FEMALE GENITAL MUTILATION (FGM) IN SIERRA LEONE: FACTORS INFLUENCING THE PRACTICE IN JAIAMA BONGOR CHIEFDOM IN BO DISTRICT

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INTRODUCTION
Female genital mutilation (FGM), also known as female genital cutting and female circumcision, is defined by the World Health Organization (2008) as all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. The term to define the practice of female genital mutilation has undergone a number of changes. Boyle (2005:4) writes that WHO adopted to use the term female circumcision because this practice was referred to as a social and cultural issue as opposed to a medical issue. According to Shell-Duncan et al (2000:6), the term female genital mutilation (FGM) was adopted at the Third Conference of the Inter African Committee on Traditional Practices. At the community level, using the term mutilation can be viewed judgmental and condemnatory. Female Circumcision is used by practicing communities because it is a close literal translation from their own languages (Population reference Bureau 2001). In 1996, the Reproductive-Educative and Community Health Programme (REACH), a United Nations Population Funded programme, opted to use female genital cutting (FGC) instead of female genital mutilation which was thought to imply excessive judgment by outsiders as well as insensitivity towards individuals who have undergone the procedure (Ni Mhordha 2007; Shell-Duncan et al 2000). For purposes of this study, the terms female genital mutilation (FGM) and female genital circumcision/cutting (FGC) were used alternately. The World Health Organization classified female genital mutilation into four types (WHO. 2008). Type I – excision of the prepuce, with or without excision of part or the entire clitoris. It is also called clitoridotomy (in Greek, means “incision”). In Islamic culture, this type is known as “Sunna” (“tradition”). Type II – excision of clitoris with partial or total excision of the Labia minora; also known as Excision (is a Greek word meaning “cut”). Type III – excision of part or all of the external genital and stitching/narrow of the vaginal opening, with or without the removal of the clitoris. Two small holes are left for urine and menstrual blood. This type is sometimes referred to as ‘Pharaonic’, and its name comes from the Latin word “infibulare” (“faster, with a clasp”) also known as Infibulations. Type IV – Unclassified types of FGM/C: All other harmful procedures to the female genitalia for non-medical purposes, for example:
- Fricking, piercing or incision of the clitoris and /or labia;
- Cauterization (burning) of the clitoris and surrounding tissue;

ABSTRACT
FGM is considered a human rights violation because the practice reflects deep-rooted inequality between the sexes; constituting an extreme form of discrimination against women nearly always carried out on minors. FGM infringes a range of rights protected by international human rights laws and millions of girls continue to be molested physically and psychologically through the practice despite states’ legal commitment to protecting them. This paper examines factors influencing the continual practice of FGM in Jaiama Bongor Chiefdom in Sierra Leone. The study was conducted in Telu Town in, Jaiama Bongor Chiefdom in Bo District, Southern Sierra Leone. A cross sectional design was used to determine the factors influencing the continued engagement in the practice of the FGM. Multi-stage random and purposive sampling techniques were used to select the District and the Bondo Society women. A validated questionnaire with semi-structured and structured questions was administered to 200 Bondo Secret Society Members. The findings revealed that majority of the initiates (74.0%) had no formal education, and have knowledge about the existence of FGM in the study area. The majority of the initiations take place in the Bondo Bush (83.0%) annually (91.0%) and those initiators used razor blades (94.0%). It was concluded that FGM/C was a traditional practice deeply embedded in the culture of the people. FGM initiation results in child bearing complications such as fetus abortion, miscarriage, bleeding, anemia, and loss of sexual feelings. It was recommended that increase Community education be undertaken to explain the disadvantages of FGM/C to help the people re-examine their beliefs and values related to the practice in a dynamic, open way that is not experienced or seen as threatening. Furthermore, NGOs and other humanitarian organization should create other means of livelihood for the initiators; and they institute adult literacy classes in the community.

KEY WORD: Female Genital Mutilation, Initiation, Bondo, Society.
FGM in Sierra Leone

- Scaping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina:
- Introduction of corrosive substances into the vagina to cause bleeding, or of herbs into the vagina with the aim of tightening or narrowing it; introduction of corrosive substance or herbs into the vagina to cause bleeding or further purpose of lighting or narrowing it, and any other procedure that falls under the definition given above. (www.irinnews.org[referred 20.7.2009])

However, the most common type of Female Genital Mutilation/Cutting is excision of the clitoris and the labia minora, accounting for up to 85% of all cases. The most extreme form is infibulations, which constitutes around 15% of all procedures. Female Genital Mutilation (FGM) is a cultural practice that started in Africa approximately 200 years ago. It is primarily a cultural practice, not a religious practice. But some religions do include FGM as part of their practices. This practice is so well ingrained into these cultures that it defines members of these cultures. So to eliminate the practice one must eliminate the cultural belief that a girl will not become a woman without undergoing this ceremony. The global picture estimates that between 100 – 140 million girls and women have been subjected to FGM, and at least 2-3 million girls a year are at risk of undergoing some form of procedure worldwide, approximately 8000 girls per day. It has been documented mainly in Africa (in 26 countries), and in a few countries in the Middle East (e.g. Yemen, Kurdish communities, Saudi Arabia), and among certain ethnic groups in Central and South America, Europe, Australia, Canada and Asia, mainly among migrants from Sub-Saharan Africa. FGM/C is predominantly practiced in 26 African countries, as stated in the most recent document on the issue, “Numbers of Women circumcised in Africa: The Production of a Total” (Yoder & Khan). They are based on International Demographic Health Surveys in the countries where these are conducted. The information is complemented by UNICEF MICS (Multiple Indicator Cluster Surveys) data, since they have the most recent information on many of these countries. (Source: Global and Regional Perspectives on FGM/C (UNICEF, 2009).

In Sierra Leone the estimated prevalence of FGM/C is 90% (women and girls). All ethnic groups practice FGM/C except the Christian Krio (Amnesty International Reach Report, 2008). The most common type of FGM practiced is type II, while only the Muslim Krio undertake excision of the prepuce, or Sunna (Type I). No ethnic group practice, infibulations. Girls usually undergo the practice as teenagers, but among the Mandingoes in the North, it is customary for the cutting to be performed on baby girls under the age of one.

The procedure is often performed by traditional practitioners, including midwives, with or without anesthesia. Cutting is carried out using an assortment of rudimentary and often un-sterile instruments ranging from knives, razors, broken glass or scissors. Instruments used for cutting maybe re-used without being cleaned. The girl is held down by a number of women, often including her own relatives.

The procedure may take 15 to 20 minutes, depending on the skills of the initiator, the extent of excision and the amount of resistance put up by the girl. The wound is dabbed with anything from alcohol or lemon juice to ash, herb mixtures, porridge or cow dung, and the girl’s legs maybe bound together until healing is completed. In certain countries scalpels are used for cutting in local health clinics. Since antibiotics and anesthetics are seldom administered children are kept restrained and immobilized by several women. To ease the wounds and prevent bleeding a variety of mixed herbs, earth, or ashes may be applied. The age at which girls undergo FGM/C varies widely, with ethnic group or geographical location. Timing is often flexible even within communities. The procedure may be carried out on infant girls, during childhood or adolescence, at the time of marriage or during the first pregnancy. In most societies, parents and close family members have the greater say in the timing of the practice. In some African communities, circumcision age has been deliberately brought down in response to heightened efforts to abolish the practice.

Girls usually undergo the practice as teenagers, but among the Mandingoes in the North, it is customary for the cutting to be performed on baby girls under the age of one. FGM is performed as part of a rite of passage marking the transition from childhood to womanhood. It is linked with the so-called Bondo Secret Society (in Temne terms, and “souwe” in Mende), which traditionally acted as an informal system of education: girls were initiated into their future role of wife and mother, and taught the use of herbs for medical purposes and personal hygiene. Subsequently, the girls were married off, willingly or unwillingly. However, in view of formal education, and the high costs of maintaining girls in the Bondo society for many weeks, initiation has now been largely reduced to genital cutting.

At the same time, the practice is being performed on younger girls. From the perspective of public health, female circumcision is much more damaging than male circumcision. Female genital mutilation/cutting (FGM/C) is a traditional practice that is always traumatic with severe health consequences for girls and women. Immediate complications include excruciating pain, shock, urinary retention, ulceration of the genitals and injury to adjacent tissue. Other complications include septicemia (blood poisoning), infertility and obstructed labour. Hemorrhaging and infection through circumcision have caused death.

The taboo about female sexuality and the related customs may be one of the reasons for the lack of historical information, as it is still presently the reason for the difficulty to get more precise data. It is not entirely clear where or when the practice of FGM originated, although, there is some evidence suggesting that it originated in Ancient Rome. In ancient Rome it was done to female slaves to oppress sexual activity and raise their value. An alternative explanation is that the practice was an old African rite that came to Egypt by diffusion. It is said that pharaoh performed female genital mutilation to their slaves. Female genital mutilation has existed for over 2000 years Herodotus talks about an Egyptian women being cut, around 500 a. (Wright J Female genital mutilation: an overview, Nurs 1996; 24:251-9, cited. In: Conroy, 2006,)
Historically, women have inaccurately been perceived to be predisposed to promiscuous behavior, and this belief persists in many cultures where FGM/C is common (Muteshi and Sass. 2005). This is a particularly unselected trait in cultures where the woman’s virginity and fidelity are closely associated with parental and familial honor” (Yuval-Davis, 1997). The aim of the procedure is therefore to reduce a woman’s ability to feel sexual pleasure and to seek it outside of marriage by removing her external sexual organs, especially the clitoris, and making sexual intercourse painful. Women are potential for promiscuous activities and, related to this, reproduction outside of the bonds of marriage is therefore believed to be managed and controlled via the act of FGM/C. In the civic history of Sierra Leone, it was Madam Yoko from Moyamba Town who the first woman Paramount Chief in Sierra Leone initiate the puberty rite of teenage girls to impart moral values and learn other traditional norms intended to make young girls become good future housewives. It was popularly called the Bondo Society and it was purely a woman’s issue and the initiation rite is generally associated with special ceremonies. The good culture that was initiated by Madam Yoko lost its meaning several years ago because girls are no longer taught how to become good house wives but the initiators only concentrate on the cutting aspect and making money.

Female Genital Mutilation/Cutting violates a series of well-established human rights principles, norms and standards. Keys among these are:

- The right to life when the procedure results in death;
- The right to freedom from torture or cruel/inhuman treatment;
- Freedom from degrading treatment or punishment.

As FGM/C interferes with healthy genital tissue and can lead to severe consequences for a woman’s physical and mental health, it is clearly a violation of a person’s right to the highest attainable standard of health, being characterized by the following:

- Discrimination against girls and women;
- Torture, cruel, inhuman and degrading treatment of girls and women;
- Abuse of the physical, psychological and sexual health of girls and women.

At the physical level, female circumcision cannot be equated to male circumcision since the former generally involves far more extensive and permanent damage to the sexual organs and frequently has significant effects on the health of the individuals subjected to it. This is part of the reason why female circumcision is abhorred, unlike male circumcision where the debate centers on stress to the infant, with relatively few people decrying its long-term effects.

The Convention on the Elimination of All Forms of Discrimination against Women defines discrimination as “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the Political, economic, social, cultural, civil or any other field” (article 1). Used as a way to control women’s sexuality, FGM/C is a main manifestation of gender inequality and discrimination related to the historical suppression and subjugation of women, denying girls and women the full enjoyment of their rights and liberties (McVeigh, Tracy and Sutton, Tara. “British girls undergo horror of genital mutilation despite tough laws” The Guardian, 25 July 2010.

The Convention on the Rights of the Child (1990) provides:

- Protection of all fundamental rights irrespective of sex;
- The right to the highest attainable levels of health;
- Freedom from all forms of mental and physical violence and maltreatment.

The Convention on the Rights of the Child refers to the capacity of children to make decisions regarding matters that affect them. Even in cases where there is an apparent desire by girls to undergo the procedure, in reality it is the result of social pressure, community expectations and girls’ aspiration to be accepted as full members of the community. That is why a girl’s decision to undergo female genital mutilation cannot be called ‘free’. Furthermore, it could be argued that girls (under 18) cannot be said to give informed consent to such a potentially damaging practice as FGM/C is an irreversible, irreversible abuse and therefore violates girl’s right to protection. As stated in the Convention on the Rights of the Child, all actions concerning children should be undertaken in the best interests of the child (article 3.1). The Convention further asserts that children should have the opportunity to develop physically in a healthy way, receive adequate medical attention and be protected from all forms of violence, injury or abuse. Because of children’s vulnerability and their need for care and support, human rights law grants them special protection. One of the guiding principles of the Convention on the Rights of the Child is the primary consideration of the best interests of the child. Parents who take the decision to subject their daughters to Female Genital Mutilation/Cutting perceive that the benefits to be gained from this procedure outweigh the risks involved. However, this perception cannot justify a violation of the fundamental human rights of girls and women.

Governments have sometimes been reluctant to address FGM/C. Considered to be a sensitive issue; it has been widely viewed as a private act that is carried out by individuals and family members rather than state actors. But the health and psychological consequences of the practice itself, as well as the underlying causes that reinforce it, make it imperative for societies, governments and the entire international community to take action towards ending FGM/C. FGM is regarded as public health concern because of its potential to cause serious complications (WHO, 1997, 1998, 2001). Short-term complications can include: severe pain and shock (neurogenic shock), hemorrhage, infection of wound, urine retention, HIV infection, death (WHO estimates that the child mortality rate as a result of FGM is high), urine retention, incontinence, urinary tract infections, longer term complications can include: permanent damage to
reproductive organs, vulval abscesses due to infected cysts, keloid cysts, dermoid cysts, vesico-vaginal fistulae, painful sexual intercourse, difficulties in menstruation, retention of menstrual blood, chronic infections, damage to the urethra, sexual dysfunction, obstructed labour, HIV/AIDS, Psychological problems (WHO, 1998, 2001; Toubia, 1995; BMA, 2001). The BMA conclude that “risks are intensified when operators work in un-sterile conditions without anaesthesia” (BMA, 2001:2). Risks and complications depend upon the type and severity of the procedure performed the hygiene conditions, the co-operation and physical condition of the child or woman and the precision and eyesight of the operator. Mutilations are predominately performed by un-trained older women, TBAs under lighting conditions that are inadequate to any surgical procedure (Lightfoot-Klein, 1991:1). It is important to note that even though risks can be substantially reduced when FGM is performed by a qualified health practitioner within a health care facility they are by no means eliminated (WHO, 1998; Mclean & Graham, 1983.

Female Genital Mutilation is a deep rooted traditional practice with severe health consequences on woman and girls, which reinforce gender inequity in society. It is a subject of global interest, with many countries of the world still practicing it despite effort by World Health Organization (WHO) and other agencies to discourage the practices. Despite the increasing efforts of advocacy and awareness campaigns that has been carried out by civil society group, local and international, non-governmental organizations towards ending Female Genital Mutilation or cutting (FGM) in Sierra Leone and in Telu Town; the practices still remain on the increase in this community. It is hoped that findings from this study would be useful to all stakeholders, researchers, government and non-governmental organizations that are concern about the eradication/elimination of FGM/C. It is further hoped that it would help policy makers and implementing partners to develop more holistic plans of action for addressing the identified factors, especially for those implementing programmers for the prevention of FGM in children and women.

PURPOSE AND OBJECTIVES
The purpose of the research was to investigate the factors influencing the perpetual practice of FGM in Telu Town Jaiama Borong Chiefdom, Bo District. To achieve this, the research was guided by four objectives as follows:

i. Identify and analyze the demographic characteristic of respondents;
ii. Assess the level of knowledge of people on FGM in the study area;
iii. Examine the practice of FGM in the community; and
iv. Assess factors influencing continuity of FGM practices in Telu Town.

METHODOLOGY
Study Design
A cross sectional design was used to determine the factors influencing the continuity of FGM amongst women in the Telu town, Jaiama Borong Chiefdom. Quantitative and qualitative methods were used to collect the data so as to ensure that they represent the views of the community and that they support the findings of the study carried out.

Study Area
The area selected for the study was Telu town the headquarters town of Jaiama Borong Chiefdom. The selection of this Town was made on the following grounds. Firstly, the researcher was born in Telu and she is best acquainted with people in this community. Thus, she has experience in dealing with the community people and has gained some knowledge so a long period of the community modulus Vivendi. Since FGM is considered as a taboo and it is a sensitive issue the study should be carried out in community where people know the researcher and information will be given without obstacle and reservation. Secondly, a project was implemented in 2008 on FGM by Praise Foundation in six communities in the chiefdom and Telu was one of the towns selected. Livelihood support in the form of cash was provided for initiators and initiates as an income generating activity in a way of stopping the practice but FGM is still deep rooted in this area. Telu is situated in southern Sierra Leone, 17 miles from Bo city, which is the second largest city in Sierra Leone. The road net work to Telu is poor during the raining season, which makes accessibility to the town sometimes difficult. Vehicles owners are often afraid to use the road during the raining season. There is however another road that leads to Telu through Sembhun 17 on the Bo-Koribondo highway with a distance of 26 miles. Telu Town is divided into two sections; New town and Old town. According to the census report (Population and Housing Census 2004) the total population of Telu Town is 1,713, which include 456 male adults, 541 female adults and 716 children respectively. Telu has one secondary school and two government primary schools including one Nursery School. Occupations of the people are farming, trading, carpentry, mining, teaching, tailoring, masonry, and civil service, and their main sources of income are agriculture, business, and mining. The town has two mosques and one Catholic Church and majority of the inhabitants are Muslims.

There is a community Health Centre in the town that provides health services to the community. Recently a gravity water system has been installed in the town by the Bo District Council.

Sample Size and Sampling Technique
The informants who took part in the study were purposively selected because either they were directly involved in the initiation of female genital mutilation, or they were personally affected by the practice or have participated in the implementation of FGM project. Research instrument: The questionnaire was developed based on the objectives of the study. The data of this study were therefore collected by structured interviews. Quantitative and qualitative methods were adopted and both methods were used to ensure that they represent the views of the community and support the findings of the study carried out. (The supervisor gave a final approval after a few amendments were made for the instruments to be administered).
**Data collection**

Choosing methods that empower the researcher is important because they allow for a deeper understanding and the complexities and challenges the unequal power relations (Limb and Dwyer 2001). Interviews and reviewing of existing data were used. The data was collected exclusively by the researcher herself. The whole exercise lasted for about one month. Since all the respondents do not understand English, the interview was conducted in a local language (Mende) which is understood by all the respondents. The questionnaire was pretested in an area similar to the study area and difficulties identified were rectified by the prepared study guidelines. These guidelines were used as the reference document throughout the data collection period. All completed questionnaires were reviewed.

**Data Analysis**

The data collected were inputted, edited and data cleaned. Analysis was done by employing the Microsoft Excel and the Statistical Analysis System (SAS). Data presentation was done by using text, tables, graphs and charts. All open ended questions were coded before entry for analysis.

**RESULTS**

1. Characteristics of Respondents

   **Age:** The results of age distribution of respondents in the study area are presented in Figure 1. The Figure revealed that 2% of the sample respondents were between ages 11-16, while 18.5%, 12% and 13% of them fell within ages 17-22 years, 41-46 years, 23-28 years, and 29-34 years respectively. Fifteen percent of them were between 35-40 years, while 7% and 6%, fell within age brackets 47-52 years, and 52-58 years respectively. Only 3% of the respondents were within age bracket 59-64 years, and 65 years and above.

   The age bracket 17-22 years represented the highest percentage of 18.5% followed by 35-40 years followed closely with 15%.

**FIGURE 1: Age Distribution of Sample Respondents in the Study Area**

![Age Distribution of Respondents](image1)

**Educational Status:** Figure 2 revealed the educational status of the respondents in the study area. The data revealed that 74% of the respondents have had no formal education, 20% had primary education whilst 4% attained secondary education. Only (2%) of them acquired tech/Voc. Education. None of the respondents had University/College education.

**Main Occupation of Respondents:** Figure 3 indicated the results of the main source of income of the people in the study area. As depicted from the histogram above, majority, 63% of the respondents were peasant farmers, whilst 19% of the respondents were petty traders, 11% were housewives. A very insignificant percentage: 2%, 1%
and 5% were hair dressers, nurses and teachers respectively.

**FIGURE 3:** Main Occupations of Sample respondents (n=200)

2. Level of Respondents Knowledge on FGM Ignitions

**Source of Knowledge about the Existence of FGM Practice:** The results of knowledge of the people about the existence FGM sorted are depicted in Figure 4. When respondents were asked whether they were aware of FGM initiation practice in their communities, all (100%) answered in the affirmative. When further asked about their source of knowledge of the FGM initiation, 30% of them said they acquired this knowledge from their mothers, 40% said they received it from friends, while 20% said they got it from their sisters. Only 10% of them said they acquired knowledge about FGM initiation from other initiates.

**FIGURE 4:** Source of Knowledge on FGM in the Study Area ((N=200)

**FIGURE 5:** Respondents Knowledge about FGM Practices in the Study Area

**Female Genital Mutilation (FGM) Practices in the Telu Bongor Chiefdom**

**Respondents Knowledge about FGM Initiations:** People’s knowledge about events enables them to either adopt or reject it. Hence, knowledge of the respondents
about FGM in the study area was investigated and the results are shown in Figure 5. The Figure showed that majority (90.0%) of the respondents know about FGM initiation process which involves that it is cutting off of clitoris while 10% of them claimed that they do not know and consider it as a cultural practice, that consists mainly of socialization.

**FGM Membership Status:** The FGM membership status of respondents in the study area was investigated and the results are shown in Table 1. The Table showed that 95% of the respondents were initiates while 5% of them were initiators. When further asked about their views about FGM, majority (90%) of the respondents said it is the cutting of clitoris in women, while the rest (10%) claimed it to be just a cultural practice- mainly as a socialization process.

<table>
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<tr>
<th>FGM Membership Status</th>
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<th>Clear View of FGM</th>
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<td>Initiates</td>
<td>190</td>
<td>95</td>
<td>Cutting of clitoris</td>
<td>180</td>
<td>90</td>
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<tr>
<td>Initiators</td>
<td>10</td>
<td>5</td>
<td>Cultural practice</td>
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<td>Total</td>
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**Categories of Initiators:** Categories of initiators were investigated and the results are presented in Figure 5. The data depicts that 90% of the initiators are the heads of ‘Bondo’, (those that head the initiation processes), 8% of the members are the community TBAs and 2% were female health workers.

**FGM Initiating Sites within the Study Area:** The sites where FGM initiation ceremonies are carried out are presented in Figure 7. Majority (83%) of the initiations take place in the bush (‘Bondo bush’), whilst 10% of it takes place at water/river side. Only 7% of the initiators perform the ceremony inside house, but none of the initiations take place in the Community Health Centers.

**Frequency of FGM Initiation:** The frequency of initiation of FGM in the study area was investigated and the results are shown in Figure 9. The data indicated that frequently initiations take place annually (91.0%), half yearly (8.0%) and quarterly (1.0%).
**Age Distribution of Initiates:** Figure 10 showed the results of age compositions of people initiated in FGM in the study. The data depicted that 45.5% of the FGM initiates are between the ages of 15-19, while 41.5% are aged 20 and above. It further showed that 7% of the initiates fall between ages of 10-14 years. Only five percent of them fall within 5-9 years. At these two age groups 15-19, 20 and above, the women are considered mature to take informed decision and to get settle in marriage.

**Types, Sources, and Sterilization of Instruments used in FGM Initiations:** The types, sources of, and sterilization status of instruments used are presented in Table 2. The Table indicated that majority of the initiators (94%) used razor blades to perform the FGM initiation ceremonies; the rest (6%) of them used knives. When asked about the source from which they acquire the instruments they use, 94% of the respondents said they get their instruments from shops, whilst 6% of them said they acquire theirs from blacksmiths. When further asked whether instruments are sterilized before used in the initiation ceremony, 94% answered in the affirmative, while 6% denied doing so.

**Factors Influencing the Continuity of FGM Practice**

The factors that influence continuity of FGM practice in the Jaiama Bongor Chiefdom are shown in Figure 14. The Figure indicated that majority (75%) of the respondents said FGM continues in their communities because they see it as traditional and cultural practices. Thirteen percent of them said that peer group (12.5%), socialization (7.5%) and a source of income (5.0%) respectively influence the continuity of FGM practices greatly in their communities.
DISCUSSION
1. Socio-Characteristics of Respondents
The data reveals that the age range 17-19 were the highest interviewed and majority of respondents has no formal education, majority of them were peasant farmers, all of them has knowledge about the existence of FGM and their main sources of information were from friends, mothers and initiators. The study further revealed that the practice of FGM has changed in a number of ways. Most encouragingly, the practice is declining. This was observed by comparing the youngest and oldest age-group in one survey, showing that women aged 15–19 years are less likely to have been subjected to FGM than are women in older age groups, which, is in line with Yoder, and Khan (2008) findings. The research also revealed that majority of the women was aware that FGM was the cutting of the clitoris but few knew that it was a cultural practice. There were three main categories of people who were involved in the initiation but majority of the initiation is done by Bondo heads and only few were done by TBA and female nurse. FGM is practiced in different places within the same community especially in the bush (‘Bondo bush’), and river side. Furthermore, medicalized FGM does not necessarily contribute to harm reduction while it may reduce some of the immediate risks; it ignores the long-term complications, including sexual, psychological and obstetrical complications. Studies do not suggest that FGM performed by health-care providers is systematically less extensive. Furthermore, while some argue that a medically performed FGM can be a first step to abandonment, there is no evidence supporting such an expectation. Providing care for girls and women suffering negative health consequences from FGM is, however, a key role for health-care providers, as well as support for its abandonment. RHR contributes to capacity building in the health-care sector through a series of training courses, and technical tools, including guidance videos for counseling training. This confirms what House et al. (2002) defined culture as shared motives, value, beliefs, identities, and interpretations of meanings that result from common experiences of members of collectives and are transmitted across age generations. Culture manifests itself in many different ways. On the concrete level, culture is expressed in material artifacts, behaviors, policies and practices, while on the abstract level in values, motives, and basic assumptions (Kallon, 2010). The so called ‘onion’ models of culture assume that more concrete, conscious and behavioral elements of culture represent the vehicles for transmission of less tangible and more subjective facets of culture (Lebbie, 2006 ). Similarly, proponents of the institutional theory approach in knowledge transfer research have found a positive correlation between host-country culture and successful adoption of practices (e.g. Kostova and Roth, 2002). This study revealed that FGM in the study area is viewed as part of the traditional practices, which in one way or the other determine the decision-making status of individuals in their community. The study found that most of the initiates end up in marrying, most of whom would have been in schools, hence the increase in the early, and forcful marriages. Therefore, this study is supportive of Thabane’s (2002) findings on one hand and contradict part it on the other hand. Likewise, FGM has been cruised in various ways in Sierra Leone, not only by politicians but by religious groups especially the Christians. They were also not allowed to go back to the formal educational schools where they were attending before joining the initiation school if they were already attending. Girls on the other hand were taught about the roles of women in the families and communities. They, therefore, had to undergo church rituals of repentance and cleansing before they were allowed in schools. The finding of this study confirms Christopher et al’s (2000); Matsela and Motlomelo’s (2002) studies. According to Christopher et al. (2000) initiation has three phases- separation, transformation and re-assimilation. A person who has undergone initiation is expected to be a changed person who could positively contribute in community debates and decision-making. The significance of the rite in many societies is that it was providing the basic informal education to the initiates. Boys were provided with economic knowledge, skills in negotiations and in how to be good leaders in their societies. The work of art, music and oratory were also offered at the initiation schools. Matsela and Motlomelo’s (2002) maintained that initiates in Lesotho acquired were expected to acquire from their training leadership skills, commitment and loyalty to their country, self-respect and self-discipline, which carry along law-abiding with it. In addition to the education that the institution provided to the initiates there was also a circumcision practice for both boys and girls. In this study, it was revealed that most people are initiated into the FGM practice because the act was seen as a sign of womanhood, male it is during circumcision is an operation of cutting the foreskin of the penis, while female circumcision is an operation of mutilating the female genitalia. However, due to secrecy, the extent to which
female genital mutilation was done is not known and not well-documented. What the respondents confirmed was labia minora elongation, which they said was very important among the Basotho for good sexual performance. The initiates had to ensure that they elongated them during this period of initiation these rites that the young women are trained to become women and wives. This study found that FGM circumcision is the removal of part of the clitoris. FGM of any type has been recognized as a harmful practice and a violation of the human rights of girls and women. Human rights—civil, cultural, economic, political and social—are codified in several international and regional treaties. Safe removal of only the prepuce of the clitoris demands that the individual performing the procedure have advanced medical and anatomical knowledge, good quality surgical tools, and that the girl on whom the procedure is to perform be motionless and anesthetized. These factors are almost always absent when Sunna is performed in African and Middle Eastern cultures (Bardach, 1993: 125). Sudden movement by the girl can result in damage to adjacent organs, cutting of an artery or shock which would harm or even prove fatal to the girl or woman (Doorknob & Hedley, 1992). As the clitoris is rich in blood vessels, hemorrhaging may occur as a result of complete removal of the prepuce and clitoris. Infection may also be a consequence of FGM. Tetanus and sepsis may ensue from the use of unsterilized tools and from unsanitary working conditions (Brown, Calder, & Rae, 1989). The risk of HIV transmission is also increased due to the use of the same unsterilized tools on several girls (Bongers, 1994). Once the lacerations resulting from FGM have healed, a scar forms, the scar tissue narrows the genital opening making it difficult to pass urine and menstrual blood. Due to the decrease in size of the vaginal opening, menstrual blood may be retained in the body, resulting in bloating and swelling of the abdomen (Armstrong, 1993). Due to the inelasticity of scar tissue, sexual intercourse and childbirth can also become complicated and painful. An infibulated woman’s husband will sometimes use unsterilized tools such as a knife or scissors to enlarge the vaginal opening in order to facilitate intercourse. The resulting open wound leaves the woman at greater risk of HIV transmission by her husband as well as infection with other agents from the unsterile tools (Hosken, 1982). Similarly, an anterior episiotomy (de-infibulations) may be required during childbirth to decrease the risk of fetal asphyxia and hemorrhaging by the woman during the birthing process (Arbesman, Buck, 1993; Baker, Gilson, Vill, and Curet, 1993). Girls undergo FGM as a rite of passage: a social transition from one individual and/or community status level to another in order to obtain communal recognition (Harris, 1987; Lowenstein, 1978). Each cultural group that practices FGM develops its own socio-cultural ‘justifications’ for its actions, which support the construction of the rite of passage. Due to the fact that most forms of female genital mutilation involve the mutilation or removal of the clitoris, several quasi-medical ‘justifications’ for this action have also been noted. For example, some members of Somali and Sudanese communities believe that the clitoris is a dangerous organ that, if not removed, will continue to grow, and that a girl with a clitoris will engage in acts of delinquency and/or prostitution. Others believe that an intact clitoris will cause death to a newborn child if the clitoris comes in contact with the infant’s head during childbirth (Hedley & Doorknob, 1992; Jones, 1992). The practicing communities looked at circumcision as a commandment passed down from ancestors and gods to be practiced without any question or alteration whatsoever and so the tradition is ultimately kept and fulfilled (UNICEF, 2004). During the whole process of the rite, one got to know the deeper culture of the society and the society’s rituals and secrets. Without circumcision, an individual was seen as a child no matter how old she could be. The female passage of rite (circumcision) was the only way the youth could be fully accepted, but the uncircumcised were seen innocent as children who were not supposed to know the deeper secrets of the society until circumcised (KDHS, 1998). The only way in which one achieved respect as a member of a society and the entire community was through circumcision. No one could be crowned as; the chief village elder, a judge, a master of a ceremony or even addressed honorably if she was uncircumcised. Though women did not climb that high in the past, the patriarchs could sometimes be given a seat amongst elders who were usually old men of outstanding performance in the society. Every circumcised woman was and is still seen as knowledgeable in the ways of the community amongst the Kenyan FGM practicing communities. This locally envious status obviously earns them the responsibility to oversee and inspect the uncircumcised girls and women anytime anywhere. (www.socyberty.com,(referred 29.4.2009]). Toubia (1994) stated that because the specialized sensory tissue of the clitoris is concentrated in a rich neurovascular area of a few centimeters, the removal of a small amount of tissue is dangerous and has serious and irreversible effects. Common early complications of all types of circumcision are hemorrhage and severe pain, which can lead to shock and death. Prolonged lesser bleeding may lead to severe anemia and can affect the growth of a poorly nourished child. Local and systemic infections are also common. Infection of the wound, abscesses, ulcers, delayed healing, septicemia, tetanus, and gangrene have all been reported (Althaus 1997). Long-term complications are associated more often with infibulations than with clitoridotomy alone, because of interference with the drainage of urine and menstrual blood. Chronic pelvic infection causes pelvic and back pain, dysmenorrheal, and possibly infertility (Toubia 1994). Chronic urinary tract infections can lead to urinary stones and kidney damage. The other long-term consequences include; increased risk of maternal morbidity, recurrent bladder and urinary tract infection, cysts, adverse psychological and sexual consequence, infertility and increased risk of neonatal death for babies born to mothers having undergone female genital mutilation (Maligaye 2007).

CONCLUSION
From the findings, it can be concluded that Female genital cutting among the Telu community is a traditional practice that is deeply embedded in their culture. Those in favour look at the custom as a form of cultural identity and a
sacred ritual that is sanctioned by ancestors and protected by cultural beliefs and myths. But it is also a contested practice. The justification among those against the practice is mainly related to health concerns of the girls and women who are coerced to undergo the procedure as a result of social pressure from the community. The initiation also has a lot of childbearing complications such as fetus abortion, miscarriage, bleeding that led to anemia, and loss of sexual feelings.

RECOMMENDATIONS
Based on the findings and conclusions, the following recommendations were made.
1. Government and all stakeholders at all levels should introduce appropriate social measures and legislation, complemented by effective advocacy and awareness efforts to success in abolishing FGM/C.
2. Increased community education is needed about the disadvantages on FGM/C in order to help them examine their own beliefs and values related to the practice in a dynamic, open way that is not experienced or seen as threatening.
3. Since most initiators look at FGM as a way of earning money, it is recommended that NGOs and other humanitarian organizations create other means of livelihood.
4. The educational levels of the respondents are very low. There is a need for adult literacy classes to be instituted in the community.

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