ORIGINAL RESEARCH ARTICLE

Female Genital Mutilation in Sierra Leone: who are the decision makers?

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Abstract

The objectives of this study were to identify decision makers for FGM and determine whether medicalization takes place in Sierra Leone. Structured interviews were conducted with 310 randomly selected girls between 10 and 20 years in Bombali and Port Loko Districts in Northern Sierra Leone. The average age of the girls in this sample was 14 years, 61% had undergone FGM at an average age of 7.7 years (range 1-18). Generally, decisions to perform FGM were made by women, but father was mentioned as the one who decided by 28% of the respondents. The traditional excisors (Soweis) performed 80% of all operations, health professionals 13%, and traditional birth attendants 6%. Men may play a more important role in the decision making process in relation to FGM than previously known. Authorities and health professionals' associations need to consider how to prevent further medicalization of the practice. (*Afr J Reprod Health 2012; 16[4]: 119-131).*

Résumé

Les objectifs de cette étude étaient d'identifier les décideurs à l'égard des mutilations génitales féminines et de déterminer si la médicalisation a lieu en Sierra Leone. Des entretiens structurés ont été menés avec 310 filles choisies au hasard entre 10 et 20 ans dans les Districts de Bombali et de Port Loko au nord de la Sierra Leone. L'âge moyen des filles dans cet échantillon était de 14 ans, 61% avaient subi des MGF à un âge moyen de 7,7 ans (entre 1-18ans). En règle générale, les décisions sur les mutilations sexuelles féminines ont été prises par les femmes, mais 28% des interviewés ont mentionné le père comme étant celui qui a décidé. Les exciseuses traditionnelles (Soweis) ont effectué 80% de toutes les opérations, les professionnels de santé 13%, et les accoucheuses traditionnelles 6%. Les hommes peuvent jouer un rôle plus important dans le processus de décision en ce qui concerne les mutilations génitales féminines que précédemment connu. Les autorités et les associations de professionnels de santé doivent tenir compte de la manière de prévenir la médicalisation de cette pratique (*Afr J Reprod Health 2012; 16[4]: 119-131).*

Keywords: Female genital mutilation, Sierra Leone, decision makers, medicalization

Introduction

The term Female Genital Mutilation (FGM) is given to the physical operation which involves the cutting or altering of female genitalia[1]. Although the practice is found in parts of Asia and the Middle East[1], it originates from Africa where it is practised in 28 countries, with more than 90 million girls and women living with its consequences[2] and 3 million girls at risk of undergoing the practice every year[3].

Over the past two decades, female genital mutilation has come to be recognised as a violation of human rights[1] and a plethora of studies have shown it to have negative health effects on girls and women[4-9]. Because of this, countries in Africa and Europe have enacted specific laws against the practice. Also, international and regional human rights treaties call on governments to recognise the practice as a violation of human rights and act for the protection of girls and women[1, 10].

The prevalence rate in Sierra Leone and similar neighbouring high prevalence countries is decreasing. In Sierra Leone, the overall FGM prevalence has declined between 2006 and 2010 from 91% to 88% [11]. The difference in prevalence between women whose mothers have no education (95%) and women whose mothers have secondary education or higher (74.2%) is higher in Sierra

Leone than in neighbouring countries (table 1)[12]. Similarly, there is a larger difference between different generations when comparing these same countries. In Sierra Leone the prevalence of FGM among women 45 – 49 years of age is much higher (96.4%) than among women 15 – 19 years of age (70.1%). These differences indicate there is an ongoing change of practice, and that some people tend to abandon the practice.

Decision-making

The process of deciding whether and when to perform female genital mutilation has been shown to be a complex one, time-consuming in some situations, involving several types of persons related to the girl in question, a process which Shell-Duncan and Hernlund have described as a "*constellation of decision makers*" in the "*arena of decision-making*"[13]. Identified arenas for decision making are the community, the family and the individual. They mention that community elders would decide when FGM was going to take place, and all the families of all girls who were of the age for the procedure would be notified.

In the Sierra Leonean context, it has been known for the Sowei (the traditional excisor) to visit families whose girls were deemed to be of the age for FGM and inform them about the next initiation ceremony. The pressure girls and women may feel in communities that practise FGM in Sierra Leone can also be seen as a "community decision maker" for girls to undergo FGM.

Decision making about FGM is more commonly made at the family level where mainly the female members of the family, mothers, and grandmothers are involved. Shell-Duncan and Hernlund note that fathers appear to have the power to "veto" decisions about FGM, this power varying depending on family[13].

Although not as usual compared to the decision makers described above, individual girls themselves can decide whether they will undergo FGM.

Medicalization

The concept of "medicalization" of female genital mutilation refers to situations when a health professional practices any form of female genital mutilation[14]. It has been argued that female genital mutilation is becoming more medicalized as a result of early campaigns which presented arguments against female genital mutilation as a health problem: many, severe health complications arise from the practice when it is performed by unskilled traditional cutters in unhygienic conditions and may be a mechanism for transmission of HIV, when the same blade is used to perform the operation on several girls[14].

The medicalization of female genital mutilation has been presented as a harm reduction strategy, rather than the sustainable abandonment of the practice, which has, so far, been difficult to achieve[15]. The theory of harm reduction has been used within public health to minimise the hazards associated with some risk behaviours, such as sexual activity and intravenous drug use[15].

Table 1: Comparing FGM prevalence rates in high prevalence countries

	Sierra Leone	The Gambia	Guinea	Mali
Rate among women 15-49 – 2006	91	78	96	85
Rate among women 15-49 – 2010	88			
Rate among women whose mothers have no education	95.0	81.1	97.1	92.4
Rate among women whose mothers have secondary education or higher	74.2	71.2	89.9	86.6
Rural rate	92.3	82.8	96.4	87.4
Urban rate	80.7	72.2	93.9	80.9
Rate among women aged 45-49	96.4	74.2	99.5	85.8
Rate among women aged 15-19	70.1	79.9	89.3	84.7

Statistics Sierra Leone and UNICEF-Sierra Leone. 2011. Sierra Leone Multiple Indicator Cluster Survey 2010, Final Report. Freetown, Sierra Leone: Statistics Sierra Leone and UNICEF-Sierra Leone.

The problem with allowing health professionals to perform female genital mutilation is that this act constitutes a break in medical professionalism and ethical responsibility[14], legitimises it, and gives the sense that the practice is either harmless or good for the health[14]. Furthermore, if female genital mutilation is medicalized, girls and women are still vulnerable to some of the long-term obstetric, psychological and sexual complications, which have been found to be associated with female genital mutilation, regardless of who performs it[14]. Allowing female genital mutilation to be performed by health professionals has not been proved as a stepping stone stage towards abandonment of the practice[14].

Studies are needed to understand the cultural significance of the practice to individuals, their families and communities that choose to continue female genital mutilation. To underscore the value of the practice to them, communities have chosen to move from performing female genital mutilation in the traditional ways to using modern medical methods in the belief that this would reduce or remove some of the problems usually attributed to the practice in advocacy messages which emphasise the negative health effects of the practice[14, 16-18].

In Sierra Leone, according to the Sierra Leone Demographic and Health Survey (SL DHS 2008), 76% of girls between the ages of 15 and 19 years have undergone female genital mutilation[19], with 22% of women reporting that they had undergone the operation during infancy[19].

Female genital mutilation takes place within the Bondo Society as part of the initiation ceremony to become a woman. The Bondo is a powerful all-woman led and run secret society, which a girl joins to become recognized as a woman in her community and which also creates a women-only space for belonging and sisterhood[20 - 22]. The names of the Societies in the various languages differ according to the ethnic groups (table 2).

Bondo Societies are organised by ethnic groups, and are run by older women –referred to as *Digba* in Temne or *Majo* in Mende, or generally as *Sowei.* They are heads of the Societies and are believed to have supernatural powers to punish anyone who reveals the secrets of the Society with curses and serious, incurable conditions. This fear is used to maintain secrecy and keep members together[21]. Traditionally, Soweis perform the cutting as part of the first activity of initiation.

Although Sierra Leone is a signatory of the Convention for the Elimination of Discrimination against Women (CEDAW), there is no national law against female genital mutilation. This study set out to identify decision makers for female genital mutilation and the extent of medicalization of the practice in Sierra Leone.

Methods

In Sierra Leone the Northern Province has Makeni as its administrative centre. Two Districts in the Province, Bombali and Port Loko, have population estimates of 409,000 and 454,000 respectively[23]. In the North, the Temne ethnic group is the largest one with smaller numbers of Limba, Korankoh, Madinka, Loko and Fulas[24]. Eight out of 10 Sierra Leoneans practise Islam, with 20% professing Christianity[19]. Some 67.2% of the population lives in rural settings and some 32.8% in urban areas[19]. Recently built new roads (2009 – present) and the restart of mining for iron ore and bauxite have enhanced access to and movement of communities in the region.

Table 2: Names of aspects of Bondo Society in the Main Sierra Leonean Languages

Ethnic Group	Name of Bondo Society	Name of Head of Society/Bush	Name of new initiate	Name of non initiate
Fulah	Baytee	Barajelli	Betijor	Jiwor
Limba	Bondo	Baregba	Gbonka	Gboroka
Loko	Bondona	Digba	Bondona/Bondofayra	Gborrga
Mende	Sande	Sokonday/Sowei/Majo	Sandewi	Kpowei
Susu	Guhngiri	Joangojeri	Taysingeh	Amoogaangeh
Temne	Bondo	Digba	Aboanka	Gburka

Under the aegis of Plan Sierra Leone, this study was conducted and funded in cooperation with two non-governmental organisations (NGOs), the Centre for Democracy and Human Rights (CDHR), which works in Bombali district, and the Amazonian Initiative Movement working in Port Loko District. Both NGOs work in human rights, using international and national legal instruments such as the Convention of the Rights of the Child and the Child Rights Act of Sierra Leone 2007 to popularise and disseminate information amongst communities about their rights.

The study was a cross sectional community based survey where simple random sampling was used to assign numbers to the streets in the communities. Data collectors chose from a bag a street number, and then selected the first household of that street and every fifth one afterwards. At this level, purposive sampling was used to select girls who were the focus of interest in this study. The age range 10 – 20 was chosen as this is the age when girls are likely to undergo FGM.

Girls were approached for this study because we wanted to know the extent of information they receive on a matter which directly affects them.

A total of 350 girls were sampled for interviews, 175 from each District.

The method for data collection was face-to-face interviews using semi-structured questionnaires. The questionnaire was used to collect socio demographic data including information on schooling. Questions on FGM focused on who made the decision for FGM, what age the operation was performed and who performed FGM. The questions on decision making for FGM and treatment of complications where these occurred were framed thus: "*If you have been to the Bondo Bush, who made the decision for you to go?*" and "*If you did seek medical care because of complication, who provided the care?*"

Training of eight data collectors and two supervisors started in November 2008. We were concerned about bias from those respondents who might wish to provide what they consider to be socially acceptable, avoid embarrassment, or try to please the interviewer, this effect more likely among the younger age groups. To address this, interviewers performed role-plays and mock interviews with feedback on performance, and were trained on how to probe in a non-directive manner. They were advised not to express their views on topics in the interview, and not to give any personal information which might provide a basis for inferring what their preferences or values might be. Pretesting of questionnaire was carried out in Makeni as part of training and necessary revisions made.

We discovered from the pretesting that girls under 13 were not as responsive as older girls, so the data collection team decided that for girls under the age of 13, the consenting parent would be asked to be in the vicinity of where the interview was taking place, in order to give the girl an added sense of security and freedom to talk about her experiences. It was noted during the pretesting that girls 13 years and older were more confident and gave their responses more readily. If the girl did not know who had made the decision for her to join Bondo, the parent or guardian was asked. If this information was not available, the girl was asked who told her that she was going to join Bondo as the proxy question. Ethical permission was sought and obtained from the Sierra Leone Research and Ethics Committee in 2008.

Once consent of parent and assent of the girl had been given, the interviews took place in a place in the community where both the interviewer and interviewee could be seen but not heard. Interviews took place in Krio and Temne and responses were written down in English.

Data collection started in November 2009 and finished in January 2010. Supervisors regularly monitored data collection and data collection forms to guarantee high quality of data. At monthly site visits by the research project officer, each data collector and supervisor was asked to anonymously complete a form of their experiences in data collection or quality control of the questionnaires, followed by a meeting of the whole group. In this way, any problems that occurred could be addressed quickly, and procedures modified, and at the same time, lessons could be learnt from each other's experiences.

A total of 335 respondents were interviewed out of the sampled 350 respondents because of time

constraints. The analysis included 310 as 25 girls were out of the age range of the study.

Statistical analysis

The data was analysed in Excel, and descriptive statistics were used to describe the data.

Results

The sample comprised 310 girls in the age range 10 – 20 with an average age of 14 years (Table 3). Most were at school (n=202, 65%), the majority still in the primary years. Over a third were illiterate (n=108, 35%). Temne (n=163, 52.6%), Loko (n=72, 23.2%), and Limba (n=48, 15.5%) were the largest ethnic groups, the majority of whom were Muslims (n=192, 61.9%).Slightly over a third of the sample was Christians (n=106, 34.2%) and 12 reported no religious affiliations. Most girls were students (54.5%, n=169) with 24.2% (n=75) describing themselves as unemployed. The category described as "Other" included commercial sex workers (aged 10 and 18); gardener (aged 14), Sowei (aged 12), Teacher (aged 15), girls who help around the house (aged 10 – 18).

In total, 189 respondents (61.1%) had undergone female genital mutilation with 18 of these (5.8%) not knowing when the operation had been performed. The average age at female genital mutilation was 7.7 years (range 1 – 18). Five girls reported they were between 0 -1 years when they underwent female genital mutilation. The most common age ranges to undergo female genital mutilation are 10 – 14 years (n=68, 21.9%), and 5 – 9 years (n=66, 21.3%) as table 4 shows. Nearly a third of the whole sample (n=94, 30.5%) had been cut before their tenth birthday.

Table 5 shows the distribution of age at female genital mutilation by ethnic group. Both Mende girls had been cut and there were high proportions amongst Madingo (83.3%), Fulah (81.8%), and Loko (65.8%). There seems to be a wide age range in which female genital mutilation takes place for all ethnic groups.

Table 3: Socio demographic characteristics of study population

	Numbers	Percentage (%)
Age		
10 – 12	100	32.3
13 – 15	113	36.5
16 – 18	87	28.0
19 – 20	10	3.2
	310	100
Religion		
Christianity	106	34.2
Islam	192	61.9
No Religion	12	3.9
Total	310	100
Educational Status		
Illiterate	108	35
At School	202	65
Primary	104	51.5
Junior Sec. School	78	38.6
Senior Sec. School	17	8.4
Tertiary	3	1.5
Total	310	100
Occupation		
Unemployed	75	24.2
Employed	235	75.8
Student	169	71.9
Trader	24	10.2
Farmer	22	9.4
Housewife	7	3.0
Other*	13	5.5
Total	310	100
Tribe		
Fulah	11	3.5
Kono	6	2.0
Korankoh	2	0.6
Limba	48	15.5
Loko	72	23.2
Madingo	6	2.0
Mende	2	0.6
Temne	163	52.6
Total	310	100

*Other Occupations included Commercial Sex Worker, Gardener, Sowei, and Teacher

Table 4: Distribution of Age at female genital mutilation

Age at FGM	Numbers	Percentage
Infant	-	-
0 – 1	5	1.6
2 – 4	23	7.4
5 – 9	66	21.3
10 – 14	68	21.9
15+	9	2.9
Don't Know	18	5.8
Total	189	

From this sample, although it is females who reportedly dominate the decision-making process, fathers were mentioned equally often as mothers as the one who decided the girl should be cut (Table 6). Other decision makers mentioned in responses were grandmothers and aunts and, to a lesser extent grandfathers, guardian (sex unknown), grandmother and mother jointly and a sister. In seven instances, a combination of relatives made the decision for FGM: in six cases, it was the mother and father together, and in one case, it was the mother and grandmother together.

Distributions of decision makers by ethnic group and age of participant; and by ethnic group and religion of participants are shown in tables 7 and 8. Our results show that, overwhelmingly, the cutting, reportedly, continues to be carried out by Soweis, the traditional excisor (n=150, 79.4%), although health professionals (nurses, n=25, 13.2%) also perform female genital mutilation (table 9). Traditional birth attendants are reported as performers of female genital mutilation on a smaller scale (n=11, 5.8%).

Table 5: Percentage Distribution of Age at female genital mutilation by Ethnic Group

Ethnic Group	0 – 1	2 – 4	5 – 9	10 – 14	15+	Don't Know	Total Cut	Proportion Cut	No Response (Don't Know if Cut)	Total Uncut	Total no. for Ethnic Group
Fulah	1	1	5	1	-	1	9	81.8	1	1	11
Kono	-	-	1	2	-	-	3	50.0	-	3	6
Korankoh	-	-	-	1	-	-	1	50.0	-	1	2
Limba	-	3	10	9	1	4	27	56.3	4	17	48
Loko	3	11	16	13	4	-	47	65.3		25	72
Madingo	-	2	1	1	1	-	5	83.3	-	1	6
Mende	-	-	-	2	-	-	2	100	-	-	2
Temne	1	6	33	39	3	13	95	58.3	27	41	163
TOTAL	**5**	**23**	**66**	**68**	**9**	**18**	**189**	**61.1**	**32**	**89**	**310**

Table 6: Decision Makers Distributed by Sex and Relationship with Decision Maker

Type of Relative	Frequency Male	Female	Male and Female OR Don't Know	% Of all who joined Bondo (n=190)
Father only	54	-	-	28.4
Mother only	-	51	-	27.4
Grandmother	-	39	-	20.6
Aunt	-	29	-	15.3
Father and Mother	-	-	6	3.2
Husband	2	-	-	1
Grandfather	2			1
Others¤	-	2	1	1.6
Myself	-	2	-	1
Don't Know	-	-	1	0.5
Total (numbers)	**58**	**123**	**8**	
Proportion (%)	*30.7*	*65.1*	*4.2*	**100**

¤Others were Guardian (n=1, sex unknown); Mother and Grandmother (n=1); Sister (n=1)

Table 7: Decision Makers Distributed by Ethnic Group and Age of Participant (%)

	10 – 12	13 – 15	16 -18	19 – 20	Total
Aunts					
Fulah	0	2	0	0	
Limba	3	2	0	1	
Loko	4	4	0	0	
Temne	4	5	4	0	
Sub-Total	***11***	***13***	***4***	***1***	
Don't Know					
Temne	***0***	***0***	***1***	***0***	
Father					
Fulah	1	0	1	0	
Limba	1	2	2	0	
Loko	8	7	6	0	
Madingo	0	3	0	0	
Temne	11	8	4	0	
Sub-Total	***21***	***20***	***13***	***0***	
Mother & Father					
Limba	1	1	0	0	
Loko	1	0	0	0	
Temne	0	1	2	0	
Sub-Total	***2***	***2***	***2***	***0***	
Grandmother					
Fulah	0	0	0	1	
Limba	0	2	1	1	
Loko	4	4	3	0	
Madingo	0	0	1	0	
Temne	7	7	7	1	
Sub-Total	***11***	***13***	***12***	***3***	
Guardian					
Temne	***0***	***0***	***1***	***0***	
Husband					
Temne	***0***	***1***	***1***	***0***	
Mother					
Fulah	0	4	0	0	
Kono	2	0	1	0	
Korankoh	0	1	0	0	
Limba	4	5	1	0	
Loko	0	3	2	0	
Mende	1	0	1	0	
Temne	4	4	16	2	
Sub-Total	***11***	***17***	***21***	***2***	
Mother & Grandmother					
Temne	***1***	***0***	***0***	***0***	
Myself					
Loko	0	0	1	0	
Madingo	0	0	0	1	
Sub-Total	***0***	***0***	***1***	***1***	
Sister					
Temne	***0***	***1***	***0***	***0***	

Table 8: Decision Makers Distributed by Ethnic Group and Religion of Participant (%)

	Christian	Muslim	No Religion	Total
Aunts				
Fulah	0	2	0	2
Limba	1	5	0	6
Loko	3	5	0	8
Temne	1	12	0	13
Sub-Total	***5***	***24***	***0***	***29***
Don't Know				
Temne	***0***	***1***	***0***	***1***
Father				
Fulah	0	2	0	2
Limba	3	2	0	5
Loko	6	15	0	21
Madingo	0	3	0	3
Temne	3	20	0	23
Sub-Total	***12***	***42***	***0***	***54***
Grandmother				
Fulah	0	1	0	1
Limba	1	3	0	4
Loko	6	5	0	11
Madingo	0	1	0	1
Temne	6	16	0	22
Sub-Total	***13***	***26***	***0***	***39***
Grandfather				
Temne	***0***	***2***	***0***	***2***
Guardian				
Temne	***0***	***1***	***0***	***1***
Husband				
Temne	***0***	***2***	***0***	***2***
Mother				
Fulah	2	1	1	4
Kono	1	1	1	3
Korankoh	0	1	0	1
Limba	7	3	0	10
Loko	4	1	0	5
Mende	0	2	0	2
Temne	5	21	0	26
Sub-Total	***19***	***30***	***2***	***51***
Mother & Father				
Limba	0	2	0	2
Loko	0	1	0	1
Temne	2	1	0	3
Sub-Total	***2***	***4***	***0***	***6***
Mother & Grandmother				
Temne	***0***	***1***	***0***	***1***
Myself				
Loko	0	1	0	1
Madingo	0	1	0	1
Sub-Total	***0***	***2***	***0***	***2***
Sister				
Temne	***0***	***1***	***0***	***1***
Subtotal	***0***	***1***	***0***	***1***

Discussion

This study shows that although FGM is still primarily a matter for women to decide on, men seem to play a more important role than previously known. There are also indications that health professionals have started to perform the operation of FGM, thus medicalizing the practice. The results of this study are particularly interesting since the respondents are the ones primarily affected by FGM: the girls.

Limitations

In our sample, there are relatively more girls in the younger age range (10 – 15) than in the older age range 16 – 20), and there are relatively many girls in education (n=202, 65%) compared to a national literacy among young women 15 – 24 years of 48.3% [11]. However, we believe that the sample, randomly obtained, is likely to be representative of the area as efforts have been made to remove the influence of systematic error. Thus, we consider the study sample to be representative of girls in the given age group in the communities studied, but not representative of the population in Sierra Leone, particularly as it does not cover all ethnic groups and is geographically limited to the studied areas. The results do, however, give a valuable insight to processes surrounding FGM that are valid in other parts of Sierra Leone and, possibly, other areas as well.

Whilst the girls asked in our study could tell who had decided for FGM, the methodology of the present study did not aim to address the whole decision making process. In addition, we did not address the issue where the cutting had taken place. From our results however, the high proportion of Soweis – traditional excisors – performing the cutting suggests that most of the cutting actually continues to take place within the Bondo Bush, and therefore within the initiation ceremony.

FGM Prevalence

The FGM prevalence in this study is low (61%) compared to the national prevalence of 88% from

Table 9: Who Performed the Cutting?

			Percentage			
Person	**Number of Responses**	**Percentage of Cut Girls (n=190)**	**DHS Sierra Leone 2008**	**DHS Guinea 2005**	**DHS Mali 2006**	**DHS Nigeria 2008**
Sowei /Traditional excisor	150	79.4	96.9	89.7	92.6	64.2
Nurse/Health Personnel	25	13.2	0.3	9.0	2.5	18.3
Traditional Birth Attendant	11	5.8				
Don't Know	1	0.5				17.5*
Nurse &Sowei	1	0.5				
Other: My Aunt	1	0.5				
Total	**189**	**100**				

*Missing or Don't Know

the Sierra Leone Multiple Index Cluster Survey 2010 (SL MICS 2010), but closer to the prevalence for girls aged 15 – 19 (70.1%) in the same survey. The SL MICS 2010 shows that both education of the woman's mother and urbanization are factors which are likely to decrease the practice of FGM. In Sierra Leone, given that FGM occurs only within the initiation ceremony of the Bondo Society, it is likely that the more educated mothers and those families living in the urban areas are less likely to choose Bondo membership as a means of identification, power, and status.

Notable social changes such as migration, urbanization, the breakdown of traditional values and mores may also be contributing to the faster rate at which FGM appears to be declining in Sierra Leone compared to neighbouring countries.

Some campaigns for FGM abandonment have not spoken out against the Bondo Society, but instead have urged families to provide education for the girl child instead of Bondo, pointing that an educated girl is more likely better able to financially assist her parental family than a girl who has not been to school.

Age at FGM

The age range 10 – 14 was when most girls underwent female genital mutilation, representing 21.9% of our sample compared to 35.6% from the Sierra Leone Demographic and Health Survey 2008 findings [19]. For the age range 5 -9, 21.3% of our sample underwent the procedure during this time compared to 13.0% from the Sierra Leone Demographic and Health Survey 2008. This difference could be due to the fact that the composition of ethnic groups in our sample is not representative to Sierra Leone, and that from our sample, it appears girls undergo female genital mutilation at different ages in various ethnic groups.

In our study, 5.8% (n=18) of the girls reported they did not know when they were cut, which might suggest that they were too young to remember. For reported ages at female genital mutilation under four years of age, we speculate that girls were told by their families when they were cut, rather than the girls themselves remembering the incident.

In our study, when we asked girls at what age they had undergone FGM, they either gave us an age or they told us that they did not know. We can speculate that the Don't Knows may correspond to some girls who underwent the procedure at infancy, but we do not know this for sure. We are not certain how the DHS survey identifies those girls who had undergone FGM at infancy.

We suggest also that the difference in proportions from our results and the Sierra Leone Demographic and Health Survey 2008 findings might be that girls who have not yet undergone female genital mutilation might still undergo the procedure, particularly those from the younger age groups.

Over 50% of respondents in our sample were from the Temne ethnic group, and some 20% from the Loko ethnic group, two ethnic groups which are reported to cut traditionally between 6 – 14 years [21]. As can be seen from our results (Table 5.) it is not unusual that FGM takes place outside this age range.

Decision makers for FGM by sex and relation to girl

Decisions, on the whole, have been made– as reported by respondents – by females (mothers, grandmothers and aunts). Men – mainly fathers – were involved in decision making for almost one third of the girls. Even though the traditional excisors are the ones who predominantly perform female genital mutilation, a relatively high proportion of operations was made by health professionals, indicating an emerging medicalization of the practice.

In our study, we specifically asked girls who made the decision for them to join Bondo and from the responses we received, we conclude that there has been a sole decision maker for each respondent. We found that mothers, grandmothers and fathers are the main decision makers for girls undergoing female genital mutilation, with females representing two thirds of the reported decision makers. This is not the case in other studies, notably the one performed in the Gambia [13]. Here it was reported that several family members were involved in the decision making process.

In another study in Sierra Leone, respondents comprising unmarried girls and married women, young and older men, traditional leaders and health personnel as well as Soweis were asked who makes the decision for female genital mutilation. There was no clear response to the questions, and the participants' answers were different within social categories, some reporting that it was the mother after family discussion, others reporting that it was the father as he had to pay, and that he also carried vetoing power, this power being more evident in Islamic households [21]. In the cases where the father may say no initially, often pressure is brought to bear upon him from his mother, aunts and other women-in-laws for him to change his mind [21].

Our study shows that the majority of decision is made by women. We found that mothers alone make 28% (n=53) of the decision makers for FGM. Other studies in Sierra Leone confirm our findings that the mother has a major role as instigator in the decision making for FGM [20, 21]. It is hardly surprising that women would not only make a decision to undergo female genital mutilation but also that the decision regarding when the operation is performed remains with women. Going to the Bondo Bush for the initiation ceremony where female genital mutilation is performed is one of the few places where they can get a break from work. It is a private, for-women-only space where they eat well, rest, sing and dance, and have sex with whomever they choose [21].

The Bondo provides "*stress relief*" for women who traditionally carry the brunt of caring for the household and farming. The women are outside the authority and reach of men who do not have the right to ask questions about the Bondo or enter into the Bush. During the time in the Bondo Bush, women can seek advice and support from older women for problems and household matters [21, 22]. It is one of the few places that women can meet which remains strictly outside the realm of men [26].

Interesting in our study is the number of males (mainly fathers) who reportedly made the decision. This is surprising because in other parts of Africa, studies have shown that when men, usually fathers, are involved in the decision making process, they generally advocate against the practice, rather than for it [27]. A Sudanese study shows that more young men than young women did not want their daughters to undergo female genital mutilation[27]. Older men have tended to be passive in the decision-making process about female genital mutilation or men have been the main sources of objection of the practice [27, 28]. It would be important to actively involve men in future studies in Sierra Leone, in order to find out their attitudes and role in the practice.

However, there is some evidence, which is in agreement with the male/father involvement that we found in this study. A study in Nigeria indicates that more fathers than mothers intended to have their daughters cut, the reasons for this being that men are the major decision makers [29]. Another study in Egypt showed that men valued female genital mutilation as a means of keeping their daughters as virgins before marriage, and faithful afterwards [30]. This might be a reason influencing males as decision makers supporting female genital mutilation, rather than opposing the practice. A study based in southern Nigeria also

found that, overall fathers were the primary decision makers in 58% of the responses, compared to mothers (27%) [31], although in one ethnic group, Etsako, mothers were the key decision makers (43%) compared to fathers (31%).

We found in our study that in two cases, it was the husband who decided for FGM. Both girls were under 18 years of age (15 & 17 years), both were Temne, and had not ever been to school.

Our study found that two girls decided, reportedly, themselves to undergo female genital mutilation. One was of Loko origin and decided at 16 years of age, the other of Madingo origin at 18 years of age. Although the girls were not asked why they decided for themselves to undergo FGM, reports of uncut girls hindered from getting water at the well, or being put last in the queue regardless of when they turn up are not unusual (*O. Bjälkander, unpublished observations, 2011*). This social pressure which can take the form of name calling, shunning and bullying girls can feel can continue into adulthood where women can be excluded from leadership positions[22, 32].

Who performed the cutting?

From our study, medicalization had occurred in 13.2% (n=25) cases of FGM, even though the results show that it is traditional excisors (79.4%, n=150) who predominantly perform female genital mutilation. The results indicate an emerging medicalization of the practice. This proportion of medicalization in our study was higher than the proportion (0.3%) reported in the Sierra Leone Demographic and Health Survey 2008[19]. The large difference in medicalization between our study and the DHS result may be due to the fact that younger aged girls, particularly those in the 15 – 19 age group and from which we mainly draw our sample, are more likely to be cut by a health professional; and also, the addition of females up to the age of 49 in the DHS survey would have the effect of reducing the proportion of medicalisation in that sample, compared to ours.

Medicalization appears to be a relatively new phenomenon in West African countries with high FGM prevalence. The prevalence of 0.3 for Sierra Leone is negligible when compared to medically performed FGM in Guinea [33], Mali [34], and Nigeria [35].

Our study shows that 5.8% (n=11) girls reported they had been cut by a traditional birth attendant (TBA), whilst in the DHS 2008 0.5% of the respondents report they had been cut by a TBA. One reason for the difference might be that the girls found it difficult to differentiate between a health professional and the traditional excisor. In many communities, Soweis also act as traditional birth attendants (TBAs). As early as in the 1920s, Sir Milton Margai, the first Prime Minister of Sierra Leone, who was also a medical doctor, upgraded the positions of Soweis to TBAs in communities, providing them with basic literacy skills as well as instruction in anatomy, physiology, hygiene, sanitation, first aid and baby care [20]. It is therefore possible that girls reported a Sowei who is a TBA as a Sowei rather than a TBA when asked who performed the cutting.

Conclusion

Men may play a more important role in the decision-making process in relation to female genital mutilation than previously known. This merits attention in future research. It would be important to find out more about the role of men in the decision process, and how to address them in future anti-female genital mutilation campaigns.
Women are still amongst the dominant actors supporting the practice. However, more studies are required to understand the role of the community, other family members, their roles in and influence on the decision making process. A more comprehensive survey of the decision making process of FGM would need a more extensive and far-reaching qualitative study. Such a study would provide data distributed by age which could used to develop models of behavior change. These models should include the numbers and types of decision makers, how their views may differ, and how views may relate to residency (rural or urban setting) of the decision maker.

Our results indicate there might be an increasing medicalization of female genital mutilation, which is a cause for concern. We do not know whether this is a result of anti-female genital mutilation campaigns focusing on health

effects, or if this is a result of another trend in the society.

Nevertheless, health personnel would benefit from culturally sensitive training on medical ethics, as well as how to address the reasons for and consequences of female genital mutilation. Authorities and health professionals' associations need to consider how to prevent further medicalization of the practice.

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