Female Genital Mutilation / Cutting

Exploring the best practices to eliminate FGM/C in Sierra Leone

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Abstract:

Female Genital Mutilation/ Cutting has a long history in Sierra Leone, where it is regarded as a passage rite to womanhood. In estimation 86% of girls/ women went through Female Genital Mutilation /Cutting (FGM/C) in Sierra Leone in 2017. The FGM/C procedure itself causes pain, and complications such as uncontrolled bleeding or septicaemia may be fatal. FGM/C changes life of women permanently and can cause mental trauma in addition to physical harm. It is also a human rights violence. There is a need to eradicate this harmful practice and the International Federation of the Red Cross and Red Crescent Societies is looking to find a safer alternativity for this tradition.

In this qualitative study, focus group interviews were conducted with a semi-structured interview guide to find answers to the research questions: 1) What is the level of knowledge among the Sierra Leone Red Cross Society volunteers about FGM/C and 2) What can be used as an alternative rite as a passage to womanhood in Sierra Leone instead of FGM/ C. The focus group interviews were conducted among ten Sierra Leone Red Cross Society volunteers in May 2019.

The results of this study revealed that the attitude towards FGM/C is changing. The destructiveness of the old tradition is acknowledged, and all the interviewees wanted to abandon this practice. The results show that the main reasons for upholding the tradition of FGM/C are old beliefs and traditions. FGM/C also provides an important income for the traditional cutters, aka soweis. Therefore, the most effective means to eradicate the practice are to find an alternative rite for transition to womanhood and to create another livelihood for the cutters. At the same time the study finds that it is important to increase public awareness in the communities and to intensify cooperation between authorities and law enforcement.

Keywords:	Female Genital Mutilation, Cutting, Behavioural Change, Eradication, Red Cross
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FOREWORD

The author would like to thank the Sierra Leone Red Cross Society's volunteers who participated in this study. Without your valuable contribution this work would not have been possible. I would like to express my gratitude for the Sierra Leone Red Cross Society's Field Health Officer Aminata Musa and Community Engagement and Accountability Officer Stella Tucker, as well as the Finnish Red Cross Programme Support Officer Sofia Itämäki. I am very grateful for Senior Health Advisor Hannele Virtanen from Finnish Red Cross for offering me to this unique opportunity. I also want to thank my class mates and MSc Anne Salonen for an important peer support and my supervisor PhD Pamela Gray from Arcada University of Applied Sciences for valuable guidance whilst muddling through this process.

Helsinki, May 2020

Kaija Ilkka

List of Abbreviations

AMNet	Advocacy Movement Network
ARP	Alternative Rite of Passage
BC	Behaviour Change
BONDO	All-female secret society in Sierra Leone
CBHFA	Community Based Health and First Aid
CEA	Community Engagement and Accountability
FGD/I	Focus Group Discussion/ Interview
FGM/C	Female Genital Mutilation/ Cutting
FRC	Finnish Red Cross
ICF	International Coach Federation
IFRC	International Federation of the Red Cross and Red Crescent Societies
KAP	Knowledge, Attitude and Practice
MCH	Mother and Child Health
MISC	Multiple Indicator Cluster Survey
RCRC	Red Cross and Red Crescent
SDG	Sustainable Development Goal
SGBV	Sexual Gender Based Violence
SLRCS	Sierra Leone Red Cross Society
SOWEI	Cutter, Traditional practitioner of FGM/C
THL	Terveyden ja Hyvinvoinnin Laitos
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. INTRODUCTION

Female Genital Mutilation / Cutting (FGM/C) has been an on-going practice in many countries for decades. FGM/C is known to be a destructive practice that has negative health impacts on female gender. There have been both an international and national aspirations to eradicate this damaging tradition. The topic is sensitive, however the author considered it was relevant to study what would be the best practices to eliminate FGM/C and consequently improve women's health. In the heart of *2030 Agenda for Sustainable Development* (SDG) there are 17 goals in which especially numbers 3 (Good Health and Wellbeing) and 5 (Gender Equality) are promoting healthy lives and working toward empowering girls and women (WHO, 2019).

The WHO (2016b, ix) has given guidance on the subject by following statement:

> 1. *Girls and women living with female genital mutilation (FGM) have experienced harmful practice and should be provided quality health care.*
> *2. All stakeholders – at the community, national, regional and international level- should initiate or continue actions directed towards primary prevention of FGM.*
> *3. Medicalization of FGM (i.e. performance of FGM by health-care providers) is never acceptable because this violates medical ethics since (i) FGM is a harmful practice; (ii) medicalization perpetuates FGM; and (iii) the risks of the procedure outweigh any perceived benefit.*

In this study the author aims to gain understanding of Female Genital Mutilation. The main purpose of the study is to investigate the present knowledge of FGM/C among the Sierra Leone Red Cross Society volunteers and consider what can be used as an alternative rite as a passage to womanhood in Sierra Leone instead of Female Genital Mutilation/Cutting. The background of this study is based on existing literature, documentation from previous interventions as well as documents and reports from organizations who are endeavouring to eradicate FGM/C. To get current information on people's attitude and knowledge about FGM/C, the author conducted focus group interviews in Sierra Leone.

There are several different ways of referring this harmful procedure. In some articles it has been referred as female genital mutilation, some others may cite it as cutting or even

circumcision. In order to cover every aspect of the topic, the term female genital mutilation /cutting (FGM/C) was chosen in this study (WHO, 2016; UNICEF, 2016a; Galukande et al., 2015; Statistics Sierra Leone [SSL] and ICF International, 2014; Gele et al., 2013).

In Sierra Leone, the practice of FGM/C is so widespread and culturally accepted that the Parliament would not criminalize it and therefore FGM was removed from the Child Rights Act No 7 of 2007. However, domestic violence has been recognized in The Domestic Violence Act No 20 of 2007, in which women and children are to be protected against any harm they might be exposed in their daily domestic life (Sierra Leone: Act No 7 of 2007; Sierra Leone: Act No 20 of 2007).

Qualitative focus group interviews were chosen in this study, because they gave the author the opportunity to explore the present nature of the subject in the research area. The focus group interviews were conducted together with Sierra Leone Red Cross Society's (SLRCS) Field Health Officer and Community Engagement and Accountability Officer. The data collected serves as a baseline for Red Cross Red Crescent Movement (RCRC) and after analysis, the results can be used to create indicators for measuring the progress of health projects including topics such as FGM/C. During a phone interview conducted on 18 October 2018, Senior Health Adviser Hannele Virtanen form Finnish Red Cross confirmed that Female Genital Mutilation/ Cutting (FGM/C) is a major problem in many countries. Among other organizations, the Finnish Red Cross is looking to discover the best methods to eliminate the practice of FGM/C. International Federation of Red Cross and Red Crescent Societies (IFRC) has recently included FGM/C in the new Mother and Child Health (MCH) module in the Volunteer Manual of Community Based First Aid and Health in Action (CBFHA). This upgraded module has been designed to be used also in Sierra Leone. Before starting the training there is a need to find out the representatives of the participants' existing knowledge on the subject. Therefore, the researcher was asked to conduct a focus group interview in one of the communities in Sierra Leone. The aim is also to develop the base line indicators to measure the progress of health projects in supporting the elimination of FGM/C. This study was planned in cooperation with the Finnish Red Cross.

This study addresses the definition and reasons of FGM/C and is including a theoretical framework such as behavioural change and guiding values of the study. Based on the existing literature, previous interventions and the focus group discussion / interview, the author is looking

for the most effective method for the community to eliminate Female Genital Mutilation/Cutting.

2. BACKGROUND

Female Genital Mutilation / Cutting has no health benefits and can cause various physical and mental health problems. Problems may arise by the chosen type of procedure and the method of cutting. More extensive cutting as well as the performing of FGM/C in an unhygienic condition are contributing factors in causing serious adverse health effects. Traditionally girls are kept in the forest in so called Bondo-houses for days, weeks or at times months, as they need time to heal after the FGM/C. The World Health Organization (WHO) classifies FGM/C into four categories, however, distinguishing the types may be at times difficult as mixed forms are common (WHO, 2016a).

2.1 Female Genital Mutilation/Cutting

The definition of FGM/C according to World Health Organization (WHO), United Nations Children's Fund (UNICEF) & United Nations Populations Fund (UNFPA) 1997 (as cited in WHO, 2016a, vii) is 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons'.

The joint statement from WHO/UNICEF/UNFPA (WHO, 2016a p.2-4) has classified FGM in four main categories:

- *Type I: clitoridectomy (the partial or total removal of the clitoris)*
- *Type II: excision (the partial or total removal of clitoris and labia minora with or without excision of the labia majora)*
- *Type III: infibulation (narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).*
- *Type IV: all other harmful procedures for non-medical purposes to the female genital area (such as pricking, piercing, incising, scaping and cauterisation)*

According to the World Health Organization (WHO, 2016a) and the United Nations Children´s Fund (UNICEF, 2016a) more than 200 million girls and women in 30 countries in Africa, Asia

and Middle East have undergone Female Genital Mutilation or Cutting (FGM/C) and estimated 3.6 million are annually at risk. Therefore, it is fair to say that FGM/C is a grave health concern globally.

The World Health Organization (WHO, 2016a) describes female genital mutilation (FGM) as the partial or total removal of the external genitalia as well as other nonmedical injury to this region. FGM is physically and emotionally painful and may cause complications such as excessive bleeding, infections, menstrual and obstetric problems and painful urination as well as psychological consequences. A prospective study (WHO, 2016a) stated that those who underwent FGM were significantly more likely to have detrimental obstetric outcomes. The risk was greater after extensive FGM. The Finnish National Institute for Health and Welfare (THL, 2017) have stated that FGM violates a number of international rights conventions and individuals right to health, safety and physical integrity. Andro and Lesclingand (2016) concurred that even if there is consensus that children's rights needed to be defended and mothers protected, women's right to a sexual life is still prone to dispute. In the light of reproductive health and gender equality FGM/C is seen as a harmful practise. Although it has been justified by hygiene reasons and girl's social approval it is hard to find a sound justification for tampering with a healthy girl's body. Several humanitarian agencies and human right agencies have addressed the issue during the past decades. The United Nations General Assembly required the international community to enhance their aspirations to end FGM. New Sustainable Development Goals (SDG) were agreed upon in 2015. In that the global community agreed on under Goal 5; Gender equality, to eradicate all practices, such as FGM/C that may impose harm for child, by the year 2030 (UNICEF, 2016a).

In Sierra Leone there is no legislation that criminalizes or punishes the practice of FGM/C. However, The Child Rights Act No 7 of 2007 has been ratified to protect individuals below the age of 18 years. In the Section 2 there is the only reference in FGM/C as is says including 'cutting or removal any part of female genitalia'. From the Section 46, in which the customary practices that are criminalized, the paragraph on FGM/C was removed owing to an excessive pressure from the chiefs of the communities. The practice is so widespread and culturally accepted that the Parliament has not yet not criminalized it. In Sierra Leone health surveys, the practice is referred to as a circumcision. Domestic violence has been recognized in The Domestic Violence Act No 20 of 2007, in which women and children are to be protected against

any harm that endangers their safety, privacy, integrity and wellbeing (Thomson Reuters Foundation ed., 2018; Sierra Leone: Act No 7 of 2007; Sierra Leone: Act No 20 of 2007).

According to the latest Sierra Leone Demographic and Health Survey in 2013, female circumcision was performed in 94 percent of rural areas and in 81 percent of urban areas. Among those 40 percent were circumcised between the ages of 10-14, and 17 percent were circumcised between ages 1-4. Between the ages of 5-9 about 13 percent were circumcised (Statistics Sierra Leone [SSL] and ICF International 2014).The more recent Multiple Indicator Cluster Survey in 2017 (MICS) have similar results, FGM/C was performed in 92 percent in rural and 80 percent of urban areas for the age of 15- 49. For younger, 0 to 14 years of age in rural areas the percentage was 9.1 and in urban areas 7.3 (Statistics Sierra Leone, 2018).

In order to gain more information of the phenomena in Sierra Leone prior to the field visit, interviews were conducted with representatives of the organizations such as UNFPA and Save the Children in Freetown. A programme Specialist from UNFPA stated during an interview (F.C.Kaikai 2019, personal communication, 22 May) that UNFPA is offering financial and technical assistance to the Government in two programmes aiming to the policy level changes. The programmes are namely 1) Zero tolerance on gender-based violence and 2) Ending child marriage. These programmes are part of the reproductive health initiative and they include a topic of FGM/C . UNFPA has also been engaged in discussions with different Christian and Muslim society leaders concerning reproductive health however, FGM/C has not yet been included in those discussions. The policy document drafted already in 2016 is addressing the need of reduction of FGM/C. The document has not yet been ratified by the Government. The Gender Officer from Ministry of Social Welfare, Gender and Children's Affairs (F. Kalokoh 2019, personal communication 21 May) recognizes the need of popularization of the Child Right Act No 7 of 2007. Currently the Police Forces Family Support Unit (FSU) is enforcing the Act. Work is being done to eradicate FGM/C, but progress is slow as the lack of legal consequences hinders the process of implementation of the Act (F. Kalokoh 2019, personal communication 21 May). The Interim Programme Development and Quality Director from Save the Children informs that they do not have direct programs on FGM/C, although it is included at times in their more general programming of child protection and violence against children, such as harmful gender norms and traditional practices, sexual gender-based violence (SGBV) and early marriage and adolescent pregnancy. The topic being sensitive, the issue is

considered better addressed through indigenous organizations, such as Sierra Leone Red Cross Society (D. Evans 2019, personal communication 24 May). A female-led organization AMNet (Advocacy Movement Network) is also working on abandoning harmful traditional practices in Sierra Leone. The social groups are considering the harmful traditional practices legitimate, even though they are violating international human rights. AMNet and Ministry of Social Welfare, Gender and Social Affairs are working together toward better behavioural models to replace those that have been exercised in the communities for decades (D. Evans 2019, personal communication, 24 May).

2.2 The reasons for FGM/C

There are deeply rooted sociological norms for families to be accepted in the communities. Attitude along with a social pressure has been found one of the strongest indicators to accept FGM/C. Older mothers, as well as less educated mothers in rural areas have more positive attitude toward FGM/C (Klein et al., 2018; Statistics Sierra Leone [SSL] and IFC International 2014; Pashaei et al., 2016). Klein et al. (2018) investigated the outcomes of FGM in the social and cultural context and possibilities and challenges in eradication. Parents have social pressure to perform FGM for their daughters as a preparation for adulthood and marriage. FGM may also be performed as to ensure premarital virginity and marital fidelity. Furthermore, they noticed that cultural and traditional significance makes eradicating FGM difficult. Similar results were found in a systematic review of 21 studies done in exile in western countries by Rigmor and Denison (2012). The authors grouped the perpetrating factors as religion, tradition, marriageability, sexual morals, male preference, aesthetics and social pressure. They stated that health issues were both perpetuating and hindering factors. Østebø and Østebø (2014) argued that in Ethiopia, the religious leaders could enhance the social change and lead a critical discussion regarding the consequences of FGM/C. The religious argument and marriageability are two main reasons FGM/C is still justified in Somalia and Ethiopia (Gele et al., 2013; Abathun et al., 2016). Jiménez Ruiz et al., (2017) had similar results when they studied men's attitude towards FGM. The informants were originally from seven African countries, now residing elsewhere. They found nine myths that men were using in justifying FGM. Those myths included [1)] health benefits, [2)] it protects the virginity of the girl,[3)] it enhances the possibility to a marriage [4)] it increases sexual pleasure [5)] the Islamic religion requires it [6)] female genitals are

cleaner after operation [7] the clitoris continues to grow if FGM is not performed [8] equality between male circumcision and female genital mutilation and [9] FGM reinforces the economy.

2.3 Previous research on FGM/C

Galukande et al., (2015) observed that female genital mutilation/ cutting (FGM/C) is still practiced in 29 countries in Africa even though there have been a decade's eradication campaigns. The survey of Galukande et al., (2015) included health risk campaigns, social economic development, alternative rite of passage (ARP), teaching of health consequences' and enforcement of legal mechanisms. There can be serious ramifications of FGM such as bacterial and viral infections, as well as psychological and obstetric consequences (Klein et al., 2018; Devi 2018; Bjälkander et al., 2012). UNICEF also sees FGM/C as a violation of an individual's rights and a manifestation of discrimination. FGM/C has been carried out as a social norm and it has been seen as prerequisite to girl's appropriate upbringing (UNICEF, 2016a).

A study conducted by the Thomson Reuters Foundation in 2018 found that the most common type of FGM in Sierra Leone was cutting or flesh removal. In most cases the procedure was performed by traditional cutter (sowei). FGM was regarded as a part of the initiation ceremony. From groups between 15-49 years of age, 69.2 percent of women and 46.3 percent of men believed that the practice should continue. There was a strong belief that the religion requires it, however, the increased level of education correlated in the decrease of FGM.(Thomson Reuters Foundation ed., 2018). The traditional cutting as a rite of passage in Sierra Leone is called Bondo, referring to the secluded site of "Bondo Bush", where the secret ceremony takes place. The root of the practice may lay on the traditional myths and cultural beliefs; however, the cutting is also a matter of soweis livelihood (Devi, 2018; Bjälkander et al., 2012).

2.4 The most effective efforts to eliminate FGM/C

There has been a decline in prevalence of FGM/C in past three decades. However, there are some countries that have not made a desired progress (UNICEF, 2016a; Johansen et al., 2018). Negative personal experience and this procedure being illegal and not a religious requirement, as well as husbands opposing it, was seen as hindering factor in FGM/C (Galukande et al., 2015). Using nationally representative survey Statistics Sierra Leone [SSL] and ICF

International (2014); Sagna (2014) examined the discontinuation of FGM/C in Sierra Leone. Evidence from authors research reveals that women were more likely to oppose the elimination of the practice than men. This was linked to un-equal social expectations and societal responsibilities for the girls and privileges they get only after FGM. Varol et al., (2015) conducted a systematic review of the role of men in abandonment in FGM. In twenty peer-reviewed articles they identified that the more educated men were, the more likely they were to support the eradication of FGM. According to the review main barriers to eradication were lack of communication between men and women, and social obligation. Abathun et al., (2016) reached similar conclusion when interviewing Somali men in their study, especially young men expressed that the bottleneck is behaviour of mothers, as they decide whether to continue the tradition of FGM/C or not. Galukande et al., (2015) stated that the educational campaign achieved significant increase in the knowledge of various health risks. The changes in attitude were also detected. The Sierra Leone Demographic Health Survey conducted in 2013 showed similar results; as wealth and education increased the percentage of women undergoing FGM/C was decreasing (Sierra Leone [SSL] and ICF International, 2014).

According to Galukande et al., (2015) the reduction of FGM/C prevalence remained still uncertain. Similar concern expressed Gele et al., (2013) in their attitude study in Sudan, Abathun et al., (2016) in Ethiopia, and Johansen et al., (2018) after conducting the study in the management of FGM/C in 30 countries. Even if the legislation and community involvement has improved, there is still room for development, especially in monitoring and evaluation. Klein et. al., (2018) demonstrates similar results in their literature review. Despite the laws against it, FGM/C is ongoing practice in certain countries. The authors observed that even if eradication has made little progress in recent years, elimination is possible if resources are efficiently directed. Interventions may include both ethnical and cultural aspects. Sagna (2014) suggests that for the ban of FGM/C might be helpful in providing structure, comprehensive policies and resources but awareness campaigns and advocacy are still needed to change the attitudes and behaviour. A cross-national study conducted 2012 by Sipsma et al., showed that only Burkina Faso and Mauritania have reduced effectively the practice of FGM due to legislation. Burkina Faso enforces the law by prosecuting those breaking the law and Mauritania has also a law against 'harming the genital organs of a female child'. In addition to the enforcement of the law, the authors recommend the use of influential people in community education and to find other means to support people still performing FGM. Collective declarations against FGM and

circumcision-free-rites of passage ceremonies have been documented successfully (Sipsma et al., 2012).

The UNFPA and UNICEF managed from 2007 to 2012 (phase I) and from 2012 to 2018 (phase II) an extensive campaign called Saleema in Sudan to end FGM/C. The emphasis of the campaign is on promoting a healthy perfect girl child, one whom is unique and complete as God made her. The adjective saleema associates with a variety of positive affiliations in Arabic: a whole, inclusive and undivided. The Saleema campaign took the approach that there is no need to tamper with God's creation, as she is good, healthy and natural the way she was born. The approach is having a positive connotation rather than negative name calling that has been used in the communities prior to the intervention (UNFPA 2012; UNICEF 2016b; Johnson et al., 2018).

The Saleema campaign included advocacy to influence legislation and was conducted in cooperation with civil society, main stakeholders, community members and their religious leaders and governments. The program was not stand-alone but was integrated in existing programme's in country. The phase II went from 2012 to 2018 (UNFPA, 2012). After a completion of the phase II, Johnson et al., (2018) conducted an interim evaluation among Sudanese adults using altogether 72 focus groups discussions in 18 states in Sudan. According to the evaluation, the most valued source of information was the community leaders. Education, solidarity and religious commitment was also highly regarded among the participants. Saleema had a positive brand and participants were keen to continue advocacy and training. The participants suggested that negative impact of FGM could be emphasized trough local leaders and elderly women and rural communities would most benefit of the awareness raising campaigns (Johnson et al., 2018). According to their evaluation of the joint project in 2012 and again in 2018 they estimated that the Saleema project has been to this date the most successful and outstanding strategy in enhancing the attitude change pertaining FGM/C (UNFPA, 2012; UNICEF, 2016b; Johnson et al., 2018).

A study conducted in Ethiopia by Setegn et al., (2016) concluded that cultural factors together with socio-demographic, religious and economic factors have a strong role in the practice of FGM. The authors recommend that interventions should be integrated and involve religious leaders in high prevalence clusters. Odemerho and Baier (2012) found five key elements of a multi-level methods that should always be combined to erase FGM:

1.The disciplined use of the participatory and process-based method

2. Analytical planning, taking into account cultural issues

3. Good support for different processes and levels of social change

4. Promoting the negotiations

5. Sustainable development and protection of the target group and as well as the institutional levels

In their systematic review Waigwa et al., (2018) concurred that same sociodemographic factors, beliefs and traditions may either hinder or facilitate the impact of health intervention. In order to create a sufficient intervention all these aspects need to be considered. Similar findings detected Nalaaki (2014) in a study made among Ugandan Sabiny community and the author recommends the alternative rites of passage for the girls, without having to expose them in serious health risks.

In 2014 Sierra Leone was in the midst of Ebola epidemic, which killed almost 4000 people. Due to security reasons the Government published new emergency health measures such as a ban of the FGM/C practice. Unfortunately, in 2017 even though the ban had not been removed, the practice of FGM/C had been returned (Devi, 2018). The new development was in January 2019 when Minister of Local Government and Rural Development sent a letter to all the Ministries where all initiations taken place in secret societies were banned in Sierra Leone. However, the ban has not been endorsed effectively and the tradition continues (F.C. Kaikai 2019, personal communication 21 May; Thomson Reuters Foundation ed., 2018).

As demonstrated in this chapter, the cultural traditions, habits, beliefs and environmental social pressure are major drivers of FGM/C. These traditions can be changed; however, the change usually involves some major changes in the individual's behaviour and perspectives.

2.5 The behaviour change framework

As earlier stated, FGM/C is known to be a destructive practice that has negative health impacts on female gender. It has physical and emotional consequences and it may cause severe complications including obstetric difficulties (World Health Organization 2016b; Andro and Lesclingand, 2016). Traditions, beliefs and myths are challenging to conquer and changing the future of young girls is requiring a changing of attitude toward this phenomenon. Increasing the level of knowledge and emphasising that the outcome has personal relevance and advantage, may enhance the changing an attitude.

If people are not aware how the behaviour change might influence in their health, there is usually little or no reason to put themselves through the agony of change. Therefore, the behaviour that one has been carried out, continues. Increased awareness usually enhances the possibilities to change the behaviour (Gele et al., 2013). In their study, Waigwa et al., (2018) suggested that it is possible to influence communal change by health interventions. The success depended on socio-demographic and socio-economic factors as well as traditions and beliefs. The authors pointed out that a properly planned and well managed programme approach increased the possibility to change the behaviour and lead to more sustainable prevention of FGM/C and improved health and wellbeing.

Measuring a behavioural change can be at times challenging. One quantitative method for that is by using knowledge, attitudes and practices (KAP) surveys. KAP is based on standardized questionnaires that are predetermined to give an access to both quantitative and qualitative data. (Médecins du Monde, n.d). Knowledge, attitudes and practices surveys are widely used in an international aid community, when conducting research on health-seeking behaviour. Understanding the economic and socio-cultural aspects are important prior to implement health programmes. Through cross-sectional KAP-surveys researchers may find vital information on existing behaviour in regard with a specific topic. However, even if the data can be highly descriptive, the relation between knowledge and action is not self-evident as people do not

necessarily change their behaviour automatically due to increased knowledge (Hausmann-Muela et al., 2003; Launiala, 2009).

There are a vast number of development agencies that have their own behaviour change frameworks in use. WHO has Communication for Behavioural Impact (COMBI), UNICEF has a Toolkit called Behaviour Change Communication in Emergencies and the United States' National Institute of Mental Health (NIMH) has a framework outlining conditions for effective behaviour change (WHO, 2016a; UNICEF, 2016a).

There were 19 behavioural change frameworks reviewed for the development of the framework in Red Cross Red Crescent (RCRC) context. In its own Strategy 2020 the IFRC has recognized the importance of behavioural change as a part of community capacity building. The three leading strategic aims in this Strategy 2020 are; [1)] saving and protecting lives and strengthen recovery, [2)] promote social inclusion, and [3)] advocate people to live healthier life. The IFRC behaviour change framework applies evidence-based tools for health teams to develop and implement their programmes. The University of Maastricht and University of Texas developed an evidence-based model of Intervention Mapping that is utilized as a basis of IFRC's behaviour change framework (Claxton, 2013). Claxton divides the Behaviour Change (BC) framework in five steps: [1)] Needs assessment, when the problem is defined, and the reason of the problem and capacity of the community is assessed [2)] Determinants identification, when the outcome is stated and changeable determinants selected [3)] Explanations identification, when community is involved and explanations found [4)] Developing a program or applying BC to existing program when community involvement continues, possible actions are changed and solutions are found, and [5)] Monitoring, where progress is assessed informally and evaluation is made.

3. AIM OF THE STUDY AND RESEACRH QUESTIONS

The aims of the study were to establish the present level of knowledge regarding FGM/C among the RCRC volunteers and examine what could be perceived as an acceptable alternative rite as a passage to womanhood in Sierra Leone instead of Female Genital Mutilation/Cutting. This study seeks to produce practical and relevant information about attitude towards the abandonment of this harmful practice. As stated earlier, discussions with Finnish Red Cross indicated that this study may perhaps in the future produce the base-line indicators for the future RCRC programmes regarding FGM/C training.

In order to meet the aim of the study the research questions were posed:

1. What is a level of knowledge among the Sierra Leone Red Crescent volunteers about Female Genital Mutilation/ Cutting?
2. What can be used as an alternative rite as a passage to womanhood in Sierra Leone instead of Female Genital Mutilation/Cutting?

Data for this qualitative study was collected by gathering information through semi-structured focus group interviews/ discussions. Thematic analyses was used to identify patterns of meaning from the data.

4. RESEARCH METHODS

In order to determine the Sierra Leone Red Cross volunteer's knowledge of FGM/C, the data for this study was collected through focus group interviews. During the interview the participants have an active role and they can express themselves and have a feeling of being listened to. Participants stories are unique and talking about sensitive topics can also provide an empowering experience. A focus group interview and an inductive content analysis were therefore chosen in this study. By content analysis the documents such as interview data can be analyzed systematically and objectively, as demonstrated by earlier studies (Pedersen et al., 2016; Kyngäs et al., 2011; Tuomi and Sarajärvi, 2018).

4.1 Data collection

For a study to be successful it is important that the research questions are carefully planned. The questions concern's specific information the researcher requires new knowledge of. The questions have to be realistic, related to the research and not to include unsolved ethical or philosophical issues. The researcher must consider the resources needed to collect, write and process the data obtained (Maladon-Maldonado, 2014; Polit and Beck, 2012). As previous researches shows, a thematic interview requires careful study of the topic in question in order to focus on specific selected research topics. Participants in this study were not randomly selected, but they were people who a researcher believed to be best sources of information on the subject. (Pedersen et al., 2016; Kyngäs et al., 2011; Tuomi and Sarajärvi, 2018).

A semi- structured interview guide (appendix 4) was prepared for this study after background literature was reviewed on the subject. The guide was structured on the following themes **1)** Causes of Female Genital Mutilation/ Cutting and current awareness of the tradition (as seen) by Sierra Leone Red Cross volunteers and **2)** What can be used as an alternative rite as a passage to womanhood in Sierra Leone instead of Female Genital Mutilation/Cutting.

Focus group discussions/ interviews (FGD/I) is a one of the qualitative research methods which is often used when investigating perceptions or experiences. FGD/I is usually defined as structured conversation. The group size is small, usually 4-12 people. The interviewer(s) also called as moderator(s) start with general question before going to the key questions, which are open-

ended. Participants are encouraged to interact with each other. Sampling - being a critical part of the study- has to be done with careful consideration. Purposive or snowball sampling, where the participants are selected according to their particular characteristic's, is most commonly used in focus group discussions/ interviews, as it will promote comfortable group dynamic. For the participants it is often easier to express their feelings and views when the other members share similar background. The downside in this method is, that there might be sampling bias, i.e. over-or under- representation of particular group of population. The recording of the interview could also be problematic, as people may talk over each other. It is also advisable to transcribe the interviews as soon as possible after the interview while it is still fresh in a memory (Masadeh, 2012; Polit and Beck, 2012; Tong et al., 2007; Hirsjärvi and Hurme, 2011; Elo et al., 2014). There are several benefits in focus group interview, the researcher is able to deepen the discussion during an interview and the interview can be flexible. The interviewer has the opportunity to repeat the question, correct misunderstandings, clarify the wording of the phrases, and discuss with as informants (Bengtsson, 2016; Tuomi and Sarajärvi, 2018; Hirsjärvi and Hurme, 2011).

The study was conducted at a time when the young generation is ready to change their behavior and re-consider traditional practices and their necessity. Previously in 2018 the IFRC has held an FGM/C sensitization workshop for SLRCS volunteers. After the workshop the participants attitude toward FGM/C was shifting from being a member of secret society to having been objected to bodily harm as child. The consensus of the workshop was unwillingness to continue the practice (H. Virtanen 2018, personal communication, 18 October).

Attitudes and experiences toward FGM/C can vary greatly among men and women. The subject of FGM/C being highly sensitive the author intended to conduct focus group discussion with two groups, one group for female and one group for male participants. In organizing the interviews and in conducting them, the author did need a local moderator who was able to take care of the practical issues, such as contacting the informants and organizing the venue. The local counterpart was naturally chosen to be SLRCS's Field Health Officer. FRC Programme Support Officer, who is currently in Sierra Leone /Freetown was acting as a contact person during the process. The interviewer and participants were from different cultures and language chosen to the interview was mutually understood. The interviews were conducted in English, although the participants were also able to use their native language Krio, which was translated by

SLRCS Community Engagement and Accountability [CEA] officer . The author clarified the answers during the interview to avoid possible misunderstandings. The interviews were recorded and transcribed. The transcriptions were read several times to ensure the quality. At end of the study after analyzing the data, the data was destroyed. The interviews were conducted in English. An inductive content analysis is used as the analysis method. The analysis started in May 2019 and the thesis was finished in May 2020.

Sample groups and the preparation for the interview

In order to test the research questions prior to the interviews in Sierra Leone, the author conducted a pre-test interviews with three medical colleagues and one non-medical colleague from work. With pre-test the author could examine the usefulness and formulation of the questions and test the body of the interview, as instructed by Hirsjärvi and Hurme (2011). A pre-test ensured the author that the questions were well understood as there was no need to change or refine the opening questions. The answers of the participants in the pre-test are not taken into account in the study results.

The aim was to interview two groups, one all-female group, and the other all-male group. Since men and women may have - especially in such a delicate matter - very different opinions, thoughts and attitude toward the topic, the author wanted to interview them separately according to their gender. Finding male interviewees proved to be difficult and eventually the author ended up with two female groups; one with five members (group A) and another with three members (group B). In addition to that, two men were interviewed as one group (group C). All participants were from the regions FRC have activities.

The opening questions for the FGD/I were as provided in appendix 4. As the interview progressed, the author asked some supporting and more specific questions to direct the interview. Sometimes the interview may have difficulties getting started and motivational cues, small comments or different use of body language might help (Hirsjärvi and Hurme, 2011). During this interview all the respondents were willing to participate even if the topic is regarded as sensitive. They openly reported their experiences in childhood and the social pressure involved in the initiation ceremony. The members of the group supported each other, and everyone was able to share their experiences in a confidential atmosphere.

In the female group A, the participants mean age was 24 years of age, and they were from two different counties. In the female group B, the participants mean age was 30 years of age and there were coming from another part of the country. All female participants had undergone the FGM/C in during their childhood or adolescence years. The mean age of the male group C was 31 years of age. The male interviewees reported that all their female family members (in extended family with three generations) had experienced FGM/C. The groups were divided according to their place of origin, as they arrived on site on different times.

Conducting a focus group discussion / interview

The actual focus group discussion/ interview took place in Sierra Leone in May 2019. The participants were collected by the designated SLRCS driver. The Focus Group Discussions / Interviews were conducted in the meeting room in SLRCS's office in Bo branch. The location is familiar to the respondents and they had an easy access to it. The office is small and located near the school, therefore some noise could be heard from the school yard. The participants were asked to speak one by one so that the answers could be heard and could also be recorded. Consent forms were signed and collected. Confidentiality, privacy and nature of voluntary information sharing was stressed before starting the session and after the interview.

The author explained the purpose and use of the interview material to the participants prior to the interview. The material consisted of pen, paper and two recording devices. Chairs were set in a semi-circle formation and a voice recorder was placed in the middle, surrounded by the participants, SLRCSs field health officer , SLRCS CEA officer, and the author. The other device, an iPad - with a voice recorder program - was placed next to the author and was used as a back-up recording device. The interview started by introducing the participants and moderators. The first question was asked from all of the participants and they took turns in answering. The recording went smoothly and there was no need to interrupt the interview due to disturbance. The participants agreed with the interview methods used as well as confidentiality. The purpose of the interview and the anonymity whilst managing the data was further explained and translated to the participants by the assistance of SLCRS CEA officer.

4.2 Data analysis

Content analysis was chosen in this study. Content analysis is defined as a method for analysing systematically and objectively and it can be used to describe a phenomenon. Content analysis is often a good method to categorize data and its core features. The data belonging to the same category can thus be exhaustively described and others excluded. The data can be grouped into main themes and sub-themes and it can be used to create concepts or concept systems. When the researcher encodes the data, it is usually done with written notes, that are used to structure the researcher's interest in the data. Content analysis aims to provide a condensed description of the phenomenon and other research findings on the subject (Pedersen et al., 2016; Kyngäs et al., 2011; Tuomi and Sarajärvi, 2018). In content analysis where data is presented in words and themes a researcher can make interpretations of the results. How thoroughly the researcher seeks to reflect the statements, will guide the choose of the analysis method. In research based on interview materials, the researcher aims to reach successful interpretations. If the researcher succeeds, the reader also finds the same things in the text as the researcher (Bengtsson, 2016; Polit and Beck, 2012; Hirsjärvi and Hurme, 2011). The process of analysing starts as soon as a researcher notices repeated patterns of significations. According to Braun and Clarke (2006) an inductive analysis can be data-driven especially when the researcher does not try to classify the data according to the pre-existing conceptions or coding frame. When the researcher encodes the data, it is usually done with written notes, that are used to structure the researcher's interest in the data (Tuomi and Sarajärvi, 2018).

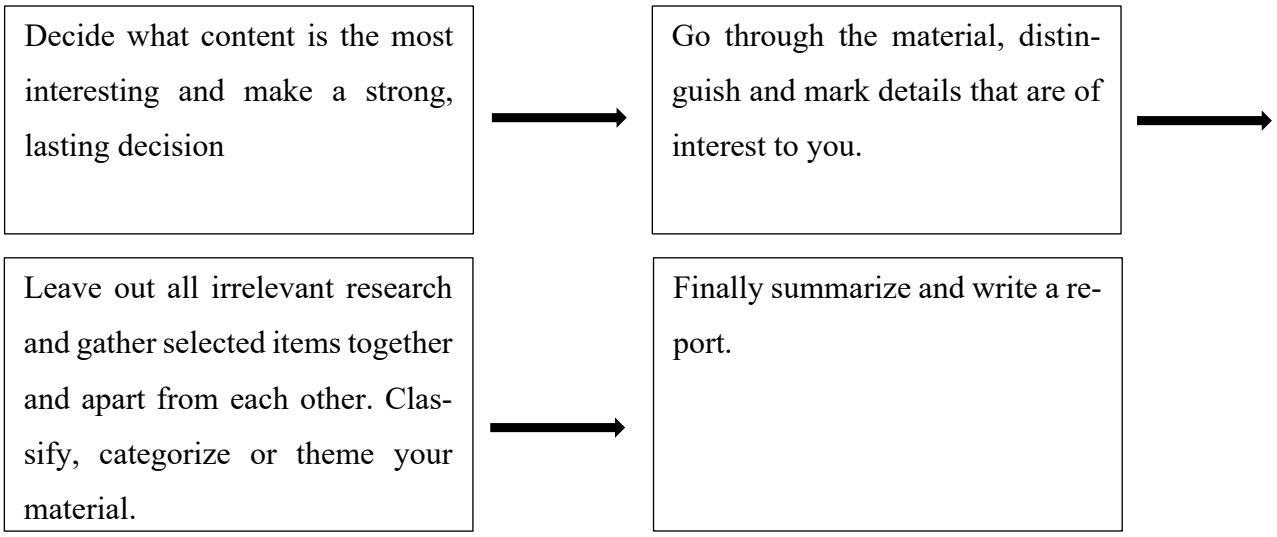

Figure 1 illustrates the analysis process from the review of the data to the conclusion of the summary (Tuomi and Sarajärvi, 2018 p. 142).

Data processing started immediately after the interviews. Field notes were taken throughout the interviews in order to recall the initial impressions. As instructed by Hirsjärvi and Hurme (2011) the recorded data was transcribed in verbatim as to generate accurate record. Transcription process started in Sierra Leone and was finished in Finland. The data was read and re-read several times in order to gain understanding and become familiar to the transcribed data (Korstjens and Moser, 2017; Hirsjärvi and Hurme, 2011).

After the preparation phase the transcribed data was coded and categorized. The headings and notes were written on the margin of the text and to separate coding sheets. (Elo and Kyngäs, 2007; Korstjens and Moser, 2017; Hirsjärvi and Hurme, 2011). The first step in the analysis was data reduction, when irrelevant material was eliminated from the study. An example of the analysis process can be found in appendix 7. Transcribed text was read and re-read and searched for expressions describing the research task. Reduced expressions were written on the separate sheet (Elo and Kyngäs, 2007; Tuomi and Sarajärvi, 2018). After reduction the data was grouped. A researcher searched for similarities or differences from the data. Concepts describing the same phenomenon were grouped and combined into different cluster, which then formed different sub-categories (Bengtsson, 2016; Elo and Kyngäs, 2007; Korstjens and Moser, 2017; Hirsjärvi and Hurme, 2011). Sub-categories were named by wording that described the content. By combining sub-categories, the researcher formed the categories. Categories were named according to the emerging theme of phenomenon. Finally, the main theme or main category was created to relate the research task (Elo and Kyngäs, 2007; Tuomi and Sarajärvi, 2018). Table 2 describes the formulation of one theme. In qualitative study human errors in the analyzing process cannot be ruled out. Fatigue and personal bias can cause mistakes. Therefore, it is paramount that the researcher maintains the reliability throughout the study as instructed by Bengtsson (2016). In order to increase validity, the background information was collected from a scoping literature review and some key-personnel interviews. Phases of thematic analyses and a 15-point checklist by Braun and Clarke (2006) was also followed to increase the trustworthiness of the study (appendix 6). Female groups were initially divided into groups A and B, and males formed a group C. The analysis phase revealed that the responses of the female groups were very similar to one another, therefore the groups were combined, and the participants were numbered from one to eight. The men's responses and experiences of FGM/C were coded as participants nine and ten.

Table 1. The focus group interview themes, opening questions and quantity of data. (Junno et al., 2019).

Theme 1 Causes of Female Genital Mutilation/ Cutting and current awareness of the tradition (as seen) by Sierra Leone Red Cross volunteers	
Opening questions	- What do you know about female genital mutilation/cutting? - Are you aware of any health implications after FGM/C? - Can you think of any alternative means to celebrate the girl's passage to womanhood? - Can you think of some specific reason why an alternative celebration would not be accepted?
Theme 2 What can be used as an alternative rite as a passage to womanhood in Sierra Leone instead of Female Genital Mutilation/Cutting?	
Opening questions	- Please tell me how do see the future in regards with FGM/C? If you think FGM/C should be eradicated, do you think there would be means that the communities could be involved in ending the practice?
Duration of interview	32 – 83 minutes
Duration of recorded data	2 hours 54 minutes
Pages of transcribed data	11 pages, font size 12, line spacing 1,5

Thematic designing started with breaking down and grouping the material into different topics. After preliminary classification the themes were searched from the data to represent the content. Thematic categories were created to support the theme.

Table 2. The formulation of a theme. An example of the abstraction process (modified from Elo and Kyngäs, 2007; Junno et al., 2019).

Theme	Causes of Female Genital Mutilation/ Cutting and current awareness of the tradition (as seen) by Sierra Leone Red Cross volunteers		
Categories	Myths and supernatural beliefs	Social acceptance and respect	Economic values
Sub-categories	Spiritual and supernatural beliefs Religious beliefs Symbolic traditions and legends Misleading information: uncontrolled sexual urges and difficulties in childbirth Intimidation and myths: uncontrolled growth of genital organs Unrealistic promises by sowei	Fame and respect the cutter (sowei) is receiving Respect form the community and feeling of belonging to the society Fear of stigma, fear of not to be accepted to the community, moral and ethical reasons e.g. marriage prospects	Economic aspect: money and other payment for the cutters (sowei) other financial expenses for organizing the initiation party

5. ETHICAL ASPECTS

The Finnish National Board on Research Integrity [TENK] lists key principles of the research in the humanities and /or social behavioural sciences. The three main areas needed to be appreciated at all times are respecting the autonomy of the informants to avoid harm, respect privacy and protect data that was collected. Voluntary participation is also emphasized in the guidelines. The researcher should actively protect the participants from harm, including the reporting / publishing phase of the study (TENK, 2012). Doody and Noonan (2016) stated in their study that the ethics of research project should be evaluated and agreed upon how the safety, wellbeing and the rights of the participants are protected. The participants should be encouraged to make their informed decision independently.

The author sought an ethical permission to conduct this study from both the Arcada University of Applied Sciences and the Finnish Red Cross, which is a part of the International Red Cross and Red Crescent Movement. Once the ethical clearance was granted the author established the contact with the FRC's Programme Support Officer in Freetown, Sierra Leone, who contacted SLRCS Field Health Officer, working in Bo community. The Field Health Officer then selected the informants for the study.

5.1 Guiding values

The International Red Cross and Red Crescent Movement has developed tools to gain access to people affected by conflict or disaster. When working with the RCRC Movement, the Fundamental Principles are ensuring the humanitarian nature of the work. Guiding values for this work are based on these seven Fundamental Principles. First principle is 1) Humanity, where aim is to protect and respect life, prevent and alleviate human suffering in both national and international levels. In 2) Impartiality the aim is to give priority to those with the greatest need, regardless of religion, ethnicity, nationality, political opinions or social status. RCRC does not take sides in hostilities. By adhering to 3) Neutrality, the Movement ensures that it does not engage with national, ideological, religious, political or ethnic disputes. Neutrality is one of the key conditions to operate efficiently. 4) Independence is one of the key values, while working as auxiliary to the public authority. RCRC does adhere to the national law, but it has to maintain

autonomy to act according to the principles. [5] Voluntary service describes the basis of the RCRC Movement. Being a volunteer-based organization, work in humanitarian field is done without any aspirations of personal or organizational benefits. RCRC has large volunteer network worldwide and those volunteers are the most important asset in the Movement. [6] Unity means that there is only one RCRC National Society in the country and that has to be open to all. The RCRC has to carry out its activities in all parts of the country, not to exclude any parts that need assistance. The RCRC operates worldwide. The principle of [7] Universality ensures that all National Societies share the same responsibilities in helping each other and have identical position in the Movement (IFRC, 2018).

5.2 Ethical aspects of the research

The author took ethical aspects into consideration. The informants were informed of the principle of voluntariness, confidentiality, anonymity and usefulness of the study. The participants were informed that they had a right to refuse or withdraw from the study at any time without having to explain the reasons, and that the refusal or withdrawal would not affect them in any way (TENK, 2012; Doody and Noonan, 2016). The information collected by interview was also discussed in the information letter. The information letter and the informed consent form (appendices 2 and 3) were written in English, however, Krio being the lingua franca in the area, the information and consent form were interpreted in Krio by the SLRCS CEA Officer. The oral and written consent for recording the interview was obtained from the participants prior to the focus group discussion/ interview. The interviews were recorded and kept confidential at all times. The material was kept in a locked cabinet where only the author had an access. After the answers were written and analyzed, the data was destroyed. The interviewees were informed that the results will be published anonymously, and the results can be used later in the development of health education and/or programs. Due to small sample size and in the attempt to protect the identity of the participants, their localities are not revealed in this study.

When the research topic is sensitive in nature, an interviewer should bear in mind that previous distressing experiences might cause painful memories and the situation needs to be handled with tact. In their guides to the researcher UNICEF (2015) suggest that when interviewing a child or any participant who is perceived as vulnerable, it is best that interviewees are divided according to their sex, women are therefore recommended to interview girls and/ or women. When collecting data, the researcher needs to balance all ethical principles in order to minimize

the stress they are possibly causing to the participants (UNICEF, 2015; Radhika et al., 2018; Decker et al., 2011). The participants in this study are all adults, however the topic being sensitive, a careful preparation took place prior to the focus group discussion/ interview. After the interview the debriefing discussion was held, and other topics introduced in order to help participants to change the focus on more pleasant thoughts.

One concern due to the chosen method is that the focus group discussions are not individual interviews. If other participants choose to forward information outside the group, there is not much than the researcher can do. In attempt to control that, the author and the participants agreed that all information passed on during the FGD/I will be kept confidential. The ethical guidelines, such as justice, fairness and honesty in which Finnish National Board on Research Integrity (TENK, 2012) has outlined in their guidelines, were taken into account.

According to WHO (2011) the reimbursement of the research costs is considered ethically acceptable. The special incentives were not offered for the participants. The expenses such as a modest accommodation for those travelling from distant part of the country and the lunch on the venue were provided for the participants. With a relatively low costs of living, the expenses remained low.

6. FINDINGS

The aim of this study was to gain understanding of what is the level of knowledge the SLRCS volunteers have about Female Genital Mutilation/ Cutting, and to investigate what would be an acceptable alternative rite as a passage to womanhood in Sierra Leone instead of Female Genital Mutilation/Cutting. Additional aim was to produce recommendations for base line indicators for the future RCRC programmes regarding FGM/C training.

The quotes in the text are based directly on the transcriptions of the interviews and they are written in *italics* to make them stand out from the text, authors comments are enclosed in brackets. The female participants were divided into two groups: group A and B, and two male participants formed as a group C. As there were no noticeable difference in the answers between the female groups A and B, their answers were grouped from one to eight (1…8) and both groups were analysed as one. Therefore, in the results- section no separate female groups are shown. The men's responses and experiences between themselves were also similar, and they are coded as participants 9 and 10. For the author, the level of awareness of the initiation rite among the men was surprisingly high. Male participants expressed their distress on their female family members who have been initiated and in that process suffered severe health complications.. Thus, we can assume that information about the initiation rite is leaking into the family members, even though the Bondo-society emphasizes the secrecy in regards with outsiders.

6.1 The level of knowledge the Sierra Leone Red Cross volunteers have about Female Genital Mutilation/ Cutting

The current knowledge and experiences of FGM/C is described in three categories with several sub-categories (Table 2). The categories are: **Myths and supernatural beliefs**, **Social acceptance and respect,** and **Economical aspects.** Myths and supernatural beliefs in this study includes phenomena such as legends, traditions, superstitions, unrealistic promises, spell casting and spiritual beliefs; either religious or otherwise. Misleading information and intimidation are also included in this category. Social acceptance and respect contain communal recognition and appreciation, honour, personal dignity and moral and ethical rules. Bullying and threatening tactics are been used to persuade girls to the ceremony that guarantees them community

approval. Economical aspects are financial, profit-making and business-related activities which includes payments to the sowei, and family expenses for the ceremony.

The interview data was divided in to three categories based on the content of the phenomenon. To make a clear distinction between the two categories; Myths and supernatural beliefs, and Social acceptance and respect, was at times difficult as some of the phenomena, such as intimidation, seemed to overlap occasionally. The results show that myths and supernatural beliefs are playing a major role in the tradition of FGM/C in Sierra Leone. The category of Myths and supernatural beliefs resulted in six sub-categories: Spiritual and supernatural beliefs, Religious beliefs, Symbolic tradition and legends, Misleading information, Intimidation and myths, as well as Unrealistic promises by soweis (cutters).

Myths and supernatural beliefs

All informants expressed their concern on strong myths surrounding FGM/C. They all conveyed that the underlying symbolic meaning of the procedure is powerful and therefore very difficult to eradicate. At times religious arguments are used when FGM/C needs to be justified. Although no religion determinates that girls should undergo FGM/C, in some communities the religious scriptures were interpreted as such, revealed one of the participants (participant 5). Sometimes the soweis are emphasizing the spiritual importance of the tradition, as it maintains their significance in the community. Blood is seen as a crucial element during these ceremonies. All female participants expressed that the blood is seen as directly proportional to soweis appreciation in the community. Blood has therefore an essential spiritual and symbolic value and it has a strong foothold in the ceremony.

> *The other thing is spiritual thing it's kind of witchcraft, when the blood comes out there is something spiritual, also when that clitoris is cut they never say to the girl where the clitoris is taken, so there is a ritual involved… (participant 1)*

Supernatural beliefs and even outright deceptions are common during the initiation rite. Intimidation in uncontrolled increase of sexual urges and even un-natural growth of female sexual organs if the procedure is not performed, are unfortunately frequent, as was expressed by some of the participants (2, 3, 4, 5 and 6) . One justification is the belief that after the procedure the girl will remain faithful to one man, without having an uncontrolled need for various sexual contacts, as was conveyed by participants 2, 3, 5, 6, 7 and 8. Participants 2 and 4 were also told

that cutting is preventing them from infections and that it will cure their illnesses and ensure that they will stay healthy after the ceremony. Bleeding during an initiation is explained by the pretext that the girl has had sexual intercourse with a man prior to the initiation. All participants declared that intimidation is used also to prevent girls from telling about the rite to anyone. All participants expressed their concern about means the girls are persuaded to accept the initiation. Decades ago, Bondo-training was comprehensive almost a year long period, when those initiators taught girls basic surviving skills such as fishing, farming and knitting. they were cut, but also taught a profession. At present they are still told that they learn how to take care of their future families and that they have an opportunity to learn the skills that adulthood requires, such as cooking and doing laundry however, the exercise lasts only long enough to allow their wounds to heal.

> *..they explained to me that if they don't cut this clitoris it will start itching and it will be difficult to deliver a child and also I will be everyday urging for a man. (participant 2)*
>
> *If you communicate about this ceremony to any of your friends who have not been cut, they say that your clitoris will reappear. (participant 7)*
>
> *..how they can take care of their homes, how they can take care of their husbands, these are the messages that they tell people…and when they come back it has to take time…if ever they have a husband, it will take time to get a contact to that person because of the pain. (participant 9)*

Predicting difficulties for childbirth, claiming that the clitoris will block the baby, is one of the arguments that is widely used. Some of the participants (2, 4, 5 and 6) had been told that if FGM/C is not done, they will have difficulties in labour. At times soweis are making unrealistic promises, such as childbirth predictions. They ask the girl how many children she wants and promises that exact number she will have in future. Some soweis also reveal the gender of the first future child during the initiation as was expressed by participants 4 and 5.

> *..they predict that like your first child is going to be a male child, or you have two sets of twins. (participant 5)*

<u>Social acceptance and respect</u>

Social acceptance and respect have sub-categories such as: Fame and respect the sowei receives, Respect from the community and feeling of belonging to the secret society, Fear of

stigma or not to be accepted, and Moral aspects such as purity and better marriage prospects. Soweis have a strong position in the community. Cutting a girl gives her direct power and respect in the community. The secret nature of the FGM/C is highlighted, and the activity is not supervised by any official authorities. FGM/C can be seen as a power issue. Only when procedure is done the girl is part of the secret society, which was disclosed by all participants.

> *It is like a symbol and they* (*soweis) will get respect from families…. more power, the more power they have when they initiate the girl. (participant 6)*
>
> *..and then they say that if you say anything to anyone at the end of the day (about initiation), if you expose the secret you will have swelling in the stomach. (participant 4)*

All of the participants agreed that refusing FGM/C has direct consequences in forms of stigma and weaker marriage prospects. Girls are experiencing social pressure also from their peers. An uncut girl is seen as " an uncomplete woman", therefore she may be discriminated and excluded from the community. Cutting is also justified on moral grounds in the light of future marriage and girl's purity. Even if the initiation for a girl under 18 years of age is forbidden, the law is not enforced and that often leads to early marriages. Some parents rush their daughter to initiation in early age because having a child before initiation is considered shameful.

> *It is part of our custom and tradition and it is something that exist long ago, so to be a full-grown woman. (participant 8)*
>
> *The society considers you as a part of them and after cutting you are a woman. They say because the ideology is, that you will then stay with one man. (participant 3)*

As described before, the initiation process has strong position in the society. In the communities also migrant workers are subjected to the tradition (participant 10). A person coming from another community is not necessarily accepted as a part of the society. If the children of the family are not initiated the work might come difficult and it will almost force them to join the secret societies. Similarly, children with disabilities are taken to the ceremony. Some families prefer that FGM/C is done individually and some choose to bring their daughter to a group initiation (participants 1, 2 and 5).

> *..disabled children are going through same initiation like others belonging to the same ethnic group. No exceptions. (participant 2)*

Economical aspects

Another main category that emerged from the interview data was "Economical aspects". Three of the participants (1, 2 and 6) emphasized that money and goods given to the sowei, play a major role in the continuation of this tradition. This was confirmed by all participants. Economic aspects include both payment to the sowei performing the FGM/C, and financial contributions from the family who pays the expenses associated with the initiation ceremony. The initiation ceremony lasts several day's and families are expected to cover all costs, including new clothing and gifts for the girl in question, as well as meals for the villagers attending to the ceremony. This may have serious and far-reaching consequences for the family's financial status and wellbeing.

> *The economic side is that sowei needs that mother, she says that if you deliver a baby girl you have to bring her to me and people will admire the baby and give her gifts and dress her beautifully… Then people give her (sowei) the money for the initiation. (participant 5)*

At times when family does not have financial means to pay the fee for sowei, various goods or food can be used as in-kind payment, as was pointed out by one of the participants.

> *Even if the parents don't have any money, they (soweis) say that come and bring ground nuts. (participant 2)*

6.2 The alternative rite that could be used in Sierra Leone instead of Female Genital Mutilation/ Cutting as a passage to womanhood

According to the participants the status of FGM/C in the communities should be addressed to and it should be changed through reliable research and facts, which in turn can change attitudes. The analysis of this study revealed that myths and symbolism have a strong influence in this practice. People performing the cutting have achieved an unyielding position in the community. The tradition has many dimensions. **Firstly**, FGM/C has a strong symbolic connotation that appears to be the most difficult aspect to change. The blood that is shed during the initiation rite displays a great importance in the ritual toward the womanhood. All the female interviewees were informed that blood had almost supernatural powers and that soweis are either unable or unwilling to perform the rite without it. The supernatural aspect causes concerns as some soweis are reported to put a curse on a girl during the ceremony. The involvement of supernatural forces is one of the reasons why in some Christian communities the church is against secret

societies initiations. According to all the participants (female and male), wider awareness rising and spreading truthful information among both the soweis and the village elders, was considered as one of the most effective methods in eradication process.

> *They should be told by the community that all the things around this are fake, not real. And we should go back to the community and tell the others, we can be like peer educators. (participant 2)*

Secondly, social pressure was highlighted during the interviews. The participants considered that social pressure from the whole community and also from the peers is significant for the development of young girl. As the result of this influence the individual is unable to refuse from taking part of the rite. According to the participants, the decision to engage the girl in initiation ceremony is often made by grandmothers.

> *..so I think small discussions, small group discussions with grandmothers, you turn to educate them more for them to see the reality of this. (participant 7)*

Sensitization was seen as a first step to change the behavior and diminish the social pressure. The communities usually hold regular meetings or informal gatherings e.g. in health posts or town halls. Those places were seen as possible venues to hold health talks and education sessions. It was pointed out by all of the participants that it is vital to involve the village leaders and religious leaders in this process, as they have the authority to change the practice in their community. Timely information was also emphasized. The communities need to be offered enough background information before the more detailed and large-scale education can be delivered. One option to eradicate FGM/C was seen as reinforcing and adhering to the legal agreements in the country. However, this would require a strong political will.

> *After the sensitization of community leaders, how to monitor the success? There are clinics in the communities, maybe they would use that for health education. The leaders could organize information sessions there in a regular basis, once or twice a month. (participant 7)*
>
> *We should sensitize the religious leaders. Most of those who are part of the church**,** do not initiate their children.(participant 5)*
>
> *First of all, we need to go to the communities, because people need to accept you first, before you can go to talk or testify in radio or other mass media. They need to accept you*

otherwise they don't listen to you or they don't accept you and they can be totally against you. (participant 8)

The leaders they will influence them (soweis) to stop. Like during the Ebola, the leaders came out saying stop doing this. There was a penalty attached. (participant 9)

In the community sensitization process, the participants saw their role as a moderator. They were willing to act as peer educators, provided that their safety is not compromised. Drama have been used before in health education and it was again seen as one option when feeding truthful information for the community. (participants 4, 5 and 8)

...when start with a programme, you need a moderator from the community. Start with communities, in grass root level, starting gradually to involve them so they understand, and it supposed to be like, let's say quarterly or monthly. (participant 8)

We should use drama, teaching all these chiefs, traditional leaders in the society and have an open discussion with them. (participant 5)

Thirdly, the interview revealed that the economic factors are greatly influencing the continuity of the tradition. Often FGM/C is sowei's only or at least the most significant source of income. If and when this tradition is to be broken; a new livelihood must be invented for this group of people.

Soweis are financially dependent on the ceremony. They stick to the tradition, since they say if there is no cutting, the rite has no same spiritual value as the one that involves cutting. They want blood…maybe if their livelihood could be guaranteed in some other way, perhaps then they would be ready to change. (participant 5)

In the community level economic factors are seen to have a negative impact on its residents. Some families have to raise money for several initiation ceremonies, and it is hindering their ability to earn a decent living and support the family. Several initiation ceremonies may have a negative influence on the development of the families. Having to spend a lot of money for initiation rites, it might affect their changes of progress as there will be no financial resources left for school and further education. (participants 2 and 4)

6.3 Summary of findings

Traditions that have been continued through the generations is one of the main reasons to sustain Female Genital Mutilation /Cutting. The findings of this study confirmed that myths, beliefs and spiritual signification in regards of this initiation ceremony are still strong and widely complied in Sierra Leone. Actively working traditional cutters have gained a strong position in the society and they seem to govern it largely through myths and beliefs. Finding a social status elsewhere or perform another culturally acceptable alternative procedure might encourage soweis to change their practice. The participants were also all aware of the economic significance of the initiation rite to its performer. There is a need to create a safe practice that does not involve cutting but which still allows soweis earn a steady income. The results of the study also reinforced the authors assumption that girl in order to become fully accepted member of the society, is under great social pressure to consent to the initiation ceremony. The increased level of knowledge in reproductive health issues was seen as empowering factor and it is also weakening the social pressure to undergo FGM/C. The awareness of FGM/C was widespread also among the male participants, despite the secret nature of the initiation ritual. The participants agreed that Female Genital Mutilation /Cutting has unfavourable impact on girls and women's life. As an alternative, a celebration that does not involve any cutting or harming to the girl was preferred. According to all the participants, becoming of a woman can be celebrated through joy and consideration rather that suffering. However, the participants were aware of the challenges in changing the life-long behaviour in their traditional communities as attitudes are more likely to change faster than practice. The enforcement of the existing Child Rights Act No 7 of 2007 was emphasized by all the participants. Leaders of the community, local by-laws and politically influenced actors as well as various organizations working against FGM/C and enhancing human rights should be actively engaged in enforcement of the existing laws. The participants of this study were willing to act as peer educators in their respective communities provided that their own safety is not compromised.

7. DISCUSSION

The result of this study shows that FGM/C is no longer self-evident and that several generations are willing to eradicate this damaging tradition. The disadvantages of FGM/C are widely recognized on both in the communities and in civil service level. The Government of Sierra Leone has had aspirations to root the practise of FGM/C in two occasions. After Ebola crises in 2014 and again separately in January 2019 there has been formal initiatives to ban the cutting in the initiation rites. Ministry of Social Welfare, Gender and Children's Affairs and Ministry of Local Government are aware of the problem and are working on toward the alternative rite. The Child Rights Act No 7 of 2007 is at present the only act where causing the bodily harm for a child is criminalized. Making that act more known and sensitize the communities is one of the common goals the Government and various organizations have. Due to strong and lengthy history of FGM/C, there are plenty of challenges in eradicating the tradition. Work is progressing slowly, however those responsible for communities social and health issues are willing to try and root these health threats (F.C. Kaikai 2019, personal communication 22 May; F. Kalokoh 2019, personal communication, 21 May).

Changing attitudes and behaviour requires a reasoned action approach, which in turn may lead to a desired change in health behaviour. The increased level of awareness is creating a positive atmosphere to behavioural change in Sierra Leone. The nature of the topic being delicate, the action toward a behavioural change must be carefully prepared. When planning on intervention, it is important to bear in mind that the key role is for the participants and the implementation should not be strict pre-determined rules of conduct but tailored to the needs and circumstances of the participants. The safety of the volunteers delivering the training was a noteworthy aspect that resulted from the interview. FGM/C is still a highly sensitive topic and any training or sensitization should be carefully considered. The security must be top priority before a new program is introduced. This should be done by seeking an approval from the community leaders and possibly also from soweis before the activity.

At the end of focus group discussion/ interview the participants were asked if they had any additional questions or comments, or if they wanted to highlight some issues regarding FGM/C that had not been addressed during the focus group discussion / interview. All the participants were aware of the ban announced by Minister of Local Government and Rural Development

in January 2019. In the letter he stated that Sierra Leone had banned FGM initiation country-wide as a part of wider clampdown of secret societies. However, the ban seems not to be enforced and one reason is considered to be the strong influence and the power the secret societies are still having in the region (F.C. Kaikai 2019, personal communication 22 May; Thomson Reuters Foundation ed., 2018). The other issue the participants wanted to emphasize was that basic human rights needs to be adhered to. FGM/C has no positive health effects and it may lead to severe lifelong symptoms and mental distress, therefore it is important to address the issue also in the higher political level.

As previous studies show, eradicating female genital mutilation / cutting is difficult. Nonetheless, as successful "Saleema-project" demonstrates, the change of behaviour is possible. Saleema can be translated as being physically and emotionally intact or whole. Campaign was developed to change the social norms and create positive associations to alternative, healthier behaviour (UNICEF, 2016b; Johnson et al., 2018). The author of this study seeks to investigate other alternatives to FGM/C as a passage to womanhood in Sierra Leone. The results indicated that the tradition is powerful. Above all, reliable and well-researched information is needed to stimulate the change of behaviour. Sensitizing and thus educating the whole community appears to be the key here. Behavior change is often slow and time consuming, however, according to Pashaei et al., (2016) and Sagna (2012) awareness raising has had positive impact on planned behaviour. Setegn et al., (2016) and Waigwa et al., (2018) concluded that cultural, socio-demographic, economic and religious factors needs to take into account when planning interventions against FGM. The findings of this study are in line with the literature and earlier studies. Education seems to play major role in changing this harmful tradition. As established from previous studies the more educated people were, the more likely they were prepared to reject this tradition (Klein et al., 2018; Statistics Sierra Leone [SSL] and IFC International 2014; Pashaei et al., 2016; Varol et al., 2015). In the study among Ethiopians Abathun et al., (2016) concluded that young generation on men was willing to marry uncut girls as opposed to those undergone FGM/C. Therefore, a women-centred approach in behavioural change communication is culturally appropriate, as was also indicated by the participants of this study.

Knowledge of possible health consequences was widely recognized among the participants. Most of the female participants reported some physical complications after the FGM/C. Male participants were also aware of the immediate and long-term effects of the operation. Similar

results have reported by Bjälkander et al., (2012). In their study 84,5% suffered physical complications such as excessive bleeding or incomplete healing. The tragic effects on women's health and wellbeing are at times under-reported. Immediate and long-term complications as well as obstetric difficulties are represented in previous studies. The negative impacts on sexual life and women's psychological health, hygiene and safety were also noted in earlier surveys (Klein et al., 2018; Devi, 2018; Andro and Lesclingand, 2016; Naalaki, 2014; WHO, 2016a).

Results of this study showed that social pressure and need to be accepted in the community was one of the major factors for the participants to consent for FGM/C. The need to be respected and to be part of a group is a forceful contributor and may prevent from doing decisions that would be more beneficial to one's health (Pashaei et al., 2016; Sipsma et al., 2012).

8. CONCLUSIONS

The tradition of FGM/C is tied to culture and beliefs. There is no religion that requires genital mutilation, however sometimes the old scripts may be interpreted that way. Socio-economic pressure and control of sexual behavior are often reasons for FGM/C. To be a fully accepted community member, to be respected by peers and the eagerness of the parents to protect their child from being rejected are common reasons this practice continues. The author's initial assumption that girls are under a great social pressure from their peers was confirmed by the participants.

According to the participants of this study, some of the soweis see the requests to abandon the practice of FGM/C as an attack on their ancient entrenched culture in Sierra Leone. Soweis view the cutting as an attempt to protect the community against evil spirits. FGM/C is regarded as a passage to womanhood. The results of this study show that the main reasons for the FGM/C are beliefs and traditions, however it also provides an important income for the traditional cutters. Therefore, the most effective means to eradicate the practice are to find an alternative rite for transition to womanhood and/or to create another livelihood for the cutters. At the same time; it is important to increase public awareness in the communities and to intensify cooperation between authorities and law enforcement. All participants, both male and female were eager to end this practise as they were unwilling to subject their children to FGM/C. Negative personal experiences, health concerns and family members /religious leaders opposing the procedure are seen as hindering factors and it could be used as a driving force to stop this practise. The participants also identified the key individuals in the community who are responsible for continuation of the tradition and to whom the sensitization should be addressed to.

8.1 Strengths and limitations

When defining the reliability of qualitative study, the criteria includes '*credibility, transferability, dependability, and conformability'* (Korstjens and Moser, 2017, p.120). The ongoing scrutiny of every phase of the process, from the preparation of the study to the reporting is vital, as the researcher needs to demonstrate the trustworthiness of the study (Elo et al., 2014; Korstjens and Moser, 2017). In order to give the reader a clear perception of the process of

analysis, as well as its limitations, the results must be described in adequate details (Bengtsson, 2106; Elo et al., 2014) .

Some researchers argue that a researcher should explore the relevant literature on the subject prior to the analysis in order to became more receptive to various nuances that you may encounter when analyzing the data. Others argue that previous literature may narrow your vision and lead you to focus on some elements at the expense of others (Braun and Clarke, 2006; Tuckett, 2005). In order to avoid the pitfalls of relying too much of the previous studies the author decided to follow the guidelines provided by Braun and Clarke (2006) to analyze the data (appendix 6, phases table 1, criteria table 2).

Purposive or snowball sampling was chosen for this study. The downside in this method is, that there might be sampling bias, i.e. over-or under- representation of particular group of population (Masadeh, 2012; Polit and Beck, 2012; Tong et al., 2007; Hirsjärvi and Hurme, 2011; Elo et al., 2014). The participants of the Focus Group Interview were selected from the volunteers of the SLRCS. One of the limitations can be seen that since the SLRCS volunteers were selected for the interview, we cannot generalize the results for the entire population. The selection was made by the Health Field Officer from SLRCS. This might be seen as weakness of the study, since they are all working as volunteers, and are familiar with different health interventions in their respective areas. However, the SLRCS has not yet had any health interventions or training on the subject of FGM/C. The aim was to interview two groups, one all-female and one all-male group. As male interviewees proved to be difficult to find, a focus group discussion/ interview was conducted with two female groups; one with five (originally six) members (group A) and another with three members (group B). I addition to that, two men were interviewed as one group (group C). In the literature the size of the focus group can vary greatly, being usually from 4 to 12 participants (Maladon-Maldonado, 2014; Polit and Beck, 2012). In this study the two groups are smaller, which can be seen as weakness, as they are too small for generalization. In any case, the researcher decided to include these groups as well, as they added important insight into the current attitude towards FGM/C. As one female chosen in group A had earlier participated on the IFRCs FGM- sensitizing workshop, consequently her answers were excluded, nonetheless she was providing valuable background information and observations on the phenomenon in her community.

The SLRCS CEA Officer's ability to translate when needed, proved to be valuable for the researcher as at times some of the participants were more at ease when using their native language. All participants understood English and the interviewer clarified the answers during the interview to avoid possible misunderstandings.

To ensure the reliable information gathered for the background, the relevant literature was reviewed prior to the focus group interviews. The literature search included academic articles written from 2012 to 2019. The author conducted library searches from Arcada Finna (Arcada University of Applied Sciences) and DIAK Finna (Diaconia University of Applied Sciences). Academic, peer reviewed articles were written in English. Some of the other documents and guidelines used in this study are from internationally recognized reliable sources, such as International Federation of the Red Cross and Red Crescent Societies (IFRC), United Nation's Populations Fund, United Nations Children's Fund, Terveyden ja Hyvinvoinnin laitos (THL), World Health Organization and Thomson Reuters Foundation. The literature search took place from autumn 2018 to summer 2019. Boolean phrases were utilized for word combination while different database searches were made. (see appendix 5).

At times it was difficult to theme the data due to overlapping phenomena. The themes and interpretation of the data are author's own and the results may differ from other qualitative studies and thus may not be generalized.

8.2 Recommendations

After the interviews and as the analysis progressed, the author became increasingly aware the power of the symbolism and myths surrounding the topic. In Sierra Leone FGM/C is still regarded as a sensitive topic, however in the future it might be useful to look even more closely at the causes and justification of these harmful traditions.

One of the aims of this study was to find methods to identify alternative rites for FGM/C in order to produce the base-line indicators for the future RCRC programmes regarding FGM/C training. The results of the study confirm that although the initiation is done secretly, the level of knowledge among the participants is sufficient, and that they are interested to be trained as peer educators in their communities. Both men and women were aware of the health risks posed by FGM/C. The author was surprised by the level of knowledge men had regarding the initiation. Although the vigorous attempts are made to keep the initiation rite secret, information

seeps out to family members and serious health threats are not overlooked. The sensitization process should start from the community elders and religious leaders. Various types of community involvements should start only after consulting the leaders. The means of sensitization could be regularly held "health talks" in the town hall or local health post and joint discussions with the political representatives. Means of stimulating the behavioural change could be drama and storytelling, methods that are already widely used and accepted in Sierra Leone. According to the participants, mass media was not considered as first option when increasing the level of awareness among the community members.

The International Federation of the Red Cross and Red Crescent Societies (IFRC) is committed to strengthen the capacity of Sierra Leone Red Cross Society (SLRCS). The plan is aligned to Sustainable Development Goals, such as SDG 3, On Better Health (IFRC, 2019). IFRC has been involved in training in Sierra Leone for several decades. The Community Based Health and First Aid in Action (CBHFA) training curriculum is structured and developed in cooperation with the national RCRC societies. CBHFA is an approach where the communities themselves assess their needs and work together in order to reach the desired goals (IFRC, nd; H.Virtanen 2018, personal communication, 18 October).The curriculum usually defines the objectives, structure and content of training. It includes goals, scope and precondition. As the IFRC already has a logistical framework on CBHFA training in Sierra Leone, there are aspirations to include FGM/C in that training. The findings of this study suggest that FGM/C could be included in an existing objective number 2: *Increased Access to and Utilization of Reproductive, Maternal and Child Health* (IFRC, n.d). The Objective could be in the lines of an increased awareness in FGM/C and access to health services, the indicators could show the number of different stakeholders such as volunteers, teachers and community leaders sensitised. The methods of verifications could be reports produced and written plans of e.g. drama sessions and health talks.

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Appendix 1/1(2)

FINNISH RED CROSS. INTERNATIONAL AID

REQUEST FOR ETHICAL PERMISSION FOR IMPLEMENTATION OF THE STUDY, IN SIERRA LEONE WITH RCRC VOLUNTEERS

I, Kaija Ilkka, am studying at the Arcada University of Applied Sciences in the Master's Degree programme of Global Health Care. The studies include writing a master's thesis and after scoping literature review I plan to conduct a focus group interview among the volunteers of the IFRC in Sierra Leone.

The aim of the study: The aim of this qualitative study is to gain understanding of suitable methods to help communities to eradicate Female Genital Mutilation/ Cutting in their communities. The aim is also to develop the base line indicators to measure the progress of health projects in supporting the elimination of FGM/C.

Background and usefulness of the study: Female Genital Mutilation / Cutting (FGM/C) has been an ongoing practice in many countries for decades. FGM/C is known to be a destructive practice that has negative health impacts on female gender. There has been both an international and national aspirations to eradicate this damaging tradition. The topic is sensitive, however the author considered important to examine what would be the best practices to eliminate FGM/C and consequently improve women's health.

This study focuses on finding evidence-based methods in eliminating this harmful practice. The main purpose of the study is to sum up the best practices through scoping literature review. The data collected will be serve as a base line for later use in creating a tool that can be utilize in the communities during their health interventions. This study is conducted in cooperation with the Finnish Red Cross. The topic of FGM/C is recently included in the new Mother and Child Health (MCH) module in the Volunteer Manual of Community Based First Aid and Health in Action (CBFHA). This study is based on existing literature of previous interventions and documents of organizations who are endeavoring to eradicate FGM/C. To gain knowledge of existing perception of the matter, there is also a plan to conduct a focus group interview in one of the communities in Sierra Leone.

Description and time schedule of the study: This is a qualitative study and the data will be collected during focus group interviews with open ended questions. (appendix 4) The interviews will be conducted in Sierra Leone in May 2019. The interviews will be recorded, transcribed and analyzed and data will be destroyed at the end of the study. The interviews will be conducted in English. Content analysis will be used as the analysis method. The analysis will start in May 2019 and the thesis will be finished in December 2019.

Practical approach of the study: The writer has established the contact with the Finnish Red Cross Programme Support Delegate in Freetown, Sierra Leone. She will contact the SLRCS Field Health Officer, who is working in Bo community and she will select the informants in the study. The purpose and information of the study is provided to the participants in a letter. (appendix 2) The consent form (appendix 3) is sent to the participants via the SLRCS Field Health Officer in Sierra Leone. The researcher will take ethical aspects in consideration. The informants will be informed of the principle of voluntariness, confidentiality, anonymity and usefulness of the study. The information collected by interview is also discussed in the information letter.

Inclusion criteria: The informants have to be volunteers of the Red Cross Society in Sierra Leone that have not previously received training on the subject in question.

The supervisor of the study is PhD Pamela Gray at Arcada University of Applied Sciences. Contact details: email and telephone number.

Appendix 1/2(2)

I have read the request for the ethical permission and I give my consent for the implementation of the study:

Place and date: _____

Signature: _____

Name clarification: _____

Pamela Gray, Supervisor, Arcada University of Applied Sciences

Place and date: _____

Signature: _____

Name clarification: _____

Hannele Virtanen, Senior Health Adviser of the Finnish Red Cross, Helsinki. April 25 2019

Kind regards

Place and date: _____

Signature: _____

Name clarification: _____

Kaija Ilkka, student

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Appendix 2

INFORMATION SHEET FOR PARTICIPATING IN THE RESEARCH

I, Kaija Ilkka, am studying at the Arcada University of Applied Sciences in the Master's Degree programme of Global Health Care. The studies include writing a master's thesis and after scoping literature review I plan to conduct a focus group interview among the volunteers of the IFRC in Sierra Leone. Focus group discussion/ interview is a one of the qualitative research methods. It is usually defined as structured conversation. The group size is small, usually 4-12 people. Moderator(s) start with general question before going to the key questions, which are open- ended. Participants are encouraged to interact with each other.

Female Genital Mutilation / Cutting (FGM/C) has been an on-going practice in many countries for decades. FGM/C is known to be a destructive practice that has negative health impacts on female gender. There have been both international and national aspirations to eradicate this damaging tradition. Even though the subject is very sensitive, the author considers it important to explore the possibilities of eradicating this practice and thus contribute to improving women's health

The aim of this qualitative study is to gain understanding of suitable methods to help communities to eradicate Female Genital Mutilation/ Cutting in their communities. This study focuses on finding evidence-based methods in eliminating this harmful practice. The main purpose of the study is to sum up the best practices to eradicate FGM/C. The data collected will be serve as a base line for later use in creating a tool that can be utilize in the communities during their health interventions. The topic of FGM/C is recently included in the new Mother and Child Health (MCH) module in the IFRC's Volunteer Manual of Community Based First Aid and Health in Action (CBFHA). To gain knowledge of existing perception of the matter, there is also a plan to conduct a focus group interview in one of the communities in Sierra Leone.

You have been asked to take part on this study. The data will be collected in May 2019 and the collection method is group interview. Interviews are held in English and there is a local SLRCS Field Officer who is able to translate in your local dialect should there be a need for that. Interviews are recorded and kept confidential. After the answers are written and analyzed, the data will be destroyed. Your confidentiality and anonymity is of utmost importance and guaranteed throughout the process. Participation of this study is optional, and you may interrupt the interview at any time without needing to explain it. The method of analysis will be a content analysis and the results will be published in the Master's Thesis in December 2019. The ethical acceptance of this study has been approved both by Finnish Red Cross and Arcada University of Applied Sciences.

Attached you find a consent form for participation of the study. Please sign it and send it to the SLRCS Field Health Officer xx no later than 19. May 2019. If possible, provide also a telephone number in which you can be contacted regarding the interview

Appendix 3

CONSENT FOR PARTICIPATING IN THE RESEARCH

I have been invited to participate in a thesis which is a part of a Master's Degree in Global Health Care program at Arcada University of Applied Sciences. The topic is Female Genital Mutilation/ Cutting - finding the best ways to eradicate this practice.

I have read and understood the information sheet provided to me. The provided sheet contains adequate information about the thesis, the data collection and the group interview process. The same information will also be provided to me orally before commencing the interview. I have been given enough time to consider participating in this thesis. The information is provided to me by Kaija Ilkka

The information collected from me during the interview will be kept and processed confidentially. I understand that my participation in the interview is voluntary and that I have the right to refuse or withdraw from the study at any time without having to explain the reasons. Refusal or the withdrawal of consent will not affect me in any way. I am aware that the results of the interview will be published anonymously in the Master's Thesis in December 2019 and the results can be used later in the development of health programs.

Place of interview: Bo community. Date of interview: 20.-21.May 2019

By signing, I confirm my participation in FGM/C- research and the related interview.

_____
Date

_____ _____

Signature Name clarification

_____

Telephone number

Send the signed consent form to the SLRCS Field Health Officer xx no later 19.May 2019

The consent form has been received

_____ _____ _____ _____

Signature of the author of the thesis
Kaija Ilkka Name clarification Date Telephone number and email address

Appendix 4

SEMI-STRUKTURED INTERVIEW QUIDE. RCRC VOLUNTEERS, SIERRA LEONE 4-2019

Topic: Female Genital Mutilation/Cutting. Finding the best practices to eradicate FGM/C

RESEARCH THEMES:

1. Based on the literature and previous interventions, what is the most effective method for the community to eliminate Female Genital Mutilation/Cutting?
2. Based on Focus Group Interview, is there an alternative rite that can be used in Sierra Leone instead of Female Genital Mutilation/ Cutting as a passage to womanhood?
3. Based on the individual interviews of health professionals, humanitarian workers, and authorities, would there be another acceptable method to celebrate the passage to womanhood?

The results for the first theme will be found in the literature reviewed prior to the interviews.

OPENING QUESTIONS IN THE FOCUS GROUP INTERVIEW / INDIVIDUAL INTERVIEW:

1. Please tell me what do you know about female genital mutilation/cutting?
   - Are you aware of any health implications after FGM/C?
2. Please tell me can you think of any alternative means to celebrate the girl's passage to womanhood.
   - Can you think of some specific reason why an alternative celebration would not be accepted?
3. Please tell me how do see the future in regards with FGM/C?
   - If you think FGM/C should be eradicated, do you think there would be means that the communities could be involved in ending the practice?

As the interview progresses, the author will ask specific questions about the subject, such as:

1. Have you, or your family member/relative experienced some health problems/ consequences due to FGM/C? What could be the benefits if the procedure would be ended?
2. Can you think of some specific reason why an alternative celebration would not be accepted?
3. Have you thought would you like to end this practice yourself? What kind of support would you need in doing that? Do you think there would be means that the communities themselves could be involved in ending the practice?

Appendix 5 Information search

Academic Search Premier (EBSCO) CINAHL®Fulltext (EBSCO)	fgm OR female genital mutilation OR female genital cutting OR female circumcision
	fgm AND eradication OR elimination AND ngo OR non-governmental organizations
	fgm AND eradication AND best practices OR guidelines OR evidence-based treatment
PubMed	fgm OR female genital mutilation OR female genital cutting OR female circumcision AND prevention of fgm
ProQuest- collection of databases	fgm OR female genital mutilation OR female genital cutting OR female circumcision
Google Scholar	fgm OR female genital mutilation OR female genital cutting OR female circumcision AND best practices OR guidelines OR evidence-based treatment

Database search included Academic Search Premier (EBSCO) Cinahl Fulltext (EBSCO), PubMed, ProQuest (collection of data base) and Google Scholar. In addition, the data was reviewed from World Health Organization (WHO), United Nations Children's Fund (UNICEF) and National Institute for Health and Welfare (THL) in Finland. Keywords were generated using Boolean logic. Inclusion and exclusion criteria were followed. Date restriction were imposed, searches were refined to articles written in English and published between 2012 to 2019. The Action Plan for the Prevention of Circumcision of Girls and Women 2012- 2016 (THL) was published in Finnish. Articles on other domains than FGM or those targeted exclusively to health care workers were excluded, such as studies conducted solely among migrant workers or asylum seekers in western countries were excluded. All articles were peer-reviewed or organizational guidelines. Results from searched database were screened for relevance and inclusion by titles and abstracts. Duplicates were removed. Articles with open access and suitable for inclusion were retrieved as full-text articles.

Appendix 6. Phases of thematic analyses and a 15-point checklist

Phases od thematic analysis. Braun,V. & Clarke,V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology, 3:2, 77-101.*

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

A 15-point checklist of criteria for good thematic analysis. Braun,V. & Clarke,V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology, 3:2, 96.*

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Appendix 7. An example of the analysis process (Modified according to Tuomi & Sarajärvi, 2018, p. 132; Bengtsson, 2016, p.11).

Original expression	Girls will be discriminated if they are not having the circumcision done. If you are not part of the society you are stigmatized. The peer group says you are not a complete woman…
Reduced expression	If you don't go through FGM/C, you are not accepted.
Code	Social and moral pressure
Sub-category	Fear of stigma, fear of not to be accepted to the community
Category	Social acceptance and respect
Theme	Causes of Female Genital Mutilation/ Cutting and current awareness of the tradition by Sierra Leone Red Cross volunteers