexually, while their wounds are healing (18).

The coming-out party serves as both the culmination of the initiation process and a lure to persuade ladies to enlist in society. In the case of the Mende, the girls are dressed in white, daubed with white mud, or given new clothing before being returned to the village as fully developed adults and the center of attention. During the tremendous celebration and acclamation of their new position, they are escorted by the Bondo devil masquerade. A feast in celebration comes next (18).

4.2. Health consequences of FGM

FGM does not have any health benefits. It only includes eliminating and causing harm to the normal healthy female genitalia, causing complications either immediately or in the long run, hindering the regular performance of the woman's body(37). The two forms of FGM commonly practiced in SL (types 1 & 2), both have health consequences (38).

4.2.1 Short-term complications

Complications that may occur during, immediately or shortly after the practice include Severe pain, excessive bleeding, wound infection, septicemia, gangrene, tetanus, harm to surrounding organs, and partial healing (1,34,36,39).

4.2.2 Long-term complications

It is widely acknowledged that FGM results in a variety of life-long issues, which can be categorized into 3 main groups, namely: Gynecological, obstetrics, and phycological scaring. Gynecological Effects include urinary tract infection, chronic genital abscess, vaginal infections, keloids, urinary symptoms, and menstrual difficulties. The obstetric effects are prolonged labor, postpartum hemorrhage, perineal tear, a high rate of episiotomy, and cesarean section. Psychological effects including sexual function include depression, anxiety, dyspareunia, absence of sexual desire, and decreased sexual satisfaction (36,39–42).

5.0. CHAPTER FIVE: THE SOCIO-ECONOMIC AND CULTURAL RELATED FACTORS AFFECTING THE PRACTICE OF FGM IN SIERRA LEONE.

This chapter presents the socio-economic and cultural factors which affect the practice of FGM in Sierra Leone. The underlying aspects that are investigated in this context include cultural values, norms and principles, religion, education level, income, marriageability, gender roles, and age, as factors that promote the continuation of FGM in SL.

5.1. Cultural tradition

Cultural traditions are the cultural norms, values, beliefs, and principles that are shared in the country and as we have seen above FGM has been greatly practiced as a fundamental part of the Sierra Leonean culture and it is practiced as an initiation ceremony among girls (20). FGM is believed to be a necessary step for girls to transition into womanhood and women in SL who have not undergone are considered to be unclean and are likely to experience societal stigma (18,36). It is considered a form of social control, identity for women, and a feature for ideal girl. The obligatory nature of the practice was reflected in the community processes that were responsible for enforcing it, and this was firmly ingrained in their social systems. The extensive collective enforcement of the practice was firmly related to honor and the avoidance of shame, and this was true not only for the daughter, but also for the mother, and often for the extended family as a whole (17,24,36).

Sexual morals form another key factor. It is built on the assertion that FGM is a cornerstone for moral virtue FGM especially infibulation was believed to reduce lust which was seen as easily aroused and difficult to control thus likely to lead the uncut woman to sexual promiscuity. It is also believed that in unmarried girls it ensures virginity till marriage and prevents married women from extramarital sexual activity (20,36,38).

All these findings are consistent with findings other findings from Sub-Sahara Africa including Nigeria (34,43–47).

5.2. Marriageability

Shell-Duncan and Hernlund found that female genital mutilation is a prerequisite for getting married in the majority of societies where these practices are deeply ingrained. For most women, marriage is their only chance for a decent existence. Because no one in the community would have the courage to marry an uncircumcised girl, she is ineligible for marriage and may end up being a financial burden on her parents (46). Without conforming to the norms of the group, in this case undergoing the procedure, a woman will have no place in the community's future. The institution of marriage guarantees the continuation of the practice because of its significance to the social and economic well-being of a woman (34,43,44,46).

In SL context it’s mainly because it is a rite of passage to adulthood, prevention of promiscuity, enhancement of the girl’s femininity by excision of the clitoris, and makes marriage an effortless process, to prevent recurrent genital infections. It prepares women for marriage and hence for sexual activity in marriage (16,31,34). A study on the situation analysis of FGM in SL found that for women to enter marriage life, an initiation to the ceremony is required, and during the initiation ceremony, they are thought domestic responsibilities and their roles in satisfying their husbands.

Marriages that take place before a person is initiated into a secret society are viewed as invalid (18).

5.3. Religion

Religious underpinnings have had a broader influence on FGM in Sierra Leone. More than 60% of the Sierra Leonean population practice Islam (13). A report published by United Nations International Children's Emergency Fund (UNICEF) revealed that FGM practice is more prevalent among Muslim women in SL at the rate of 93% compared to 78% among Christians, 56% of women also affirmed that FGM is required by religion compared to 47% among men and boys. Different communities give numerous justifications for practicing FGM. In diverse communities, FGM is practiced for a variety of reasons. However, in communities that are largely Muslim, the practice has been linked to Islam, and there is a strong notion that every Muslim woman must be subjected to FGM (17,27,36).

Another study noted that although FGM has been approved by Islam, many Muslims do not engage in it, and many believe it is not permitted by the Holy Koran. FGM is not mentioned in the Holy Bible, which means that Christians who engage in it may be doing so out of culture or misinformation. Also, most religious leaders including Muslims leaders and various Christian dominations accept and engage in the practice, in fact many religious leaders take great pride in belonging to the Bondo society and claim that membership gives them power to the point where certain clergy are recruited to carry out their religious duties. The Pentecostal churches, on the other hand, are adamantly opposing to its members taking part in the Bondo society. They compare the Bondo society to witchcraft and demonic worship (19).

5.4. Education level

A key tactic for putting an end to FGM has been seen to be education. However, this is only possible when the health literacy level is high. A higher level of education has been perceived to positively influence health literacy levels. According to a study conducted in Sierra Leone investigating whether education is a factor in the continuation of FGM, most of the women with formal education (65.5%) and 15.6% of those without formal education asserted that FGM should be discontinued (17,24). According to a report published by Adventist Development and Relief Agency (ADRA) in Sierra Leone affirmed that women are disproportionately affected by economic, social, and health issues which contribute to slowed economic growth and development. High rates of poverty, illiteracy, and gender inequality have been fundamental in the continuation of practices such as FGM (48).

FGM has been considered a social stratification mechanism in most societies where it is practiced where those who practice FGM are perceived to be of higher status (49,50). In a study examining the socioeconomic dynamics of FGM trends across Africa, it was discovered that while higher educated women and those residing in cities tend to have lower incidence, the opposite pattern is seen in other nations (51).

Another study in SL also discovered that, although education may not have an immediate or direct impact on FGM, it is seen to be the most effective long-term solution. Girls who receive education are more equipped to withdraw parental and peer pressure, and to learn about the dangers of FGM

and their rights. Also, as the mom's educational level increase, the frequency of FGM and their wish to keep doing it decline (19).

5.5. Gender role

Numerous studies throughout Africa, including SL, have demonstrated that women look up to their husbands for all decisions regarding the home, as the men as considered head of the household (52). FGM is not performed without first the permission of the father (20). The practice of FGM which is classified as a form of gender-based violence has its origins in unequal power relations between men and women. These power relations are ingrained in a system that perpetuates discriminatory gender norms and stereotypes, as well as unequal access to and control over resources. The societal and systemic implications on the decision-making process of FGM are intricate. As a result of their gender roles within the patriarchal system, men are seen as exogenous sources of social influence on decisions pertaining to FGM, and the practice is internalized by the women, also contributing to its existence (53).

The female genitalia is believed to contain a male part of it, that is, the clitoris, hence a girl child can only attain a true femininity when her clitoris is cut off, and also, the clitoris and vulva are regarded as unclean body parts, so young girls are told that, it they are not cut, they will stink (19)(46).

6.0. CHAPTER SIX: THE ROLE OF THE HEALTH SYSTEM RELATED TO FGM IN SIERRA LEONE.

This chapter explores the role of the health system relating to FGM and how the existing health structures have been involved in the fight against FGM in Sierra Leone.

6.1. The role of the health system

SL the health system is structured into different categories aimed at enhancing the delivery of care (29). Even in contexts where many women and girls are subjected to this practice, the health industry has not actively worked to prevent FGM or ensure quality care to manage the health complications associated with it (68). There are many reasons why the health system pays so little attention to the problem of FGM. These include pandemics and other health emergencies that demand prompt and integrated responses (68). In addition, the health sector is frequently not considered an active player in the process of achieving the SDG related to harmful practices such as FGM (SDG 5.3) (55) and investment from governments and the international community has traditionally been directed toward other sectors (24) (69).

In the past ten years, there has been an improved emphasis on a multi-sectoral approach in tackling the problem of FGM. A study involving 30 countries including SL investigating health sector involvement in the prevention of FGM, revealed that a total of 24 countries had a policy on FGM of which 19 had assigned coordination bodies and 20 of the countries had partially or fully implemented the plans. Further, allocation of funding and incorporation of monitoring and evaluation systems was lacking in 11 and 13 of these countries respectively (54). The extent of the health sector's participation varied greatly between nations. SL did not have a national policy on FGM, coordination bodies, budgetary allocation, or a monitoring and evaluation system in place to empower health systems in controlling FGM (54). Most nations reported banning health care professionals (HCP) from performing FGM on both minors and adults, however, they did not always report banning re-infibulation, SL did not report neither (27,54). The study also investigated the countries that have medical services for women with FGM including DE infibulation, psychological counselling, sexual counselling or clitoral reconstruction, but reported that SL does not have any medical services available for women with FGM (54). Depending on the type of treatment, healthcare services for girls and women with FGM-related problems varied between nations. The findings have also established that recording of FGM in medical records was completely lacking in countries of origin and limited in countries of migration (54).

Healthcare providers have also been involved in carrying out this practice. The traditional excisors, also known as Soweis, were responsible for performing 80% of all operations, while medical professionals were responsible for 13% and traditional birth attendants were responsible for 6% according to one study (20).

The health sector is increasingly serving a health promotion and prevention role in addition to a curative role(54). Emphasis on quality of care through person-centered service delivery and application of rights-based approaches has shown that health workers can promote health not just to ensure the absence of disease but also to achieve ‘‘a state of complete physical, mental and

social well-being'' as articulated in the World Health Organization (WHO)'s constitution. Promoting well-being includes preventing harmful practices that violate human rights and cause ill health (55).

Indeed, the health sector in low- and middle-income countries has a history of community outreach and a large network of service outlets and providers of different cadres serving com- munities (54,56). This includes involving community members or leaders in community health committees to promote behavior change in a wide range of health topics, including violence prevention, immunization, breastfeeding, and HIV prevention. As respected members of their communities who are also familiar with and subject to the same social norms, pressures, and beliefs, they are well placed to engage with their patients and clients in preventing FGM through one-on-one counseling during clinical visits or home visits or in groups during health education sessions and community health outreach activities (29,57).

6.2. Anti-FGM efforts in Sierra Leone

Preventing FGM has been facilitated by legal framework in place and the help from international organizations. The Child Rights Act also promotes these practices by encouraging girls to consent after the age of 18 years before being cut. Similarly, the anti-FGM Act by the Sowei council also states that practitioners must allow women and girls to consent to take part in these practices (23,27). The government is also a signatory to the Sustainable Development Goals (SDG) 2030 and the Maputo call to Action (58). Services related to sexual and reproductive health (SRHR) should be made available at every public health facility in the country.

UNFPA among other international organizations have strongly focused on advocating for the end of FGM in the country. In 2019, at the community level, UNFPA collaborated with Care International, with financial support from the Canada Fund for Local Initiatives to train and empower young people to advocate for to end of FGM (10). A youth-led network was established and conducted school and community awareness-raising activities in the Western Area district of Freetown on two international days of observance, International Day of Zero Tolerance for FGM and International Day of the Girl Child (49).

The Forum against Harmful Practices (FAHP), a partnership of national and international non-governmental organizations seeking to end FGM, is one anti-FGM campaign organization in SL that has tried to include a variety of cultural custodians and specialists in this campaign. These cultural custodians and experts include religious leaders, political leaders, medical professionals, paramount, and section chiefs, and the Soweis themselves. The FAHP was founded in June 2014 as a coalition of more than 20 National Non-Governmental Organizations in SL to promote the restriction and abolition of harmful traditional practices, including FGM. By creating and supporting Alternative Rites of Passage to replace FGM in Bondo Secret Society for Women, we work to abolish FGM in Sierra Leone. We support Bondo Society as a place where women can feel protected. So FAHP says "YES to BONDO and No to FGM" (19,59).

Sierra Leone has put in place major processes aimed at creating an improved context for change. In 2015, Kemoh Sesay, who was serving as the minister of works at the time, officially denounced female genital mutilation and cutting (FGM) and pledged her support for the movement to end the

practice of FGM. He also asserted that 70 percent of politicians are against the practice, do not excise their daughters, and are "playing politics" with people's lives because they believe that publicly condemning the practice is equivalent to committing political suicide(27).

Soweis politicize the anti-FGM campaign by claiming, first and foremost, that as practitioners they have the sole rights to cultural expertise and, further, that those against cutting are stooges of the west, who no longer have any respect for "African ways" of being. These claims are made in an effort to imply that those against cutting do not respect "African ways" of being (19,27). It is abhorrent for lay people to question the Bondo and its customs, and it is even worse for "non-natives" and "initiates" to be encouraged to criticize the practice The Bondo is not a topic that is brought up in conversations between initiates or members, let alone "airing" the topic or providing non-initiates and outsiders with specific details regarding the practice (19,27).

7.0. CHAPTER SEVEN: BEST PRACTICES ADDRESSING FGM IN WEST AFRICA AND BEYOND TO APPLY IN SIERRA LEONE.

Unless appropriate steps are taken to address the factors perpetuating the practice of FGM, these factors will continue to exist. So, this chapter presents best practices that are being implemented in West Africa and other parts of the world to help in addressing the problem of FGM. In searching for these practices, a different literature search was done, and five best practices were identified. Key search terms include 'Best Practices', 'Efforts to prevent', 'Successful Practices', 'Prevention Efforts', 'Interventions', 'Programs', and are included in table 2.

These examples are presented because they are practices that have been found useful in helping in the fight against FGM and they have been proven successful in its reduction. The idea is that these examples are also being applied in SL for reduction and changes in the practice of FGM in SL.

Different countries have adopted varied measures which have been tasked with preventing FGM.

7.1. National strategic plan for abandonment of FGM in Guinea

In 2011, the Office for protection of Gender, Children and Morals (OPROGEM) was restructured and located in each of the country's 8 regions, as well as a number of police stations. In 2012, the Government drew up a National Strategic Plan for the Abandonment of Female Genital Mutilation, 2012-2016 (NSP), with a roadmap for operationalization in 2013. This was followed by extensive training of judicial and security personnel, as well as training and awareness raising for medical and paramedical personnel and in the context of medical schools. An awareness-raising kit has been produced for use in primary school classes. Other training and awareness-raising campaigns have been organized with local authorities, traditional and religious chiefs, traditional communicators (griots) and performers, including poster campaigns, and advertisements on TV and radio (60). This approach was essential considering that it involved a multi-agency approach which is vital in creating awareness on FGM.

The Office of the High Commissioner for Human Rights participates actively in the gender thematic group within the UN Country Team in Guinea, and in the sub-cluster focusing on gender-based violence (61). These groups provide a framework for reflection and discussion with the national authorities regarding ways to fight discrimination and violence inflicted on women and girls. In partnership with the authorities, medical and teaching professionals, NGOs, human rights defenders and other civil society actors, the office has organized and participated in numerous awareness-raising activities on FGM (61). Other UN entities are also active in the fight against FGM/E in West Africa, including UNFPA, UNICEF and UNDP, which in 2013-14 invested 1,000,000 USD to fight gender-based violence (including FGM/E) through training and awareness-raising within communities, and with judicial, security and health personnel (59,61).

7.2. TOSTAN Community empowerment program

Tostan is an International non-governmental organization based in Dakar, Senegal, and is registered with the US government. Its main goal is to "empower communities to define and realize their vision for the future and inspire large-scale movements leading to dignity for all" in several West African nations, including Senegal, Guinea, Guinea-Bissau, The Gambia, Mali, and Mauritania. It promotes human rights-based, informal educative initiatives, markedly the CEP,

with the purpose of assisting and empowering people and communities to drive their own development and achieve positive change on social norms (62)The program was established in Senegal as a community project with a focus on putting a stop to FGM. Community involvement is emphasized by TOSTAN through participatory engagement activities like discourse, discussions, and public affirmations an end FGM Although the focus of this initiative is on women and girls, it has recently included men in order to counteract negative gender norms through community sensitization (61–63).

7.3. Yes, I do program Kenya

This initiative has actively promoted long-term relationships with communities to address the social norms and cultural practices that are responsible for FGM in Kenya (64). The intervention resulted in the active participation of community members in the modification of attitudes and cultural practices that support FGM (64). The Yes, I do combines community mobilization, youth engagement, access of youth to education and services, economic empowerment, and a positive legal context. This worked in favor and reducing FGM, teenage pregnancy, and child marriage (65). The assessment demonstrates that community members, notably men's groups, women, young girls, and boys, engaged in gender transformative community-based education to deal with matters of gender equality in the affected community. The most advantageous aspect of the community-based program is that it approaches the issue of gender imbalance methodically and comprehensively at all levels of the community (64).

7.4. The chain approach (Ketenaanpak), the Netherlands

This practice was identified by the European institute of gender equality as a good practice for the prevention of FGM. It is operated by the ministry of health, welfare, and sport, the Netherlands. It is a technique for important players dealing with FGM to work together. It is vital when issues of FGM affect numerous structures and sectors that are not the purview of a single body. The chain approach incorporates key individuals from the community and experts and uses existing structures to address FGM from child safety and health care standpoint. It mainly targets professionals who are pertinent to the field of FGM protection, prevention, and service delivery., and the chain includes, all healthcare providers, schools, police, child protection agencies, and migrant organizations. Each participant is aware of their position within the chain and their counterparts. This strategy was evaluated and found to be successful in accomplishing the suggested objective whit is the fight against FGM (66).

7.5. Provision of services for FGM: The well-woman clinics

In the United Kingdom, one response to the presence of migrant women who had undergone FGM was the formation of a specialized service to meet their medical requirements. Because of this, the African well woman clinic was established, and it has been running since 1993 to date. The primary goal of this clinic is to give obstetric and gynecological care to victims of FGM. The clinic also focused on family members and communities of these victims in an effort to change behaviors. The African well woman clinics have made tremendous efforts to meet the unique requirement of girls and women who have gone through FGM. Along with providing health care, they have shaped policies, advocate against FGM and empower the affected communities. The clinic’s goals have

so far been accomplished and the services offered have been effectively utilized by the clinic's beneficiaries (66).

8.0. CHAPTER SEVEN: DISCUSSION

The findings from the literature review have shown that FGM remains a problem in SL despite the fact that efforts have been made to end it. The findings have revealed that key factors promoting FGM include cultural norms and principles, lack of policy implementation, and government support. FGM is practiced as a fundamental part of the SL culture, especially the way it is been organized around secret societies. The practice is considered sacred and vital and being part of the Bondo society as it is called in SL is vital in the tradition. The significant impact that cultural norms and values have on the various aspects of service provision within the health care system (86). It was revealed that women and girls' cultural beliefs influence how they understand female genital mutilation (FGM) and seek the care and prevention services they require. The decision to seek medical attention is significantly impacted by gender roles, particularly the role of men as the key decision maker at household levels, and women often having internalized the practices and attached gender roles also adhering to it.

Religion was also found to be a contributing factor, the majority of those involved in the practice are Muslims. Religion is linked with sociocultural factors and beliefs, as a number of women believe that FGM is required by religion. Marriageability also found as a promoting factor is linked to culture, as it is believed that women who are circumcised are prevented from promiscuity, and this makes it easier for them to find husbands and married (37).

Similarly, the effect of gender roles within the health system, particularly within the health workforce, can be a barrier to individuals in culturally sensitive communities that have a high prevalence of FGM. It is important to consider this overarching influence of gender preference as a reflection of cultural values and norms that influence the provision of FGM care services for women and girls, despite the fact that the issue of culturally sensitive care for FGM survivors is outside the scope and objectives of this study (57).

FGM is associated with various health consequences that can occur immediately of in long term, notwithstanding, the prevalence is still high because the practice of FGM is embedded on culture. all types of FGM commonly practiced in SL is associated with complications.

Another fundamental aspect that has been identified from the present study is the legal framework. Sierra Leone in 2019 banned FGM practice and its bid to eliminate the secret societies in the country. As a tool for regulation, the law prohibits the practice of FGM in the country. The law that prohibits FGM interacts with cultural values and norms, particularly in situations when health care personnel have cultural values that are compatible with the practice of FGM. It is believed that this common cultural value is a primary motivator for healthcare providers who practice FGM, even though they do so in secret to avoid the possibility of being arrested for their actions (27).

Sierra Leone has also been part of international treaties which agreed to end FGM practice in the country. Thus, international organizations have been at the forefront in the efforts to prevent FGM.

There are also international non-governmental organizations in the country that are working to implement SRH services. These organizations include the International Rescue Committee (IRC), Plan International, the United Nations Population Fund (UNFPA), and Marie Stopes International (MSI).

It is crucial to conceptually characterize how the health system interacts with the community and other sectors as well as the greater social structure. The continuance or discontinuation of FGM as a social norm can be influenced directly or indirectly by macro-level elements as socioeconomic, political, legal, and developmental issues. Additionally, the scope and success of measures to cease this practice will depend on the political stance and commitment of government officials or other players, the existence of criminalizing legislation, and the availability of financial or human resources (37).

The practice is common because it has been normalized by the society and it is not considered as a violation of girls' and women's right and dignity but a regular cultural practice. The situation is dire to the extent that those who do not practice FGM are victimized. The efforts by international organizations such as United Nations in the country have been trivialized with assertion that they do not respect the values and culture of the natives. Also as clearly described in the findings, being a member of the "Bondo Society" as the practice of FGM is referred to in SL, is an honor, Women who undergo the procedure gain respect and are considered to have good manners, suitable for marriage (wife material), and are highly recognized in society. Limited commitment from the government has created a greater level of laxity in the implementation of better structures to aid in FGM prevention.

Best practices in other countries found in this study that may be applicable in SL to combat the fight against FGM include the Tostan community empowerment program, the yes I do Kenya, provision of services for FGM, the chain approach, and national strategies for the abandonment of FGM in Guinea. All these practices have been proven to be effective and sustainable in the fight against FGM and have yield positive results.

Strengths and limitation of the study

The study has provided an in-depth understanding on the factors promoting as well as factors hindering FGM in SL. The conceptual framework helped me in understanding and analyzing these factors. The literature that has formed the basis of focus has been predominantly conducted in Sierra Leone which present a clear knowledge on the existing context on both factors that promote FGM and the factors that hinder FGM. The findings from the study are fundamental in informing policy change through review of the existing approaches as well as critically investigating interventions that have been used in other countries and have been successful.

Even though the framework was useful in achieving the general objective of this study, it did not clearly explain best practices in addressing in FGM which was one of the specific objectives of the study.

The study has focused on secondary data which might not present a clear understanding on the current context in the country. The study however has focused on most current peer reviewed and

published literature which present a wider perspective of the problem and possible interventions that can be adopted to improve the quality of study findings.

9.0. CHAPTER NINE: CONCLUSION AND RECOMMENDATIONS

9.1. Conclusion

This literature review looked at the factors affecting the practice of FGM in SL., that is, perpetuating and hindering factors. It was discovered that tradition and culture have a significant influence in the practice of FGM. The socioeconomic and cultural factors affecting the practice include cultural traditions, marriageability, religion, educational level, and gender.

FGM is a fundamental part of the SL culture. The tradition is considered important for the rite of passage from girls to womanhood, where girls are prepared for marriage and motherhood. Those who undergo the procedure are regarded as respectful, ready for marriage, and are believed to easily find husbands.

Religion was identified as a perpetuating factor and is directly linked with culture and beliefs. The prevalence of FGM is higher among Muslim women than among Christians.

Gender generally, decisions to perform FGM are made by women, but men plan a vital role, as they are considered the head of the household and they have the final say in decision making.

The education level of women is important in combating FGM in SL. Women with higher educational levels are less likely to continue the procedure as they believe that it should be discontinued.

FGM is associated with various short-term and long-term health consequences, including, severe pain, shock, hemorrhage, tetanus or infection, urinary retention, complications from childbirth, keloids, anemia, dyspareunia, sexual dysfunction, etc.

The health system plays minimal role in preventing FGM and managing the health consequences presented by women who have undergone the practice. The fight against FGM has not been particularly successful. Additionally, efforts to combat it are hindered by the lack of legislative laws which criminalize the act. In order to overcome these challenges and get better results, there is a critical need to broaden and increase efforts to end FGM, taking into account community-based initiatives and advocacy campaigns against FGM.

9.2. Recommendations

Recommendation for Government:

- Implement laws prohibiting the practice of FGM and those who go against these laws should face consequences.

- Involve relevant stakeholders, such as, MOHS, religious and community heads, women groups, adolescent, and youth groups, and even the men, when making decisions about these anti FGM policies and laws.

- Actively engage the community and create campaigns against the practice of FGM which will target the above-mentioned stakeholders and educate all members of the community about misconceptions and cultural beliefs surrounding the Bondo society and why it needs to be stopped.

- Make provision for women empowerment programs; these programs should aim at educating young girls and women, should provide them with financial stability, protect them from all forms of violence including FGM. In this also, men and young people should be engaged.

- Collaborate with other anti FGM non-governmental organizations in their effort to end the practice.

Recommendations for the MOHS:

- Develop a policy or adjust the current RMNCAH policy, to address the health consequences of FGM and better manage women and young girls who develop these health consequences.

- Educate health workers at all levels and encourage them to participate in improving the role the health sector plays in preventing FGM.

- Educate the community, especially women and young girls about the health consequences of FGM, and what they should do/ how they should seek medical care should they present with any of such complications.

Recommendations for the community:

- Positive behavioral change towards the abandonment of FGM.

- Encourage relevant community stakeholders to cooperate with the government and MOHS in the fight against FGM and the management of its health consequences.

- Suggest to women, other ways of teaching their daughters, and preparing them for adulthood, motherhood, or marriage without practicing FGM. These alternative ways can be, teachings about dating and relationships, comprehensive sexuality education, teachings of modesty, positive attitude, good manners, etc.

- Encourage men in protecting their wives and daughters against the violence of any type including FGM.

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