COUNTRY PROFILE: FGM IN SIERRA LEONE

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28TOOMANY FGM... let's end it.

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FOREWORD

In disease control and social movements alike, there are three principles that define what leads to an epidemic: contagiousness, small causes having big effect, and that change happens at one dramatic moment.

Having worked on aid projects since 2001 and in anti-female genital mutilation (FGM) for ten years, there seems to be an appetite for, and a window of opportunity, to change, that has not been there for 2000 years. Could the passing of the UN General Assembly resolution in December 2012; strong leadership and momentum in Africa; together with increasing numbers of communities, NGOs, FBOs, policy makers and ambassadors working to end FGM be the beginning of the tipping point for change?

In excess of 125 million women and girls alive today have experienced FGM in Africa and 30 million more girls will be affected by 2022 – one girl being cut every ten seconds. Whilst FGM is practised primarily in 28 African countries, clustered from West Africa to Egypt and the Horn, it is also seen in some of the Middle East, Asia and across the world by diaspora groups who bring traditions with them on migration.

FGM is known to have no health benefits and has serious, immediate and long-term physical and psychological health consequences, which can be severe, including post-traumatic stress disorder, depression, anxiety and reduced desire or sexual satisfaction. Babies born to women who have experienced FGM suffer higher rates of neonatal death, and mothers can experience obstetric complications and fistula.

Globally, reasons for FGM are highly varied between ethnic groups and communities; it is a deeply embedded social practice associated with adulthood, marriageability, purity and sexual control. This is true too in Sierra Leone, where it is also linked to the ordering of community power structures, through membership of secret societies where FGM is the badge of belonging, but is also linked to early child marriage and girls dropping out of compulsory education. At the end of the civil war Bondo initiation was used as a way of normalising social relations lost in the destruction. It also presented itself in a war torn economy as an economic opportunity for younger women, a rarity in Sierra Leone. Traditionally FGM is carried out by older community women, in unhygienic conditions in isolated bush camps.

This Country Profile shows that there has been a slight reduction in the overall prevalence of FGM in Sierra Leone from 91.3% in 2008 to 89.6% in 2013 according to DHS or 88.3% (MICS, 2010). The rate is 94.3% in rural areas, with Northern districts having the highest rates. With no national anti-FGM law in Sierra Leone, this report covers the twelve measures we feel are required to address FGM in the context of post-war reconstruction. Amongst these is wider access to education as a viable alternative or delaying factor in FGM, improvements in the healthcare system and reduction in numbers living below the Government's defined poverty line.

Since first visiting Africa in 2001, I have visited twelve African countries, and communities in Malaysia and Pakistan, the Middle East, USA/Canada and Australia/New Zealand that have migrant communities that practise FGM. Having listened to the stories of over two thousand survivors, no woman or girl was pleased she was cut. All have physical or mental trauma from FGM and many had begun themselves to campaign for FGM to end.

After an initial meeting with our research team in 2012, I was personally delighted to meet representatives of the Sierra Leone Inter Africa Committee (IAC) in April 2014, and hear how they are working with NGOs and CSOs nationally and internationally to help advance the work towards FGM ending. Whilst we highlight in this report areas that need addressing, we also recognise the work of CSOs and NGOs on areas such as alternative rites of passage (ARPs); working with 'men against

FGM' and the reduction in importance of FGM in urban youth, among other initiatives as progress.

We look forward to seeing further progress and talking with activists in my forthcoming visit in Sierra Leone.

Dr Ann-Marie Wilson

28 Too Many Executive Director

During our research in Sierra Leone we came across an organisation which appears to bridge the need for cultural continuity and the ethos of no harm to women or girls. Among the Temne in Masanga village and surrounding areas, FGM is often carried out on girls between the ages of 3 and 5. Masanga Education Assistance (MEA) has been working in the area since 2004 sponsoring education for young children both in the private and state sector. In 2007 they opened their own kindergarden and made the condition that anyone who is to access education with their help, has to 'trade excision for education'. In 2009 reports came back to MEA that these girls were being socially excluded from even simple activities like bathing with Bondo initiates. It was at this point that Michèle Moreau the founder of MEA came up with the idea of persuading the Soweis to initiate without cutting. An early convert and now president of MEA Sierra Leone Ramatu Fornah was the head Sowei in the village. Her conversion and 'putting down of the basket' representing a ceremonial renunciation of the Soweis' cutting tools was very influential in the community. Following her lead a number of Soweis in Masanga and surrounding villages have also renounced FGM, discarded the old Bondo colours of red and white and embraced yellow as the colour of the new Bondo.

In 2010 the first ceremony without FGM was conducted, after which the Paramount Chief of Tonkolili, the district's highest authority, asked Michèle to extend the programme to the District's seven sections. Since then there have been five more initiations incorporating 391 girls in total. Eight of them have subsequently been subjected to FGM and suffered total exclusion from the programme and community censure from the village. The rite's cultural dimensions have been maintained along with the 'reproduction process of norms and ethical principles'. It was further noted that the 'symbolic weight of excision seems to have been dissolved in the rest of the ritual' (Bracher, 2014).

Fig. 1: Soweis wearing their new colours in a MEA run project, showing they now conduct Bondo without cutting (MEA)

BACKGROUND

28 Too Many is an anti-female genital mutilation (FGM) charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010, and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework, where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We hope to build an information base, including the provision of detailed Country Profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop a network of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

PURPOSE

The prime purpose of this Country Profile is to provide improved understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. Whilst there are numerous challenges to overcome before FGM is eradicated in Sierra Leone, many programmes are making positive active change.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced, provided the due acknowledgement is given to the source and 28 Too Many. We invite comments on the content, suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

ACKNOWLEDGEMENTS

28 Too Many is extremely grateful for all who have assisted us in accessing information to produce this Country Profile. We thank you, as it would not have been possible without your assistance and collaboration. 28 Too Many carried out all its work as a result of donations, and is an independent objective voice not being affiliated to any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced. Please contact us on **info@28toomany.org**.

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Mark Smith creates the custom maps used in 28 Too Many's country profiles.

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Photograph on front cover: Untitled © Grant Faint. Please note the use of the photograph of the woman on the front cover does not imply she has, nor has not, had FGM.

LIST OF ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome
APC - All People's Congress
ARP - Alternative Rites of Passage
CBO - Community Based Organisation
CCSL- Council of Churches Sierra Leone
CEDAW - Convention on the Elimination of Discrimination against Women
CPJ - Committee to Protect Journalists
CRC - Convention on the Rights of the Child
CSO - Civil Society Organisation
DfID - Department for International Development (UK)
DHS - Demographic Health Survey
ECOSOCC - The Economic, Social and Cultural Council of the African Union
FBO - Faith Based Organisation
FGC - Female Genital Cutting
FGM - Female Genital Mutilation
FPU - Family Planning Unit
FSU - Family Support Unit
GBV - Gender Based Violence
GDP - Gross Domestic Product
JSS - Junior Secondary School
LGBT - Lesbian, Gay, Bisexual, Transgender
MCH - Maternal and Child Health
MDG - Millennium Development Goal
MICS - Multiple Indicator Cluster Survey
NAP-GBV - National Action Plan on Gender Based Violence
NGO - Non Governmental Organisation
OECD - Organisation for Economic Co-operation and Development
RUF - Revolutionary United Front
SIGI - Social Institutions and Gender Index
SLANGO - Sierra Leone Association of Non-Government Organizations
SLBS - Sierra Leone Broadcasting Services
SLL- Sierra Leonean Leones
SSS - Senior Secondary School
STI - Sexually Transmitted Infection
TB - Tuberculosis
TBA - Traditional Birth Attendant
UK - United Kingdom
GPI - Gender Parity Index
HIV - Human Immunodeficiency Virus
HTP - Harmful Traditional Practice
IAC - Inter-African Committee on Traditional Practices
ICESR - International Covenant on Economic, Social and Cultural Rights
IDP – Internally Displaced Persons
IMC - Independent Media Commission
INGO - International Non-Governmental Organisation
IRC - Inter-Religious Council of Sierra Leone
UN - United Nations
UNDP - United Nations Development Programme
UNFPA - United Nations Population Fund
UNICEF - United Nations Children's Fund
UNIPSIL- UN Integrated Peacebuilding Office in Sierra Leone
US - United States
VAWG - Violence against Women and Girls
WFP - World Food Programme
WHO - World Health Organisation
WWSF - Women's World Summit Foundation (UN)

EXECUTIVE SUMMARY

This Country Profile provides comprehensive information on FGM in Sierra Leone. The report details the current research on FGM and provides information on the political, anthropological and sociological contexts of FGM. It also includes an analysis of the current situation in Sierra Leone and reflects on how to improve anti-FGM programmes and accelerate the eradication of this harmful practice. The purpose of this report is to enable those committed to ending FGM to shape their own policies and practice to create positive, sustainable change.

In Sierra Leone the percentage of girls and women who have undergone FGM is 89.6% (DHS, 2013) or 88.3% according to MICS (2010). These rates are lower than the reported 91.3% in the 2008 DHS. Prevalence of FGM is higher among those residing in rural areas (94.3%) than urban areas (80.9%) (DHS, 2013). Northern districts have the highest rates, whereas the West has the lowest and these correspond to rural and urban trends. Further data will be available in the forthcoming full DHS 2013 report. FGM in Sierra Leone is part of initiation into secret women's societies, known as Bondo (Sande). 90% of women are members of Bondo and these women's societies exist in all ethnic groups, except the Krio. Membership to these societies marks a girl's transition into womanhood and becoming a community member. Girls receive training for their roles as wives and mothers, but this training has decreased in some communities as parents want their girls to return to school before marriage, or they live in Internally Displaced Persons (IDP) camps, which were created during the civil war, and have limited resources. FGM is therefore seen as a social norm tradition that is heavily enforced by community pressure. As part of this social norm rationale, cutting is considered anatomically necessary for a girl to become an unambiguous gendered female. Uncut women are also often labelled as unclean. There is furthermore a common belief that FGM is more aesthetically acceptable. Other reasons FGM is practised include it being necessary to preserve a girl's virginity, and a small minority (of Mende ethnicity) believe that it is a religious requirement. Finally, in a survey discussed in this report, 39.3% of Mende men stated that there was no benefit to FGM.

Traditional practitioners conduct the vast majority of FGM, with no trend towards medicalisation. These female practitioners are called Soweis, and are authoritative members of the women's society and the community. They also have a symbiotic relationship with village and Paramount Chiefs, who have authority over large areas. The majority of women and girls undergo Types I and II (excision). There has been a reported increase in prevalence of Type III (infibulations). DHS 2008 reports that 86% of daughters were cut by the time they reached age 14. Though MICS (2010) found

that 10.7% of daughters were cut by age 14, the same data set shows that the next cohort aged 15-19 were reported at 70.1% with FGM. There is data to show that some communities, particularly the Temne, are reported to be cutting girls younger. These two data sets appear to be contradictory and require further research. A quarter of women do not support the continuation of FGM while 54% of men are against it (DHS, 2008). However, support for FGM varies across age cohorts and regions. 52.9% of women aged 15-19 want FGM to continue, while 75.4% of women aged 45-49 are in support. Geographically, women in the north are 67% in favour, in the west 44% in favour, and in the south and east 73% and 76% respectively.

It is crucial to understand FGM in Sierra Leone in the context of post-war reconstruction. The cost of initiation is high, posing significant economic constraint on families who must save to cover the costs and often have to choose between initiations, or sending daughters to school. It has been suggested that initiating girls younger is cheaper, and this may explain the trend in the decreasing age of girls cut. Given the socio-economic climate, many practitioners of FGM are leaving out much of the traditional training that is part of Bondo initiation, meaning that the ceremony is completed in a matter of days. Moreover, women in IDP camps are the breadwinners and many consider a Sowei career as an economic opportunity. Hence, FGM is struggling in Sierra Leone to maintain its cultural justification as it increasingly becomes solely a commodity.

There is no law that criminalises FGM outright in Sierra Leone, and the Government remains indecisive with respect to eradication efforts. The Child Rights Act states that girls must be of legal age (18) before they can consent to being cut. This Act is supported by anti-FGM organisations and the Sowei Council, who encourage practitioners to wait until girls are able to consent to initiation. Since the end of the civil war there has been a growing human rights discourse in Sierra Leone and this has created opportunity for organisations to work on a range of matters concerning women's and girls' rights, health and education. There are numerous INGOs, NGOs and CSOs working to eradicate FGM using a variety of strategies, including a harmful traditional practices (HTP) approach, addressing health risks of FGM, promoting girls' education, and using ARPs. A comprehensive overview of these organisations is included in this report.

We propose measures relating to:

- Adopting culturally relevant programmes
- Understanding FGM in Sierra Leone within the context of the cultural and political agency of the Bondo

- Sustainable funding
- Considering FGM within the Millennium Development Goals and post-MDG framework
- Facilitating education
- Improving access to health facilities and in managing health complications of FGM
- Increased advocacy and lobbying
- The criminalisation of FGM and increased law enforcement
- Fostering the further development of effective media campaigns
- Encouraging FBOs to act as agents of change and be proactive in ending FGM
- Increased collaborative projects and networking
- Further research

INTRODUCTION

'It is now widely acknowledged that FGM functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families' (The General Assembly of the United Nations, 2009).

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the WHO as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Over 125 million girls and women alive today have had FGM in the 28 African countries and Yemen where FGM is practised and 3 million girls are estimated to be at risk of undergoing FGM annually (UNICEF, 2013).

HISTORY OF FGM

FGM has been practised for over 2000 years (Slack, 1988). Although it has obscure origins, there has been anthropological and historical research conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision' (Slack, 1988). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983).

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996) (Sources referred to by Wilson, 2012/2013).

GLOBAL FGM PREVALENCE AND PRACTICES

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past, and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

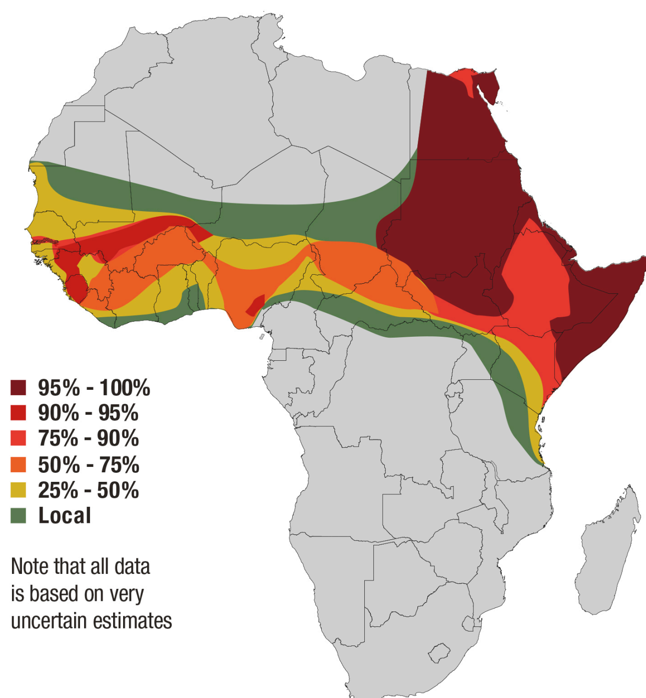


Fig. 2: Prevalence of FGM in Africa (Afrol News)

The WHO classifies FGM into four types (WHO, 2008):

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood, and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious scripts require the practice, practitioners often believe the practice has religious support. Girls and women will often be under strong social pressure, including pressure from their peers and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic (UNICEF, 2005). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth complications and new born deaths, and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

The eradication of FGM is pertinent to the achievement of four Millennium Development Goals (MDGs): MDG 1 – eradicate extreme poverty and hunger, MDG 2 – achieve universal primary education, MDG 3 - promote gender equality and empower women; MDG 4 - reduce child mortality, MDG 5 - reduce maternal mortality and MDG 6 - combat HIV/AIDS, malaria and other diseases. The post-MDG agenda is currently under discussion and it is hoped that it will include renewed efforts to improve the lives of women.

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM. A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well as providing more general information relating to the political, anthropological and sociological environments in the country to offer a contextual

background within which FGM occurs. It also offers some analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound knowledge base from which to determine the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we have met many anti-FGM campaigners, CBOs, policy makers and key influencers. We wish to help facilitate in-country networking to enable information sharing, education and increased awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

NATIONAL STATISTICS

GENERAL STATISTICS

POPULATION

6,384, 376 (Country Meters 3 June 2014)

Median age: 19 years

Growth rate: 2.33% (World Factbook 2014 est.)

HUMAN DEVELOPMENT INDEX

Rank: 177 out of 186 in 2013 (UNDP)

HEALTH

Life expectancy at birth (years): 47.5 (WHO) or 57.39 (World Factbook)

Infant mortality rate (per 1,000 live births): 73.29 deaths

Maternal mortality rate: 890 deaths/100,000 live births (2010); country comparison to the world: 4 (World Factbook)

Fertility rate, total (births per women): 4.83 (2014 est.)

HIV/AIDS – adult prevalence rate: 1.5% (2012 est.)

HIV/AIDS – people living with HIV/AIDS: 57,700 (2012 est.); country comparison to the world: 58

HIV/AIDS – deaths: 3,300 (2012 est.) (World Factbook)

LITERACY (AGE 15 AND OVER WHO CAN READ AND WRITE)

Total population: 43.3%

Female: 32.6%; male: 54.7% (2011 est.) (World Factbook)

Total Youth Population: 61.0%

Female youth (15-24 years): 52.0%; male youth: 70.0% (2013) (World Bank)

GDP (IN US DOLLARS)

GDP (official exchange rate): $4.607 (2013 est.)

GDP per capita (PPP): $1,400 (2013 est.)

GDP (real growth rate): 13.3% (2013 est.)

URBANISATION

Urban population: 39.2% of total population (2011)

Rate of urbanisation: 3.04% annual rate of change (2010-15 est.)

ETHNIC GROUPS

Temne 35%, Mende 31%, Limba 8%, Kono 5%, Kriole 2%, Mandingo 2%, Loko 2%, other 15% (includes refugees from Liberia's recent civil war and small numbers of Europeans, Lebanese, Pakistanis, and Indians) (2008 census) (World Factbook).

RELIGIONS

Muslim 60%, Christian 10%, indigenous beliefs 30%

LANGUAGES

English (official, regular use limited to literate minority), Mende (principal vernacular in the south), Temne (principal vernacular in the north), Krio (English-based Creole, a lingua franca and a first language for 10% of the population but understood by 95%) (World Factbook).

MILLENNIUM DEVELOPMENT GOALS

A note on data

UNICEF highlights that self-reported data on FGM needs to be treated with caution since women may be unwilling to disclose having undergone FGM due to the sensitivity of the subject or its illegal nature. In addition, they may be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age.

The DHS data does not directly measure the FGM status of girls aged 0-14 years, however, pre-2010, the DHS surveys asked women whether they had at least one daughter with FGM. This data cannot be used to accurately estimate the prevalence of girls under the age of 15 (UNICEF, 2013). From 2010, the DHS methodology changed so that women are asked the FGM status of all their daughters under 15 years. Measuring the FGM status of this age group who have most recently undergone FGM or are at most imminent risk of undergoing FGM gives an indicator of the impact of current efforts to end FGM. These figures however (unless they are adjusted) do not take into account the fact that these girls may still be vulnerable to FGM after the age of 14 years. The full report for the DHS 2013 should be published later this year.

The eradication of FGM is pertinent to a number of the UN's eight Millennium Development Goals (MDGs). Throughout this report, the relevant MDGs are discussed within the scope of FGM.

CHALLENGES WITH DATA AND ANALYSIS

Fig. 3: Millennium Development Goals

Much of the data is lacking for the Government to make a clear prediction of whether their MDG targets will be met. It is suggested that monitoring in Sierra Leone is limited because of a lack of specialised knowledge and research capacities, an absence of processes to capture good practices and data, and limited public documentation. There is also restricted freedom of information legislation. Civil Society Organisations suggest that MDGs are unrealistic for a national context and that it would be more effective to set targets locally (Commonwealth Foundation, 2013).

POST-MDG FRAMEWORK

As the MDGs are approaching their 2015 deadline, the UN is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace. Currently, the UN is working with its partners on an ambitious post-2015 development agenda, and striving for open and inclusive collaboration on this project (UN website). The UN is also conducting the MY World survey in which citizens across the globe can vote offline and online (including using mobile technologies) on which six development issues most impact their lives. These results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).

Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's sixteen areas of focus for development. On the issue of gender violence, there has been a growing call for the post-MDG agenda to include a distinct focus on ending violence against women (Harper, 2013). Though it is unlikely that FGM will be eliminated in Sierra Leone by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM. Perhaps most significantly, an important milestone was reached this year at CSW58 - a clear call for a standalone goal on women's rights and gender equality by the Commission. This is an important step in the Post-2015 negotiations as a strong and unified call for the goal had not previously been made by governments. The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the decade for African women will certainly assist in promoting gender equality and the eradication of gender violence in Sierra Leone.

POLITICAL BACKGROUND

HISTORICAL

Sierra Leone has been inhabited for over 2,500 years, with an Iron Age beginning in the ninth century and agriculture arriving by AD 1000. During first documented contact with Europeans in 1462, Portuguese explorer Pedro de Cintra named the mountainous area *Sierra Lyon* (Lion Mountains). The area was populated by autonomous indigenous groups with distinct languages (see ethnic groups section). By the 1530s the slave trade began, with ships patrolling the coast and conducting kidnapping raids. Walter Rodney has argued that some indigenous chiefs participated in the slave trade in exchange for trade items, transforming human life into an export business. Chiefs used secret society rules and 'trumped up Bondo and Poro charges to capture victims for sale' (Rodney, 1970). The slave trade continued in Sierra Leone throughout the seventeenth and eighteenth centuries under British control, and perpetuated for several decades after it was banned in 1807.

A turning point in the ethnic and political history of Sierra Leone was the invasion of the warrior ethnic group the Mande (Mane) in the sixteenth century. Today, the term 'Mande people' is used to refer to a large collection of ethnic groups which speak related languages. It is thought that their female chief Macario was expelled from her homeland, resulting in a mass migration. The Mande conquests, and resulting ethnic blending and cultural assimilations, are what give Sierra Leone its present day ethnic diversity. It is believed that the practice of FGM was brought to Sierra Leone by the Mande (Bosire, 2012). These invasions also militarised Sierra Leone and resulted in the construction of larger, permanent villages. Although internal conflicts between indigenous groups continued for around 350 years, these groups were united by Poro and Bondo (Sande) secret societies. In the seventeenth century the British took over control of Sierra Leone from the Portuguese. Towards the end of the slave trade, the Committee for the Relief of the Black Poor planned to settle London's 'black poor' in the 'Province of Freedom'. In 1789 this settlement was inhabited by 400 formerly enslaved Black Britons and African Americans. Freetown was established in 1792.

The colonial era in Sierra Leone lasted from 1800 to 1961 and much of the territory remained under the control of the Mende and Temne. The British and Creoles (persons of mixed African and European race/ancestry) were based in Freetown, and the Government's focus was trade, treaties and military expeditions. British colonialism resulted in diplomacy disputes and violence between the British and local chiefs, and territory disputes between Britain and France. Sierra Leone became a Protectorate in 1896, with much contestation. Out of 149 chiefdoms, Governor Cardew gave sole authority of local government to a small set of Paramount Chiefs. Paramount Chiefs retain this power in conjunction with systems of local councils that were implemented in 2004. Moreover, only individuals from ruling families (aristocracy) were given the right to rule by the British (Reed and Robinson, 2013). There were continued violent disputes, such as the Hut Tax War of 1898. In 1924 a new constitution was drafted, dividing Sierra Leone into a Colony (Western Area) and Protectorate with separate political systems. In 1960 the Independence Conference led by Sir Milton Margai took place in London and this resulted in Sierra Leone gaining independence on 27 April 1961, with Margai becoming the first Prime Minister. This independence came as a result of the educated Protectorate elite allying with the Paramount Chiefs in opposition to Krio intransigence. After the Sir Albert administration in the mid-1960s, the All People's Congress (APC) won a majority in the contested 1967 elections, making Siaka Stevens Prime Minister. His controversial victory quickly resulted in several military coups, but he was reinstated in 1968. Stevens was succeeded by Joseph Saidu Momoh in 1985.

The civil war in Sierra Leone occurred from 1991 to 2001 and was influenced by the war in neighbouring Liberia. Rebels quickly gained control of eastern Sierra Leone, including the diamond mines in Kono. Despite promises of political reform, Prime Minister Momoh and the APC were accused of corruption, hoarding arms and planning violent campaigns. Between 1992 and 1996 the National Provisional Ruling Council was responsible for a military coup. After a short period of civilian rule in 1996 there was a further junta under the Armed Forces Revolutionary Council, which was finally ousted in 1998. UN peacekeepers were sent in 1999 and there was significant British involvement in restoring peace. There are unclear statistics on the number of people killed during the civil war, ranging from 50,000 to 300,000 (but it is likely around 100,000). Between half and 2.5 million people were displaced. During the civil war over 250,000 women were victims of sexual and gender-based violence including: rape, trafficking, enslavement, mutilation, sexual slavery, forced pregnancy, labour and detention (Abdullah, 2012).

CURRENT POLITICAL CONDITIONS

In 2002 elections were held and President Kabbah was re-elected. The court, set up to try those responsible for serious violations of human rights during the civil war convicted all nine defendants. Many people still struggle to cope with the devastation of the war, particularly those who remain in IDP camps. With respect to the political authority of Bondo and Poro secret societies, rural members are still angered by the transgressions of the RUF rebels, who broke society laws by entering bondo bushes to hoard weapons and food (Fanthorpe, 2007). Fanthorpe argues that Sierra Leoneans have been trying to re-establish political order based on secret societies. Part of post-war recovery and political stability is initiation (FGM) into the secret societies. However, young adults who have grown up without the old social matrix are beginning to question the need for FGM and the authority of society chiefs (2007).

As part of post-war reconstruction, the Government instituted a number of reforms to promote good governance and economic development, protect human rights and advance gender equality. The military also took over the country's security after the departure of UN peacekeepers in 2005. In March 2014, the closure of the UN Integrated Peacebuilding Office in Sierra Leone (UNIPSIL) marked the end of more than 15 years of peacekeeping. In 2012 the APC won a majority in peaceful elections and President Ernest Bai Koroma was re-elected. Widespread corruption remains a problem for the Government of Sierra Leone and it continues to implement its five-year national action plan to combat corruption (Human Rights Report, 2013).

BONDO

Bondo is a name for the initiating secret society of women in the south and east of Sierra Leone, (Sande in the north and west of the country and broadly throughout Guinea and Liberia). It is also the name of the spirit mediator between the living and the dead. This institution is central to women's lives, affording them a measure of political autonomy, respect within the community, freedom of movement and association when the bondo bush is in session and also power within their communities to mediate social relations and the conditions women live in. At present the cost of this social good is FGM or disenfranchisement if it is refused. The heads of the separate bondo bushes, with the complicity of local chiefs, act as gatekeepers, financially rewarded for their work, providing strong vested interests in its continuation.

Fig. 4: A gathering of Soweis in Masanga (MEA)

Though commonly referred to in the literature as Bondo society and the circumcisers as Sowei, there are other local names for the societies and titles for those women in their hierarchy (Table 1). The names all refer to the same basic tenets of initiation and purification mediated through the heads of the society who control the 'medicine' (once called fetishes in early ethnographies) that provides the societies' powers. This report will refer to Bondo to mean all women's secret initiating societies, unless otherwise indicated.

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	Bonka	Gboroka
Loko	Bon-dona	Ligba	Bond-ofayra	Bborrga
Mende	Sande	Sowei/ Majo/ Digba	Mbo-rgbinie	Kpowei
Susu	Gany-ee	Yongoye-lie	Gany-ee Gineh	Amoog-aangeh
Temne	Bondo	Digba	Bonka	Gburka
Kono	Sand-eneh	Soko	Sein-ama	Dumisu-uneh
Kissi	Fanga-bondo	Sokonoh	Sumu-noh	Kwendenoh
Kuran-ko	Sayere	Biriyele/ nu		

Table 1: Names of aspects of Bondo Society in main Sierra Leonean languages (Bjälkander et al., 2013)

In Sierra Leone, 90% of women are members of Bondo and it includes seventeen ethnic groups (Boyle, 2005). The Christian Krio are often reported as the only ethnic group that does not participate in Bondo. The Bondo have laws of secrecy prohibiting members from discussing their practices, with supernatural and physical sanctions on those who break the laws. All males and uninitiated girls and women are non-members, and also are not permitted to discuss Bondo issues (including FGM). There are stories of forced initiation as punishment for breaking Bondo law carried out on non-members (see Challenges section).

For women in Sierra Leone, FGM is not about female passivity and control; women can gain political power and community status through initiation. There is a severe stigma against uninitiated women with concomitant peer and community pressure to be initiated. All ethnic groups have pejorative terms for uncut women usually meaning 'foolish', 'childish', 'stupid' or 'impure'. All women's meetings in a village are

under the auspices of Bondo, and news and information, such as new child health initiatives, is only shared with initiates, so there are other important costs associated with non-membership.

Bondo gives women agency and a sense of community. For example, in rural northern Sierra Leone women are required to gain their husband's permission to do tasks outside the home. Yet, Bondo is a place where a woman can go without her husband's permission. The initiation activities are considered holidays. Women gather three or four times a year, wear elaborate clothes and jewellery, and go to the bondo bush without seeking permission from men. Bondo initiation is tied to conceptions of sexual/gender identity and fertility. The Bondo 'bush' represents fertility and the essence of ancestral and supernatural spirits (Koso-Thomas, 1987).

During the ceremony, the Bondo perform a masquerade, with both the masks and dances having ritualistic powers. These masquerades are the only known instances of women in Africa wearing masks.

The initiation was traditionally reserved for women ready to join marital life. Traditional teachings included domestic duties, community involvement, marriage and responsibilities to a husband. Marriages performed before initiation to the secret societies are considered illegitimate. The Bondo have a close reciprocal relationship with community chiefs. They generate income for the chiefs through marriage and initiation license fees and in return, the chiefs enforce Bondo rules. However, the practice is evolving in contemporary life. Some parents delay their daughter's initiation until she has completed her schooling, due to the prohibitive initiation costs and the fact that a marriage licence fee must be paid by all initiates, regardless of age or readiness for marriage. Other parents want to initiate their girls young and have them continue with their studies before marriage. Some members feel that with more girls attending school, there is a lesser role for the society in training. Bosire argues however that

The Bondo Mask

Bondo/Sande masks are viewed as the spirit of the Bondo societies, with rich symbolism carved into each one. These masks often use the following symbols: the bird on top represents women's intuition, the high forehead implies good luck or a sharp mind and down cast eyes symbolise spirituality. The small mouth represents the ideal character for a woman as quiet and humble. Scars on the cheek depict the new hard life as a woman. The rings around the neck show idealised health and beauty in a woman, or can be seen as the ripples of water around the head of the Bondo spirit as it emerges from water (the spirits' realm). Around the base of the mask are drilled holes for the black raffia fringe to be attached. The body of a mask wearer must not be exposed at all as it would allow entry of an evil spirit to possess her.

Fig 5: Mende Sande mask (Indianapolis Museum of Art)

All Bondo masks follow the same basic symbolism, with variations in hair dress and animals represented, symbolising fertility or the supernatural powers of the spirit of the mask.

in post-war Sierra Leone, the education sector is still undergoing reconstruction and therefore the state is ambiguous about its position on FGM and Bondo because the Bondo partly fills an education role.

Bondo initiation has evolved significantly in response to the post-war socio-economic climate and as a result of anti-FGM discourse. Increasingly, the ceremony leaves out much of the traditional training. This has consequently diminished the symbolic authority accorded to Soweis. Thus, Bondo members now have to find a balance between FGM practice as a commodity, while retaining its cultural importance in ordering community social relations. There are tensions between the different chapters of Bondo (particularly urban versus rural) and the degree of practise. Bosire suggests that chapters which add or remove cultural elements of the society are practising 'invented traditions'. The human rights discourse has also changed Bondo society.

Children's rights, consent, choice, violence against women and harmful traditional practices are all themes discussed in relation to Bondo. Bosire argues that 'the powerful anti-FGC eradication discourse thus represents a very threatening change to the Bondo, at least in Bondo public discourse, because the whole edifice of the sodality is held together by the ritual of FGC and by the accompanying oath of secrecy'. Yet, Bondo confrontation with anti-FGM discourse has arguably led to greater self-organisation, solidarity, and even retaliation to eradication campaigns (see section on challenges faced by anti-FGM initiatives).

Unless otherwise stated, all references from Bosire, 2012.

BONDO INITIATION

The initiation ceremonies of most girls in Sierra Leone follow the same basic course, regardless of the name of the society. The ceremonies now happen at different times of the year, where traditionally they happened after the harvest in the dry season. Villages may not hold annual ceremonies so girls older and younger than the traditional age of puberty may be initiated together.

The five main phases of the ceremony are the calling to the bondo bush; seclusion in the bush; FGM and other initiation rites; teaching and the coming out ceremony. These phases are called different names according to the ethnic group. The start of the ceremony is announced by the beating of the bondo drums and the Soweis entering the village to collect the children and any members of the society who wish to attend and leading them off to the bush, a segregated site several miles from the village. The first rite of the initiation is the ritual cutting of the girls' genitalia, and while their wounds heal they are taught the secrets of the society, ritual dances and songs and domestic and sexual care of their husbands. This phase of teaching has been shortened in recent times to a matter of days or weeks, when it used to continue for up to a year. The final stage of the initiation and the lure used to get girls to agree to enter the society is the coming out celebrations. The girls are dressed in white and daubed with white clay (among the Mende), or given new clothes to wear, and are taken back to the village as newly formed adults and are the centre of all attention. They are accompanied by the bondo devil masquerade amid much rejoicing and acclamation of their new status. There follows a celebratory feast.

'Plain condemnation of the practice tends to push Bondo followers deeper into "defence of tradition" position as opposed to changing the culture of FGC initiation' (Bosire, 2012).

THE ECONOMICS OF FGM IN SIERRA LEONE

There are two ways to address the economics of FGM, the cost to the family and the cost to the State. There are no figures published for the latter, but they may be extrapolated from available data and knowledge.

A number of studies report the cost of initiation to the family or future husband for when the girl is already betrothed (in itself a strong economic incentive for early marriage). Bosire (2012) reports his interviewees quoting the cost as between 200,000-600,000 Leones ($46US- $139US), and the Fambul Initiative Network for Equality (FINE) (2013) reports that the cost can be up to 1 million Leones ($231 US). These costs include 30,000 Leones ($7 US) to the chief as a registration fee, and 15,000 Leones ($3.50 US) for the marriage license, which are always granted at the same time. There is also payment to the Sowei and her helpers in the bush, and food for the initiate and other society members residing with them, which is not the ordinary fare, but meat rich. There is also the cost for the musicians and celebrations for the coming out ceremony, and a cost for new clothes that are demanded by right by the girls to wear after initiation to attract suitors. 70% of the population live on less than 8,580 Leones ($2US) per day, making the initiation cost a huge figure. In 1987, Koso-Thomas wrote that families often use their whole harvest to pay for initiation in rural communities. These costs can push poor families further into poverty.

Due to the civil war, many Bondo members (particularly of the Mende group) continue to reside in IDP camps (Bosire, 2012). The Bondo have established training 'bushes' in IDP camps across Sierra Leone. In IDP camps in Freetown, the initiation fee ranges from 20,000 Leones ($5US) to 100,000 Leones ($23US). Women living in IDP camps are often the breadwinners for the family, with few opportunities for paid work and therefore consider a Sowei career as an economic opportunity. Consequently, young women want to train as Sowei in their late 20s and late 20s and early 30s (or younger, like the 5 year old girl in Fig. 6) when traditionally the age of a Sowei is over forty. This means that the practice is now viewed mainly as a source of income and this has compromised the core cultural reasons for initiation.

Men in discussions held by Fambul Initiative Network for Equality (FINE) said the cost was one of the reasons girls were being cut younger as it was cheaper (FINE, 2013). In addition to the cost of the rites, families face further economic costs if healthcare is needed to help with complications of FGM, either immediate, or future long term ill health.

The other side of the economics is the additional costs to the state in healthcare and loss of human potential. Additional healthcare provision needed by women with all types of FGM, is shown by WHO to be about .1%-1% of healthcare spending on women aged 15-45. Deaths caused by complications during or after initiation and the school drop-out rate fuelled by early marriage both add losses of human potential to the State and its development. The high number of teenage pregnancies, which is often linked to FGM, causes more loss of human potential as girls enter a cycle of poverty and ill health.

Fig. 6: A 5 year old Sowei in training (IRIN NEWS)

ANTHROPOLOGICAL BACKGROUND

There are at least seventeen ethnic groups in Sierra Leone. These groups have been divided into three language categories: Mande, Mel and Others. The Mende, Vai/Gallinas, Kono, Loko, Koranko, Soso, Yalunka and Mandingo belong to the Mande. The Temne, Bullum/Sherbro, Kissi, Gola and Krim form part of the Mel group. The Others are Limba, Fula, Krio and Kru. The two largest communities are the Mende and Temne making up 65% of the country's population.

Figure 7 shows the traditional homeland of the various ethnic groups in Sierra Leone before the civil war. Due to the displacement of peoples during the eleven years of fighting, the population has become more mixed, with many people living in IDPs. In particular, the Mende now reside in large numbers in the Western urban area (Bosire, 2012). Similarly the ethnic mix in the Kono district and other eastern areas have changed due to diamond mining and other resource extraction industries that draw in young men as labourers. This employment opportunity is rare in Sierra Leone, which has a predominately agricultural economy and a youth unemployment rate of 60% (The World Bank, 2013). Religious affiliation among ethnic groups is often reported in terms of Muslim or Christian, but in most groups these beliefs are held alongside traditional beliefs in the supernatural and the power of ancestors' spirits. Many groups believe in witchcraft and supernatural causes for health complaints.

Historically, tension has existed between the Mende and Temne vying for political control and was a main driver for the civil war, with the RUF being led by a Temne. The war was not purely ethnic in nature, however, cut the main participants were the Mende and Temne. The main division now within Sierra Leone is the deep

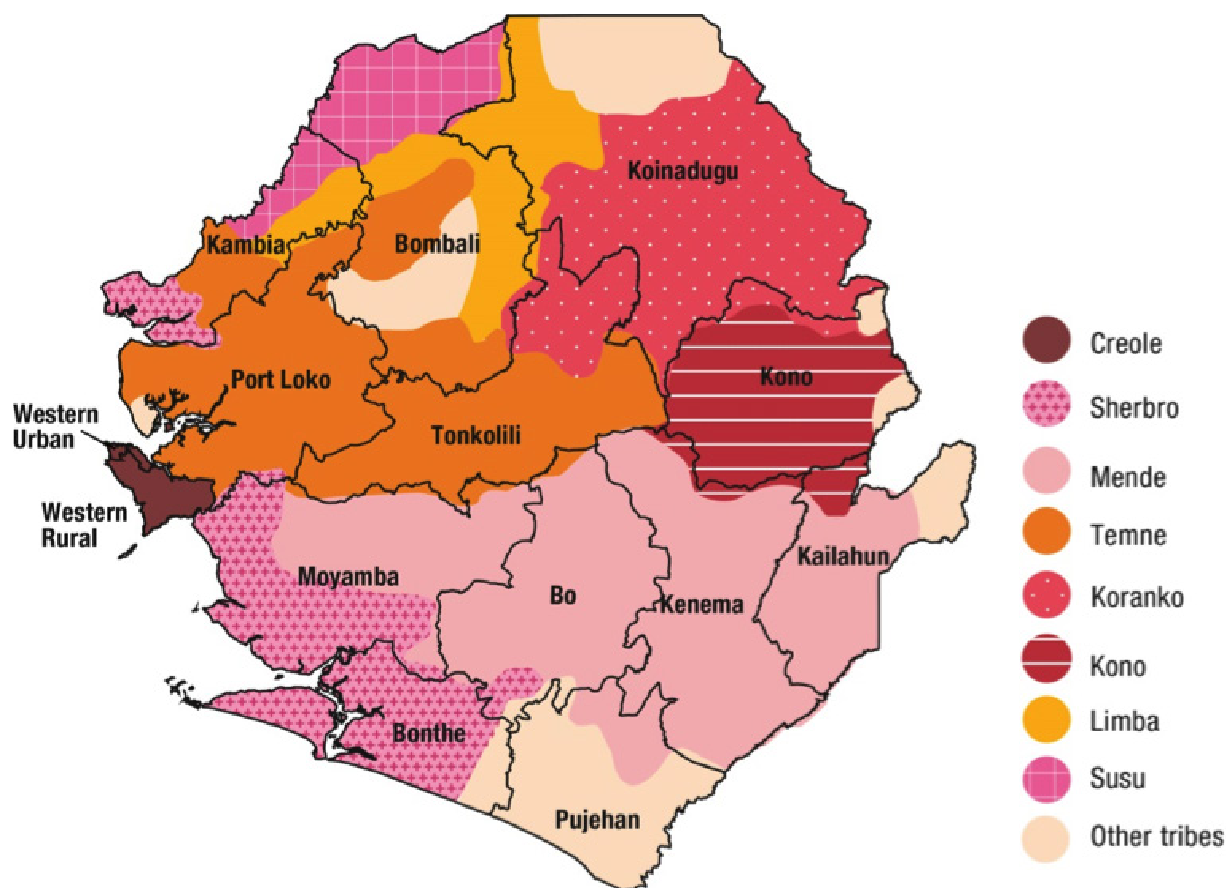


Fig. 7: Geographical distribution of ethnic groups within SL and the district boundaries in which they live

rift found between the few rich elites and the bulk of all religions and tribes (Minority Rights Group International Website). The most recent figures for Sierra Leone show that 70% of the population live below the Government's definition of the poverty line. Agriculture, mainly the subsistence variety, is the principal economic activity, accounting for 53% of GDP on average since 2004 and employing 61% of the active population.

ETHNIC GROUPS

FULA

The Fula originally arrived in Sierra Leone as traders in gold and slaves in the late seventeenth century. They forged trade routes down to the coast and Freetown from their homeland in Guinea. The Fula are committed Muslims and brought with them Islamic education systems, converting many groups on their travels. The Fula who settled in Freetown are not members of secret societies, viewing them as anti-Islamic, but the Fula who reside in other parts of the country initiate their children into both men's and women's societies (Jalloh, 1997). Those Fula who did not settle, remained pastoralist herders (Taylor, 2014).

GOLA

The Gola or Gula are a tribal people living in western Liberia and southern Sierra Leone. The Gola language is an isolate within the Niger–Congo language family and is now largely replaced by Mende in Sierra Leone. The name Gola is a possible source for the name of the Gullah, a people of African origin living on the islands and coastal regions of Georgia and South Carolina, in the United States, originally brought over as slaves from West Africa and prized for their rice cultivation skills. They continue to farm rice in Sierra Leone as their main livelihood. Many anthropologists believe that the Sande society originated among the Gola people and spread from them to the Mende and Vai. Uniquely the Gola's Sande mask represents a male spirit.

KISSI

The Kissi live on the eastern border with Liberia and Guinea. Along with the Gola, they are the oldest inhabitants of Sierra Leone. They self-report themselves as 75% Christian, 5% Islam and 25% indigenous religions. Traditionally they believe in a creator God and that ancestors' spirits mediate between the living and this God. Many wear charms against witchcraft and evil spirits. They live in compact villages that contain no more than 150 people, ruled by a chief and the village elders. Agricultural work is divided equally between the genders; boys tend to the livestock. Men also hunt and fish and women trade in markets, undertake childcare, tend the vegetable garden and fish. Iron workers as well as farmers, they made the Kissi penny which was up until recently a widely used currency in central and western Africa. Initiation into the women's secret society is called Biriye and is believed essential for a child to pass through to become an adult (Taylor, 2014).

KONO

The Kono make up 5% of the population, and were originally found in the Kono district of the Eastern region, but many were displaced during the civil war. Diamond mining still dominates the area's economy and the region has undergone a large population influx as young men are drawn to the area for employment (Coulter, 2005). The Kono are part of the large Mande people group. They originally migrated to Sierra Leone from the Mali Kingdom via Guinea (Fumba in Shell-Duncan, 2000). A part of this original immigrant group continued south and became the Vai ethnic group.

Kono are matrilineal, and girls are initiated into the Bundu secret society traditionally at puberty. The head of the Bundu society is called a Soko priestess and her assistants are Digbas. The age of FGM among the Kono is now falling to as young as toddlers (as among other ethnic groups) because mothers do not want their daughters to grow up and refuse the ritual, or be displaced by war into non-practising communities. For the Kono, 'A woman is a woman by virtue of being initiated, nothing else' (Fumba in Shell-Duncan, 2000).

DIMISU BIRIYE INITIATION CEREMONY

Dimisu Biriye is the name of the girls' initiation ceremony among the Kuranko into their women's secret society, the Segere. It is one of the few traditional non-Muslim ceremonies they still practise. Though the men have largely embraced Wahabiyya Islam and their secret societies, the Kome and Gbangbe are only active once a year, the Segere is active year round. During Segere activities in the village, uninitiated women and all men go inside, leaving the public spaces open solely to the women. Traditionally it was reported that men had no involvement in the girls' initiation ceremonies, but post-civil war this appears to have changed with the fathers taking active parts in the public dances and singing. The planning for the ceremonies starts a year in advance as it is expensive to perform, and requires at least the harvest of one extra rice field to pay the initiators, the musicians and to feed the guests. Kola nuts are sent to relatives to let them know that an initiation is to take place the following year.

There are many ceremonies involved in Dimisu Biriye, both private and public. Its function is one of social cohesion and training of young girls in the art of being a wife and woman in the community. Traditionally it would have led straight on to marriage. The girls' preparations start several months before the ceremonies, learning the required dance and songs. The ceremony itself starts with three days of dancing and singing leading up to the initiates' seclusion in the biridela (equivalent of the bondo bush). The first act of this period is FGM performed by biriyele/nu. A girl's character and social standing for life is believed to be determined by her behaviour while being cut. To show suffering is a social disgrace. The mothers stay with the girls during their turn to have the clitorises removed, telling them not to be afraid. If the girls are fearless, they receive gifts. The cut genitals are inspected by the older women and a girl may need to undergo two or three cuts before they are satisfied (Coulter, 2005).

KRIM/KIM

The Krim now live in the most inhospitable area of their previous range in the Southern Province, the coastal mangrove swamps. They are an isolated people of which little is known, and do not seek interaction with other groups. They are surrounded by Sherbro on all sides. Palm wine is still central to their rituals and festivals, unlike many related groups who have been influenced by Islam to not drink alcohol (Portland State University).

KRIO (KRIOLE)

The Krio make up 2% of the population of Sierra Leone. They are divided into the Muslim Krio called Oku/Aku Krio, and the Christian Krio and live predominately in the Western Area, particularly Freetown. The population is predominately Christian at 85%, with Aku Krio making up 15%. The Krio were originally comprised of returned Africans from England, ex-slaves from the United States, Maroons from Jamaica and recaptured slaves from along the coast of Africa. Initially they did not form a cohesive group in their new territory bought off the Temnes on the Sierra Leonean peninsula, but kept distinct identities. These boundaries eventually broke down through intermarriage and a single Krio identity was forged.

The majority of the women slaves repatriated to Africa from slavery were from the Yoruba ethnic group, where traditionally men tended the fields and women were traders. This pattern of labour gave the women a large degree of financial freedom and autonomy. After 1900 many of the trading positions were taken over by European companies and the Krio turned to medicine and teaching as alternatives (French, 2008). The Christian Krio are purported to be the only ethnic group not to initiate their daughters into secret societies (though there is some evidence that the Kru and Mandingo do not either).

KRU

The Kru are found in Liberia, Cote d'Ivoire and Sierra Leone. It has been claimed they originally came from Mozambique (Limany, 2007). They refused to participate in the slave trade and successfully fought off capture as slaves themselves. Traditionally subsistence farmers and hunters, they live in lineage defined villages in coastal areas of their countries (Gates, 2010). They have expertise as sailors and work now as fishermen or dock workers in Sierra Leone (Gates, 2010). The Kru traditionally do not initiate their girls into secret societies (Limany, 2007).

KURANKO (KORANKO, KOURANKO)

The Kuranko live in the mountainous regions of north-eastern Sierra Leone and across the border in southern Guinea (Taylor, 2014). They speak Kuranko which is similar to and understood by both the Mandingo and Soso with whom they are allied (Taylor, 2014). They are rice farmers, and supplement their diet with fish caught by the women. They also maintain fruit trees and grow corn and pumpkins along with cotton and indigo to supplement their incomes (Taylor, 2014). 75% of Kuranko are Muslim, 5% Christian and 20% Animists. They have beliefs in witchcraft, which is symbolised by the vulture, bat and black cat and the existence of quasi-humans called Nyenne who affect their lives for the good and bad (Taylor, 2014). The girls' initiation ceremony at puberty into the Sageree women's society is called Biriye (see inset box) and is thought to be needed to transform children who are seen as incomplete and impure humans into adults (Taylor, 2014). Traditionally, though no longer always the case, the girls go straight from initiation to their marital home. Marriage involves the payment of bride wealth and for the future son-in-law to work for the bride's father (Coulter, 2004).

LIMBA (YIMBA)

The Limba make up the third largest ethnic group in Sierra Leone, about 8.5% of the population. They are one of the earliest inhabitants of Sierra Leone and as such they speak a language largely unrelated to other languages in the area. The majority of Limba live in the Northern region but are also found in the Southern region and both in the rural and urban Western Area. Traditionally the Limba are rice farmers, hunters and traders. Those in the Northern region adopted Islam as it fitted easily with their traditional beliefs allowing both polygamy and sacrifices (Minority Rights Group International Website). The Limba believe in a creator god named Kanu, who ordains all aspects of human activity, conception, birth, death, initiation and farming (Conteh, 2004). Thus the Limba word Dina which means both culture and religion exemplifies the notion that there is no line to be drawn between sacred and secular spheres (Conteh, 2004).

They initiate their girls into the Bondo society at 13-16 years in the north, but at 8 years or younger in Freetown and the Western Area, as they believe it discourages premarital sex (Conteh, 2004).

LOKO (LANDOGO)

The Loko are patrilineal, patrilocal and polygamous. They live mainly in the Northern Province and around Freetown and form 2% of the population (World Factbook). They are divided into nine districts ruled by a chief, with each village ruled by a headman answerable to the chief. Their economy is based on agriculture and mining. They initiate their girls into the Bondo society at any age between infants and 15 years (Koso-Thomas, 1987). In her small scale study, Koso-Thomas found that 50% of Loko were cut before they were 10 years old. They believe that most humanistic and scientific power is passed down through the secret societies such as the Kpangbani. They also believe in witchcraft and wear charms or carry medicine to ward it off (Fyle, 2006).

MANDINGO (MANDINKA)

The Mandingo are found in Mauritania, Burkina Faso, Liberia, Niger, The Gambia, Guinea, Mali, Cote d'Ivoire, and Senegal. They are part of the Mande, the largest ethno-linguistic group in West Africa and were originally migrants from the Mali Kingdom in the 13th century. They live in all areas of Sierra Leone, but are mainly found in the Eastern and Southern provinces in Bombali, Kono and Koinadugu and form 2% of the population (World Factbook). They are agrarian farmers and one third of the population was taken as slaves to the USA. The group is patriarchal and 99% Muslim. They have Koranic schools teaching Arabic and some claim that literacy in Arabic is 50% of the adult population. Fanthorpe claims that they strictly adhere to Islamic teaching and therefore do not initiate their children into secret societies as a rule (2007).

MENDE

Prevalence of FGM among women and girls aged 15-49 years is 90% (DHS, 2008).

The Mende are predominantly found in the Southern and the Eastern Provinces and are the second largest ethnic group making up 30% of the country's population. Some of the major cities with significant Mende populations include Bo, Kenema, Kailahun and Moyamba. They speak the Mende language and it has become the lingua franca among other ethnic groups that live in the south and east, spoken by around 46% of Sierra Leone's population. 75% are Christians, mainly Catholic, 15% Muslims and 10% practise traditional beliefs (Koso-Thomas, 1987). They traditionally held a belief in a creator god, as do most of the ethnic groups.

Historically, women were not politically subordinate to men. In the pre-colonial era, the Mende had female chiefs and war leaders. One such female chief, Madam Yoko (1849–1906), was the leader of the vast Kpa Mende Confederacy. She was formally recognised by the British as a Paramount Chief in 1894, ruling an area that was eventually divided into fourteen chiefdoms (Lifshitz, 2009). In West Africa the bearing of children signifies women as strong and active agents in a society (MacCormack, 1974).

Fig 8: Girls from Kailahun District daubed in Hojo, during the 'wash hands' ritual at the end of the initiation (NMDHR)

Sande society is the women's secret society among the Mende. The Sande spirit is viewed as the guardian of women, their protector and guide through life. It is Sande that grants a woman with an identity and a personality. Initiation into the Sande for the Mende occurs in the early morning near a flowing stream. The initiates sit in the cool water in the hope of numbing their genitals to lessen the immediate pain of the cutting. They are cut using either traditional knives or broken bottles; the clitoris is cut off first then the labia minora are excised. The resulting wound is treated with ash and a compound of local herbs. The ceremony is conducted to the sound of loud drumming, singing and shouting to drown out the cries of pain (Koso-Thomas, 1987). This procedure is necessary to change Mende children, who are considered to be of neutral sex before the procedure, to heterosexual, gendered adults. The reasons for FGM fit with data from DHS 2008 for older women aged 15-49 as 76% of them were initiated after the age of 10, but not the 42% of their daughters who were cut before 10 years old, suggesting that the motivations for FGM are evolving. FGM is also thought to remove the female's residue of maleness.

Hojo is the name of the white clay used to adorn initiates after the ceremony. White symbolises cleanliness and the protection of the Sande. Buildings and objects may also be daubed in this clay for the same reasons.

Majos are the highest officials of Sande for the Mende, a position that is inherited and for life. They are hieratically above the Sowies, who are heads of individual Sande camps and responsible for teaching the initiates. They act as a role model for all Mende women. Their duty outside of the bush is to enforce proper social relationships within their communities. Their rulings are binding on men and women alike. They are respected for their access to ancestral spirits and the forces of

nature. Nyaha is the name for a Sande member, an initiate in training is a Mbogdoni and a non-member is a Kpowa, which means ignorant, stupid or retarded. Ligbanga are responsible for the actual cutting of the girls' genitals and Klawas act as counsellors for the initiates in the Sande camps (Mgbako et al., 2010).

SHERBRO

Following the historic Mande invasion from the south and east and subsequent domination and interaction with indigenous groups, new ethnic groups arose (Fyle, 2006). Mande with the Bullom gave rise to the Sherbro, while another north-eastern group of Mande gave rise to the Loko. The Sherbro are now 3% of the total population and are 99% Christians. They are also known as the Bullom (Taylor, 2014). They make up 45% of the population of Bonthe and are found in the coastal areas of the Mojamba district as well as in the Western area and Freetown (Taylor, 2014). Pre-colonisation, the Sherbro were a prominent ethnic group. Historically, they employed the Mende to source slaves for sale to traders. They have a Westernised culture similar to the Krio. Girls are initiated into the Sande society traditionally at puberty. It is widely stated that Poro societies started on Sherbro Island in Yoni village and spread to the mainland (Manson, 2009).

SOSO (SUSU)

The Soso live in Guinea and Sierra Leone where they mainly reside in the Kambia district, in which they are the second largest ethnic group at 28% after the Temne (Taylor, 2014). Their language belongs to the Mande group. The Soso and Yalunka believe they were once one people divided by the Fula invasion in the seventeenth century and their language is now still understandable to each other. The Soso live in marshy areas and cultivate rice; they are also fishermen and small traders. All members of a household regardless of age are expected to provide labour to maintain the family (Taylor, 2014). The Soso are predominately Muslim and they use the Bondo society to initiate girls into womanhood believing it confers fertility, instils notions of morality and proper sexual comportment.

TEMNE

Prevalence of FGM at 95.2% among women and girls aged 15-49 years (DHS, 2008).

The Temne are currently the largest ethnic group in Sierra Leone, at 35% of the total population. They are predominantly found in the Northern Province and the Western Area, including Freetown. 90% are Muslim and 10% Christian, though both have incorporated traditional (including supernatural) beliefs into their religious practice. The Temne language, along with the creole Krio, serves as the major trading language and lingua franca in northern Sierra Leone, spoken by around 40% of the population. Temne culture revolves around the Paramount Chiefs, and the Poro and Bondo societies. The most important Temne rituals focus on the coronation and funerals of Paramount Chiefs and the initiation of new secret society members. Initiation of girls is conducted in the Bondo bush at an increasingly young age. The DHS 2008 found that 29% of women aged 15-49 had FGM by the age of 10, but the figure for the daughters of Temne women was 69% by the age of 10.

The Temne are rice farmers, fishermen, and traders. They practise subsistence farming. At times of peak labour input, cooperative work groups are utilised when possible, for hoeing and harvesting. This livelihood is difficult for a single adult, thus making marriage of huge import. In the traditional Temne marriage system, bride-wealth, composed of consumer goods especially kola nuts passes from the groom's kin to the bride's and is subsequently distributed more widely. The exchange of bride-wealth and dowry seals the transfer of rights and obligations from the bride's father or guardian; this transfer marks a true marriage. The rights transferred are those with respect to domestic service, labour and the income from that labour, children and sexual services. All subsequent major decisions are made

by the husband. The Temne are closely allied to the Limba, Loko and Kuranko and often intermarry with the offspring of male Temnes viewed as belonging to the Temne group.

VAI

With a population of approximately 35,000 the Vai people are found in the Southern province of Sierra Leone, along the Liberian border over which a larger population is found. The majority of the Vai live in the Pujehun district and are part of the large Mande people group (Taylor, 2014). They originally migrated to Sierra Leone from the Mali Kingdom via Guinea; part of this migration stopped in the east of the country becoming the Kono and the rest continued south becoming the Vai. They are 95% Muslim and 5% Christian, with a long tradition of Koranic schooling in Arabic. Belief in Islam is held alongside beliefs that spirits have the power to bring evil down on individuals or the group (Taylor, 2014). Girls are initiated into the Sande society around puberty.

YALUNKA

The Yalunka live in large settlements in the Northern Province of Sierra Leone. Originally inhabitants of the Futa Jallon mountainous border region, they were driven out by the Fula in a seventeenth-century Jihad (Taylor, 2014). They are mainly subsistence farmers of rice and millet but also keep cattle which are herded by children and are used to pay bride wealth. 99% of the Yalunka are now Muslims, but they still practise ancestor worship and have strong belief in the supernatural and the spirit world. They wear charms to enhance personal power and make sacrifices to ward off the effects of evil spirits (Taylor, 2014).

OVERVIEW OF FGM IN SIERRA LEONE

This section gives a broad picture of the state of FGM in Sierra Leone. The following sections of the report give a more detailed analysis of FGM prevalence set within their sociological and anthropological framework, as well as efforts at eradication.

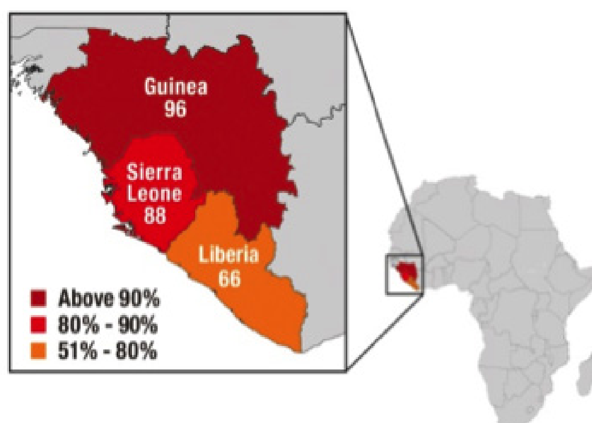


Fig. 9 Prevalence of FGM in West Africa

NATIONAL STATISTICS RELATING TO FGM

The estimated prevalence of FGM in girls and women (15-49 years) is 89.6% (DHS, 2013), 88.3% (MICS, 2010). These rates appear to have decreased slightly from 91.3% (DHS, 2008). Sierra Leone is classified as a Group one country, according to the UNICEF classification, with high FGM prevalence. Group one countries have a prevalence of more than 80%.

Statistics on the prevalence of FGM are compiled through large scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Cluster Indicator Survey (MICS). For Sierra Leone these are DHS of 2008 and 2013 (2013 full report forthcoming) and the MICS 2010, which provides the most up to date, complete statistics, but does not compile data by ethnicity or religion.

Fig.10: Districts and Provinces of Sierra Leone

PREVALENCE OF FGM IN SIERRA LEONE BY PLACE OF RESIDENCE

There is a difference in the prevalence of FGM between those who reside in urban areas (80.9%) as opposed to rural locations (94.3%) (DHS, 2013). There are also variations in prevalence of FGM between the districts of Sierra Leone. As shown in Figure 11, rates are highest in the Northern district and lowest in the West.

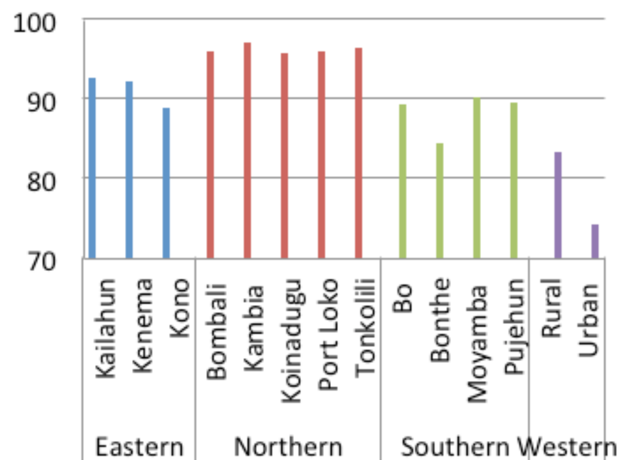


Fig 11. District level prevalence of FGM (DHS, 2013)

FGM PRACTICES IN SIERRA LEONE

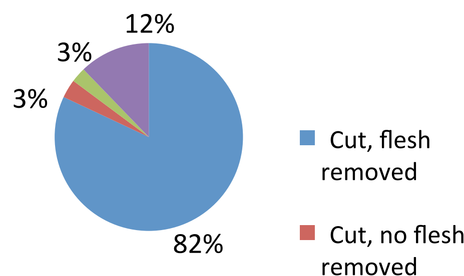
TYPE OF FGM

The DHS and MICS asks women who have undergone FGM questions to ascertain the extent of FGM carried out, but the categories used do not neatly match the WHO classifications and none of the reports are verified by genital inspection. In all three country-wide surveys, the large majority of women are cut with flesh removed (excision or Types I and II). It is unclear how many women aged 15-49 have had their genitals sewn closed from the three data sets shown in Figure 12, with reports of infibulations varying from 3% (DHS, 2008) rising to 17% (MICS, 2010) and falling back to 9% (DHS, 2013). The rise of WHO Type III FGM (sewn closed), is alarming as this is the most invasive and dangerous form of FGM.

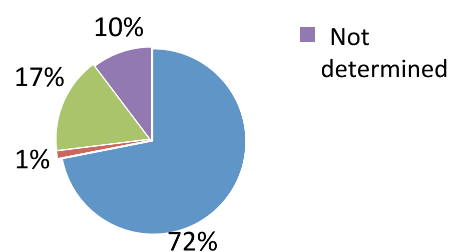
In three small scale studies reported by Bjälkander et al. (2013) that used genital inspection to verify the extent of the FGM, 99% of respondents identified correctly that they had undergone some form of FGM, but were unable to identify correctly the extent of the cuts. The largest proportion of women reported that they were cut, flesh removed in all the surveys, and Bjälkander found after inspection that these reported cuts accorded with WHO's Type Ib and IIc in Sierra Leone. Two women reported that they were sewn closed but in fact had undergone excision of the clitoris and labia minora. Anecdotal evidence suggests that respondents would assume from watching the operation being conducted on others in the bondo bush that the same operation was performed on them. Moreover, Bjälkander questions whether participants do not understand the question about being sewn closed and this was a reason for 1% of respondents in her studies reporting this type of FGM, when none had been evident on inspection (2013).

Figure 13 clearly shows a reported rise in infibulations (sewn closed) in all provinces, but the variation in the data over a short time period raises questions about the validity of the reporting. The Western area shows a staged increase over the

DHS 2008



MICS 2010



DHS 2013

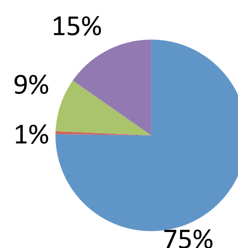


Fig. 12: Types of FGM and their prevalence in the 3 national data sets (DHS 2008, 2013 and MICS 2010)

Percent distribution of women infibulated by province and over 3 different surveys

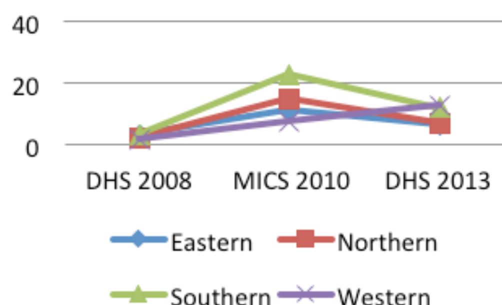


Fig. 13: Percent distribution of women infibulated by province and over 3 different surveys (DHS, 2008; MICS, 2010; DHS, 2013)

surveys from 1.8 to 7.5 to 12.9% - the highest figure of any province in 2013. The other provinces show a pronounced increase in reporting of this type of FGM in MICS 2010, but subsequent decreases by DHS 2013, all still higher than the universally low data from DHS 2008. This trend requires further research to clarify the situation.

PRACTITIONERS OF FGM

Unlike many countries in Africa, there does not appear to be a trend towards medicalisation of FGM in Sierra Leone. Traditional practitioners carried out 95.5% of FGM (DHS, 2008). For more information on Sowei practitioners, see section on the Bondo.

Medical personnel	0.3
Traditional practitioner (Sowei)	95.5
Don't know/missing	4.2

Table 2: Percent distribution of women who have been circumcised by person performing the circumcision (DHS, 2008)

PREVALENCE OF FGM IN SIERRA LEONE BY AGE

Surveys conducted prior to 2010 asked women whether they had at least one daughter with FGM. This data cannot be used to estimate accurately the prevalence in girls under the age of 15 (UNICEF, 2013). From 2010, the DHS methodology changed so that women are asked the FGM status of all their daughters under 15 years. The MICS data records the FGM status of girls aged 0-14 years. Measuring the FGM status of this age group who have most recently undergone FGM or are at most imminent risk of undergoing FGM gives an indicator of the impact of current efforts to end FGM. These figures (unless they are adjusted) do not take into account the fact that these girls may still be vulnerable to FGM after the age of 14. Figure 14 shows a clear difference in the prevalence of FGM between the oldest age group 45-49 and 15-19 cohort, 96.4% and 70.1% respectively. Only 10.7% of daughters under 15 have reportedly had FGM.

In the 2008 DHS as reported by UNICEF 2013, 60% of daughters were cut by the time they were 10 years old and another 26% by the time they were 14 years old. The more recent data collected (Figs. 14 and 15) by MICS 2010, found by asking the respondents for the FGM status of all daughters, show that only 10.7% of daughters had been cut by age 14. It should be noted that the next age cohort reported 70.1% prevalence. These figures show that there has been a large change in rate of either reporting or prevalence, even taking into account the change in question format between the two surveys. Boisre (2012) notes that his informants tailored their responses to NGO discourse and insisted that they never cut girls below the age of 18 (due to concerns regarding legal repercussions). This may account for the significant reduction seen in the two data

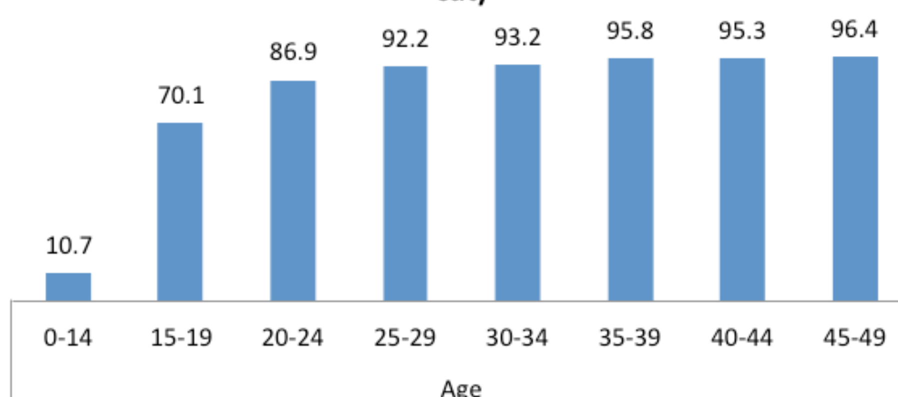


Fig. 14: Percentage of girls and women up to age 49, cut by age group

Percent of daughters cut by the age of 14

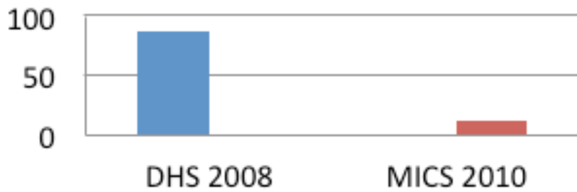
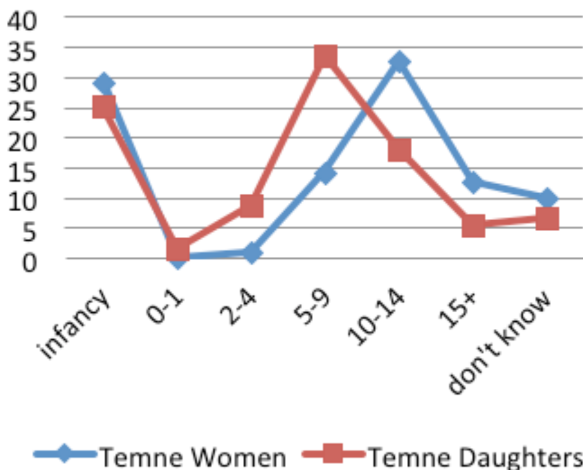
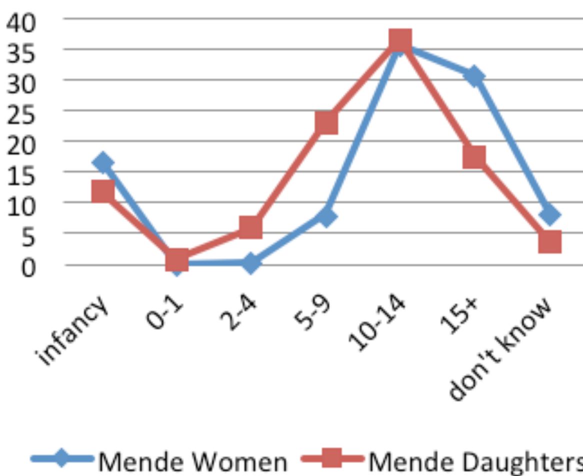


Fig. 15 Percent of daughters cut by the age of 14 (DHS, 2008 and MICS, 2010)

Comparison of age at FGM of Temne women and daughters



Comparison of age at FGM of Mende women and daughters



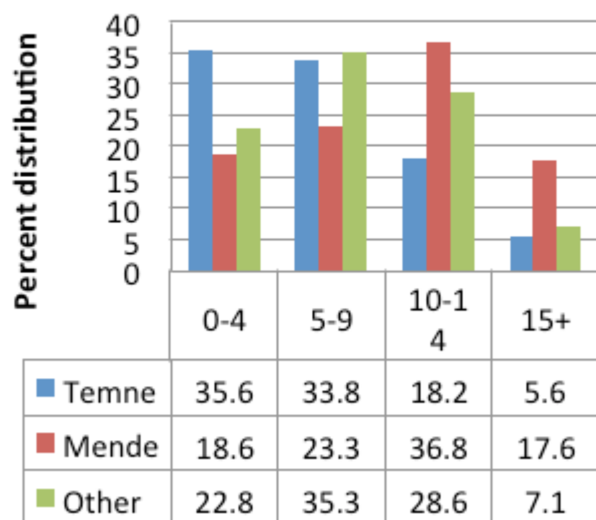
Figs: 16 and 17: Age at FGM of Temne and Mende women and their daughters (DHS, 2008)

sets only two years apart. The forthcoming DHS 2013 full report may illuminate this issue.

The 2008 DHS shows not only a move towards cutting girls at a younger age, but that this trend varies by ethnic group. Regarding the Mende and the Temne, Figures 16 and 17 show that the daughters' line has shifted to the left of women aged 15-49, illustrating the younger age at which FGM is now being carried out. Temne women had FGM predominately at 10-14 years (32.7%); Temne daughters had it at 5-9 years (33.8%). The Temne also cut a significant percent of both women and daughters in infancy, unlike the Mende.

When the data is collated for all daughters cut in infancy and up to the age of 4 (by their ethnic background), it shows the distribution presented in Figure 18. This illustrates clearly that the Temne favour cutting younger girls, with 35% before age 5 and 69% in total before age 10. The Mende cut the majority (54%) of their daughters after age 10, with 17.6% of the total cut after age 15. Other ethnic groups have cut almost 60% of girls by age 10.

Percent distribution of daughters who have had FGM by age at cutting according to their ethnic background



	0-4	5-9	10-14	15+
Temne	35.6	33.8	18.2	5.6
Mende	18.6	23.3	36.8	17.6
Other	22.8	35.3	28.6	7.1

Fig. 18: Percent distribution of daughters who have had FGM by age at cutting according to their ethnic background (DHS, 2008)

COUNTRYWIDE TABOOS AND MORES

The countrywide taboos that are of particular importance to this report are those surrounding FGM and the rules of secrecy within women's secret societies. These are discussed in the section on the Bondo Society and include taboos against non-initiated girls and women, and society's customs.

Sex and sexual behaviour are topics not normally discussed publicly. Domestic violence, especially spousal rape, is surrounded by a culture of silence. In 2013, NGOs reported that in many cases women withdrew charges of rape and violence due, in part, to social stigma. Wife beating is prevalent and women suspected of marital infidelity often face abuse. Husbands can claim monetary indemnities from their wives' partners and this perpetuates beatings. There are also reports that women suspected of infidelity are forced to undergo animalistic rituals to prove their innocence.

In rural areas, the Ministry of Health and Sanitation and NGOs attempt to provide oral contraceptives, but these are often refused by parents of sexually active teenagers because of the belief that contraceptives will cause infertility long term.

LGBT persons in Sierra Leone face discrimination. There is an 1861 law prohibiting male-to-male sexual acts, but no prohibitive legislation for female-to-female sex. In 2011 the Government rejected the Working Group recommendations from the UN Human Rights Council that same-sex sexual activity between consenting adults be decriminalised and another recommendation to prohibit discrimination based on sexual orientation and gender identity. Social discrimination against LGBT persons is prevalent. Confidentiality rights for health services are ignored and many choose not to be tested for STIs to avoid abuse. Lesbians were also victims of 'planned rapes', which were efforts to change their sexual orientation.

There are also a number of taboos concerning health. Though Sierra Leone has a Persons with Disabilities Act, funding for programmes and rehabilitation centres remains low. Children living with disabilities are less likely to attend school, and persons living with disabilities are more likely to be unemployed and rely on begging. There is significant discrimination against persons with mental health issues, and the majority remain untreated. HIV/AIDS prevalence is low in Sierra Leone. Despite few reports of violence against persons with HIV/AIDS, it is common for families to abandon them. Due to discrimination and stigmatisation, there have been cases of persons living with HIV/AIDS committing suicide. The HIV/AIDS Secretariat, created in 2004, leads efforts to distribute free anti-retroviral drugs and has played a leading role in raising awareness and combating stigmatisation of HIV/AIDS (UN Human Rights Committee, 2014). There is additionally a taboo against blood transfusions, and this is particularly challenging for women in need of blood transfusions during childbirth (*Concord Times*, 2013). Cancer, particularly breast cancer, is also considered taboo. Due to low literacy rates and lack of health knowledge, patients are unaware of the symptoms and complications of cancer and hide tumours from family members (Thomas Reuters Foundation, 2014).

There are numerous taboos and customs associated with pregnancy. Among the Mende, taboos include: standing in a doorway causes obstructed labour; going halfway on any journey and then returning can cause prolonged and difficult labour; talking about the unborn child or preparing for the birth can attract witches and encourage evil curses (Lefèber, 1998). There are also foods, which are taboo to consume during pregnancy or lactation, such as chicken and eggs, which are believed to cause dysentery and hiccups in the baby and infertility in the mother, but in reality cause poor nutrition in the mothers (Packer, 2002).

Unless otherwise stated, all information is from US Dept. of State, Human Rights Report, 2013.

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

Sierra Leone was ranked 66 out of 86 in the 2012 OECD Social Institutions and Gender Index (SIGI). Though very low, the rank has risen from 100 out of 102 in the 2009 SIGI.

In a patriarchal society with few employment opportunities, the main roles for women are viewed to be as wives and mothers. Under civil law, girls must be 18 to legally marry and forced marriage is prohibited (SIGI website). The National Statistical Office of Sierra Leone showed that in 2004 34.1% of girls aged 15-19 were married, divorced or widowed (SIGI website). Women in Sierra Leone first marry young; DHS data from 2008 shows that 22.2% of women aged 20-49 had been married by the time they were 15. The median age at first marriage for those aged 20-49 is 17.2 years (DHS, 2008). The median age is slightly higher for those aged 20-24 at 18.2 years. Moreover, the median age of marriage for women is significantly less than that of men entering their first marriage, who marry roughly seven years later than women. Early marriage is often linked to Bondo society initiation and cultural expectations. The patriarchal structure of society in Sierra Leone is reflected strongly in the marriage statistics, with 37% of women who are currently married reporting that they are in polygamous unions (DHS, 2008). The number of women in polygamous unions is higher for those in rural areas than in urban areas, 42% to 27% respectively. Polygamy is prohibited in Sierra Leone's civil code, punishable by up to eight years in prison, but is accepted in both Sharia (Islamic) and Customary law (CEDAW/C/SR.778).

The Domestic Violence Act, the Registration of Customary Marriages and Divorces Act and the Devolution of Estates Act (The Three Gender Bills) were enacted in 2007. The Domestic Violence Act was legislated to make domestic violence a criminal offence. Under this act, rape is punishably by 14 years in prison, but not spousal rape, and rape continues to be a 'societal norm' (SIGI website). Domestic violence is rarely reported, or is ignored by the authorities. Administrative inefficiencies and corruption mean that many rape cases are frequently settled out of court, or do not reach the trial stage (Human Rights Report, 2012). Yet, the creation of the Family Support Units has shown an increase of the number of rape cases reported, specifically those involving children (SIGI website). Women often appear to resign themselves to abuse. Wife beating is accepted by a significant proportion of Sierra Leonean women at 64.6%, with 54% of women thinking it is acceptable for a man to beat his wife in domestic arguments. 50% of women think going out without telling their husbands justifies being beaten, and 39% believe that if a wife refuses to have sexual intercourse with her husband, her husband is justified in beating or hitting her (DHS, 2008).

Fig. 19: International women's day March 2014 (Mark Collins)

The position of women in Sierra Leonean law varies depending upon the ethnic group to which they belong, though they are routinely viewed as inferior to men. Under customary law, i.e. traditional or common social practices, the status of an adult woman is equal to that of a minor (Human Rights Report, 2012). There is furthermore a lack of training for customary judges, meaning that most of the time judges are unaware of formal law, or choose to ignore it (Human Rights Report, 2012). The Registration of Customary Marriage and Divorce Act require the registration of marriages performed under customary law, the consent of both parties, and that both parties be

over the age of 18 (SIGI website). The Devolution of Estates Act states that men and women have the same inheritance rights in the event of the death of a spouse or a parent, regardless of religious or ethnic identity (SIGI website). Only 12% of the married women interviewed made independent decisions about their healthcare, while 47% stated that their husbands decided for them (DHS, 2008). Similarly 34% of married women who have cash earnings, compared with 50% of married men, report that they were solely responsible for deciding how their wages were to be spent (DHS, 2008).

HEALTHCARE SYSTEM

Healthcare is provided by the Government, private care and NGOs, and most care is charged for in Sierra Leone. Each of the thirteen administrative districts has its own health sector. The Ministry of Health and Sanitation is responsible for organising healthcare and increasing its coverage. They also monitor and train healers, who administer traditional medicine, which is widely used. Due to the civil war's extensive destruction of infrastructure, the country still lacks healthcare facilities, but these are being gradually reconstructed. Each district manages approximately fifty peripheral health units and staff, which deliver primary healthcare. Under this care, there are Community Health Centres, Community Health Posts for hospital referrals and Maternal and Child Health posts for first contact.

Sierra Leone has some of the poorest health indicators in the world, with a life expectancy of 57.30 years (2014 est.), an infant mortality rate of 73.29 deaths per 1,000 live births, and a maternal mortality ratio of 890 per 100,000 births (World Factbook). On average, Sierra Leone has a health facility density of 2.2 facilities per 10,000 people. Problems the Ministry of Health and Sanitation report facing include lack of: basic infrastructure, water supply, basic equipment, safety equipment such as eye protection, diagnostic equipment and lack of medications (2011). There is also a shortage of healthcare professionals; in 2008 the primary healthcare worker density was only 3.9 per 1000 people (MacKinnon & MacLaren, 2012) and three doctors for 100,000 people (WHO minimum recommendation is 228 per 100,000). There are 111 midwives to cover the whole population, (including nurse-midwives) giving one midwife per 1000 live births (UNFPA, 2011). Staffing shortages in hospitals range from 40% to 100%. The majority of healthcare providers in rural areas are health aids, who outnumber state enrolled community health nurses by around 6.5 to one (MacKinnon & MacLaren, 2012).

The National Health Sector Strategic Plan for 2010-15 (2009) is focused on improving healthcare for vulnerable groups, including mothers, children and the poor, and aims to reduce infant and maternal mortality rates, reduce preventable deaths in children and tackle poverty related to ill health. The plan aims to strengthen six 'pillars' of the healthcare system: leadership and governance; service delivery; human resources for health; medical products and technologies; healthcare financing and health information systems. In 2010 the Free Medical Insurance system (Free Healthcare Initiative) was launched for pregnant and breast-feeding women, and children under five. This scheme is funded mainly by the UK and the United Nations. Since this reform, three times as many babies are delivered in hospitals, three times as many children are receiving malaria treatment and fatality rates for malaria have drastically fallen by around 90% (Oxfam Website). Despite these promising outcomes, maternal care remains inconsistent and of poor quality. Corruption in the medical supply system and insufficient management means that drugs are not properly stocked, and many patients are forced to pay for medication (Amnesty International, 2011).

HEALTH AND THE MDGS

GOAL 4: REDUCE CHILD MORTALITY

This goal is to reduce the under-five mortality rate by two thirds, between 1990 and 2015. The goal might be met with 'scaled and sustained efforts' as the rate continues to decrease. At present 49.4% of mothers will lose at least one child in their lifetime. This figure decreases with the level of the mother's education.

GOAL 5: IMPROVE MATERNAL HEALTH

This MDG has the aim of reducing maternal mortality by three quarters between 1990 and 2015. It also aims to achieve universal access to reproductive health. In addition to the immediate health consequences arising from FGM, it is also associated with an increased risk of childbirth complications. This goal might be met with 'scaled and sustained efforts' as, with the introduction of the Free Heath Care Initiative, maternal mortality rates continue to decline and the rate of professionally-attended births continues to increase. However, it was noted in *The Lancet* that Sierra Leone may not achieve MDGs 4 or 5 if some of the cultural norms do not change, such as birth spacing of less than a year and teenage pregnancy. Girls between 12 and 18 years make up a large proportion of maternal morbidity and death (Maxmen, 2013).

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

This goal aims to have halted and begun reversing the spread of HIV/AIDS by 2015 and it aimed to achieve universal access to HIV/AIDS treatment by 2010. It also aims to halt and reverse the incidence of malaria and other major diseases by 2015. This goal is likely to be met according to the Government. However, CSOs consider the goals related to HIV/AIDS are likely to be met, but not the ones related to other major diseases like Malaria and TB. By June, 2012, 97% of all health facilities could test patients for malaria, half for HIV, and just 13% could test for TB, in a country with one of the world's highest rates of the pulmonary disease (Maxmen, 2013). Although the correlation between HIV/AIDS and FGM is not as direct as some research has previously claimed, there are a number of potential sources of HIV/AIDS transmission associated with FGM and its consequences. However, as the rate of HIV/AIDS is low in Sierra Leone at 1.5%, its relationship to FGM is not significant and will not be discussed in this report.

WOMEN'S HEALTH AND INFANT MORTALITY

WOMEN'S HEALTH

Sierra Leone has high rates of teenage pregnancy with 41% of first time mothers aged between 12 and 14. 92.2% of young women aged 15-19 use no form of contraception. In poverty stricken areas many girls' only real option for survival is to rely on sexual relationships with older men who provide them with food and shelter (Government of Sierra Leone, 2012), but often abandon them once they become pregnant. Prostitution and rape are also common causes of teen pregnancy; despite the passing of the Child Rights Act, men are able to buy sex from underage girls without consequence.

In countries with almost universal FGM prevalence, the complications that arise directly from FGM either in general health or during childbirth are often not recognised by health workers or sufferers as related to FGM. Bjälkander et al. (2012) found that the majority of women and girls who undergo FGM in Sierra Leone suffer adverse health effects, yet many do not seek professional help for these problems. 85.8% who suffered health complications due to FGM sought treatment, but only a minority accessed professional healthcare. Their report emphasised the need for healthcare professionals to understand, look for and recognise symptoms of FGM related health complications and to encourage women to seek appropriate medical care. The most commonly reported complications in girls with FGM (Fig. 20) were wounds, swelling and bleeding and the report highlights the increased likelihood of fever following FGM in the under tens (41.4%) compared to girls over ten (24.1%) probably caused by worse, though not more frequent, infections.

Who treats the immediate complications of FGM

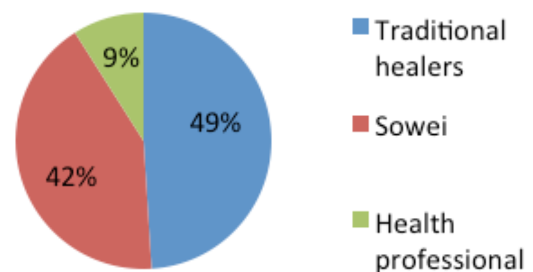


Fig. 21: Who treats the immediate complications of FGM (Bjälkander et al., 2012)

Percent distribution of the most commonly reported complications of FGM in children by age cohort

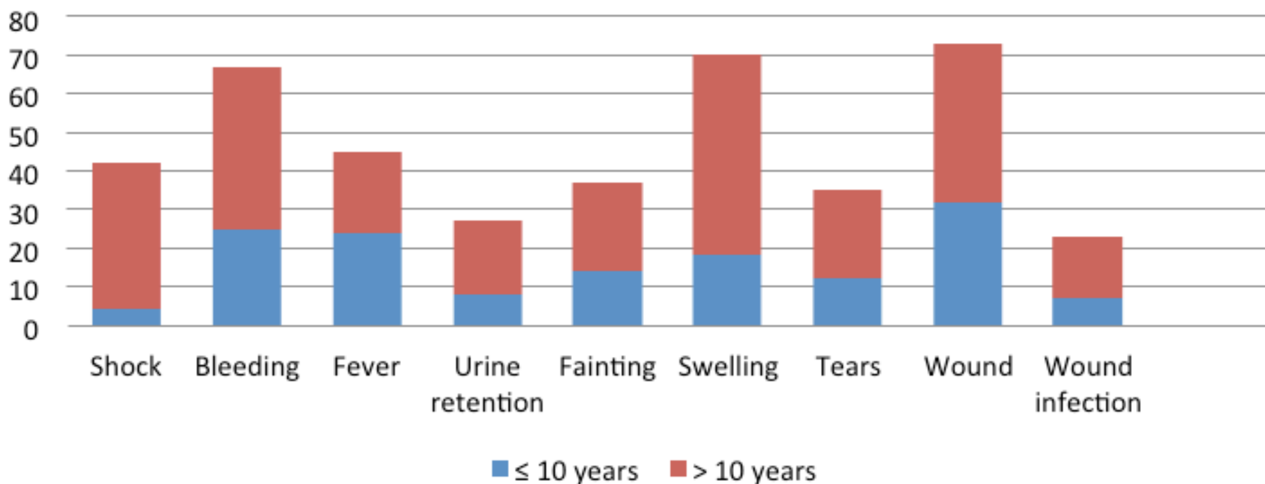


Fig. 20: Most commonly reported complications of FGM in children (Bjälkander et al., 2012)

The age at which a respondent was cut was a factor in the choice of treatment for complications. Those who had undergone FGM before the age of ten were more likely to be treated by a Sowei (52.9%) and those who underwent FGM after the age of ten were more likely to be treated by a traditional healer (53.1%). A Sowei may also be a TBA who may have had some training as a TBA or may be a traditional healer as part of the role as a Sowei.

REPRODUCTIVE HEALTHCARE

According to preliminary reports (DHS, 2013), 97.1% of women received antenatal care from health personnel; this has risen from 93% in the 2010 MICS. Moreover, 56.1% of women had made the 4+ antenatal visits (as recommended by the WHO), 59.7% of women received delivery assistance from health personnel and 57.5% received postnatal care from health personnel within the first two days after delivery (DHS, 2013). The fertility rate in Sierra Leone is 4.88 births per woman and the vast majority of married women (83%) use no methods of family planning (DHS, 2013), whereas a quarter of unmarried women use a modern method of family planning, most commonly the contraceptive pill (Ministry of Health and Sanitation, 2011).

Haemorrhage is a known birth complication for women who have had FGM of all types due to the inelasticity of the scar tissue, which leads to tearing during delivery and potential excessive loss of blood. 26% of maternal deaths in sub-Saharan Africa are due to haemorrhage; even births conducted in a health facility may not receive proper treatment as there is a shortage of donated blood throughout Sierra Leone, meaning transfusion is uncommon. In general, Sierra Leone has only 25% of the blood donated that is required in a year (*The Guardian*, 2013) and only five hospitals have functioning blood banks according to the Government - three in the Western area and one each in Bo and Kenema (Government of Sierra Leone, 2012). A multi-country modeling study was set up to estimate the increased costs in obstetric

Fig. 22: Signage for Maternal and Child Healthcare Centre (Wallstalking.org)

care due to increased obstetric complications as a result of FGM. The annual cost was estimated to be US$3.7 million and ranged from 0.1% to 1% of Government spending on health for women aged 15-45 years (WHO, 2011).

It is estimated that around two million women and girls across Asia and sub-Saharan Africa are affected by fistula, a condition caused by long and obstructed labour. Prolonged pressure from the baby getting stuck in the birth canal damages the tissues between the vagina and the urethra and/or the rectum resulting in incontinence. Prolonged and obstructed labour is more common in young mothers due to underdevelopment and 80% of those affected by fistula are under 15. As well as being physically devastating, fistula is a socially crippling illness; sufferers are mocked and ostracised due to the smell and leakage. Fistula can often be successfully treated by surgery, but there is currently only one fistula repair clinic in Sierra Leone and it is not treating at full capacity. Those affected are either too embarrassed to seek help or are unaware of the help available. Most of the patients are in their teens, but they have

treated children as young as eight. The majority of patients have also undergone FGM prior to childbirth.

Freedom From Fistula's (FFF) work in Sierra Leone is based from the Aberdeen Women's Centre in Freetown. Capable of treating up to 600 fistula patients every year, this is the only comprehensive fistula repair centre in Sierra Leone. Over 100 babies are delivered every month in its maternity unit, which focuses on providing high standards of maternal healthcare and training of local midwives to prevent obstetric fistula. The centre also runs a children's clinic treating 12,000 children every year, provides primary care to children aged under 12, and partners with the telecommunications company Airtel to run a free hotline for women suffering from fistula.

PLACE OF DELIVERY

Overall, 54.4% of babies are delivered in a healthcare facility. The percentage of births taking place in health facilities depends on the mother's demographic status; births to younger women, richer women and more educated women are more likely to take place in a healthcare facility. Urban births are more likely to be in healthcare facilities than rural births and rates vary widely across regions: Eastern 72%, Southern and Western approximately 60%, and Northern 37.1%.

Prior to the introduction of the Free Healthcare Initiative, TBAs benefited from the business of childbirth, either in the form of money or payment in kind for attending home births, or through a share of the user fees women used to pay to give birth in health centres. Now that women are no longer required to pay to give birth in healthcare facilities, TBAs are losing a vital source of income. This has led to reluctance to bring women in to deliver in health centres. Health Poverty Action warn that the Government needs to give TBAs training and incentives to take on non-delivery roles in order to ensure they break down barriers to women accessing professional delivery assistance, especially in rural areas (2012).

INFANT MORTALITY

Currently, the infant mortality rate in Sierra Leone is 73.29 per 1,000 births (World Factbook, 2014 estimates) and there has been a definite downward trend. Infant mortality has decreased from 152 deaths per 1,000 births (1999-2003 survey) to 127 (2004-2008 survey) to 92 (2009-2013 survey) (DHS, 2013).

The WHO (2006) demonstrated that death rates among new born babies are higher in mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had had FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.

EDUCATION

The importance of 'education on human development is noteworthy. Many fertility and maternal and child health indicators improve with education: the average age at first childbirth rises, women have fewer children and the probability of at least one child dying drops. The risk of FGM also decreases as discussed below. Gains are greater in urban areas, regardless of the availability of local health services. The probability of poverty also drops considerably' (Ministry of Education, Science and Technology, 2013).

Education is compulsory for all children at primary level for six years and three years at the junior secondary level. Following the Education Act 2004, there are no school fees for primary children and no junior secondary school (JSS) fees for girls in the Northern and Eastern regions. Though tuition is free, other costs of education such as textbooks, uniform and transport costs may be difficult to meet and are factors in attendance rates.

Region	Pre-Primary	Primary	JSS	SSS	TOTAL NUMBER OF SCHOOLS	PERCENTAGE OF All SCHOOLS
East	8	100	11	3	1,652	22%
North	4	100	14	2	2,682	35%
South	7	100	12	3	1,828	24%
West	41	100	30	10	1,509	20%
National	11	100	15	4	7,671	
National percent distrib-uton of types	8%	77%	12%	3%		

Table 3: Ratio of schools by region for every 100 primary schools, plus total figures of schools in each area (Ministry of Education, Science and Technology, 2010-11)

Optional senior secondary school (SSS) lasts for three years, or vocational education, and this is followed by tertiary education (university). The civil war resulted in the destruction of 1,270 primary schools (Bureau of International Labor Affairs, 2002), but this situation has improved significantly in recent years.

Nationally, for every 100 primary schools there are approximately 11 pre-primary, 15 JSS and four SSS facilities as Table 3 shows. These figures are universally low, but are highest in the Western Area. The table also highlights the problem that there is an expectation that not all who enter the primary level will proceed to subsequent levels. This has serious implications given that formal basic education covers primary, junior secondary and, lately, pre-primary schooling. This province level data though masks a worse situation at council and chiefdom level in which there is a wider variation. Freetown Council has 14% of all schools - more than the six lowest councils combined. In addition, nationally out of 149 chiefdoms, 85 have no pre-primary schools, 15 have no junior secondary and 100 chiefdoms have no senior schools (Ministry of Education, Science and Technology, 2010-11).

Given the above information, school attendance levels become clearer. In 2010, the pre-school attendance rate for Early Childhood Education was low at 14.8% (MICS, 2010). Once children reach primary education, attendance varies, despite being compulsory. Enrolment rates were high after free primary education was introduced in 2004 but, between 2006 and 2008, the rate plateaued at 62%. 45.3% of children aged six attended the first grade of primary school and 74% of primary aged children were attending school, according to the 2010 survey. 92% of children who were enrolled in primary school completed up to grade six. Only 37% of secondary school aged students were attending school. The ratio of girls to boys in Sierra Leone's schools, 0.95 in primary school, falls to 0.82 in JSS and to 0.61 in SSS. While boys and girls complete primary school at comparable levels, completion rates for girls and boys in JSS

and SSS diverge radically; the rates for girls are 41% for JSS and only 17% for SSS, compared to rates of 57% and 35% for boys (Ministry of Education, Science and Technology, 2010-11).

Adult literacy in Sierra Leone (over age 15) remains low at 43.3%, with males at 54.7% and females at 32.6% (World Factbook, 2011 estimates). Literacy levels for young people aged 15-24 are unclear. MICS data show levels at 48.3% of the population, young men at 69% and young women at 43.5% (2010), while UNICEF reports young men at 70.5% and young women at 52.1% (UNICEF, 2008). Literacy rates are highest in the west of the country and in urban areas.

Child labour is not a factor in Sierra Leone when looking at the low completion rates for primary education. Around 43% of children aged 5-11 are engaged in child labour. While nearly half the children of primary school age are working, data shows a slightly higher rate of school attendance among child labourers than children who do not work. The more affluent Western Region, which includes the capital Freetown, has markedly lower levels of child labour than the more impoverished areas, like the Southern Region: only 13% of children in the Western Region are involved in child labour, compared to 46% of children in the Southern Region (DHS, 2008).

EDUCATION AND THE MDGS

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Sierra Leone is listed by the Food and Agriculture Organization as one of the countries most impacted by food insecurity. The World Food Programme and the UN support the Government in its 'Agenda for Prosperity', which focuses on agricultural and infrastructural development. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity (Burchi and Muro, 2007). The return of displaced rural populations since 2002 has accelerated agricultural recovery. Challenges Sierra Leone still faces in relation to food security are: unemployment; low labour productivity; lack of irrigation; overharvesting, and poor infrastructure and access to food markets (World Food Programme website). The Government of Sierra Leone has assessed that it will not meet this goal. The Civil Society assessment has calculated that, in order to meet this target by 2015, annual growth rates of over 10% would be needed (currently around 5%) (Commonwealth Foundation, 2013).

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

The aim of this MDG is to provide universal primary education with the target to ensure that by 2015 all boys and girls complete a full course of primary schooling. This is relevant in the context of FGM as the chances of girls undergoing FGM are reduced if they complete their schooling. There is currently insufficient data to track this goal and it is unlikely to be met. UNESCO reports that in 2011 the Gross Enrolment Ratio for all primary pupils was 128%, with 123% for males and 125% for females. These numbers are greater than 100% because students younger or older than the official age for a given level of education are enrolled in that level. In 2012, 2.9% of the GDP was spent on education (World Factbook).

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The aim of this MDG is to eliminate all gender disparity in primary and secondary education no later than 2015. This is highly relevant given that FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. Moreover there is a correlation between the level of a woman's education and her attitude towards FGM. The Government of Sierra Leone has said that this goal will not be achieved by 2015. CSOs have said that significant progress has been made and that, with increased efforts, the goal could be met. As of 2008, the Gender Parity Index (GPI) is 1.00. This indicates equality in the participation rates for males and females at primary school, whereas

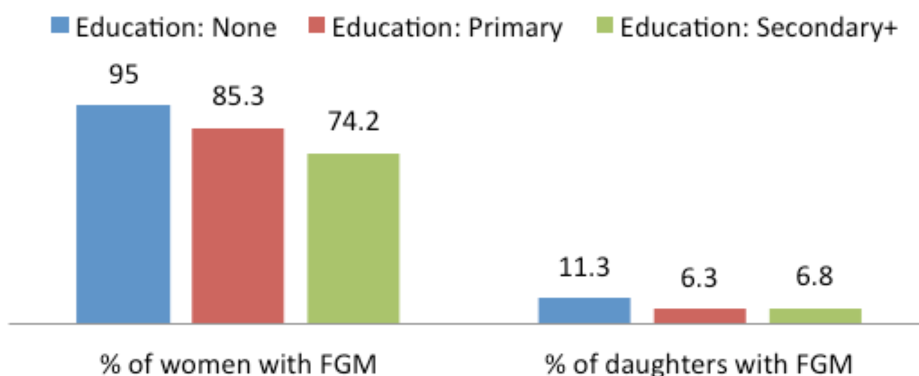


Fig. 23: Percent distribution of women with FGM aged 15-49 years by education achieved and the percent of daughters 0-14 cut by level of mothers' education (MICS, 2010)

the rate is 0.67 for secondary school. There is also regional variation with GPI higher in urban areas (0.73) than rural (0.55) and ranges from 0.57 in the North to 0.74 in the West (DHS, 2008).

EDUCATION AND FGM

It has been shown in some studies that 'educational attainment alone did not change attitudes and practices', rather that it acted as a mediating variable through which other processes, such as the diffusion of new information, operate' (UNICEF, 2008). Education's effects may not be immediate or direct, but it is believed to be the best long-term intervention to address FGM. With education girls are better able to resist family and peer pressure and engage with information about the harm of FGM and their rights (UNICEF, 2008).

Generally, girls' education is supported, and universal education for girls remains a long term goal. Bjälkander et al. (2013) found that parents and elders believed a daughter's education to be more valuable than a son's because a daughter will later support the parents, whereas a son will support his own family once married. Interviews with Mende girls concerning their opinions on whether girls and boys should attend school were also conducted. The schoolgirls' responses were positive, claiming that education can help reduce their village's poverty, and that women can gain independence resulting in 'mutual respect in society'.

Nevertheless, drop-out rates remain high for girls reaching puberty (Commonwealth Foundation, 2013). This is because initiation to Bondo society often occurs at puberty and is then linked to early marriage and pregnancy. Families face the dilemma of following tradition where girls are married young and need to be initiated before they are considered marriageable.

The prevalence of FGM and the desire to continue the practice decrease in accordance with the level of mothers' education attained as shown in Figure 23.

The effectiveness of the strategy to keep girls in education to prevent early initiation is challenged by the lack of provision of schools past primary level. For every 100 primaries there are only 12 JSSs and 3 SSSs. This is likely to impact both FGM and child marriage negatively. There is a discrepancy of school provision between rural and urban areas.

Fig. 24: School children in a MEA project school, whose motto is 'trading FGM for education' (MEA)

To encourage girls to continue their education, the Government offers to pay for up to three years of junior secondary school fees for girls, but parents must pay these fees themselves and then seek reimbursement from the Government, which can involve significant delay. Bjälkander et al. (2013) found that Bondo initiation costs were significantly higher than education costs in any given year. However, a comparison is difficult since education continues for a longer period. The study also reports that a Wesleyan minister in Makeni conducted an exercise with fathers, where they calculated the financial costs of initiation versus school fees to demonstrate that the former was more expensive in an effort to promote eradication of FGM.

The girls interviewed felt that families preferred to spend money on initiation, despite their belief that school has achievements while initiation does not (Mende girls Kailahun). Kono girls in Koidu said that the ceremony cost their families a lot of money because they had to pay the chiefs, then the 'Mammy Queens' and finally the barigba (cutters). Limba girls from Yagala furthermore expressed the view that initiation was a waste of money, believing that the money spent on the ceremony is spent on others, not themselves.

RELIGION

The Inter-Religious Council (IRC) of Sierra Leone estimate that 77% of the population is Muslim, 21% Christian and 2% other faiths (US Dept. of State, 2011). These figures differ from the commonly cited ones of 60% Muslim, 10% Christian and 30% traditional beliefs (World Factbook). The IRC was formed in 1997 and includes the following members: Supreme Islamic Council, the Sierra Leone Muslim Congress, the Federation of Muslim Women Associations in Sierra Leone, the Council of Imams, and the Sierra Leone Islamic Missionary Union. Christian members include the Roman Catholic Church, the Pentecostal Churches Council and the Council of Churches in Sierra Leone (an umbrella for eighteen Protestant denominations). Sierra Leone has never experienced religious conflict. While some groups have attempted to foster animosity toward opposing faiths, these are minority groups and they have generally been unsuccessful. The turmoil of the civil war displaced many Sierra Leoneans, blurring not only regional divides, but also the divide between Islam and Christianity. Lack of religious conflict in Sierra Leone can also be put down to the constitution of 1991, which provides for freedom of religion and is enforced by the Government. Governmental ceremonies are opened by both Christian and Islamic prayers.

While Christianity arrived in Sierra Leone as early as 1462 through Catholic Portuguese expansion, the spread of its influence is minimal. Protestantism arrived later in the eighteenth century through missionary expeditions. Christianity is most successful in urban areas in Sierra Leone, where traditional African influence is weaker and educational and medical facilities are better received. Creole (Krio) settlers also make up a large proportion of the Christian following in Sierra Leone and they are dominated by the Anglican and Methodist churches.

Establishing itself between the thirteenth and the seventeenth centuries, and arriving in another wave in the nineteenth century, Islam has become

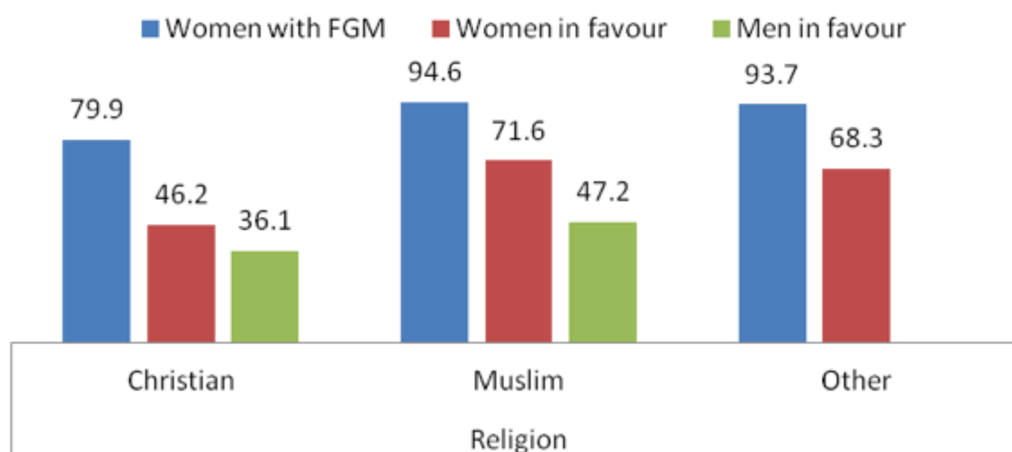


Fig. 25: Percent distribution by religion of women with FGM and both women's and men's attitudes towards continuing the practice (DHS, 2008)

the fastest growing religion in Sierra Leone since the Second World War. Strong and widespread Islamic political and social networks have helped to consolidate the faith in Sierra Leone. Sierra Leonean Muslims are mainly Sunni. Muslims in Sierra Leone recognise four stages of life: birth, puberty, marriage and death. In particular, puberty rites are extremely important, marking the stage from childhood to adulthood. Generally speaking, Muslims in Sierra Leone are socially conservative, and choose to send daughters to traditional Sande or Bondo (Bundu) camps to be taught housekeeping and child-raising. The majority of domestic affairs, which include issues related to women and children, are administered under customary law. Sharia (Islamic) law in certain areas governs some domestic issues.

Traditional African religious practices are popular throughout Sierra Leone, with up to 30% of Sierra Leoneans identifying themselves with the faith, and many Christians and Muslims engaging with traditional forms of religion alongside their own faiths. Stronger in villages and rural areas, where the influence of Christianity and Islam may not be so widespread, African traditional religion has existed in the area as far back as 200 C.E. Membership to traditional religion is through kinship groups that include the unborn, the living and the dead. Traditionalists believe that birth, puberty, marriage and death link the unborn to their ancestors. Rituals and rites conducted by the Poro and Bondo secret societies, such as sacrifice and initiation, call on the ancestral spirits for protection from evil and for their assistance. Traditionalists also believe in witches, good and evil, and wear charms, amulets and medicines for protection. Belief in totemic power is also prevalent in traditional religion: animals and plants which are identified as being an individual's totems are prohibited from consumption, and are believed to have a mystical and sacred relationship with an ethnic group, providing them with assistance.

All references from Groelsema, 2006 unless otherwise stated.

RELIGION AND FGM

FGM predates the major religions and is not exclusive to one religious group. FGM has been justified under Islam, yet many Muslims do not practise FGM and many agree it is not in the Koran. Within Christianity, the Bible does not mention FGM, meaning that Christians in Sierra Leone

who practise FGM do so because of a cultural custom. Figure 25 shows the level of support of both women and men for continuing the practice of FGM by religious affiliation and compares the prevalence of FGM in women within those religions. The largest disparity between women's support for and the actual level of FGM is found in the Christian community with 80% of women cut, while support for FGM is only 46 %. This pattern is repeated to a lesser degree across other religions. Christian and Muslim men are significantly less in favour of continuing FGM than women. These data reflect that there are other motivations for FGM within each group, rather than a religious requirement, which is believed by only 2% of this population (DHS, 2008).

The UNICEF report in 2006 found that the majority of religious leaders (including Muslims and several denominations of Christians) tolerate and participate in Poro and Bondo. Many are proud of their exclusive society membership and claim that membership gives them authority, to the extent that some clergy are initiated to accomplish their religious work (UNICEF, 2008).

In contrast, Pentecostal churches are growing in popularity and influence in Sierra Leone and they strongly oppose congregants' participation in the societies. They equate the practices of Bondo society to devil worship and witchcraft (UNICEF, 2008). To set an example, some ministers have 'resigned' or otherwise distanced themselves from the societies and encourage their congregants to follow suit. Similarly, some members of the missionary Pakistani Ahmadiyya Muslim sect (whose adherents believe their founder, Mirza Ghulam Ahmad, is the promised Messiah) have adopted militantly anti-Christian and anti-traditional attitudes. They have publicly declared their intention to rid West African Islam of its indigenous beliefs, including FGM (Groelsema, 2006). FBOs are involved in the eradication of FGM. In 2006, Target sponsored a conference between Muslim scholars from many nations; they deemed FGM to be against the Islamic faith as it is a harmful attack on women (Target, 2006).

MEDIA

PRESS FREEDOM

The Constitution guarantees freedom of speech and press and this is generally effective. International media can operate freely after registering for a license. There is no Government restriction on access to the internet. Government officials sometimes have used criminal libel provisions of the Public Order Act on anti-corruption and anti-government matters (Human Rights Report, 2013). In 2013 there were two reporters arrested on charges of sedition and libel criticising the President (Committee to Protect Journalists (CPJ), 2013). Afri Radio (a popular music station) had its license revoked by the Independent Media Commission (IMC) in April 2013, in response to high-level official pressure. This has resulted in the Government reviewing media laws and licensing of foreign entities (Human Rights Report, 2013). Newspapers are mainly independent and routinely criticise the Government, but are subject to increasing official investigation (Human Rights Report, 2013). There are currently 58 newspapers registered with the IMC, 72 radio stations and 10 television stations (US dept. of State).

MAIN NEWSPAPERS IN SIERRA LEONE

Awareness Times
Awoko
Cocorioko (online)
Peep
Sierra Herald
Sierra Leone Daily Mail
Sierra Leone Telegraph

ACCESS TO MEDIA

Following the civil war, the access to media outlets remains low in Sierra Leone, with the exception of radio. The majority of Sierra Leoneans do not have access to television, mobile telephones or the internet. Mobile phone usage was reported as being at its highest in the Western and Southern regions, with 50% of the population

in the South and 62% in the West having regular access to a mobile phone (Audiencescape, 2008). In 2012 UNICEF reported there being an average of 36.1 mobile phone users per 100 people. Reading of newspapers remains low in Sierra Leone, which is expected given low levels of literacy. Only around 10% of those in the North, East and South had ever read a newspaper. Those living in the Western area, with higher levels of education, were more likely to have read a newspaper, though the number is not much greater at 24% of respondents. A regional divide can again be seen reflected in the statistics concerning access to television. In Western areas, 21% of households have access to a television compared to the other regions, where it is less than 5%. Computers are virtually unavailable to all Sierra Leoneans. In 2012 the International Telecommunication Union reported that less than 1% of citizens used the internet (Human Rights Report, 2012).

Media exposure at least once a week	Female	Male
Reads a newspaper	6.6	17.7
Watches television	10.6	16.0
Listens to radio	45.6	62.8
All three media	3.1	8.3
No media	52.3	34.8

Table 4: Exposure to Mass Media % of Population by gender (DHS, 2008)

The most popular and easy to access form of media for Sierra Leoneans is radio. Over 70% of households have access to a battery-powered radio, with the exception of the Southern Region, where only 60% of households have regular access. The majority of households in Sierra Leone listen to radios in their own homes, ranging from 58% in the South to 86% in the West. The UN Radio Network and the SLBS radio station have the highest levels of listenership both nationally and provincially. The most popular radio station in the Southern Region was reported as being Kiss FM (Audiencescape, 2008). In a questionnaire on media and information communication, the largest proportion of respondents chose radio as their most important source of information (Audiencescape, 2008). Affluent areas in the West rely more exclusively on the radio for information at 77% of respondents, compared to 57% in the East, 44% in the North and 52% in the South. In the less developed provinces, 4-9% of respondents relied on town criers, and 4-13% used community leaders as their source of information. Respondents in the North relied more on religious leaders (6%), and Eastern respondents got limited information from seminars and workshops (5%). Regarding health information, Westerners depend heavily on radio (59%). Only 20% of Southerners use the radio for health information, preferring to follow advice provided by doctors and health centres. In the East and North, respondents said that health centres are only half as important as radio. Northern respondents also rely to some extent on their neighbours/friends and traditional healers (9% and 6% respectively).

ATTITUDES AND KNOWLEDGE RELATING TO FGM

Knowledge of FGM is near universal in Sierra Leone with 99% of women and 96% of men aged 15-49 having heard of the practice (DHS, 2008).

Sierra Leonean Zainab Bangura, UN special representative on sexual violence in conflict, states that the traditional values symbolised by FGM still have a powerful hold over the population whose lives have been decimated by the recent civil war. The attitudinal response given in surveys (Fig. 26) does not reflect this statement. Though the majority of women (67%) do want FGM, 54% of men are against it continuing and support for FGM varies across backgrounds in wealth, religion and education.

With the end of the civil war in 2002 there was a massive influx of INGOs into the country working in all areas of civil society. Many of these INGOs introduced sensitisation discussions in the fields of health and education about FGM and leant their support to local initiatives aimed at eradicating HTPs. The secrecy around FGM was breached and community programmes were instigated to raise awareness about the negative physical and psychological consequences of FGM. In the intervening years, support has fallen for its continuation and some young girls and women are expressing their views that they no longer see the need for initiation. A report commissioned by UNICEF in 2006 quoted Mende school girls in an urban area saying 'It is expensive and a waste of money' (UNICEF, 2008). A similar view was expressed by 24% of young men when asked their view on Bondo initiation (Bjälkander et al., 2013). On the other hand, girls interviewed by the INGO FORWARD in 2011 felt that FGM was important and gives girls advantages in the community. Some felt under pressure to be initiated to prevent discrimination. However, other girls said access to modern media had given them more knowledge about FGM and they were beginning to question the practice. The cost of initiation was also raised as a concern (FORWARD, 2011).

Figure 26 clearly shows a difference in attitude about continuing the practice of FGM across the age range, with older women more in favour of the practice (75.4%) than the younger women at 52.9%, but with men fairly evenly against FGM (54% average) across all ages (DHS, 2008).

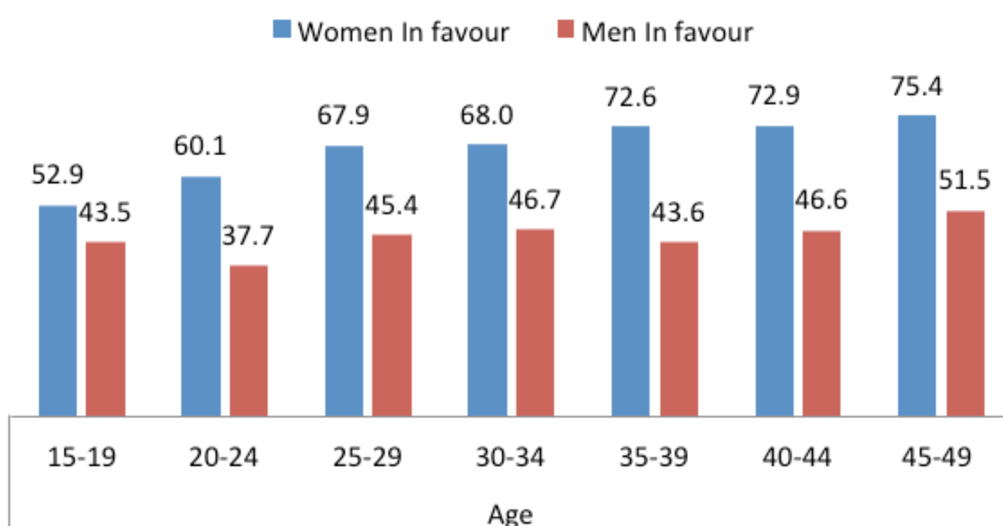


Fig. 26: Percent distribution of positive attitudes of women and men towards continuing FGM, by age cohort (DHS, 2008)

When the data for women's attitude towards continuation of FGM is broken down by background characteristics, as in Figure 27, it is evident that the poorest women and those living in rural locations are most committed to continuing. Women in the Eastern and Southern provinces (76% and 73% respectively) show the most support, while women in the Western Area are least likely to support it with 48% approval only. These figures are shown in a slightly different context in Figure 29 when participants were asked about the different benefits if any of FGM, and the second largest category was for no benefits of FGM.

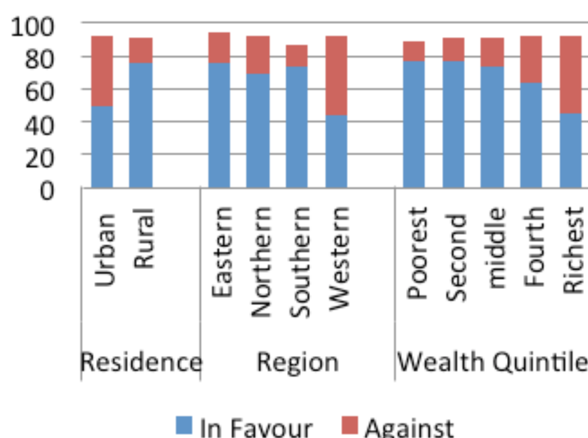


Fig. 27: Women's attitudes towards continuing FGM by background characteristics (DHS, 2008)

Figure 28 shows a breakdown of approval and prevalence among daughters and women. Whereas the Western areas have the lowest level of FGM and women's approval of the practice, Bonthe in the Southern province has the highest level of desiring the practice to continue (92.4%), but one of the lowest levels of FGM prevalence (84.5%) among women and 7.6% of daughters have been reported cut. Kono in the Eastern province has a low level of approval, but a high prevalence rate. More research is needed to see what is affecting the desire to continue or abandon FGM across these regions. This could give insight into effective practical interventions to eradicate FGM.

REASONS FOR PRACTISING FGM AND ITS PERCEIVED BENEFITS

FGM is a social norm tradition, often enforced by community pressure and the threat of stigma. Although communities in which FGM is found in Sierra Leone may have different specifics around the practice, within each practising community it manifests deeply entrenched gender inequality.

FGM is considered necessary for a girl to become a woman. By removing the clitoris it is believed that the vestigial male anatomy in a woman is removed, creating an unambiguous gendered female (MacCormack, 1979). Though traditionally performed as part of an initiation into womanhood, the data on age at FGM has shown the age is getting younger and the idea that it acts as a gateway to adult status is losing credibility.

Figure 29 shows the perceived benefits if any of FGM to Sierra Leoneans, according to the two largest ethnic groups making up 65% of the total population and all other groups together and by both men and women. Below each benefit is looked at in turn with reference to the data.

SOCIAL ACCEPTANCE /CULTURAL IDENTITY

The overwhelming reason to continue FGM for all groups and both sexes is the social acceptance accorded initiates. Within each ethnic group this was seen as more important by the women compared to the men as would be expected given the centrality of Bondo to women's lives, status and the ordering of community relations.

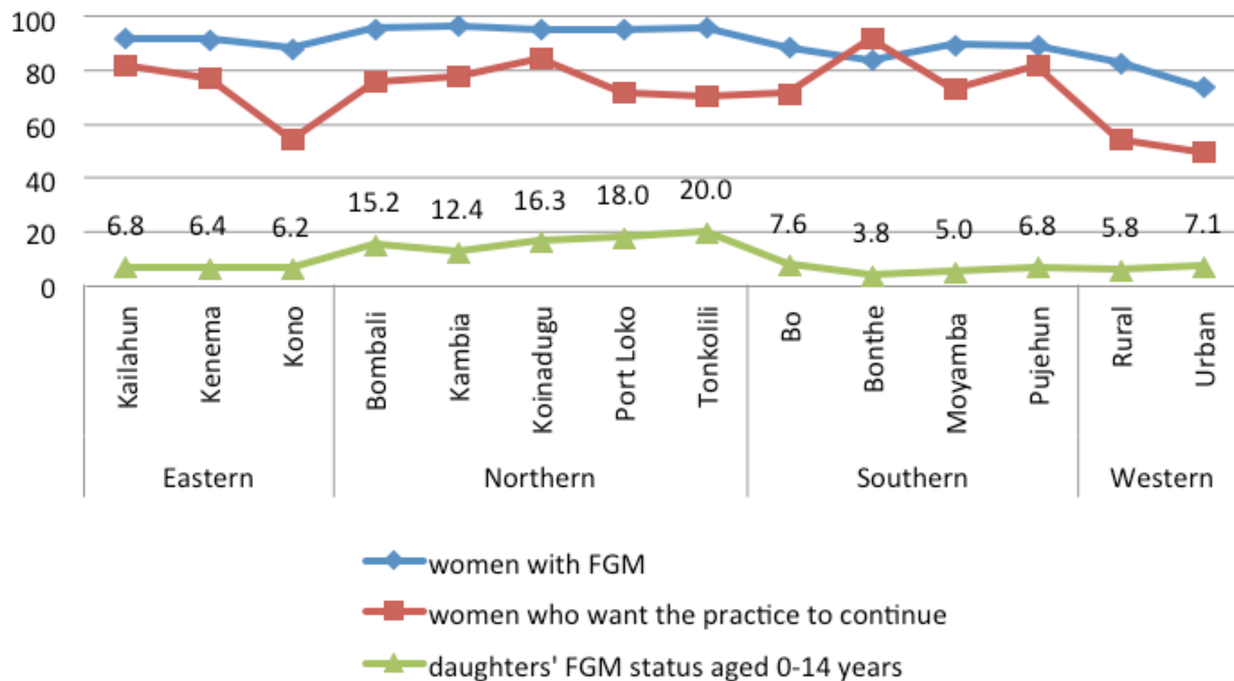
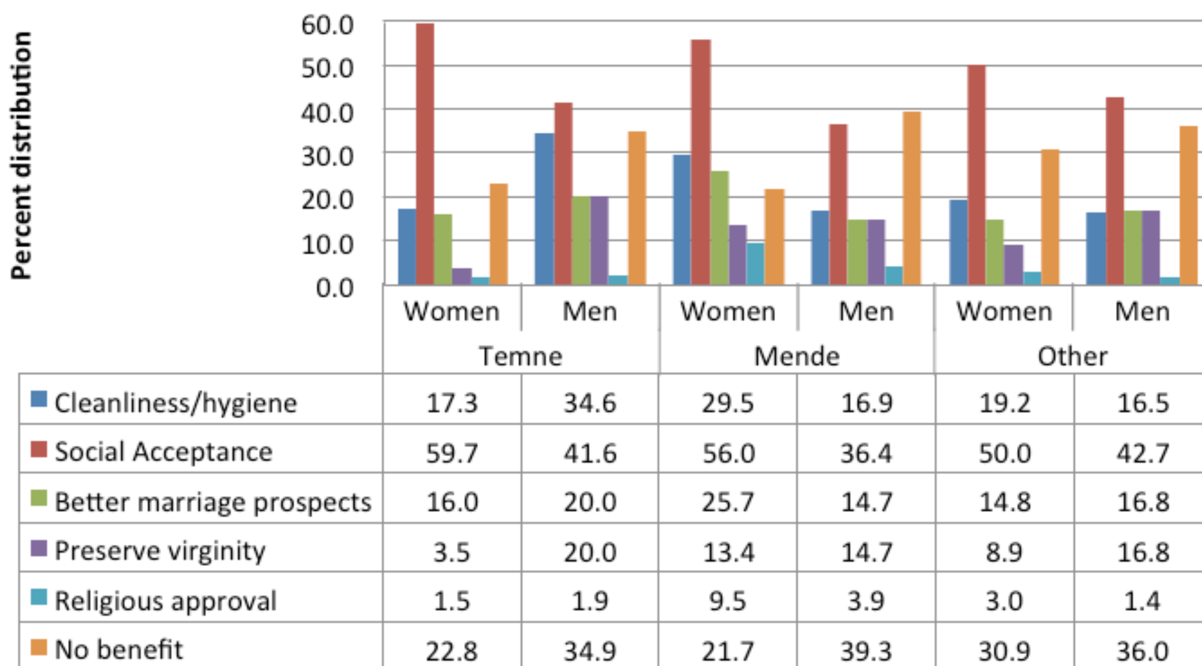


Fig. 28: Regional comparison between women's FGM status (aged 15-49), desire to continue the practice and what they report as their daughters' (aged 0-14) FGM status (DHS, 2008)



	Temne		Mende		Other	
	Women	Men	Women	Men	Women	Men
Cleanliness/hygiene	17.3	34.6	29.5	16.9	19.2	16.5
Social Acceptance	59.7	41.6	56.0	36.4	50.0	42.7
Better marriage prospects	16.0	20.0	25.7	14.7	14.8	16.8
Preserve virginity	3.5	20.0	13.4	14.7	8.9	16.8
Religious approval	1.5	1.9	9.5	3.9	3.0	1.4
No benefit	22.8	34.9	21.7	39.3	30.9	36.0

Fig. 29: Perceived benefits of FGM of both men and women aged 15-49, by ethnic group (DHS, 2008)

FOR CLEANLINESS/HYGIENIC REASONS

Cleanliness and hygiene were the second largest benefits which showed large variations both between and within ethnic groups. In the Temne, 34.6% of men compared to 17.3% of women felt this was important, and the position was reversed for Mende men at 16.9% compared to 29.5% of Mende women. The uncircumcised vulva is often considered dirty and young girls are taught that they will stink if they are not cut (UNICEF, 2008). It is believed that the secretions of the clitoris and labia smell foul and can contaminate anything that comes into contact with it (Koso-Thomas, 1987).

BETTER MARRIAGE PROSPECTS

This was the third largest benefit of FGM in the survey for all ethnic groups, especially for Mende women at 25.7% but less so for Mende men at 14.7%. Temne men viewed marriageability as more important than Temne women at 20% and 16% respectively. Traditionally a girl could not marry before initiation but would go from the bondo bush to her husband's house. Still today a fee is paid to the Chief before initiation for both the initiation and a marriage licence to be issued. It is no longer the case that girls marry straight away, with many returning to school as parents see more benefit from keeping their daughters in education to support them in their old age, rather than depending on their successful marriage and subsequent large family (Greenbaum, 2008).

PRESERVE VIRGINITY

There are two sides to this belief, one that you must remain a virgin until you are initiated; this confers honour on the family when virginity is confirmed by the Soweis. Supernatural sanctions were used to threaten girls to stop them sleeping with men before initiation (Greenbaum, 2008).

The second is that initiation will preserve a girl's virginity by reducing her sexual desire, a benefit for the family as well as the husband, who may be in a polygamous marriage and have a lot of wives to satisfy. Groups like the Limba in the Western urban area believe this and cut pre-pubertal girls accordingly (Conteh, 2004).

RELIGIOUS REQUIREMENT

This is universally the least important benefit seen by all groups, but the Mende women record a 9.5% belief in it and Mende men 3.9%. All other groups record less than 3% importance attached to FGM on religious grounds. See Figure 25 for a data on attitude to continuing FGM by the different religious affiliations.

NO BENEFIT

The second largest category in the data is for no benefits from FGM for all groups apart from Mende women. Further, Mende men expressed a belief that there are no benefits 39.3% to an even larger degree than benefits of social acceptance 36.4%. Another reason not surveyed in the DHS but expressed by Sierra Leoneans as reason for FGM is aesthetic. Fanthorpe (2007) reports that some Sierra Leoneans find uncut female genitalia ugly, in comparison to the beautiful, hidden genitalia of Bondo initiated women. Koso-Thomas (1987) says this view is commonly held by the Loko, Mandingo, Limba and Temnes.

LAWS RELATING TO FGM

INTERNATIONAL & REGIONAL TREATIES

Sierra Leone has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights:

- Convention on the Elimination of Discrimination Against Women (CEDAW) (2007)
- Convention on the Rights of the Child (CRC) (1990)
- International Covenant on Economic, Social and Cultural Rights (ICESR)
- African Charter on the Rights and Welfare of the Child (signed 1992 ratified 2002)
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (the 'Maputo Protocol'). This has been signed but has not yet been ratified.
- African Charter on Human and People's Rights (the 'Banjul Charter')

The African Union declared the years from 2010 to 2020 to be the Decade for African Women. In December 2012, the UN passed an historic resolution, calling on countries to eliminate FGM, and in 2013 the 57th UN Convention on the Status of Women agreed conclusions including a reference to the need of states to develop policies and programmes to eliminate FGM as well as other forms of violence against women (UN, 2012).

The CEDAW and the CRC clearly prohibit traditional practices that discriminate against women and harm children. Article 2 of CEDAW directs 'State Parties...(f) To take all appropriate measures, customs and practices which constitute discrimination against women.' Additionally, Article 5 states, 'State Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes...'. Article 24(3) of the CRC states that, 'State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'. In addition, Article 19(1) provides that 'State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse'. CEDAW has not been effectively domesticated in Sierra Leone (Abdullah, 2012).

Under the ICESCR, FGM is a violation of the right to health. Article 12(2) provides that '[t]he steps to be taken by State Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for: (a) The provision for...healthy development of the child'. 'Health' is defined so as to include 'maturity, reproductive and sexual health'. FGM thus violates the convention due to the numerous health consequences, as discussed in the section Women's Health and Infant Mortality above.

The African Charter on the Rights and Welfare of the Child requires member states of the African Union to abolish customs and practices harmful to the 'welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status'.

The Maputo Protocol explicitly refers to FGM. Under Article 5, 'state parties shall prohibit and condemn...through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them'. On the Government's failure to ratify and domesticate the Maputo Protocol, Abdullah argues that it is a serious violation of women's human rights because it is a legally-binding document which all African governments should adhere to (2012).

The Banjul Charter includes provisions related

to the right to health (Article 16), right to physical integrity (Articles 4 and 5).

Unless otherwise stated, all references in this sub-section are to Mgbako et al, 2010.

NATIONAL LAWS

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

In Sierra Leone, the age of suffrage is 18. Under the 2012 Sexual Offences Act the age of consent is now 18. In 2007 the Child Rights Act made child marriage (before age 18) illegal. Sierra Leone also adopted the definition of a child as anyone under 18 years of age. However child marriage remains a major issue in Sierra Leone with 44% of girls married before they reach 18 (UNICEF, State of the World's Children, 2013). Currently the Registration of Customary Marriage and Divorce Act is not consistent with the Child Rights Act, meaning that there is no absolute prohibition of marriage before age 18 (PLAN UK, 2013). Furthermore, the legal age-based conception of adulthood is inconsistent with local cultural standards, where womanhood is associated with physical maturity. This discrepancy poses a significant challenge to enforcing the Child Rights Act and the prohibition of child marriage in rural communities (PLAN UK, 2013).

CONSTITUTION

Article 6(2) of the Sierra Leonean Constitution requires the State to 'discourage discrimination on the grounds of...sex' and Article 15 guarantees 'fundamental human rights and freedoms' without regard to sex. Articles 15(a and c) ensure the rights to 'life, liberty, security of the person' and Article 8(2)(b) maintains that the State shall recognise, protect, and enhance 'the sanctity of the human person and human dignity'. Finally, the Constitution gives special protection to children in Article 8(3)(f), which provides that 'the care and welfare of the...young...shall be actively promoted and safeguarded'.

ANTI-FGM LAW

There is no law in Sierra Leone that specifically prohibits FGM. The national 2007 Child Rights Act supersedes all other national laws related to children's rights (including the Young Persons Act of 1960) and is considered compatible with the Convention and the African Charter on the Rights and Welfare of the Child. This bill was drafted by the Sierra Leone Ministry of Gender, Social Welfare and Children's Affairs with the assistance of experts from UNICEF. It incorporates clauses from the UN Convention on the Rights of the Child prohibiting 'cruel, inhuman or degrading' treatment of children, which are applicable to FGM. International commentators interpreted the banning of 'harmful traditional practices' against children as an effective ban on FGM. After much delay the Bill was presented to Parliament in September 2006 and passed in June 2007. However, the 'FGM clause' was removed from the final version during parliamentary debate. The final consensus was that Parliament will not outlaw FGM (Fanthorpe, 2007). The Child Rights Act means that parents are discouraged from initiating girls under 18 and the girls must be of age to consent to the initiation (Bosire, 2012). Many children, however, are unaware of their rights and responsibilities under this Act and cannot access or claim assistance (Abdullah, 2012).

There are also the Sierra Leone National Action Plan on Gender-Based Violence (NAP-GBV 2012-2016) and the National Referral Protocol on Gender-Based Violence which were adopted to minimise gender–based violence and provide quality care to survivors. This plan is being implemented based on five thematic intervention strategies: prevention, provision, protection, prosecution and participation. For this plan to succeed, medical personnel, social workers and the police are being trained in GBV issues (Abdullah, 2012). There are two national policies, the Gender Mainstreaming Policy and the National Policy on the Advancement of Women that were adopted by parliament in 2000. These are intended to represent the Government's commitment to

strengthen gender oriented policies (Abdullah, 2012). However, this is reliant on donor funding. Without funding, the Ministry of Social Welfare Gender and Children's Affairs (MSWGCA) can only host two celebrations, the annual celebrations for International Women's Day and the Sixteen Days of Activism on Violence Against Women. Total dependence on development partners means this programme is not sustainable (Abdullah, 2012).

In 2012 eight of the country's fourteen districts signed a Memorandum of Understanding criminalising FGM among children in Western Area Rural, Western Area Urban, Bo, Kambia, Port Loko, Pujehun, Bonthe, and Kailahun. However, the practice continues in many of these districts (Human Rights Report, 2013).

ENFORCEMENT

Sierra Leone has a dualistic legal system. Approximately 85% of Sierra Leoneans are under the jurisdiction of customary law, which they view as more relevant to their lives than formal law. Customary law is under the authority of chiefs whereas the formal legal system is derived from the British legal system with constitutional, statutory and common law. Sierra Leone has fourteen districts with 149 chiefdoms, which are led by Paramount Chiefs and then town and village chiefs. Depending on the chiefdom, there could be by-laws in place related to child marriage, women's rights, and FGM. The formal legal system only has jurisdiction over criminal cases with prison sentences of at least six months or fines of 50, 000 Leones. The 2013 Human Rights Report states that the Government has not effectively enforced the prohibition of discrimination based on gender as it affects women and girls. Sierra Leone does however have a special department for dealing with domestic violence and gender-based crimes called the Family Support Unit (FSU). This unit is partly sponsored by UNIFEM and UNDP.

CHALLENGES TO ENFORCEMENT

- FGM is undertaken as part of a society's initiation ceremony, sometimes in secret (e.g. the bondo bush).
- Politicians avoid discussing Bondo Society and FGM because it could jeopardise their success in elections.
- Court cases involving violence by Bondo members are not prosecuted and withdrawn under the pretext of endangering 'national security', or are continually adjourned.
- Post-war displacement has meant that Bondo members in Freetown have access to political leverage in parliamentary and presidential general election campaigns. This creates a strong and complex relationship between political leaders and Bondo members.
- In 2010 56% of voters were women. Given that the majority of women belong to pro-FGM Bondo societies, this creates difficulties in promoting anti-FGM political agendas and eradication programming.
- The Bondo have aggressively reacted against anti-FGM campaigns, which they view as an attack on their culture. This is partly because they feel exposed as the secrecy of their society it compromised. They also feel slighted for not being consulted before the enactment of the Child Rights Act.
- Some people feel that the Child Rights Act has encouraged Bondo groups to initiate young girls out of retaliation.
- Formed in 1993, the Bondo Sowei council is an organisation that exists to safeguard FGM. This council is trying to match medical strategies of anti-FGM campaigners by giving the Bondo a public presence. Their exposure has turned into a symbolic resistance which has arguably strengthened the Bondo community. The Freetown council coordinates the other councils.

All citations from Bosire, 2012.

INTERVENTIONS AND ATTEMPTS TO ERADICATE FGM

BACKGROUND

In the aftermath of the civil war, Sierra Leone has received substantial international aid, first in the form of humanitarian aid and more recently for supporting the rebuilding of the country's infrastructure, both civil and governmental. In 2007, 18% of the GDP came from this aid. The international community therefore has significant leverage in terms of the use of funds and influences the Government to sign international agreements. As a result of this aid, Sierra Leone has been increasingly exposed to INGO human rights discourses, particularly those relating to the rights of women and girls.

The first publication on the dangers of FGM in Sierra Leone was published by Koso-Thomas in 1987 and was promptly banned. Koso-Thomas has continued her campaign against FGM for 30 years amidst death threats and public abuse. She has said in relation to the political parties, that to ban FGM would be suicide (IRIN, 2012). Shirley Yeama Gbujama, a past Minister for Social Welfare, Gender and Child Protection, once threatened 'to sew up the mouths of those preaching against bundu', and stated that legislation would only be passed banning the practice when women themselves ask for it. In the 2002 general elections the sole woman candidate for the Presidency [Zianab Bangura] felt obliged to deny rumours that she had advocated a ban on FGM (Fanthorpe, 2007). Thus, FGM in Sierra Leone remains a contentious subject that is intimately connected to social and political constructs of authority, adding to the challenge of eradication.

GOVERNMENT POLICY AND SUPPORT

Yvette Stevens, the Permanent Representative of Sierra Leone to the United Nations Office at Geneva, reported the following to the UN's Human Rights Committee in March 2014. Stevens stated that combating FGM of girls under 18 years of age is a priority for the Government and a prohibition of it was included in the Agenda for Prosperity. A Memorandum of Understanding to this end was also signed at the local level. Stevens stressed that FGM should be culturally contextualised and that it can only be eliminated through sensitisation. Campaigns were being undertaken throughout the country to raise awareness, and dialogues with local authorities were held on the dangers of HTPs. Stevens argued that Sierra Leone as a nation wants to give women over 18 the right to choose. The Government is committed to reach out to all communities and women groups' leaders (UN Human Rights Committee, 2014).

The Human Rights Report, 2013 states that 'the Government were often cooperative and responsive to the views of local and international NGOs' and further, that they 'often arranged forums with NGOs to discuss such topics as women's rights'. Despite positive intentions for facilitating change, the Government appears to be actively engaged with VAWG, and it can be argued that the Government supports FGM by not introducing specific laws against it. Instances of paying for girls' initiations have been recorded during local and national elections, even after ratifying international treatises like CEDAW, which many believe was ratified because of the Government's dependency on foreign aid. Mgbako et al. (2010) are clear that 'without political pressure from the citizens of Sierra Leone, government officials will not feel compelled to act'.

ANTI-FGM INITIATIVES NETWORKS

In 2012 Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ) undertook a mapping of FGM initiatives in Sierra Leone, and their findings are in line with 28 Too Many's research with NGOs, though we found networks to be more formalised in 2014. In particular, recognition of the importance of building national consensus and taking collaborative action on FGM has led to a coalition of key organisations participating in joint meetings and working towards a national strategy for abandonment. Currently chaired

by Rugiatu Turay of the Amazonian Initiative Movement (AIM), recent participants include the Department for International Development (DfID), Advocacy Movement Network (AMNet), NaMEP, SHADE, CIP, WAVES, ACT-SL, Graceland and the Taia Development Programme (TDP).

28 Too Many did not find evidence of as many organisations engaging religious leaders as did GIZ.

Peddle's (2012) study of 37 organisations working towards FGM abolition in Sierra Leone found that, due to the political sensitivity surrounding the topic of FGM, there is a notable lack of governmental commitment to approaching the issue and that NGOs are the main advocates of FGM abolition. While the growing number of NGOs working against FGM is encouraging, there is reluctance amongst development partners to engage directly in activism and a lack of communication and coordination. There is evidence of collaborations and partnerships between organisations, but these tend to be based only on either belonging to the same sector, e.g. child protection, or sharing the same approach. Sharing information across sectors on different approaches is uncommon.

The majority of respondents (74%) do not see FGM as a primary focus of their work, but those working under the Government's direction believed that they would focus more on FGM once it is on the Government's official agenda. The most common thematic areas in which FGM is approached include: GBV and women's rights; sexual and reproductive health; HIV/AIDS and women's empowerment. All participating organisations believed that a multi-pronged approach targeting a wide range of groups is necessary to end FGM. The most common approaches to abandonment are awareness raising, intergenerational dialogue and public education. Most organisations focus on targeting people; with 65% targeting children under 18. Religious leaders and Soweis are also targets of around 51% of respondents at the grassroots level, while only 25% of the respondents aim to change the legal system and policy at the national level.

Originally Peddle approached 289 organisations, but only 37 responded before the deadline, with a further two responding after this. Peddle suggests that the survey elicited more replies than it would have in previous years and that the number of replies evidences a positive change in Sierra Leone, showing a newfound willingness to engage in FGM dialogue. The findings demonstrate that abandonment activities, or activities related to abandonment are evident in all areas of Sierra Leone, with the Northern region having the most organisations working within it and the Southern region having the least. Respondents noted an increase in formal dialogues on FGM being held with greater participation, behavioural changes, policy changes and evidence of change with the police FSU.

Overall, the study found that due to the political climate and lack of overt Government support, organisations tend to focus more on working with individual communities rather than addressing FGM through legal, health or educational systems, and tend to approach FGM indirectly to avoid political conflict. This has led to little evidence of change at a national or political level. Most organisations are ready and willing to tackle FGM more directly once the Government officially supports abandonment. Efforts to share information between organisations are informal, rather than systematic and, if better structured, could be of greater benefit to organisations.

OVERVIEW OF INTERVENTIONS

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM. Often a combination of the interventions and strategies below are used:

- Health risk/harmful traditional practice approach
- Addressing the health complications of FGM
- Educating traditional excisors and offering alternative income
- Alternative rites of passage

- Religious-oriented approach
- Legal approach
- Rights approach/ 'Community Conversations'/ Intergenerational Dialogue
- Promotion of girls' education to oppose FGM
- Supporting girls escaping from FGM/child marriage
- Media influence
- Working with men and boys

HEALTH RISK/HARMFUL TRADITIONAL PRACTICE APPROACH

Strategies that include education about the negative consequences of FGM have been the most frequently used globally for the eradication of FGM, and are a common element of programmes within Sierra Leone. However, convincing people in areas of a very high FGM prevalence of the health problems can be a challenge. Difficult childbirth and long post-partum recovery periods, which are often exacerbated by FGM, are often seen as the norm. Communities may not therefore attribute the complications of FGM to the procedure itself (Winterbottom, 2009).

A number of organisations provide community education on the harms of FGM, including AMNet, the Community Initiative Programme (CIP) and the TDP. FINE educates men specifically on the mortality rates caused by FGM. Moreover, schools throughout the country now run classes and clubs specifically addressing the harm of FGM in the hope that girls will refuse initiation. Organisations such as AIM and the Masanga Education Association (MEA) are in the process of persuading cutters to give up their knives, explain to them the harm they cause. Though the generalisation in the past of dangers of Type III FGM were used to cover all types of FGM and slightly discredited this approach, appropriate use of the data with targeted audiences appears to have some effects especially with children and Soweis.

ADDRESSING THE HEALTH COMPLICATIONS OF FGM

According to FORWARD, the medical and health community in Sierra Leone 'appears to ignore the practice of FGM at best, or deny any medical or health effects of the practice at worst' (2006). FORWARD add that the 'situation is further complicated by the fact that traditional birth attendants (TBAs) and maternal and child health aides are often Soweis in the communities' (2006). With the continuing paucity of evidence-based studies in Sierra Leone on FGM and its negative health consequences, this position will be hard to change. CAUSE is a Canadian INGO working with women's groups, students and communities to raise awareness of the dangers and health complications caused by FGM. It is also part of the network supplying, building and administering birthing huts to improve the health and well-being for mothers and children in the Moyamba and Koinadugu Districts.

Though not specifically providing solely for FGM survivors, Graceland has set up five counselling centres in different districts to support victims of GBV. It is the only incidence of psychological services being provided for women that 28 Too Many has found.

EDUCATING TRADITIONAL EXCISORS AND OFFERING ALTERNATIVE INCOME

This continues to be a common intervention in Sierra Leone, though lack of funding means that promises made by both organisations and excisors are often not fulfilled.

Successful campaigns have been run, however, by AIM through organised events linked to the 'International Day of Zero Tolerance', which have enabled public declarations by traditional practitioners to give up performing FGM. AIM has found that about half of these former practitioners have since joined them and gone on to become activists taking part in awareness campaigns against FGM.

Fig. 30: Photos from MEA's project encouraging women to put down their tools of the trade, here burning the traditional red and white headscarves of Soweis (MEA)

The Inter-African Committee (IACSL) are educating excisors about the health risks of FGM and providing alternative employment opportunities. This has been done in partnership with the local police force, schools and the MEA in the Brayama, Thoko-Limba and Magbama chiefdoms of the Kambia District. Three farms have been established with the Soweis employed as farmers.

Although such initiatives may be successful in supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address demand for FGM, but alone they do not have the elements necessary to end FGM (UNICEF, 2005). As long as the demand is not met, then young girls will continue to train to be Soweis to earn an income for their families.

ALTERNATIVE RITES OF PASSAGE (ARP)

For those ethnic groups where FGM is part of a rite of passage initiating girls into adulthood, one approach that has shown some success is Alternative Rites of Passage (ARPs). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve the cultural traditions while eliminating the cutting. The success of ARPs depends on the group practising FGM as part of a community ritual, such as a rite of passage. In addition, ARPs will have limited impact unless they are accompanied by education, which engages the whole community in collective reflection and leads to changes in the expectations of community members. The use of ARPs is further limited by the trend for communities to cut girls at a younger age and with less ritual (UNICEF, 2005).

Students are calling for these alternative rites. During workshops conducted by the Centre for Safe Motherhood Youth and Child Outreach (CESMYCO) (2010), for example students at the Umuro Muchtarr Muslim Secondary School said they wanted 'education' instead of 'cutting.' 'You can go to the bush and [the FGM initiators] can teach you what they want, but they shouldn't

touch you,' declared a student. The rest of the students burst into applause. They were affirming that traditional rituals from childhood to adulthood should not involve harm.

There are two organisations in Sierra Leone that 28 Too Many has identified as working with this method, MEA and CIP. CIP state that because the practice is a rite of passage to womanhood, they, along with stakeholders, have 'Bondo Without Cutting', where girls and women are taught marital and motherhood duties without cutting. CIP further claims that this initiative is gaining momentum. Unlike MEA, who engage the Soweis in the new ARP practice in an attempt to allow them to retain their position in society and their livelihood, CIP works on finding alternative livelihoods for the practitioners.

RELIGIOUS-ORIENTED APPROACH

A religious oriented approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour.

In December 2013, for instance, the IACSL successfully hosted a workshop for religious leaders in the Kambia district to share knowledge and provide training in both the harmful effects of FGM and child marriage, but also to teach them the skills to become advocates of change within their communities. AIM also works with religious leaders to facilitate discussions on FGM.

'Human rights say you have a right to practice your culture. However, when the culture violates rights, more so the child rights and women's rights, we do step in'. – Moderator of a consultative meeting working for an NGO (Bosire, 2012)

LEGAL APPROACH

NGOs are working with the Sowei Council to ensure that they follow the prohibition on cutting girls under 18. Bosire believes that getting the Bondo society to accept the idea of the age of consent is a major milestone. He notes that this age restriction is challenging for groups like the Fula, Themne and Limba who initiate young girls before 12 years (2012).

At a local level, community interventions against FGM have, in many cases, been more successful than the Federal Government's efforts. Chiefs throughout Sierra Leone have passed community by-laws relating to FGM. These by-laws may prove in the long term to be effective for outlawing FGM at the local level. Mgbako et al. advise that one option for grassroots organisations working against FGM is to approach the Paramount Chief of a community who has already expressed opposition to FGM, and advocate for him to pass such a by-law. Then, the organisation can work with these Chiefs to lobby the Government to pass national legislation banning FGM. They further suggest that various communities banning FGM via community by-laws may signify shifting attitudes towards FGM and encourage national anti-FGM legislation (Mgbako et al., 2010).

RIGHTS-BASED APPROACH

A rights-based approach acknowledges that FGM is a violation of women's and girls' rights. This approach is sometimes used alongside other strategies to eradicate FGM based on the social abandonment theory of FGM (derived from the social change theory behind foot-binding in China). The components of this theory include (i) a non-judgemental human rights approach; (ii) community awareness raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective decision by the entire community; (iv) the requirement of community public affirmation of abandonment; (v) intercommunity diffusion of the decision and (vi) a supportive change-enabling environment, including the commitment of the Government. This approach was pioneered by Tostan in Senegal (UNICEF, 2005).

This approach is based on the principle of listening and questioning between different generations, aided by a facilitator. It enables participants to reflect on their values, customs, traditions and expectations and to consider whether, when, how and under what conditions change should take place (GIZ, 2011). A number of organisations use collective abandonment as part of their programmes, for example both Men's Association For Gender Equality (MAGE) and Centre For Democracy And Human Rights (CDHR) work with a number of stake holders to advocate for collective abandonment and positive deviance to end FGM.

In Sierra Leone, the rights approach is developing as people begin to understand and use the language of rights (Bosire, 2012).

PROMOTION OF GIRLS' EDUCATION TO OPPOSE FGM

There is a strong link between FGM and early marriage among some ethnic groups, such as the Mende. Girls are cut prior to getting married and often drop out of school following being cut. This approach encourages the girls to remain in education and in some cases encourages them to speak out against FGM. There is a growing recognition of the value of girl's education. The Bondo societies in urban areas actively support it and the Public Relations Officer of the Sowei Council was reported to say 'initiating young girls and keeping them in the bush for too long isn't supported because it interferes with their education' (Bosire, 2012). For NGOs, the hope is that the longer girls can be protected from FGM, the higher the chance that they would have been sensitised against it at school and refuse to be cut.

Within communities, the Centre for Democracy and Human Rights (CDHR) works with traditional leaders, FGM practitioners, school children and parents, teachers, health workers and the police through several projects including campaigns for girls' education.

EducAid provides support to both sexes to help young people make informed choices about FGM. The organisation has established five schools, two training centres and a safe house for girls. They run the only free secondary school in the country.

Trading FGM for education is the by-line for MEA. Through the provision of schools and co-opting the power of local Soweis to their cause, they have changed peoples' perceptions so that the cutting of girls is not needed to initiate into the Bondo society and that education for all is the way out of poverty for women.

SUPPORTING GIRLS ESCAPING FROM FGM/ CHILD MARRIAGE

AIM runs a safe house for 15 girls escaping FGM, abuse and child marriage. The safe house is in Lunsar, Port Loko district and is supported by Terre Des Femmes, a non-profit women's rights organisation based in Berlin, Germany.

MEDIA AND COMMUNICATION

Radio is the most common form of media used by the majority of the population. In 2009, early attempts by broadcasters on the UN radio station to raise FGM awareness by holding a discussion on air ended with a female journalist from the radio station being stripped naked in the street and paraded by the Bondo society. Despite that setback, more stations now hold discussions on air and CSOs are instrumental in keeping FGM in the public's awareness. For instance, weekly radio programmes that reach local communities are run by Youth Partnership for Peace and Development. School children's clubs in Lunsar are learning with the support of AIM to produce radio broadcasts as well as theatre projects to raise awareness about child rights. All the national media have been the target of awareness programmes about FGM abandonment by NaMEP and IACSL, among others.

WORKING WITH MEN AND BOYS

This is a recent but important new strategy in the fight against FGM. Men were found to participate in 35% of the decisions to initiate their daughters (Bjälkander et al., 2012), expected to pay for the ceremonies for their brides or daughters and traditionally expected to be responsible for family provisions. This provides an opening for interventions directed at household economics among other strategies.

Men have not only been the target of CSOs' and FBOs' interventions addressing the economic consequences of FGM, but are also men's organisations working to eradicate GBV including FGM. FINE works with mainly men to educate them about the harm of FGM and the consequences for their wives and daughters. The Men's Association For Gender Equality (MAGE) is another men's organisation working across Sierra Leone and globally with men's alliances working to eradicate inequality. A boys' white ribbon campaign has been started in several schools' boys clubs where they discuss anti-GBV strategies and wear a white ribbon to show their support of girls and women. Bjälkander et al. (2013) conducted a survey just of adolescent boys' attitudes to Bondo and FGM, and sees this approach as another way in to stop FGM.

INTERNATIONAL ORGANISATIONS

ACTION AID

Action Aid is a UK INGO working in Sierra Leone since 1988, which is one of the 20 African countries in which they work. Their two main focuses are women's empowerment and universal health and education. They have been instrumental in rebuilding schools after the civil war, providing accommodation for teachers and promoting education in rural communities. They also provide healthcare and safe childbirth practices, and lobby governments to change policies to improve the lives of those living in poverty.

CAUSE CANADA

CAUSE Canada is a faith-based INGO working on relief and development activities in Sierra Leone. Priorities include promoting women's health rights, helping to establish and support the growth of grassroots CSOs in the country and promoting discussion and awareness of FGM.

CAUSE Canada has formed partnerships to share knowledge and campaign alongside women's groups, students and communities to raise awareness of the dangers and health complications caused by FGM. It is also part of the network supplying, building and administering birthing huts to improve the health and well-being for mothers and children in the Moyamba and Koinadugu Districts.

CONCERN WORLDWIDE

Concern Worldwide is an INGO working in Freetown and Tonkolili. Although not the main focus of the organisation, FGM is tackled as a component of their programmes on gender-based violence, child protection and women's empowerment. They have reached over 60,000 people with their health programmes. Within communities, Concern works mainly with health workers to help them reach their target community, rural populations.

COOPERAZIONE INTERNAZIONALE (COOPI)

Cooperazione Internazionale (COOPI) was formed in Italy during the 1960s and has been providing humanitarian relief and implementing development projects in Sierra Leone since 1971. Whilst COOPI works in different sectors, including agriculture, healthcare, education and socio-economic services, since the civil war, it has prioritised gender issues, recognising that women continue to face widespread discrimination and violence.

Working in various parts of Sierra Leone including the Kono, Kailahun and Koinadugu Districts and the Western Area, COOPI has provided assistance on the following issues:

- Within the governance and social service sector, making improvements in preventing and responding to violations of women's and children's rights
- Education and training projects, with particular attention on women and promotion of their rights to literacy and access to land
- Creation and launch of income-generating activities, including technical training and business management skills
- In the health sector, enhancing medical care for women who experience difficulties in pregnancy (eg. in Kono and Kissi). Ten clinics have so far been improved in terms of communication, equipment and trained medical staff.

DEFENCE FOR CHILDREN INTERNATIONAL – SIERRA LEONE (DCI-SL)

Defence for Children International is an INGO that promotes and protects children's rights. Defence for Children – Sierra Leone (DCI-SL) was founded in 1998 during the civil war and continues to operate across all four regions of the country. It focuses on the following areas:

- Child Justice - promoting protection and justice for children in conflict with the law
- Supporting child victims of abuse/violence and witnesses
- Addressing Gender-Based Violence
- Addressing Child Exploitation - particularly focusing on child trafficking and child labour
- Promoting Civil Rights of Children - birth registration programmes, child participation in programmes and the expression of children's views

DCI-SL is also actively involved with other organisations in advocating for the eradication of FGM in Sierra Leone.

EDUCAID

EducAid is an INGO operating in Freetown, Port Loko and Makeni. It tackles FGM through its established education programmes, which are its main route to address a range of gender-based violence issues. It aims to promote collective abandonment through promoting education and communication. They provide support to students of both sexes to make informed choices about FGM.

The organisation has established five schools, one of which is a free secondary school, two training centres and a safe house for girls. Their students' educational attainment is impressive with many going on to tertiary education in Sierra Leone and abroad. Women's projects have been created in each of the schools to educate and support women of all ages, and a Girls Power Group has enabled young girls to learn about gender issues and encourages them to achieve their full potential. A similar White Ribbon project aims to raise awareness amongst boys.

EducAid works in partnership with the Government, family support units and the police to confront individual cases of abuse and to

develop policy and best practice.

ENHANCING THE INTERFACE BETWEEN CIVIL SOCIETY AND THE STATE (ENCISS)

ENCISS is supported by Aid from the UK Government and by the European Union and its programme in Sierra Leone is managed by Christian Aid. ENCISS works throughout the country on gender issues, the needs of young people, justice and security and supports grantees working in the following areas:

- Southern and Eastern Provinces – Bo, Bonthe, Kenema and Kailahun districts
- Northern Province – Bombali and Koinadugu districts
- Western Province – Western urban and rural Areas

ENCISS is focused on supporting socially excluded groups across Sierra Leone's poorest communities, especially women, young people and persons living with disabilities, to become active participants in the decisions that have an impact on their lives. This is achieved through grants, building skills and sharing best practice.

FOUNDATION FOR WOMEN'S HEALTH, RESEARCH & DEVELOPMENT (FORWARD)

FORWARD (Foundation for Women's Health Research and Development) is an African Diaspora women led UK registered campaign and support charity dedicated to advancing and safeguarding the sexual and reproductive health and rights of African girls and women. They work in the UK, Europe and Africa to help change practices and policies that affect access, dignity and wellbeing. FORWARD tackles FGM, child marriag and related rights of girls and young women.

INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES (IAC)

The Inter-African Committee on Traditional Practices (IAC) is an umbrella body with national chapters in 29 African countries. It is an NGO that has been working on policy programmes to stop FGM for the last 28 years. The headquarters of the IAC is in Addis Ababa, Ethiopia and it has a liaison office in Geneva. The IAC collaborates with a number of international organisations, including partnerships with UNFPA, WHO and UNICEF. The Sierra Leone chapter (IACSL) advocates for the removal of harmful traditional practices, including FGM. It plays a leading role in campaigning and educating through a number of different activities.

The IACSL undertakes a range of training workshops amongst different sections of the community to advocate for change. In some circumstances, the subject of FGM requires an introduction through discussion of other issues such as child marriage. These workshops have been held for both women and men, for the media (to empower them to report and discuss FGM issues) and most recently with community and religious leaders. In December 2013, for instance, the IACSL successfully hosted a workshop for religious leaders in the Kambia district to share knowledge and provide training.

Other successful interventions include:

- Educating excisors about the health risks of FGM and providing alternative employment opportunities. This has been done in partnership with the local police force, schools and the MEA in the Brayama, Thoko-Limba and Magbama chiefdoms of the Kambia District.
- School outreach, youth activities and peer mediator training for students in the Kambia District
- Participation in the International Day of Zero Tolerance to FGM, including community sensitisation programmes, radio discussions, student debates and rallies.

Whilst these initiatives have been successful in building relationships between the IACSL and local communities to advocate for the abandonment

of FGM, constraints such as lack of mobility and communication, technical support for staff and consistency of funding continue to be challenges.

LEMONAID FUND

The LemonAid Fund is an INGO founded by Dr Nancy Peddle in 1999. The organisation works alongside a variety of other organisations and funders to support sustainable projects that make progress towards meeting the MDGs. It works within the community to support locally developed projects that contribute to the health, education and economic development of children and their families. It also engages in key research and mapping study activities.

The LemonAid Fund has been instrumental in the movement towards eradication of FGM in Sierra Leone over the last ten years and it participated in the research study evaluating the work of AIM to offer alternative livelihoods to traditional practitioners. It was involved with the original inception of the National Movement for Emancipation and Progress (NaMEP) and continues to partner with them today, along with AIM and other groups.

MASANGA EDUCATION ASSOCIATION (MEA)

The Swiss organisation - Masanga Education Association (MEA) - was originally founded in 2004 to sponsor underprivileged children in Masanga and the surrounding villages. Masanga is located in the Chiefdom of Rowalla in the Tonkolili District of Sierra Leone. The majority of the population are Temne and Muslim. Since 2010 the activities of MEA have widened to facilitate alternative practices within the traditional Bondo ritual to eliminate FGM on young girls. As a result, the first alternative ceremony in January 2010 saw the founder of MEA, Michèle Moreau, and a friend being the first white women to be initiated into Bondo society following a week long excision-free ritual. By calling on the support of local authorities, this led to the Paramount Chief of Tonkolili requesting that MEA extend their alternative programme to other sections of the District.

MEA provides funding for this alternative ceremony, as well as funding for a 'conversion' ceremony for the traditional Soweis to give up their practice known as the 'put-down-your-basket' ceremony. Some thirty Soweis have stopped the traditional practice and have been financially helped to find alternative livelihoods. Education for young girls, either in the school founded by MEA in Masanga or in the public schools, is also subsidised by the organisation. MEA offers the chance for girls to receive an education if their parents commit to not performing FGM. To date, MEA has organised seven alternative ceremonies involving some 391 girls and over 34 villages are affiliated with the programme.

SAVE THE CHILDREN

Save the Children is an INGO working in 120 countries across the world, with a strong child rights focus. Their programmes range from child protection to food security and education, with projects focusing on everything from grassroots aid to high level policy change. In Africa, Save the Children works to end FGM in Nigeria, Liberia, Ethiopia and Sierra Leone. Their approach is one of women's empowerment, delivering information and services to help women and girls protect themselves and, in turn, advocate against the practice. They also work at a policy level to try to change legislation to ban FGM completely.

In Sierra Leone, Save the Children works with community leaders and parents to break the silence around FGM. This approach has been highly successful; they have achieved a ban on FGM for children under 18 in three of the districts in which they work (Kailahun, Freetown and Pujehun), by collaborating closely with Soweis and local government.

THE FUND FOR GLOBAL HUMAN RIGHTS

The Fund for Global Human Rights (based in the United States) operates as a development

partner in 19 countries, including Sierra Leone, Liberia and Guinea. The Fund supports grassroots organisations working on a range of activities throughout Sierra Leone, including gender-based violence such as FGM. A variety of strategies are being used by their grantees to reduce the prevalence of FGM. These include:

- Peer education of girls in schools
- Intergenerational dialogue
- Engagement with the traditional practitioners/cutters
- Direct action to stop the practice where required

At present it provides grants to four CSOs who are working on women's rights and the eradication of FGM as follows:

- **Action for Community Task (ACT)** – Activities include training police and Government officials in the Pujehun district to implement national legislation that protects women's and children's rights
- **Centre for Democracy and Human Rights (CDHR)** – Activities include helping female victims of violence access the justice system
- **Defence for Children International – Sierra Leone (DCI-SL)** – Activities include documenting abuses committed against children in the justice system and pressing for the implementation of policies that protect children's rights. DCI-SL is amongst those advocating at a national level for a total ban on FGM.
- **Women's Action for Human Dignity (WAHD)** – Activities include challenging traditional practices that prevent girls from being educated, helping women seek justice for violence, and creating awareness of women's rights to health.

UNICEF

Whilst Sierra Leone is not one of the 15 countries that form part of the UNFPA-UNICEF Joint Programme set up in 2008, UNICEF has recently advertised a consultancy position, based in Freetown, to assist in the development of a national strategy towards the reduction of FGM. Together with UNFPA, UNICEF will support this government-led process to bring it together with civil society and development partners with the aim of enhancing coordination, accountability and implementation of evidence-based programmes at a sub-national level. This will be achieved through a number of activities; including identifying initiatives that have claimed success in addressing FGM in Sierra Leone, exploring the links with other harmful practices such as child marriage and teenage pregnancy, as well as facilitating a platform for consultation and discussion on the findings of the assessment. A national strategy, following validation with key stakeholders, will be the outcome of this project.

WOMANKIND

Womankind is an INGO which partners with women's rights organisations in Africa, Asia and Latin America. In Sierra Leone, their work focuses on enabling women to be independent, helping women to understand and use their rights, and supporting women to tackle gender-based violence.

Womankind partners with three separate organisations in Sierra Leone to achieve their aims. Partnering with Women Against Violence and Exploitation in Society (WAVES), Womankind aims to enable women to discuss and fight for equal rights by training advocacy groups to build support within their communities. They also work with Women's Partnership for Justice and Peace (WPJP) to introduce community laws on violence against women and abolish discriminatory practices. Finally, they support Graceland Sierra Leone in their work to provide counselling to survivors of gender-based violence.

YOUTH PARTNERSHIP FOR PEACE AND DEVELOPMENT (YPPD)

Youth Partnership for Peace and Development (YPPD) is a youth-led organisation working in Sierra Leone, Liberia and Rwanda. As a relative newcomer to FGM advocacy, the group has used existing networks and well-established campaigning methods in its work across Sierra Leone. Based in Freetown, YPPD partners with a number of international organisations including UNDP. They are members of the African Union ECOSOCC, the International Youth Foundation and the African Youth Foundation.

YPPD see their target audience as the key policy and community influencers, including traditional leaders, government and community stakeholders. To tackle FGM on the ground, the organisation encourages positive deviance and educates communities, using a women's rights approach. Achievements include:

- Gaining recognition from traditional leaders, which has helped them achieve entry into communities
- Using weekly radio programmes to reach local communities
- Initiating the Gentlemen Against Domestic Violence network alongside Democracy and Development Associates in 2011; introducing a male-led approach towards ending FGM
- Partnering with health workers and recognising their roles as agents of change

NATIONAL AND LOCAL ORGANISATIONS

SIERRA LEONE ASSOCIATION OF NON-GOVERNMENT ORGANIZATIONS (SLANGO)

Their stated mission is to foster mobilisation and integration of NGO intervention effectively in the development of Sierra Leone by providing a mechanism for coordination (Health Research Web). NGOs are required to register with the Ministry of Finance and Economic Development and be a member of SLANGO; registration must be repeated every two years. NGOs are subject to a number of legal barriers affecting their operational activity. Community-based organisations pay a fee to the Ministry of Social Welfare and Children's Affairs or Local Councils. International NGOs need accreditation from their government or embassy, proving their legal status and credibility before they can operate in Sierra Leone (ICNL, 2013).

In recent years civil society has come under renewed pressure from the Government through the enactment of laws governing the sector. The Government of Sierra Leone enacted the Revised NGO Policy Regulations in 2009; the National Revenue Authority Act; and the Anti-Corruption Act, which subjects civil society organisations to increased interference from Government and other state agencies.

ACTION FOR COMMUNITY TASK (ACT)

Action for Community Task (ACT) is a community-based organisation working in the Pujehun District in the Southern Province of Sierra Leone since 2003/4. From 2006 it has focused on gender issues, particularly VAWG (including FGM), the early removal of girls from school and forced marriage. ACT provides valuable monitoring and reporting of women's rights issues from the Southern Province and it works in collaboration with a number of organisations:

- At the international level, ACT receives funding from the Fund for Global Human Rights (US).
- At the national level, ACT is registered with the Ministry of Social Welfare, Gender and Children's Affairs and is a member of the National Civil Society Movement. It also works alongside organisations including the Human Rights Commission of Sierra Leone and United Nations Peace Building in Sierra Leone (UNIPSIL). It participates with others in the recently formed Forum Against Harmful Practices.
- At the local level, ACT is registered with Pujehun District Council and collaborates with groups such as the Council of Churches Sierra Leone (CCSL), Paramount Chiefs (particularly in PangaKabonde, PangaKrim, SowaMalen, Gallinassperri and Kpaka chiefdoms), the Family Support Unit of the Sierra Leone Police and local school teachers.

Regarding community abandonment of FGM, approaches ACT uses include training and constructive engagement with traditional practitioners/Soweis, intergenerational dialogue forums, education and information sharing with the community and using health workers as agents of change. Outcomes of their work include:

- Support Groups for women and girls in six chiefdoms
- 120 women and girls trained in women's rights and acting as peer educators and monitors reporting acts of violence
- A rapid response group for violence against women
- International Women's Day commemorated in six chiefdoms
- Programmes organised during the 16 days of activism for women in the Pujehun district

ADVOCACY MOVEMENT NETWORK (AMNET)

The Advocacy Movement Network (AMNet) was first registered in Sierra Leone in 2006. It works throughout the country, with its main operations concentrated in Kambia, Bonthe and the Western Area. AMNet advocates for an end to all forms of violence particularly against women, children and young people. It participates in the Forum Against Harmful Practices and advocates for an end to FGM through a range of activities, from community-based programmes through to policy level and strategic campaigning.

In 2013 AMNet signed a Memorandum of Understanding with the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA). Two key areas of cooperation include prevention and response to GBV (including a study of Traditional Harmful Practices and the passing and implementation of the law to criminalise FGM of girls under the age of 18 and child protection initiatives (including anti-FGM/teenage pregnancy campaigns and the enrolment and retention of girls in education).

As well as a commitment to network and partner with other key organisations, AMNet's activities include:

- Education programmes and workshops, including community and intergenerational dialogues where participants have pledged not to undertake FGM (e.g. in the Bonthe, Kambia and Western areas)
- In the eight districts where AMNet facilitated the signing of a Memorandum of Understanding to prevent FGM being performed on minors, it works with communities to monitor and enforce the implementation of this ban and report any FGM related issues. This work includes education programmes within schools in the Kambia, Port Loko and Bonthe Districts.

- Involved with providing start-up grants to 100 former FGM practitioners to seek alternative employment (e.g. in Kambia, Port Loko and western areas)

AMAZONIAN INITIATIVE MOVEMENT (AIM)

Based in the Port Loko District in the northern region of Sierra Leone, the Amazonian Initiative Movement (AIM) was formed by a group of women in 2002 who had met in refugee camps during the civil war. Their primary focus is the abolition of FGM, as well as actively campaigning against forced marriage and honour based violence. Led by Rugiatu Turay (who currently also acts as Interim Chair for the Forum Against Harmful Practices), AIM uses a comprehensive multi-pronged approach to raise public awareness about the risks of FGM and seeks to involve a wide audience through its education programmes, including political, traditional and religious leaders, teachers, health workers and families. A key component of this work is the reaching out to traditional practitioners (who are often older women with no formal education).

Key activities of AIM include:

- Visiting villages to talk to the traditional practitioners about the risks and harm of FGM. To date some 700 practitioners across 111 villages have been persuaded to give up performing FGM. However, funding to educate and provide alternative employment for these women is limited.
- The provision of a safe shelter shelter in Lunsar for girls and young women who are fleeing the threat of FGM and sexual violence. This initiative is supported by Terre Des Femmes, a non-profit women's rights organisation based in Berlin, Germany.
- Organised ceremonies linked to the 'International Day of Zero Tolerance' and enabled public declarations of abandonment by traditional practitioners. AIM has found that about half of these former practitioners have since joined them and gone on to become activists taking part in awareness campaigns against FGM.
- Seminars take place in more than 15 schools in Lunsar to educate students on human and child rights. These have led to 'clubs' being set up to allow students themselves to raise awareness amongst the school community (e.g. through radio broadcasts and theatre projects).
- Undertakes spot checks in villages to talk with children and establish if any initiations have taken place. AIM targets the next generation who will benefit from the eradication of FGM.

CENTRE FOR DEMOCRACY AND HUMAN RIGHTS (CDHR)

The Centre for Democracy and Human Rights (CDHR) is based in Makeni and works across five districts in northern Sierra Leone. Funded by a range of donor partners, including the Fund for Global Human Rights (US), Accessing Justice and Security Programme (DFID) and the Big Lottery Fund through PLAN UK, CDHR undertakes three broad thematic programmes at regional, district and chiefdom/community levels:

- The promotion and protection of women and child rights
- Local governance and democracy building
- Access to justice

Within communities CDHR works with traditional leaders, FGM practitioners, school children and parents, teachers, health workers and the police through several projects including those that work on the collective abandonment of FGM, campaigns against domestic violence and campaigns for girls' education. Successful approaches being used in the work against FGM include intergenerational dialogue sessions, using health workers as agents of change, education through workshops and targeting traditional practitioners/Soweis. CDHR is also a member of an 'Accessing Justice for Rural

Women Programme' (along with other national organisations).

COMMUNITY INITIATIVE PROGRAMME (CIP)

The Community Initiative Programme (CIP) was originally established by community members affected by the civil war in the early 1990s. The organisation has grown and its advocacy and development activities have expanded to include women's rights and the eradication of FGM as an issue to be addressed in attaining the MDGs in Sierra Leone.

CIP works in over 50 communities in the northern Yoni chiefdom. Its activities focus on education, health, community enrichment, agriculture and sport. CIP conducts training and awareness campaigns on a range of issues, including FGM. It aims to engage traditional and religious leaders, FGM practitioners and men and boys in FGM debates. It also advocates at a national level for women's rights and is part of the Forum Against Harmful Practices. CIP has further been involved with the initiative to introduce alternatives to the traditional Bondo ceremony (i.e. 'Bondo without Cutting').

FAMBUL INITIATIVE NETWORK FOR EQUALITY (FINE)

Fambul Initiative Network for Equality (FINE) works to shift men's attitudes towards women by challenging traditional patriarchal beliefs in communities. Following the training of hundreds of volunteer educators, FINE reached over 10,000 men across Sierra Leone with their workshops on the effects of gender-based violence, including FGM. FINE also works with local governments to develop and improve laws which affect how men can legally treat women. Results from their activities show a 60% decrease in maternal mortality and a 75% increase in hospital births. FINE has now grown into a network of 16 organisations countrywide.

In order to begin their work on FGM, FINE first carried out three meetings of its coordinators in different chiefdoms in 2013. These meetings allowed them to develop a checklist with which to interview 1,500 men, with the aim of understanding men's role in FGM and providing recommendations for change.

FINE's research revealed a desire for organisations to target men more, in order to help them understand girls' sexual and reproductive rights, promote better parenting, and understand the mortality rates from FGM. FINE has since produced a report on their 'First Consultative Forum for Men on the Accelerated Reduction of Teenage Pregnancy and Eradication of Female Genital Mutilation', in which they provide recommendations for policy makers, chiefs and parents to tackle FGM. They continue to use this report to aid their advocacy and grassroots education work (FINE, 2013).

FREEDOM FROM FISTULA

Freedom From Fistula is an INGO working in Freetown. Their work includes financing access to healthcare during pregnancy and labour, and developing fistula services across the country. Nurses and midwives are trained at their Aberdeen Women's Centre in preventing the occurrence of fistula, a common complication of FGM during childbirth.

GRACELAND SIERRA LEONE

Graceland Sierra Leone is a Civil Society Organisation focusing on counselling, women's rights and economic empowerment in order to reduce gender-based violence. Formally a service providing psychosocial treatment, care and support, Graceland has expanded into capacity building and empowerment activities for survivors of gender-based violence and women and girls infected with HIV.

Graceland Sierra Leone has established five counselling centres in Njala, Bo, Mattru Jong, Kono and Lumley, which have offered counselling to over 2,000 individuals since their launch. Women and girls at these centres are also offered life skills

training in subjects such as agriculture and health, and are given medical assistance if needed. Part of the Forum Against Harmful Practices, Graceland also partners with national and international organisations such as UMC Health Centre, Network on Collaborative Peace Building and the Truth and Reconciliation Working Group. The organisation is also supported by International NGO Womankind to organise local events such as rallies and training sessions to promote discussions on violence against women, and to train community advocacy groups.

MEN'S ASSOCIATION FOR GENDER EQUALITY (MAGE)

Men's Association for Gender Equality (MAGE) is a Civil Society Organisation based in Sierra Leone, which operates across the country in Kailahun, Kenema, Koinadugu, Moyamba and Freetown. An organisation which tackles violence against women and girls through engaging men, MAGE has recently implemented a project entitled 'Strengthening the implementation of GBV laws and policies for gender equality and empowerment of women in Sierra Leone', into which FGM advocacy is incorporated.

MAGE targets a broad range of actors in their advocacy, including policy makers, legal practitioners, traditional and religious leaders and excisors. Approaches adopted include collective abandonment and positive deviance to end FGM. MAGE is part of a wider network of organisations working together on women's rights, including the MenEngage Africa Alliance and the Global MenEngage Network. It is also a member of the National Movement for Emancipation and Progress Sierra Leone (NaMEP) in Sierra Leone.

NATIONAL MOVEMENT FOR EMANCIPATION AND PROGRESS (NaMEP)

The National Movement for Emancipation and Progress (NaMEP) is a coalition of 43 civil society organisations working for the abandonment of HTPs which affect women and children in Sierra Leone. Their work towards the abandonment of FGM includes:

- Training and awareness programmes amongst forum members, the community and representatives from the media
- Radio discussions and newspaper articles on issues affecting women and girls
- Engagement with Central Government and policy makers
- Sharing of best practice
- Participation in events such as International Day of Zero Tolerance to FGM and International Women's Day
- Providing a safe haven for girls seeking refuge from the threat of FGM

NETWORK MOVEMENT FOR DEMOCRACY AND HUMAN RIGHTS (NMDHR)

The Network Movement for Democracy and Human Rights (NMDHR) was set up in 2002 after the end of the civil war. It comprises community organisations working throughout the Northern, Southern and Eastern provinces of Sierra Leone. NMDHR is involved with the eradication of FGM in so far as it advocates for the rights of women and girls, including gender-based violence, healthcare and teenage pregnancy issues.

NMDHR has worked in partnership with a number of organisations, including Cordaid and Marie Stopes. In 2011-12 NMDHR took part in a strategic project aimed at improving the reproductive rights and health conditions of rural pregnant women, lactating mothers and victims of teenage pregnancy. Activities included training for healthcare workers, economic and income generating training for teenage mothers and community discussion programmes on local radio stations. Themes discussed included reproductive healthcare rights of women, monitoring of the free healthcare policy and causes of fistula.

SELF-HELP AND DEVELOPMENT EVERYWHERE (SHADE)

Self-Help and Development Everywhere (SHADE) was established in 2000 and is a CSO based in the Kambia district helping some of the poorest communities affected by the civil war. SHADE focuses on issues such as gender equality and food security and is an active member of various networks and forums, including SLANGO and the Forum Against Harmful Practices.

With financial support from the Global Fund for Women, SHADE has undertaken a number of community sensitisation and awareness raising programmes amongst local women leaders and Soweis regarding the harmful effects of FGM. The response to these has been positive, with participants giving their full support to the project. As a result, SHADE hopes to extend their campaigns to include early marriage, teenage pregnancy and the retention of girls in full time education.

TAIA DEVELOPMENT PROGRAMME (TDP)

The Taia Development Programme (TDP) works in the Kori chiefdom in Moyamba District of Sierra Leone. It works alongside other organisations in researching, advocating and implementing projects that will enhance the living standards of women, children and young people in the local area. TDP aims to ensure food self-sufficiency within communities, prevent child abuse and promote gender equality.

TDP advocates for women's and children's rights at all levels, including acting as an umbrella organisation for local community-based organisations, participating in the Forum Against Harmful Practices and extending its efforts to the Women's World Summit Foundation (WWSF) of the UN. Regarding efforts to eradicate FGM within Sierra Leone, TDP undertakes community education on the health impacts of FGM and provides alternative livelihood opportunities to Soweis (in the form of small entrepreneurship schemes).

VOICE FOR THE VOICELESS WOMAN (VVW)

Located in Bo in southern Sierra Leone, Voice for the Voiceless Woman (VVW) works on women's and children's rights through education, capacity building, networking and partnership activities. It participates in the Forum Against Harmful Practices and through community-based initiatives seeks to:

- Enlighten women and children on their rights and responsibilities
- Enhance women's participation in governance
- Promote non-violent attitudes towards women and children
- Raise awareness of health issues affecting women and children especially STIs and HIV/AIDS

WOMEN AGAINST VIOLENCE AND EXPLOITATION IN SOCIETY (WAVES)

Women against Violence and Exploitation in Society (WAVES) is a Civil Society Organisation working in three chiefdoms in the Bo District – Selenga, Bagbwe and Niawa Lenga. FGM is one of their top priorities within a broader agenda of VAWG in rural communities. WAVES is committed to increasing rural women's access to justice by breaking the norms that perpetuate discrimination against women and girls. They see customs such as male inheritance, land rights, and male decision making as directly linked to FGM, citing a high dependency on men as the key reason for the continuation of violence against women. To reduce this dependency, the organisation provides economic support through agricultural activities. These economic programmes have encouraged excisors to participate as they can provide an alternative source of income, reducing their reliance on FGM as a livelihood.

WAVES also aims to end FGM through providing information and education to communities. They seek not only to change communities' perceptions

but also to affect key influencers such as chiefs, parents and excisors, whom they encourage to sign their 'Memorandum of Understanding to Stop Child FGM/C'. Their training and outreach sessions about local laws on violence against women have reached over 200 people.

Over the past few years WAVES has partnered with the Advocacy Movement Network in order to raise awareness on abandoning FGM in 8 of the 14 districts of Sierra Leone. The organisation is also part of the Forum Against Harmful Practices. Their main supporter is Womankind Worldwide UK, which provides funding and on the ground support.

WOMEN'S ACTION FOR HUMAN DIGNITY (WAHD)

Women's Action for Human Dignity (WAHD) was formed in 2003 in Makeni in the Northern Province of Sierra Leone to work on women's empowerment, gender equality, education, agriculture and governance. The organisation advocates for the implementation of legislation on women's rights and trains court monitors to follow cases for women. WAHD also conducts radio and community education on legal rights and women's political participation; provides women's rights and advocacy skills training for women; and trains decision-makers on the importance of girls' education, ending HTPs (including FGM), and reducing maternal mortality.

CHALLENGES FACED BY ANTI-FGM INITIATIVES

There are many challenges faced by anti-FGM initiatives and a number of activists have left Sierra Leone due to death threats. Four activists reportedly stopped working for the anti-FGM campaign group AIM after receiving death threats (Fanthorpe, 2007). Persecution for fighting FGM in Freetown remains prevalent, despite wide-spread anti-FGM campaigning. In March 2014, a CSO called Conscious Family launched a campaign called 'say no to bondo'. Since then the organisation's leader has gone into hiding under threat from Bondo members (*Standard Times Press*, 2014). The often challenging environment makes it difficult for organisations working on FGM to declare their specific interest and advertise their work.

'A pattern emerges where FGC is used as a kind of symbolic weapon to make a statement in the setting of the anti-FGC debate, but in a way that itself contradicts the way in which Bondo practice is socially justified' (Bosire, 2012).

The greatest obstacle for anti-FGM groups are the Soweis from the Bondo societies. The fact that FGM takes place within exclusive societies in Sierra Leone makes eradication efforts challenging. It is for this reason that Sierra Leone has been described as 'ground zero' in the fight to eradicate FGM (Taina Bien-Amie, Executive Director of Equality Now quoted by Mgbako et al.). There are numerous reports of forced initiation as punishment for speaking out against FGM. Bosire notes that 'young girls [are] being initiated forcefully after the slightest accusation of breaking Bondo law. The Soweis believe that they should initiate girls before they are "taken up" by the human rights discourse'. In Bo in 2009, uninitiated girls were abducted from a Bondo coming out celebration

and taken to the bush for initiation (Bosire, 2012). In May 2014 a 9 year old girl in Bongama died of a haemorrhage after being forcefully initiated on the charge of breaking Bondo law. Her family could not pay the fine the Bondo women imposed (UN in Sierra Leone Website).

The Government is hesitant about FGM and this is another major obstacle. In 2011 it was recorded in *Concord Times* that politicians were expending huge resources to promote FGM as a campaign strategy to gain electorate popularity ahead of the 2012 Presidential and Parliamentary elections. Furthermore, the UK House of Lords' judgment in favour of a young Sierra Leonean woman who had claimed asylum in the UK due to a fear of forced initiation provoked a strong reaction from the Sierra Leone Government. A spokesman condemned the asylum claim on the grounds that Bondo initiation is entirely voluntary and that the asylum seeker was besmirching Sierra Leone's international reputation (BBC, 2006).

There are numerous infrastructure challenges to the work of campaigners. Lack of roads in rural areas, lack of electricity in rural communities, giving no access to computers/internet and incomplete coverage of mobile phones make communication and coordination difficult.

Lack of sustainable funding is cited by several organisations in direct contact with 28 Too Many as being a major limitation to effective long-term programming.

CONCLUSIONS

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. We propose the following general conclusions, many of which are applicable within the wider scope of international policy and regulation and some specific to Sierra Leone.

ADOPTING CULTURALLY RELEVANT PROGRAMMES

As FGM is part of girls' initiation ceremonies into Bondo societies, programmes need to be sensitive to the cultural, political, and socio-economic role Bondo plays in Sierra Leonean life. Some practitioners view attacks on FGM as attacks on Bondo, hence efforts must be made to preserve the social and cultural significance of Bondo without cutting (such as ARPs). Anti-FGM programming must address the institution of Bondo and engage with its initiates. Programmes helping Sowei find alternative sources of income should be used in parallel with strategies, for example, related to FGM and education, health, and men's involvement.

SUSTAINABLE FUNDING

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. This is a challenge in Sierra Leone given that the Government does not support the eradication of FGM and has recently imposed restrictions on NGOs. Sierra Leone is also in a period of recovery following the civil war; the country still faces extreme poverty and relies heavily on foreign aid. Continued publicity of current FGM practices at a global level, particularly through the UN and WHO, is crucial for ensuring that NGOs and charities are given support and resources long term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as is discussed

in this report, FGM is a focal issue connected to these crises and directly relates to several of the MDGs.

FGM AND THE MILLENNIUM DEVELOPMENT GOALS

Considering FGM within the larger framework of the MDGs conveys the significant negative impact FGM makes on humanity. Stopping FGM is connected to promoting the eradication of extreme poverty and hunger, the promotion of universal primary education, gender equality, reducing child mortality, improving maternal health and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research for broader social change. There has been a momentum for change, with the UN global ban on FGM in December 2012 and the UN CSW 57 focusing on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, and FGM, are reflected in the post-MDGs agenda.

FGM AND EDUCATION

Literacy rates are low in Sierra Leone, and despite primary education being free and compulsory, many children do not have access to schools. Education is a central issue in the elimination of FGM. The lack of basic education is a root cause for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM hinders girls' ability to obtain basic education and prevents them from pursing higher education and employment opportunities. This lack of education directly relates to issues surrounding child marriage. We recommend that organisations continue to provide programming related to education for boy and girls, and that the Government makes efforts to comprehensively report on education conditions.

FGM, MEDICAL CARE AND HEALTH EDUCATION

Sierra Leone continues to have some of the poorest health indicators in the world. There are shortages in basic equipment, infrastructure and healthcare professionals. 28 Too Many encourages the Government, foreign aid bodies, and other organisations to continue improving healthcare with the aim of meeting the MDGs related to child mortality, maternal health and infectious diseases. Education programmes on health, particularly sexual health, are extremely important for Sierra Leone given the high rates of teenage pregnancy. We applaud the work that has already been done by Freedom From Fistula and encourage further programming and research into the relationship between fistula and FGM. As many women and girls are unaware of the health complications surrounding FGM, we recommend the Ministry of Health and Sanitation and other organisations to continue their programming efforts raising awareness of these risks.

FGM, ADVOCACY AND LOBBYING

Advocacy and lobbying is essential to ensure that the Government continues to be challenged on its hesitancy to criminalise FGM, and to support programmes that tackle FGM.

FGM AND THE LAW

Though the Government of Sierra Leone has made many positive steps in safeguarding the rights and wellbeing of women and girls by ratifying three gender laws, more work is needed to implement the legislation which will effectively combat FGM. We recommend that the Government outright criminalise FGM. Greater support is needed to enforce district and community by-laws that prohibit FGM on girls under 18. In particular, the Child Rights Act needs to be better enforced. Further work is needed to reinforce the age at which a girl legally becomes a woman (18) versus the customary beliefs that initiation marks the transition to adulthood.

FGM IN THE MEDIA

Media has proven to be a useful tool against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on FGM and encourages these projects to continue. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level. In Sierra Leone, radio is an important form of communication and should be optimally used for programming related to health issues, FGM, and women's rights.

FGM AND FAITH-BASED ORGANISATIONS

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision regarding issues such as FGM. They can also work with global bodies such as the UN and its agencies.

COMMUNICATION AND COLLABORATIVE PROJECTS

There are a number of successful anti-FGM programmes currently operating in Sierra Leone, with the majority of the progress beginning at the grassroots level. We recommend continued effort to communicate their work more publicly and encourage collaborative projects. A coalition against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success, and efforts in Sierra Leone are headed in this direction.

The strengthening of such networks of organisations working against FGM and more broadly on women's and girls' rights, integrating anti-FGM messages into other development programmes, sharing best practice, success stories, operations research, training manuals and support materials, advocacy tools and providing links/referrals to other organisations will all strengthen the fight against FGM.

FURTHER RESEARCH

There is a need for further research and up-to-date data on the prevalence of FGM that includes infants and girls under 15 years old, so as to capture recent trends. The reported rise in Type III (infibulations) needs urgent further study to confirm the data and stop the trend towards the most extreme form of FGM.

APPENDIX I - LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO DEVELOPMENT GOALS AND WOMEN'S AND CHILDREN'S RIGHTS IN SIERRA LEONE

Action Aid

Action for Community Task (ACT-SL)

Advocacy Initiative for Development (AID)

Advocacy Movement Network (AMNet)

Advocacy of Democracy and Human Rights (Sierra Leone) ADHR

AdvocAid

Amazonian Initiative Movement (AIM)

Campaign for Good Governance (CGG)

Campaign on Accelerated Reduction of Maternal, New born and Child Mortality in Africa (CARMMA)

CARE International

Caritas Sierra Leone

CAUSE Canada

Centre for Democracy and Human Rights (CDHR)

Centre for Safe Motherhood, Youth and Child Outreach (CESMYCO)

Children of the Nations International (COTNI-SL)

Christian Aid

Christian Health Association of Sierra Leone (CHASL)

Christian Outreach Justice Mission (COMINS-SL)

Coalition for All Women's Organisations (Kailahun)

COMAHS (University of Sierra Leone)

Community Initiative Programme (CIP)

Concern Worldwide

Cooperazione Internazionale (COOPI)

Council of Churches in Sierra Leone (CCSL)

Defence for Children International Sierra Leone (DCI-SL)

Democracy and Development Associates (DADA-SL)

Department for International Development (DfID)

Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ)

EducAid

Enhancing the Interface between Civil Society and the State (ENCISS)

Fambul Initiative Network for Equality (FINE)

Foundation for Women's Health, Research and Development (FORWARD)

Freedom From Fistula

Graceland

Health Poverty Action

Human Rights Commission of Sierra Leone (HRC-SL)

Human Rights Respect Awareness Raising Campaigners Sierra Leone (HURRARC-SL)

IBIS (Sierra Leone)

Inter African Committee Sierra Leone (IACSL)

International Rescue Committee

Katanya Women's Development Association (KAWDA)

LemonAid Fund

Leitner Center for International Law & Justice

Marie Stopes

Masanga Education Association (MEA)

Men's Association for Gender Equality (MAGE)

Midwives on Missions of Service (MOMS)

National Movement for Emancipation and Progress (NaMEP)

Network Movement for Democracy and Human Rights (NMDHR)

Network Movement for Justice and Development (NMJD)

Oxfam

PLAN International

Planned Parenthood Association of Sierra Leone (PPASL)

Praise Foundation

Rehabilitation and Development Agency (RADA)

Save the Children

Self-Help and Development Everywhere (SHADE)

Service for Peace – Sierra Leone Chapter (SFP-SL)

Street Child of Sierra Leone

Taia Development Programme (TDP)

Tearfund

The Fund for Global Human Rights

The Global Network of Women Peacebuilders (GNWP)

Thorough Empowerment & Development for Women & Girls in Sierra Leone (TEDEWOSIL)

Tinap for Peace and Development Organisation (TIPDO)

Trocaire

United Nations Children's Fund (UNICEF)

United Nations Development Programme (UNDP)

United Nations Population Fund (UNFPA)

UNIFEM

UN Women

United Rural Development Organisation (URDO)

US Agency for International Development (USAID)

Voice for the Voiceless Woman (VVW)

War Child

Womankind

Women Against Violence and Exploitation in Society (WAVES)

Women in Action Against GBV

Women's Action for Human Dignity (WAHD)

Women's Partnership for Justice and Peace (WPJP)

World Health Organisation (WHO)

World Vision International

Youth and Regional Development (YARD-SL)

Youth Partnership for Peace and Development (YPPD)

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