

COUNTRY PROFILE: FGM IN TANZANIA

December 2013



28 TOO MANY
FGM...
let's end it.



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Foreword

Collecting, documenting and sharing systematically checked data is vital if we are to effectively tackle harmful traditional practices, some of which are forms of child abuse. This needs to be combined with good processes for the identification of children at risk by empowered professionals who are held accountable for reporting cases and supporting those at risk and survivors. This is also the case for female genital mutilation (FGM): data is central to governments' and civil society's efforts to safeguard the rights of children and improve their lives, enabling them to fulfil their potentials.

The magnitude and persistence of FGM continues to shock those who come across it, as it affects vulnerable girls by violating their rights and entitlement to bodily integrity. Globally, more than 125 million women and girls have undergone FGM, and a further three million girls in Africa will undergo FGM annually if current trends continue. The practice affects women and girls in 28 African countries and some Middle Eastern and Asian countries. Due to international migration, it also affects diaspora communities in Europe, North America and Australasia.

This Country Profile of FGM across Tanzania discusses new research from our study visits and helps to investigate why, despite efforts to eradicate the practice, the overall prevalence of FGM in women aged 15–49 remained static at 14.6% between 2004–05 and 2010.¹

New evidence suggests that girls are undergoing FGM at a younger age. The percentage of those cut before the age of one increased from 28.4% in 2004–05 to 31.7% in 2010, with FGM more often being done in secret.² A change in the law has brought fear of prosecution and is driving the practice underground.

FGM is practised for a variety of reasons, often at a particular age and sometimes as a rite of passage. Up-to-date evidence is required to understand the rationale for the practice and how that is changing in different communities due to social dynamics and influencers. This data can then inform government policies and legislative changes; enhance innovative programme design and implementation; improve the monitoring of progress towards abandonment; and aid the sharing of good practice and successful models of change. For example, one reason for the practise of FGM is the belief that it cures a bacterial infection, *lawalawa* (a belief that only took hold after laws against FGM were introduced). This belief needs addressing through teaching and retraining.

FGM affects both the physical and psychological health of girls, directly impacting their attendance and performance at school. This in turn impacts their right to equality, economic potential and security. Girls often have lower literacy rates and are pressured into early marriages. They are vulnerable to HIV/AIDS transmission and childbirth complications such as obstructed fistulae, yet often have poor access to healthcare.

Since my first trip to Africa in 2001, I have made visits to seven African countries and communities in Asia, the Middle East, USA and Australia that have migrant communities that practise FGM. Over ten years working to end FGM, I have never met a girl who was pleased that she was cut. Every one that I met regretted it and wished she had been left physically intact.

During our research in Tanzania, anti-FGM campaigner Mary Laiza shared her story with us and explained why she is now committed to protecting others from FGM. Mary, a Maasai, had FGM when she was 14 years old.

'My mother told me that FGM was important for my family's dignity, bringing glory and respect to my parents, and that after FGM I would gain higher status and recognition in the community and be able to marry a rich, respected and caring husband.'

The reality of FGM was, however, very different to what her mother had told her. Mary recalls the day of her cutting:

'The cutting does not involve the application of anything that can help minimise pain. I believed I was in grave danger and almost dying.'

Mary was married to a Maasai husband when she was 19 years old. She did not enjoy sex with her husband, but was told by her mother that this was normal. When she was about to give birth to her first daughter, she was told by nurses that she could not deliver her baby safely without medical help because of the FGM. Mary had three children with her husband, but then he abandoned her and moved away.

Through working with World Vision, Mary began to learn more about FGM and the harm it causes. She also became aware that in some communities FGM was being abandoned and girls were having alternative rites of passage (ARP) ceremonies instead. When her daughter reached the age at which Maasai girls are cut, Mary decided that her daughter should have an ARP instead of FGM.

'I informed my parents, my in-laws and my relatives about my decision. I then invited the district commissioner, a member of the parliament, ward councillor, ward executive officer, village chairman, political leaders, religious leaders, traditionalists, traditional Maasai elders and excisors. They all attended and witnessed how I was doing an ARP to my daughter. My daughter is now in her final year at school and I hope she goes to university next year.'



*Mary Laiza with Maasai women
(© 28 Too Many)*

Mary now works for the Tanzania Education and Micro-Business Opportunity Trust, educating local schools about FGM.

One of the highlights for me this year has been to hear how FGM research we undertook for the international non-governmental organisation (NGO) Tearfund has led to opportunities to share with 75 stakeholders, including the Government, NGOs, activists and 25 faith leaders. It is hoped that an action plan building on their experience will shape communities' responses to FGM and lead them to support survivors. This will directly impact efforts to bring about the abandonment of FGM in Tanzania by making sustainable changes to knowledge, attitudes and practices.

This new research, Mary's story and Tearfund's Action Plan give hope in some areas and enable focused attention on the areas in which there is the greatest need. We look forward to seeing future progress, and I look forward to seeing what further progress has been made when I visit Tanzania in 2014.

Dr Ann-Marie Wilson
28 Too Many Executive Director

1 - DHS 2004–05, p.248.
- DHS 2010, p.296.
2 DHS 2010, p.298.

Information on Country Profiles

Background

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

Purpose

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

Use of this Country Profile

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

Acknowledgements

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

The 2013 Team

Producing a Country Profile such as this is a collaborative process. We are very grateful to the following key contributors:

Katherine Allen is a research intern for 28 Too Many and a DPhil (PhD) student in the history of medicine and science at the University of Oxford.

Lisa Glass is a research volunteer for 28 Too Many and a freelance writer, editor and blogger on various issues, focussing on gender inequality and women's healthcare.

Gosbert Lwentaro is a research consultant for 28 Too Many. He has a BA in Culture and Heritage from the University of Dar es Salaam in Tanzania and a Postgraduate Certificate in Project Cycle Management from MDF Training and Consultancy in the Netherlands. He has six years' practical working experience as a professional development practitioner based in Tanzania.

Ruth Samuels is a research volunteer for 28 Too Many. She completed an MA in Development and Rights at Goldsmiths College, the University of London. She has since worked for The Salvation Army International Development UK (SAID UK) as project support coordinator, a role which has taken her to Zambia, India and Nepal.

Johanna Waritay is research coordinator for 28 Too Many. Prior to this, she worked for 13 years as a lawyer at a leading international law firm in London. She has carried out research in three countries that practise FGM.

Ann-Marie Wilson founded 28 Too Many and is the executive director. The *Journal of Gender Studies* published in 2012 her paper, 'Can lessons be learnt from eradicating foot-binding in China and applied to abandoning female genital mutilation in Somalia? A critical evaluation of the possibilities offered for developing strategies to expand current promising practice.'

Rooted Support Ltd donated time through its director, Nich Bull, in the design and layout of the original version of this Country Profile (www.rootedsupport.co.uk).

We are grateful to the rest of the 28 Too Many Team, who have helped in many ways.

We are also grateful to **Tearfund**, who kindly gave us permission to reference its study, *Working to end Female Genital Mutilation and Cutting in Tanzania – the Role and Response of the Church*, for which they commissioned 28 Too Many (referenced as Johanna Waritay and Dr Ann-Marie Wilson).

Photograph on front cover: Maasai women in line, @www.lafforgue.com.

Please note the use of a photograph of any girl or woman in this Country Profile does not imply that she has, nor has not, undergone FGM.

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List of Abbreviations

INGO and NGO acronyms are found in the International, National and Local Organisations sections towards the end of this Country Profile

AIDS	Acquired Immunodeficiency Syndrome
ARP	alternative rites of passage
CBO	community-based organisation
CCM	Chama Cha Mapinduzi (political party)
CCMP	church and community mobilisation process
CEDAW	Convention on the Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
DHS	Demographic Health Survey
FBO	faith-based organisation
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
HTP	harmful traditional practice
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
IAC	Inter-African Committee on Traditional Practices
IAGG	UN Inter-agency Gender Group
LHRC	Legal and Human Rights Centre
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PEER	participatory ethnographic evaluation and research
PPP	Public Private Partnership
SIGI	Social Institutions and Gender Index
STD	sexually transmitted disease
TANU	Tanganyika African National Union
UN	United Nations
UNDAP	UN Development Assistance Plan
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VICOBA	Village Community Banks
WDCG	Women Development Children and Gender
WHO	World Health Organization

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 1996' refers to:

Bureau of Statistics [Tanzania] and Macro International Inc. (1997) *Tanzania Demographic and Health Survey 1996*. Calverton, Maryland: Bureau of Statistics and Macro International. Available at <https://dhsprogram.com/pubs/pdf/FR83/FR83.pdf>.

'DHS 2004–05' refers to:

National Bureau of Statistics (NBS) [Tanzania] and ORC Macro (2005) *Tanzania Demographic and Health Survey 2004–05*. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro. Available at <https://dhsprogram.com/pubs/pdf/FR173/FR173-TZ04-05.pdf>.

'DHS 2010' refers to:

National Bureau of Statistics (NBS) [Tanzania] and ICF Macro (2011) *Tanzania Demographic and Health Survey 2010*. Dar es Salaam, Tanzania: NBS and ICF Macro. Available at [https://dhsprogram.com/pubs/pdf/FR243/FR243\[24June2011\].pdf](https://dhsprogram.com/pubs/pdf/FR243/FR243[24June2011].pdf).

A Note on Data

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

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the Demographic and Health Survey (*DHS*) and the Multiple Indicator Cluster Survey (*MICS*). The surveys used in this Country Profile, however, are all from the DHS.

The DHS data does not directly measure the FGM status of girls aged 0–14, although pre-2010 surveys asked women whether they had at least one daughter with FGM. However, this data cannot be used to accurately estimate the prevalence of FGM in girls under the age of 15. From 2010, the DHS methodology changed so that women are now asked the FGM status of all their daughters under 10 or 15 years, depending on the country. Analysing FGM among girls in this age group, who have most recently undergone FGM or are at most imminent risk of undergoing FGM, gives an indicator of the impact of current efforts to end FGM (and potentially the effect of laws criminalising the practice). However, unless they are adjusted, these figures do not take into account the fact that these girls may still be vulnerable to FGM after the age of 14.

It is also important to note that, because of the large number of regions in Tanzania, the number of women surveyed in some regions may have been small. Therefore, any breakdowns of the data according to region should be interpreted with caution.

Executive Summary

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

It is estimated that 7.9 million women and girls in Tanzania have undergone FGM.¹ According to the Tanzania Demographic and Health Survey 2010 (*DHS 2010*), **the prevalence of FGM in women (aged 15–49) is 14.6%.**² This figure has not changed from 2004–05, when that DHS survey found the same figure, but it has decreased by 3.3 percentage points from 17.9% at the time of the DHS in 1996.³

While in both **rural and urban areas** there has been a reduction in prevalence since 1996, the percentage of women who have undergone FGM in rural areas has continued to be at least double (17.3%) the percentage of women in urban areas (7.8%).⁴

FGM is **most prevalent** in the Central (58.8%) and Northern (37.8%) zones, and women living in these zones are also the most likely to have at least one daughter who has been cut and to intend to have their daughter(s) undergo FGM. The Southern (0.9%) and Western (1.7%) zones and Zanzibar (0.2%) have the **lowest prevalence.**⁵

However, prevalence may vary widely between **different ethnic groups** living within the same region, and this is not reflected in the DHS reports, which do not collect data according to ethnicity. For example in Mara, FGM prevalence is high (possibly as high as 75%) among the Kuria ethnic group, but much lower among others. Among the practising ethnic groups profiled in this report are the Nyaturu, Gogo, Maasai, Pare, Kuria and Hadza.

Of those women aged 15–49 who have undergone a **type of FGM**, 90.9% have been cut with flesh removed. 2.2% have been cut with no flesh removed and 0.7% have been 'sewn closed' (Type III FGM/infibulation).⁶

While there was little change reported in **the age at which women and girls are cut** between the DHS 2004–05 and the DHS 2010, a look back at the DHS 1996 does indicate that girls are now being cut at a younger age.⁷ Other studies have suggested similarly, and noted that this change may be attributable, at least in part, to the abrupt nature of attempts to abolish FGM which started in the 1970s following the Arusha declaration (President Nyere's statement of Unjuuma, or brotherhood).⁸ This coincided with the emergence of **lawalawa**, a disease believed to be a curse from the ancestors that could only be cured by FGM. This disorder is in fact easily treatable vaginal or urinary tract infections, but has become a pretext among some ethnic groups under which to continue performing FGM, although on infants and amid much secrecy.

Of the regions that practise FGM, those that are predominantly **Christian** appear to have the highest proportion of women who have had FGM.⁹ There does not appear to be a strong connection between **Islam and FGM** in Tanzania; a number of ethnic groups that practise Islam do

not practise FGM. Some Muslims, however, reportedly perform a 'lesser' form of FGM, referring to it as *sunna* (sunna is the body of traditional sayings and customs attributed to the Prophet Muhammad and supplementing the Koran), suggesting a link in some cases. There also appears to be a link between **traditional animist beliefs** and FGM among the Kuria in Mara.

In Tanzania, FGM is most frequently **carried out by traditional practitioners** within communities, called *ngaribas* in Kiswahili. While the DHS data does not suggest a trend towards medicalisation, there are reports that, in urban areas, FGM is sometimes performed by health personnel such as midwives and doctors.¹⁰

While traditionally FGM was carried out as a rite of passage into womanhood and linked to bride-prices, the trend among some ethnic groups (for example, the Nyaturu, Gogo and Maasai) is towards cutting much younger girls, and often newborn babies. This reflects **how the practice of FGM adapts** to modern circumstances, including legislation and changing social perceptions.

In one region in Manyara (the Manjaro district), it was discovered that, after FGM had taken place, the flesh was being dried and sold as **charms** to traders. It was found that even old women were undergoing FGM to supply this trade.

The continuation of FGM is supported by 5.5% of women aged 15–49 who know about the practice, and the majority of **support** comes from women living in rural areas. The highest proportion of support for the continuation of FGM comes from Lake zone, where 10.9% of women support the practice. Opposition to FGM tends to be more common among the wealthier, more educated sections of Tanzanian society, but, overall, 91.9% of women believe that the practice should be discontinued.¹¹

A number of measures have been used to **combat FGM** in Tanzania. The parliament of Tanzania passed an amendment to the Penal Code to specifically prohibit FGM, but this only applies to minors (those under 18 years of age). The Government also has a National Plan of Action to Combat FGM for 2001–2015. There have been prosecutions of persons found carrying out FGM; however, evidence suggests that the fear of prosecution is driving the practice underground in some regions and, in areas such as Mara, mass FGM ceremonies still take place with little or no legal repercussions.

There are a number of NGOs working to combat FGM and undertaking a variety of strategies, including educating about health risks and human rights, tackling women's empowerment, providing alternative sources of income for traditional cutters and providing safe refuges for girls fleeing FGM.

There is **a need for further research and up-to-date data on FGM** that includes infants and girls under 15 years of age, so as to capture recent trends, especially given the trend of cutting infants.

28 Too Many proposes that the following measures be taken:

- adopting culturally relevant programmes;
- implementing sustainable funding;
- considering FGM within the Millennium Development Goals and any post-MDG framework;
- facilitating education;
- improving access to health facilities and the management of any health complications of FGM and lawalawa;
- increasing advocacy and lobbying;
- increasing law enforcement;
- fostering the further development of effective media campaigns;
- encouraging faith-based organisations to act as agents of change and be proactive in ending FGM;
- increasing collaborative projects and networking; and
- conducting further research.

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- 1 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, opening pages. Available at https://www.unicef.org/publications/index_69875.html.
 - 2 National Bureau of Statistics (NBS) [Tanzania] and ICF Macro (2011) *Tanzania Demographic and Health Survey 2010*, p.296. Dar es Salaam, Tanzania: NBS and ICF Macro. Available at [https://dhsprogram.com/pubs/pdf/FR243/FR243\[24June2011\].pdf](https://dhsprogram.com/pubs/pdf/FR243/FR243[24June2011].pdf). **[Referred to hereinafter as the 'DHS 2010'.]**
 - 3 - National Bureau of Statistics (NBS) [Tanzania] and ORC Macro (2005) *Tanzania Demographic and Health Survey 2004–05*, p.250. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro. Available at <https://dhsprogram.com/pubs/pdf/FR173/FR173-TZ04-05.pdf>. **[Referred to hereinafter as the 'DHS 2004–05'.]**
- Bureau of Statistics [Tanzania] and Macro International Inc. (1997) *Tanzania Demographic and Health Survey 1996*, p.168. Calverton, Maryland: Bureau of Statistics and Macro International. Available at <https://dhsprogram.com/pubs/pdf/FR83/FR83.pdf>. **[Referred to hereinafter as the 'DHS 1996'.]**
 - 4 DHS 2010, p.296.
 - 5 DHS 2010, p.299.
 - 6 DHS 2010, p.296.
 - 7 - DHS 2010, p.298–300.
- DHS 2004–05, p.252 & 254.
- DHS 1996, p.169.
 - 8 See for example Chiku Ali and Agnete Strøm (2012) “It is important to know that before, there was no lawalawa.” Working to stop female genital mutilation in Tanzania’, *Reproduction Health Matters* 2012(20), pp.69–75.
 - 9 DHS 2004–05, p.205.
 - 10 - Sosthenes Mwita (2013) ‘Tanzania: FGM Remains Quite Dangerous to Health’, *Tanzania Daily News*, 28 October. Available at <https://allafrica.com/stories/201310280010.html>.
- DHS 2004-05, p.254.
 - 11 DHS 2010, p.301.

Introduction

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

~ The General Assembly of the United Nations¹

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (FGM) is defined by the World Health Organization (WHO)² as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.³

History of FGM

FGM has been practised for over 2,000 years.⁴ Although it has obscure origins, there has been anthropological and historical research conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision'.⁵ Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'⁶.

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently among different peoples⁷, aided by Egyptian slave raids from Sudan for concubines and the trading of maids through the Red Sea to the Persian Gulf⁸.

Global FGM Prevalence and Practices

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

The WHO¹⁰ classifies FGM into four types:

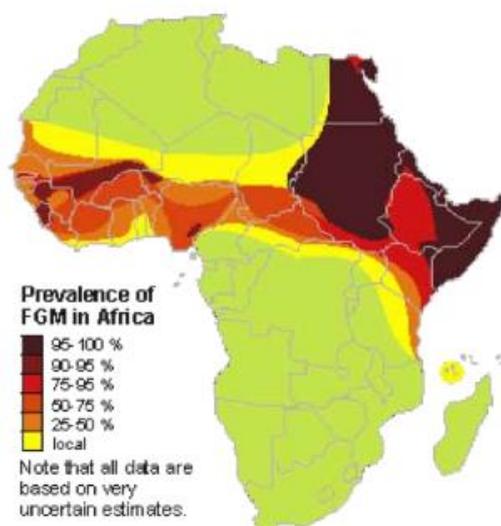


Figure 1: Prevalence of FGM in Africa⁹

Type I	Partial or total removal of the [external] clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.]
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
Re-infibulation	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

Table 1: Types of FGM as classified by the WHO

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

FGM is always traumatic.¹¹ Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, psychological problems, infertility, an increased risk of newborn deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.¹²

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we connect with many anti-FGM campaigners, community-based organisations (CBOs), policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally and internationally.

1 UN General Assembly (2009) *The girl child: report of the Secretary-General*, p.17. Available at <http://www.refworld.org/docid/4ac9ac552.html>.

2 World Health Organization (2015) *Female Genital Mutilation*. Available at http://www.who.int/topics/female_genital_mutilation/en/.

3 UNICEF (2016) *Female Genital Mutilation/Cutting: A Global Concern*, p.2. Available at http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf (accessed June 2016).

4 Alison T. Slack (1988) 'Female Circumcision: A Critical Approach', *Human Rights Quarterly*, Vol. 10, p.439.

5 *Ibid.*, p.444.

6 Lightfoot-Klein cited in Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22:1, p.4. Available at <http://dx.doi.org/10.1080/09589236.2012.681182>.

7 *Ibid.*

8 Mackie cited in Ann-Marie Wilson, *op. cit.*

9 *Afrol News* [no longer available].

10 World Health Organization (2016) *WHO guidelines on the management of health complications from female genital mutilation*, pp.2-4. Available at <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (accessed 18 June 2017).

11 *Ibid.*, p.1.

12 *Ibid.*, p.vii.

General National Statistics

This section highlights a number of indicators of Tanzania's context and development status.

Population

48,261,942 (July 2013 est.)

Median age: 17.3 years

Growth rate: 2.82% (2013 est.)

Human Development Index

Rank: 152 out of 186 in 2012¹

Health

Life expectancy at birth (years): 60.76

Infant mortality rate (deaths per 1,000 live births): 45.1

Maternal mortality rate (deaths per 100,000 live births): 460 (2010)
(country comparison to the world: 22)

Fertility rate, total (births per woman): 5.01 (2013 est.)

HIV/AIDS – adult prevalence: 5.6% (2009 est.)

– people living with HIV/AIDS: 1.4 million (2009 est.)
(country comparison to the world: 6)

– deaths: 86,000 (2009 est.)

Literacy (percentage age 15 and over who can read and write)

Total population: 67.8% (female: 60.8%; male: 75.5%) (2010 est.)

Total youth population (15–24): 77.3% (female: 76.5%; male: 78.2%) (2013)²

GDP (in US dollars)

GDP (official exchange rate): \$28.25 billion (2012 est.)

GDP per capita (PPP): \$1,600 (2012 est.)

GDP (real growth rate): 6.9% (2012 est.)

Urbanisation

Urban population: 26.7% of total population (2011)

Rate of urbanisation: 4.77% annual rate of change (2010–15 est.)

Ethnic Groups

Mainland – African 99% (of which 95% are Bantu consisting of more than 130 tribes), other 1% (consisting of Asian, European, and Arab).

Zanzibar – Arab, African, mixed Arab and African.

Religions

Mainland – Christian 30%, Muslim 35%, indigenous beliefs 35%.

Zanzibar – more than 99% Muslim (see section on Religion below).

Languages

Kiswahili or Swahili (official), Kiunguja (name for Swahili in Zanzibar), English (official, primary language of commerce, administration, and higher education), Arabic (widely spoken in Zanzibar), and many local languages.

Unless otherwise noted, all citations from Central Intelligence Agency (2013) *The World Factbook: Tanzania*. Available at <https://www.cia.gov/Library/publications/the-world-factbook/geos/tz.html>.

1 UN Development Programme (2013) *Human Development Indicators: Tanzania*. Available at <http://hdr.undp.org/en/countries/profiles/SLE>.

2 The World Bank (2013) *Literacy rate, youth total (% of people ages 15-24): Tanzania*. Available at <https://data.worldbank.org/indicator/SE.ADT.1524.LT.ZS?locations=TZ>.

National FGM Trends

This section gives a broad picture of the state of FGM in Tanzania. The following sections of the report give more detailed analyses of FGM and efforts at eradication, set within sociological and anthropological frameworks.

UNICEF calculates that 7.9 million women and girls in Tanzania have undergone FGM.¹

The prevalence of FGM in women aged 15–49 is 14.6%.² This figure has not changed from 2004–05, when that DHS survey found the same figure, but has decreased by 3.3 percentage points from 17.9% at the time of the DHS 1996.³

Tanzania is classified as a Group 4, 'low prevalence' country, according to UNICEF's classifications. Group 4 countries have a prevalence of between 10% and 25%.⁴

Prevalence of FGM According to Age

Figure 2 shows the prevalence in women of different age-groups in 2010, 2004–05 and 1996. In all three datasets the prevalence is much lower in younger age-groups; for example, 7.1% of women aged 15–19 had been cut compared to 21.5% of women aged 45–49 (2010 data). This supports the argument that the practice has become less common in recent years; however, the issue of under-reporting of FGM should also be held in mind when considering the data.

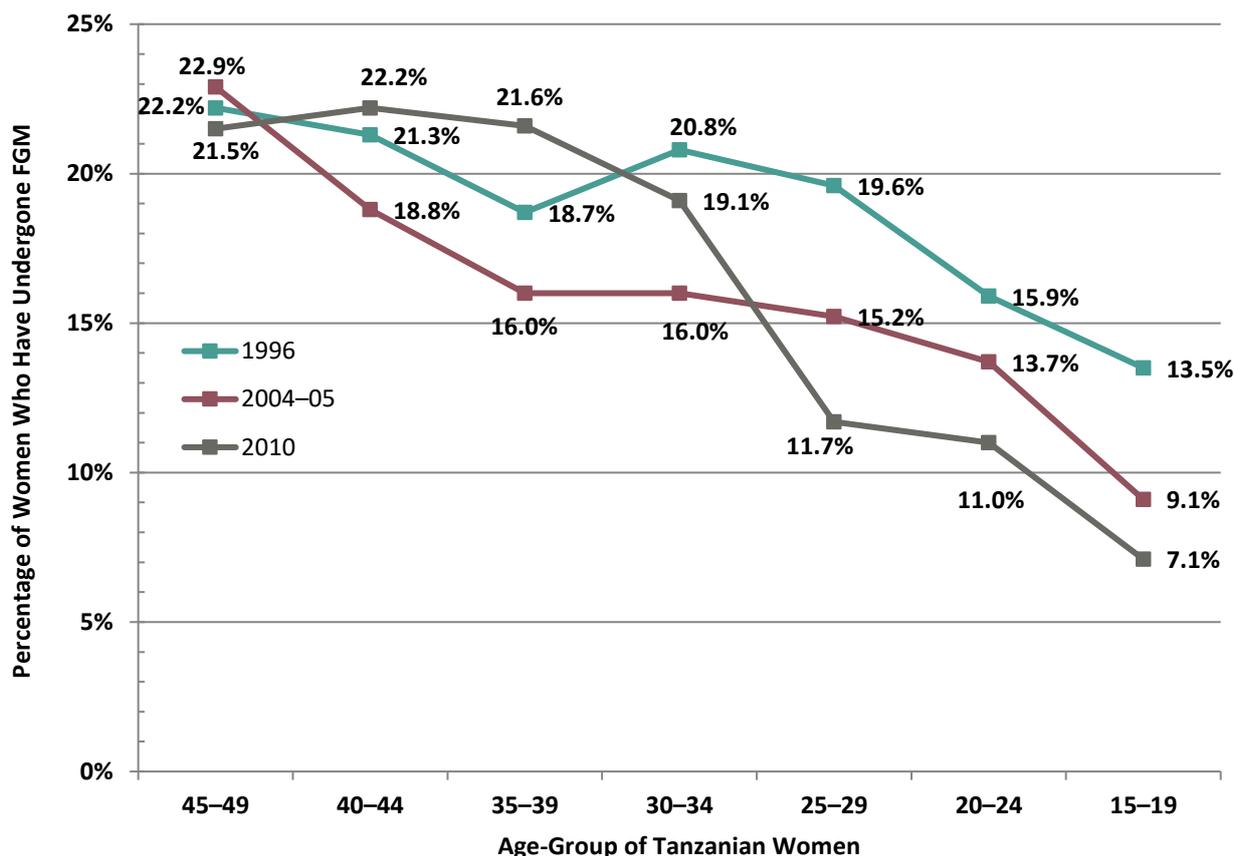


Figure 2: Prevalence of FGM in Tanzanian women aged 15-49, according to age group⁵

In some older age-groups, the measured prevalence increased between 2004-05 and 2010. However, this observation should be treated with caution, and more data would be required to confirm whether it is a statistical fluctuation.

Prevalence of FGM According to Education

As shown in Figure 3, there is a general trend towards a lower prevalence of FGM among women who are more highly educated.

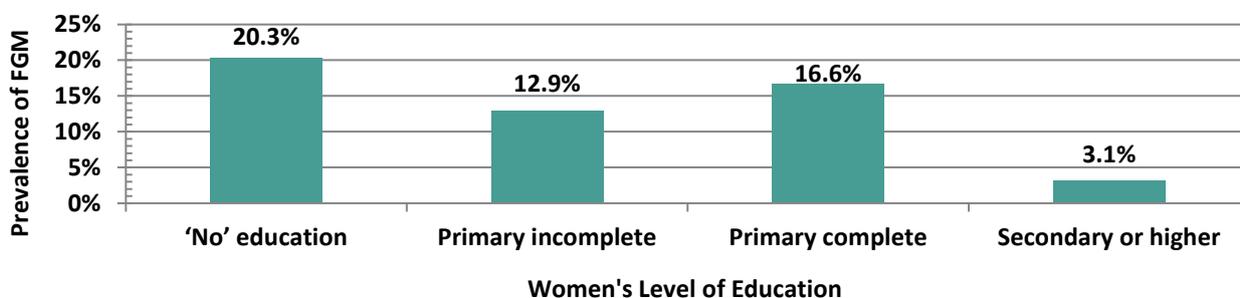


Figure 3: Prevalence of FGM in Tanzanian women aged 15-49, according to level of education⁶

Prevalence of FGM According to Household Wealth

As shown in Figure 4, the DHS 2010 shows a general correlation between household wealth and the prevalence of FGM.

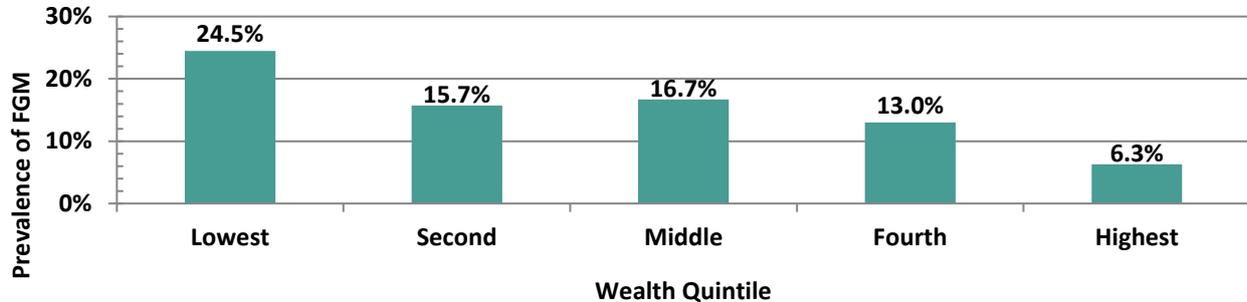


Figure 4: Prevalence of FGM in Tanzanian women aged 15–49, according to level of wealth⁷

Prevalence of FGM According to Place of Residence

The Tanzanian DHS surveys consistently show that FGM prevalence among women residing in rural areas is much higher than it is among women residing in urban areas. The DHS 2010 found that the percentage of women aged 15–49 who have undergone FGM is 17.3% in rural areas and 7.8% in urban areas.

While in both rural and urban areas there has been a reduction in prevalence since 1996, the percentage of women who have undergone FGM in rural areas has continued to be at least double the percentage of women in urban areas.⁸ These findings correspond with the fact that FGM is most commonly practised by pastoralist and agrarian groups (see ‘FGM and Ethnicity’ below).

FGM is most prevalent in the Northern and Central zones of Tanzania. Women living in these zones are also the most likely to have at least one daughter who has been cut and to intend to have their daughter(s) undergo FGM.⁹

Of the six zones in Figure 5 below, the Central zone has the highest prevalence of FGM in women aged 15–49 (58.8%), followed by the Northern zone (37.8%). The Southern (0.9%) and Western (1.7%) zones and Zanzibar (0.2%) are the zones with the lowest prevalence.¹⁰

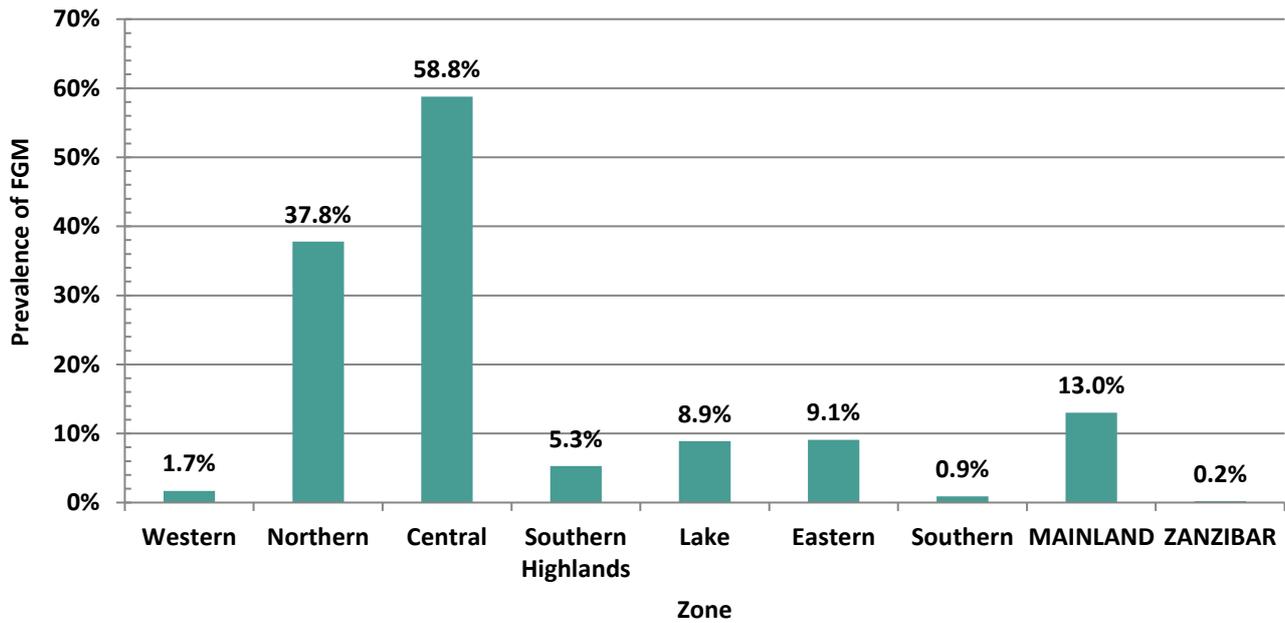


Figure 5: Prevalence of FGM in Tanzanian women aged 15–49, according to zone of residence¹¹

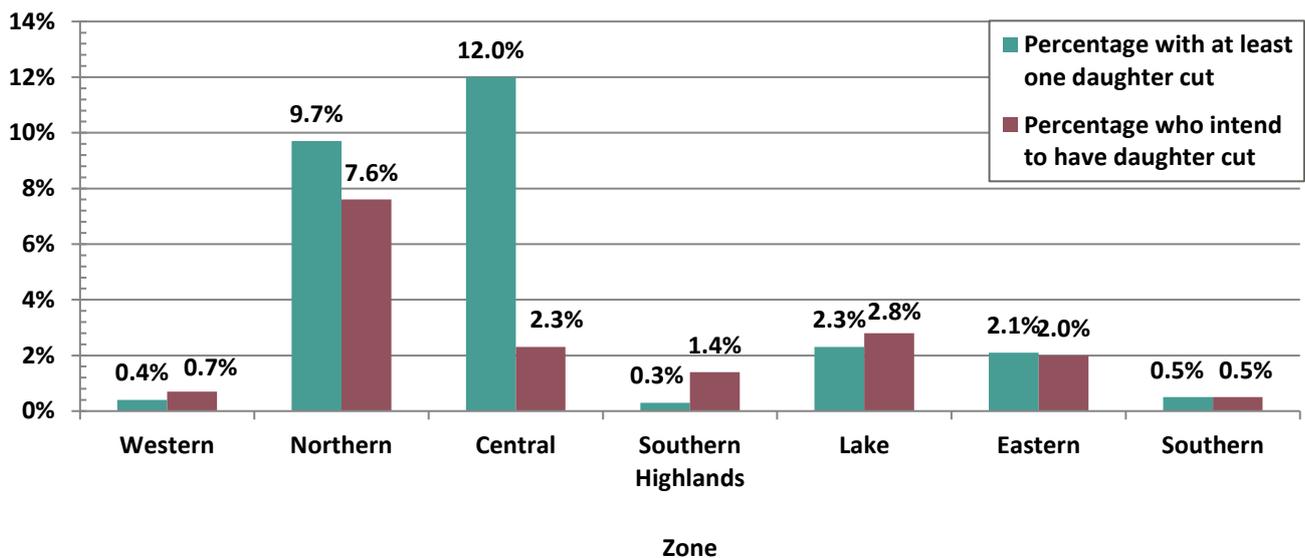


Figure 6: Percentages of Tanzanian women aged 15–49 who have at least one daughter who has undergone FGM, and percentage who intend to have a daughter undergo FGM, according to zone of residence¹²

However, prevalence may vary widely between different ethnic groups living within the same region, and this is not reflected in the DHS reports, which do not collect data according to ethnicity.

TERMINOLOGY

'Different terms are used in Kiswahili. In the past, *tohara* was used, but later the right term became *ukeketaji*, and sometimes the two are used interchangeably.'¹³

Types of FGM

The following data from the DHS 2010 shows the prevalence of FGM by the type performed. The most common type is 'cut, flesh removed', at 90.9%, followed by 'cut, no flesh removed' at 2.2%, and 'sewn closed' (Type III/infibulation) at 0.7%. Overall, the prevalence of Type III is low, and the types of FGM practised in urban and rural areas are very similar.¹⁴

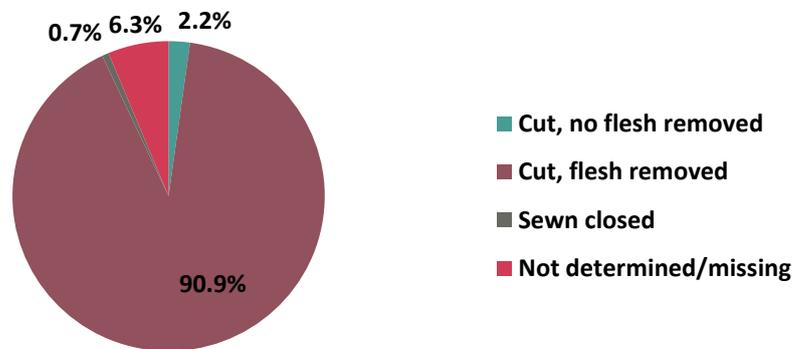


Figure 7: Prevalence of FGM by type among women aged 15–49 who have undergone FGM¹⁵

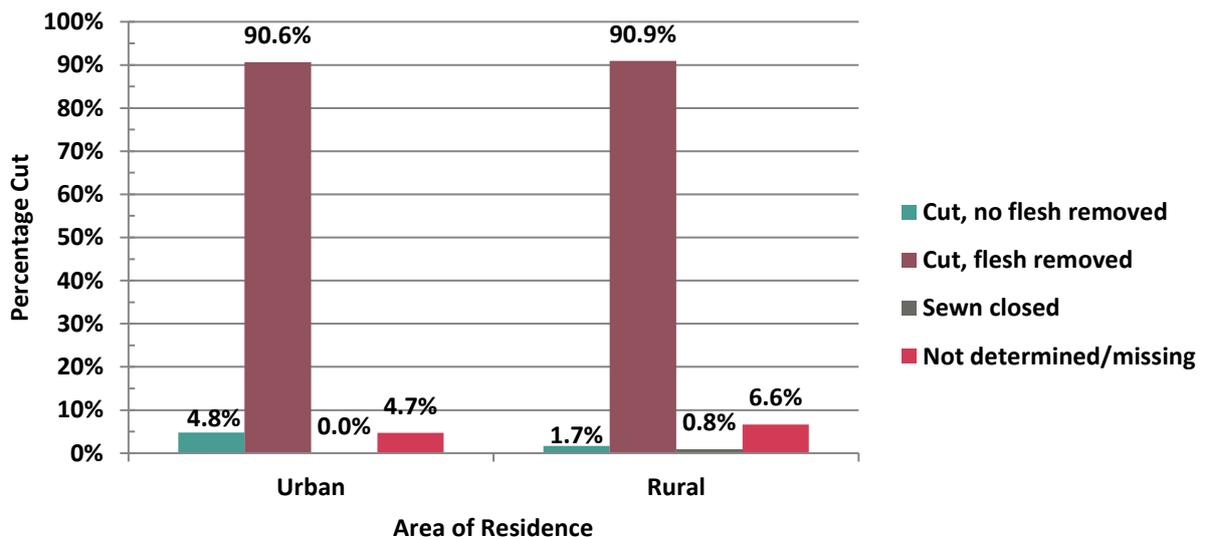


Figure 8: Types of cutting by area of residence among women aged 15–49 who have undergone FGM¹⁶

Practitioners

In Tanzania, FGM is most frequently carried out by traditional practitioners ('excisors') within communities, called *ngariba* in Kiswahili. The DHS 2010 reports the person who performed FGM on the most-recently-cut daughter of the women surveyed. Three out of every four instances of FGM (73%) were reported to have been carried out by traditional excisors (*ngariba*), while 21.9% had been carried out by traditional birth attendants and 4.4% by other traditional cutters. Only 0.4% had been carried out by nurses/midwives.¹⁷



Cutting tools and other paraphernalia from excisors who had laid down their tools, collected by AFNET (© Waritay, J. (photographer)/28 Too Many)

The DHS data does not appear to suggest a trend towards **medicalised FGM**: 1% of instances were carried out by health professionals in 2004–05.¹⁸ There are, however, indications that, in urban areas, wealthier families prefer to use the services of health personnel such as midwives and doctors.¹⁹ Such indications include reports of midwives performing FGM at hospitals in Kilimanjaro during deliveries.²⁰

Although medicalised FGM may decrease the negative health effects of the procedure, there is a misconception that FGM within a hospital/clinical setting is a benign and acceptable form of the practice. According to UNICEF and other NGOs, medicalisation obscures the human-rights issues surrounding FGM and prevents the development of effective and long-term solutions for ending it.²¹ Moreover, medicalisation does not give protection from many of the long-term health consequences of FGM. Research has shown that changing the context of FGM or educating about the health consequences does not necessarily lessen the demand for it.²² Furthermore, there is concern from older and more traditional members of communities that performing the surgery in a health facility with anaesthesia takes much of the meaning out of the ritual (i.e. the need for the strength to endure the pain).²³

Traditional excisors, *ngaribas*, often inherit the position, with the right to being an *ngariba* being passed down from mother to daughter within a particular clan.²⁴ *Ngariba* are held with high regard in their communities. In Singida, *ngariba* are thought by some communities to possess supernatural powers.²⁵ They are also reported to be feared in the Tarime district, as community members recognise that, if they provoke an *ngariba*, she may cut their daughters badly and cause even more harm.²⁶

Ngariba receive payment for performing FGM ceremonies, earning between 5,000 and 10,000 Tanzanian Shillings (US\$3–6) per initiate.²⁷ Payment may also be received in kind with bowls of millet and chicken or goats. Such payments mean that the continuation of FGM is often vital to the livelihoods of these women. As the vast majority of traditional practitioners have not completed primary school education, they are often ill-equipped to find other means of income. This has meant that, while there is widespread knowledge of the illegal status of FGM, the need to maintain a livelihood encourages most practitioners to continue the practice. In addition, the *ngaribas* are expected to pay a portion of their payment to the traditional elders.²⁸

Traditional birth attendants also perform FGM. A number of excisors are reported to have started out as traditional birth attendants before becoming *ngaribas*. As traditional birth attendants already have an alternative profession, these women may be more likely to abandon the practice of FGM, when considering FGM purely as an income-generating activity. However, this does not account for the complexities of individual economic circumstances or the strength of feeling for FGM as an integral cultural practice.

Performing FGM may not necessarily be an income-generating activity – in many cases, excisors receive only symbolic payments.

Additionally, in a study among the Waarusha in Arusha, one excisor told how she had inherited the skill from her mother and was obliged to continue offering the service. It was almost an insult for an **alternative source of income** to be offered.²⁹

Age of Cutting

A study of HIV prevalence in relation to FGM found that, in Tanzania, FGM generally takes place before puberty.³⁰

Figures 9 and 10 below show comparisons of the ages at which women aged 15–49 and their most-recently-cut daughters underwent FGM.³¹

The DHS 2010 reports that 71.5% of women aged 15–49 who have undergone FGM were cut between birth and the age of 12, and 80.4% of most-recently-cut daughters were cut between birth and the age of 12. However, a significant proportion of most-recently-cut daughters (about one in five) were cut after the age of 12.³²

Overall, the two periods at which girls are most at risk of cutting are when they are infants and during their teenage years.

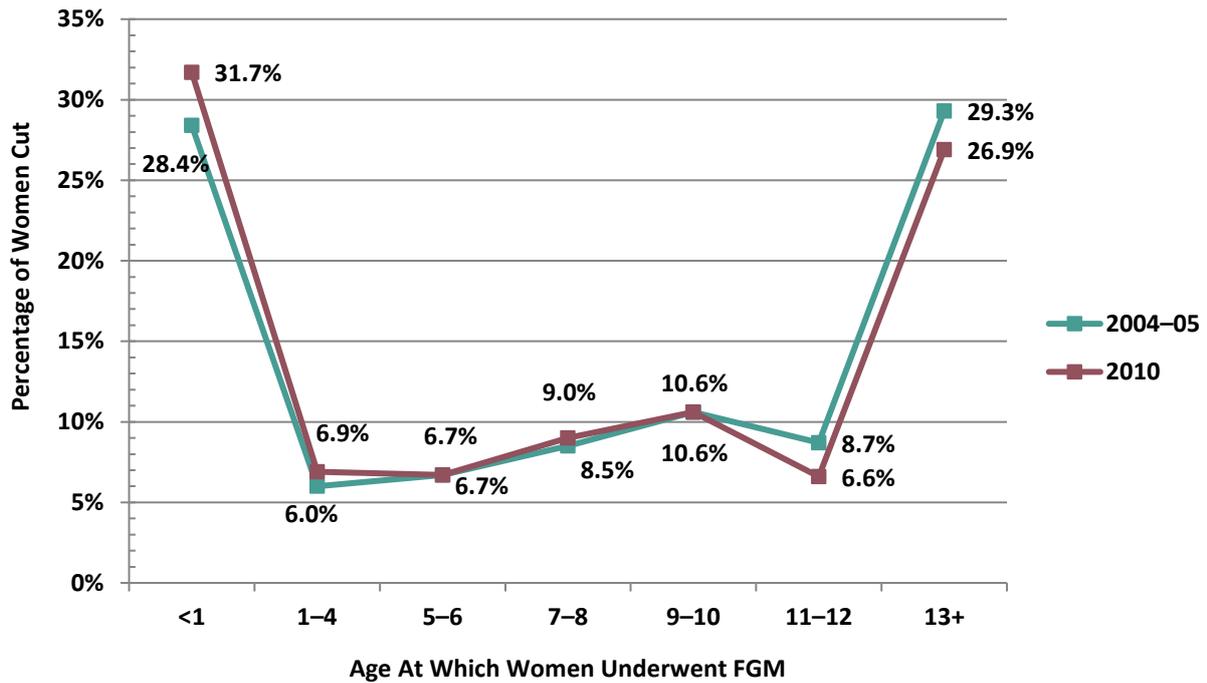


Figure 9: Percentage distribution of cut Tanzanian women (aged 15–49) by the age at which they underwent FGM – comparison 2004–05 and 2010
(NB: the percentages of women who do not know have been omitted from this graph)³³

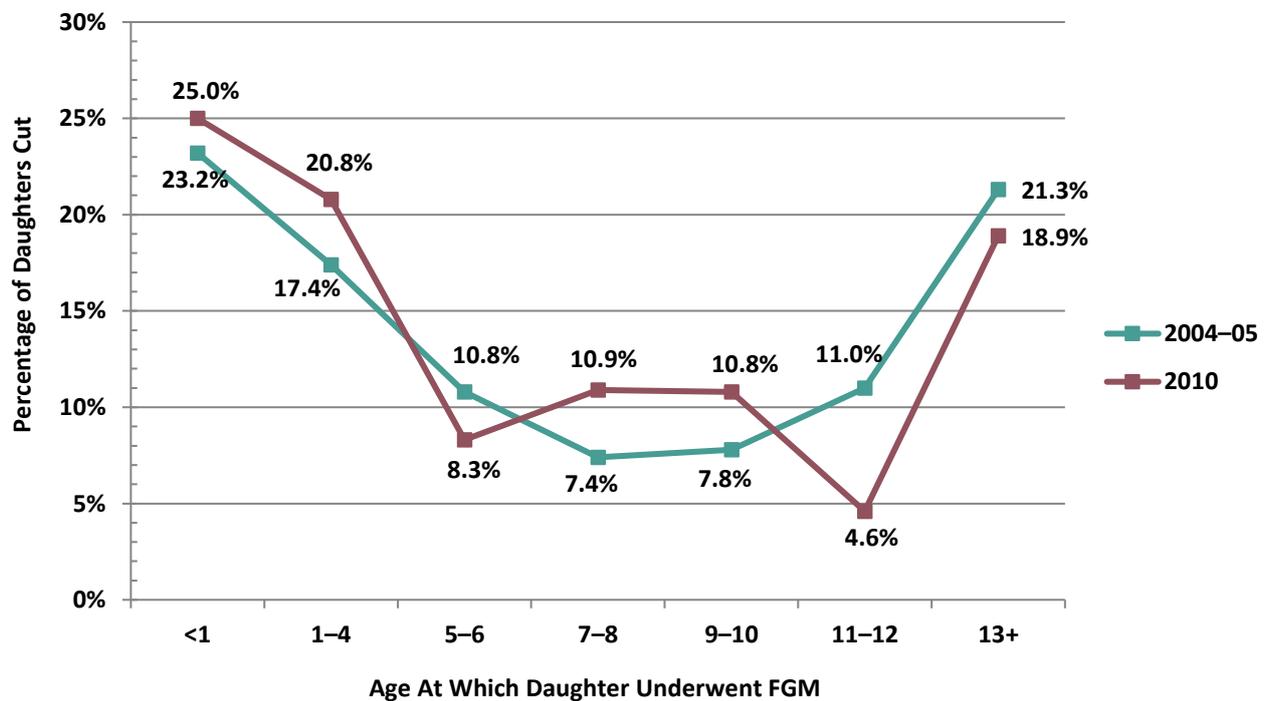


Figure 10: Percentage distribution of most-recently-cut daughters by age at which they underwent FGM, as reported by their mothers – comparison 2004–05 and 2010
(NB: the percentages of daughters whose mothers do not know have been omitted from this graph)³⁴

However, the ages at which girls undergo FGM can vary between zones and regions. For example, data collected by the Christian Council in Tanzania in three separate districts in Mara shows that the majority of girls are subjected to FGM between the ages of 13 and 18, whereas approximately 94% of

respondents in Singida reported that girls undergo FGM before the age of five.³⁵ Table 1 sets out the DHS 2010's findings of the age at which women underwent FGM according to their zone of residence.

Zone	Age At Which FGM Was Carried Out							
	<1	1-4	5-6	7-8	9-10	11-12	13+	Don't know/missing
Western	77%	0%	0%	0%	3.1%	0%	17.8%	2.1%
Northern	53.6%	1.5%	4.3%	4.5%	6.5%	3.1%	23.1%	3.4%
Central	18.9%	18.8%	13.4%	17.2%	17%	8.2%	6.4%	0%
Southern Highlands	10%	3.6%	5.9%	6.5%	2.4%	1.3%	68.3%	2%
Lake	1.3%	0%	0.5%	3.8%	10.2%	16.2%	66.4%	1.5%
Eastern	23%	0%	3%	9.1%	10.8%	8.6%	45.5%	0%
Southern	9.6%	0%	11.8%	11.8%	23.5%	0%	43.4%	0%
COUNTRY-WIDE	31.7%	6.9%	6.7%	9%	10.6%	6.6%	26.9%	1.7%

Table 1: Percentage distribution of cut Tanzanian women (aged 15–49) by the age at which they underwent FGM, according to zone of residence³⁶

Looking back at the DHS 1996, 8.6% of women were cut between birth and the age of five, 29.9% between the ages of six and ten, 32.3% between the ages of 11 and 15, and 15.3% after the age of 16, which suggests that more girls are being cut at a younger age.³⁷

Ali and Strøm have also suggested that there has been an increase in girls being cut at a younger age due, at least in part, to the abrupt nature of attempts to abolish FGM through the Arusha Declaration in 1968.³⁸ They note that a number of parents from the Gogo and Nyaturu tribes prefer to cut girls before they can speak in order to 'avoid harassment from the authorities'. Interestingly, the younger the age at which FGM takes place can lead to girls not even being aware that they have undergone FGM. The coordinator of the Anti-FGM Network (AFNET) in Manyoni conducted small-scale research in primary schools and found that most of the students interviewed were unaware of the fact they had been cut:

'Most of the girls we talked to in primary schools were found to have been mutilated; we asked them and they all said they did not recall undergoing the knife[,] saying that they had assumed that was how they were born. This made us realise that mutilating toddlers had not begun now but has been around for some time.'

~ AFNET coordinator in Manyoni

There was also a trend reported in 2008 of elderly women in Manyara undergoing FGM to sell the flesh as part of a trade in body parts to be used in witchcraft (see inset box on page 40).

- 1 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, opening pages. Available at https://www.unicef.org/publications/index_69875.html.
- 2 DHS 2010, p.296.
- 3 - DHS 2004–05, p.250.
- DHS 1996, p.168.
- 4 UNICEF (2013), *op. cit.*, p.27.
- 5 - DHS 1996, p.168.
- DHS 2004–05, p.250.
- DHS 2010, p.296.
- 6 DHS 2010, p.296.
- 7 DHS 2010, p.296.
- 8 - DHS 1996, p.168.
- DHS 2004–05, p.250.
- DHS 2010, p.296.
- 9 DHS 2010, p.299.
- 10 - DHS 2004–05, p.250.
- DHS 2010, p.296.
- 11 DHS 2010, p.296.
- 12 DHS 2010, p.299.
- 13 Legal and Human Rights Centre and Zanzibar Legal Services Centre (2012) *Tanzania Human Rights Report 2012*. Available at http://www.zlsc.or.tz/documents/Tanzania_Human_Rights_Report_2012.pdf.
- 14 DHS 2010, p.296.
- 15 DHS 2010, p.296.
- 16 DHS 2010, p.296.
- 17 DHS 2010, p.300.
- 18 DHS 2004–05, p.254.
- 19 Sosthenes Mwita (2013) 'Tanzania: FGM Remains Quite Dangerous to Health', *Tanzania Daily News*, 28 October. Available at <https://allafrica.com/stories/201310280010.html>.
- 20 *Information from NAFGEM (2010)*.
- 21 UNICEF (2005) *Female Genital Mutilation/Cutting: 2005 – A Statistical Exploration*. Available at https://www.unicef.org/publications/files/FGM-C_final_10_October.pdf.
- 22 Bettina Shell-Duncan, 'Chapter 6: Women Without Choices: The Debate Over Medicalization of Female Genital Cutting and Its Impact on a Northern Kenyan Community' in Bettina Shell-Duncan and Ylva Hernlund (eds) (2000) *Female Circumcision in Africa: Culture, Controversy, and Change*. Boulder, CO: Lynne Rienner Publishers.
- 23 A. Christoffersen-Deb (2005) "'Taming tradition": medicalized female genital practices in western Kenya', *Medical Anthropology Quarterly* 19(4), pp.402–418.
- 24 - Children's Dignity Forum and FORWARD (2010) *Voices of Child Brides and Child Mothers in Tanzania: A PEER Report on Child Marriage Tanzania*. Available at <http://www.forwarduk.org.uk/wp-content/uploads/2013/11/Voices-of-Child-Brides-in-Tanzania.pdf>.
- Charles Ngowi (2011) 'A Culture of Circumcision in the Kurya Tribe of Tanzania', *Compassion*, 22 July. Available at <https://blog.compassion.com/circumcision-in-africa-a-culture-of-circumcision-in-the-kurya-tribe-of-tanzania/>.
- 25 Christian Council of Tanzania (2008) *Singida FGM Status Report*.
- 26 Children's Dignity Forum/FORWARD (2009) PEER Research Report on Child Marriage in Tarime District, Mara Region, Tanzania. Available at <http://cdfztz.org/files/Peer%20Research%20edited%20doc.pdf>.
- 27 Johanna Waritay and Dr Ann-Marie Wilson/28 Too Many (2012) *Working to end female genital mutilation and cutting in Tanzania: The role and response of the church*. Tearfund.
- 28 - Christian Council of Tanzania (2008) *Singida FGM Status Report*.
- Christian Council of Tanzania (2009) *Tarime FGM Status Report*.
- 29 Dr Angelina Dawa (2013) *Mukalat FGM Eradication Project 2012–2014, Baseline Survey Report*, September–November 2013. World Vision Tanzania.
- 30 D.D. Brewer, J.J. Potterat, J.M. Roberts Jr. and S. Brody (2007) 'Male and female circumcision associated with prevalent HIV infection in virgins and adolescents in Kenya, Lesotho, and Tanzania', *Annals of Epidemiology* 17(3), pp.217–26.
- 31 - DHS 2004–05, p.252.
- DHS 2010, p.298.
- 32 DHS 2010, pp.298 and 300.
- 33 - DHS 2004–05, p.252.

- DHS 2010, p.298.
- 34 - DHS 2004–05, p.2542.
- DHS 2010, p.300.
- 35 - Christian Council of Tanzania (2008) *Singida FGM Status Report*.
- Christian Council of Tanzania (2009) *Tarime FGM Status Report*.
- 36 DHS 2010, p.298.
- 37 DHS 1996, p.169.
- 38 Chiku Ali and Agnete Strøm (2012) “It is important to know that before, there was no lawalawa.” Working to stop female genital mutilation in Tanzania’, *Reproduction Health Matters* 2012(20), pp.69–75.

Millennium Development Goals

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



Goal 1: Eradicate Extreme Poverty and Hunger

According to the World Food Programme, Tanzania is one of the least-developed and lowest-income countries. The country’s GDP has grown in the last decade, but this increase has not translated to improved living standards for most Tanzanians. More than 40% of the population lives in regions with chronic food deficits. Tanzania is among the African countries with the highest levels of malnutrition. Some 42% of children under the age of five are stunted, and 80% of children under the age of one are anaemic. In addition, more than 50% of pregnant women are anaemic and 10% of women are undernourished.¹

This MDG is relevant to FGM, given the correlations between food insecurity and education, and education and FGM. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity.² Education is also important in tackling FGM, as discussed in FGM and Education (page 100). This illustrates the links between each MDG and the key role education plays in combating not only FGM, but also other important development issues for Tanzania, such as food insecurity.

Goal 2: Achieve Universal Primary Education

The aim of this MDG is to provide universal primary education and ensure that, by 2015, all boys and girls go through a full course of primary schooling. This goal is relevant in the context of FGM, as the chances of girls undergoing FGM are reduced if they complete their schooling (see FGM and Education on page 100).

Goal 3: Promote Gender Equality and Empower Women

The aim of this MDG is to eliminate all gender disparity in primary and secondary education by no later than 2015. This is highly relevant, given that FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. Moreover, there is a correlation between the level of a woman's education and her attitude towards FGM (see FGM and Education on page 100).

Goal 4: Reduce Child Mortality

FGM has a negative impact on child mortality. A WHO multi-country study, in which over 28,000 women participated, has shown that newborn baby death-rates are higher among mothers who have had FGM (see Women's Health and Infant Mortality on page 60).

Goal 5: Improve Maternal Health

This MDG has the aim of reducing maternal mortality by three-quarters between 1990 and 2015. In addition to its immediate health consequences, FGM is also associated with an increased risk of childbirth complications (see Women's Health and Infant Mortality on page 60).

Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Although the correlation between HIV/AIDS and FGM is not as direct as some research has previously claimed, there are a number of potential sources of HIV/AIDS transmission associated with FGM and its consequences (see HIV/AIDS and FGM on page 72). In addition, combating vaginal and urinary-tract infections will also combat FGM, given the mistaken belief in Tanzania that FGM cures such infections (see FGM and *Lawalawa* on page 50).

Post-MDG Framework

As the MDGs are approaching their 2015 deadline, the UN is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace. Currently, the organisation is working with its partners on an ambitious post-2015 development agenda and striving for open and inclusive collaboration on this project.³

The UN is also conducting the MY World survey, in which citizens across the globe can vote offline and online (including using mobile technologies) on which of the six development issues most impact their lives.⁴ The results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).⁵

Coinciding with this survey is the 'The World We Want' platform, an online space where people can participate in discussions on the UN's 16 areas of focus for development. There has been a growing number of calls for the post-MDG agenda to include a distinct focus on ending violence against women.⁶

Although it is unlikely that FGM will be eliminated in Tanzania by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM. The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives.

Additionally, the African Union's declaration of the years 2010 to 2020 to be the Decade for African Women will certainly assist in promoting gender equality and the eradication of gender-based violence (GBV) in Tanzania.

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- 1 World Food Programme (undated) *Tanzania: Overview*. Available at <http://www.wfp.org/countries/tanzania-undated-republic-of/overview>.
 - 2 Pasquale De Muro and Francesco Burchi (2007) *Education for Rural People: A Neglected Key To Food Security*. Available at https://www.researchgate.net/publication/24125377_Education_for_Rural_People_A_Neglected_Key_To_Food_Security.
 - 3 United Nations (2013) [no longer available].
 - 4 United Nations (undated) *My World: The United Nations Global Survey for a Better World*. Available at <http://www.myworld2015.org/>.
 - 5 *The World We Want* (undated) [website]. Available at <http://www.worldwewant2015.org/>.
 - 6 Caroline Harper (2013) 'Gender, Violence and the Post-2015 Framework,' *Overseas Development Institute*, 24 January. Available at <https://www.odi.org/comment/7220-gender-violence-and-post-2015-framework>.

Political Background

Historical¹

The area within the national borders of Tanzania was populated by Bantu-speaking tribes from the north and west of Africa. Many of these peoples were governed by long-held tribal traditions of rule by chiefs and elders, and, though modern party politics today govern the Republic of Tanzania, respect and power is still afforded to these traditional rulers.

In the 8th century AD a port was established by Arab traders on the island of Kilwa, off the coast of modern southern Tanzania, and Persian traders came and settled in the islands of Zanzibar and Pemba two centuries later. A distinctive, successful Swahili culture was formed between these two incoming groups and native Africans, and by the 13th century Kilwa was one of the centres of Swahili civilization, able to dominate the trade in and around the Indian Ocean and into mainland Africa.

The Portuguese navigator Vasco da Gama explored the East African coast in 1498. By 1506 the Portuguese had claimed control over the entire coast, violently enforcing a monopoly on Indian Ocean trade, denying the Swahili city-states their main means of livelihood.

By the 19th century, Omani Arabs had taken control of Zanzibar and used it as a centre for slave trading. In 1891, the German Government took over direct administration of the territory and appointed a governor, whose headquarters was at Dar es Salaam. German colonial domination of Tanganyika ended after World War I, when control of most of the territory passed to the United Kingdom under a League of Nations mandate. After World War II, Tanganyika became a UN trust territory under British control.

In subsequent years Tanganyika moved gradually toward self-government and independence. In 1954 Julius Nyerere organised a political party, the Tanganyika African National Union (*TANU*). TANU candidates were victorious in the Legislative Council elections of September 1958 and February 1959. In December 1959 the United Kingdom agreed to the establishment of internal self-government following general elections to be held in August 1960. Nyerere was named chief minister of the subsequent government. Full independence was achieved on 9 December 1961. Tanganyika was the first East African state to gain independence.

Nyerere set about strengthening his political control of both TANU and the country. To help build national unity, he adopted Kiswahili as the national language, making it the only medium of instruction and education. Tanganyika became one of the few African countries with an indigenous official national language.

Nyerere also expressed a fear that multiple parties, as seen in Europe and the US, would lead to ethnic conflict in Tanganyika; he therefore in 1963 established a one-party state (which lasted until 1 July 1992), outlawed strikes and created a centralised administration. He stated that a one-party state would allow collaboration and unity without any suppression of opposing views.

The United Republic of Tanzania was formed out of the union of two sovereign states, namely Tanganyika and Zanzibar. Tanganyika became a sovereign state on 9 December 1961 and became a republic the following year. The two sovereign republics formed the United Republic of Tanzania on

26 April 1964. However, the Government of the United Republic of Tanzania is a unitary republic consisting of the Union Government and the Zanzibar Revolutionary Government.²

Current Political Conditions

Since independence, Tanzania has held general elections every five years, despite there being, until 1992, only one party. The country enjoys political stability, and all former presidents, vice presidents and prime ministers live in Tanzania and are accorded respect. On 25 June 2006 President Jakaya Mrisho Kikwete was elected chairman of Chama Cha Mapinduzi (CCM), the ruling political party, by its General Congress.³

According to the BBC, 'Tanzania has been spared the internal strife that has blighted many African countries.'⁴ Although it remains one of the poorest countries in the world, with many of its people living below the World Bank poverty line, it has had some success in attracting donors and investors. Unlike many African countries, whose potential wealth contrasts with their actual poverty, Tanzania had few exportable minerals and a primitive agricultural system. In an attempt to remedy this, its first president, Julius Nyerere, issued the 1967 Arusha Declaration, which called for self-reliance through the creation of cooperative farm villages and the nationalisation of factories, plantations, banks and private companies. However, a decade later, despite financial and technical aid from the World Bank and sympathetic countries, this programme had completely failed due to inefficiency, corruption, resistance from peasants and rises in the price of imported petroleum. Tanzania's economic woes were compounded in 1979 and 1981 by a costly military intervention to overthrow President Idi Amin of Uganda.

After Mr Nyerere's resignation in 1985, his successor, Ali Hassan Mwinyi, attempted to raise productivity and attract foreign investment and loans by dismantling government control of the economy. This policy continued under Benjamin Mkapa, who was elected president in 1995. The economy grew, though at the price of painful fiscal reforms.

Tourism is an important revenue earner; Tanzania's attractions include Africa's highest mountain, Kilimanjaro, and wildlife-rich national parks such as the Serengeti. Tanzania hosts thousands of refugees from conflict in the neighbouring Great Lakes region. Experts fear that a planned highway threatens the Serengeti game park, Tanzania's biggest draw for tourism.⁵

Self-governing Zanzibar (wherein resides 3% of Tanzania's population) has long been the tempestuous exception to mainland Tanzania's peaceful politics. Serious irregularities and sporadic violence have marred every election in Zanzibar since 1964.⁶

1 Unless otherwise indicated, all references in this section are to the US Department of State (2012) *Country Reports on Human Rights Practices for 2012: Tanzania*. Available at <https://www.state.gov/j/drl/rls/hrrpt/2012humanrightsreport/#wrapper>.

2 United Republic of Tanzania (2012) [website].

3 *Ibid.*

4 BBC News (2012) *Tanzania Country Profile*. Available at <http://www.bbc.com/news/world-africa-14095776>.

5 *Ibid.*

6 US Department of State, *op. cit.*

Anthropological Background

The **ethnic make-up of Tanzania** is vast, with 130 Bantu tribes comprising 95% of the overall population (1% consists of Asian, Arab and European peoples).¹ A number of sources, however, refer only to approximately 120 ethnic groups, based on socio-linguistic lines.² The largest of these groups are the Sukuma and Nyamwezi peoples.³ Other socio-linguistic groups include the Barabaig, Hadza/Hadzabe, Shirazi, Maasai and Tatoga.⁴

Although surrounded by nations whose instability has often resulted from ethnically-motivated **conflict**, Tanzania has remained relatively peaceful. This is possibly because no single ethnic group has been large enough to have significant influence within the country or to make a considerable impact upon the nation's politics.⁵ A more commonly cited suggestion is that the 'nation-building' initiatives of the 1960s – the spread of socialism and anti-colonial nationalism, the banning of 'ethnic terms' in the media, and the installation of Kiswahili as the national language – unified the peoples of Tanzania, breaking down barriers of ethnicity. Consequently, Tanzania does not record the ethnicity of its citizens in the national census.

*In many settings, FGM/C derives much of its meaning and tenacity from its intimate association with ethnic identity.*⁶

The DHS 2010 does not break down the **prevalence of FGM according to ethnicity**. However, variations in the prevalence of FGM across regions are best understood in terms of ethnicity.⁷

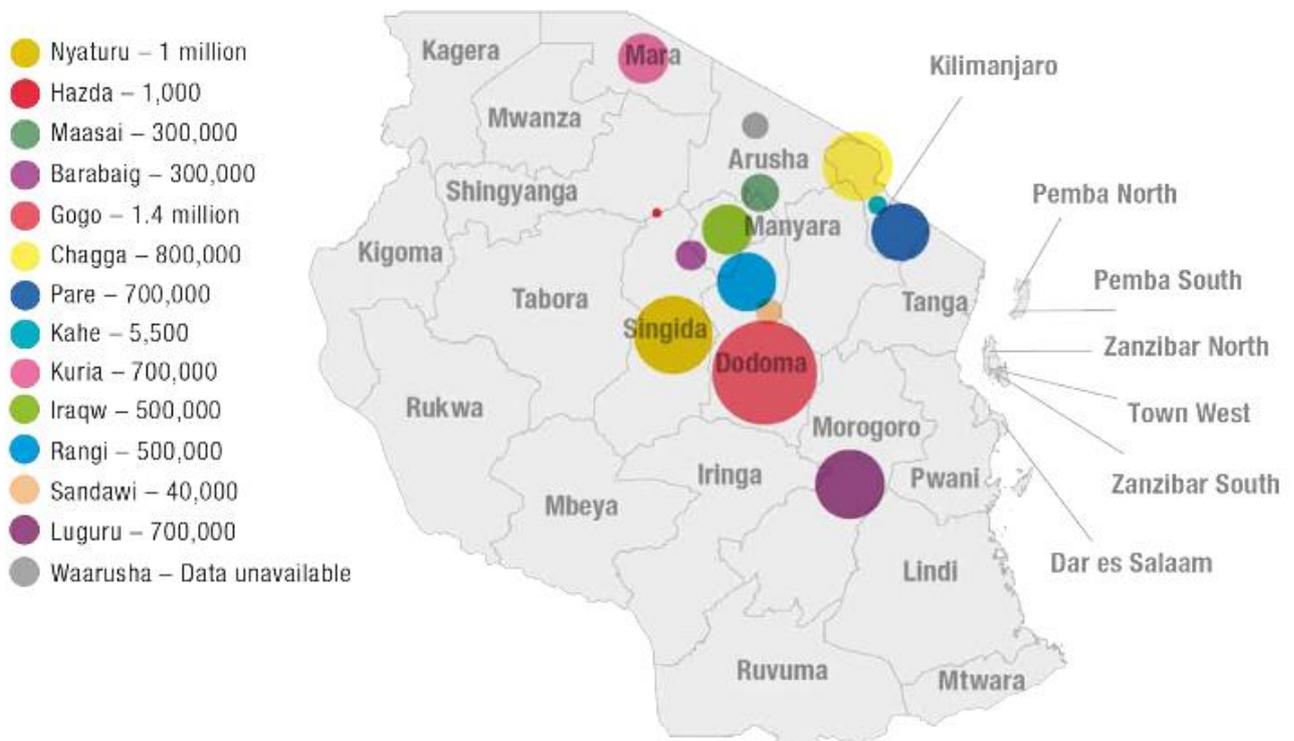


Figure 11: Approximate distribution and size of practising ethnic groups

The DHS 2010 indicates that there are five regions within which FGM is practised at a rate of well over 20% – Mara, Arusha, Manyara, Singida and Dodoma – while in Kilimanjaro, Tanga and Morogoro, prevalence is approximately 20%.⁸ However, due to the relatively small numbers of women surveyed in some of the regions, this data should be interpreted with caution. It has not been possible to profile all of the ethnic groups that practise FGM; however, this sub-section focuses on some of the most frequently practising groups within these regions. Other groups include the Rangi and Sandawi (Dodoma region), the Waarusha (Arusha region), the Luguru (Morogoro region), the Hazabe (Manyara region), the Mwera Yao and Makua (Lindi and Mtwara regions) and the Simbiti, Rieny, Ugu, Bakabwa, Kine, Natta, Zanaki, Kiroba and Tatiro (Mara region).

Chagga

The third largest group in Tanzania, the Chagga are a Bantu-speaking group of approximately 834,000 people residing in the Kilimanjaro region.⁹ It is frequently cited that the Chagga migrated to the region roughly 600 years ago, settling into agricultural homesteads on the eastern, western and southern slopes of Mount Kilimanjaro.¹⁰

Traditionally, the Chagga economy has centred on the cultivation and marketing of coffee, bananas, millet, beans, cassava and other vegetables; cattle, pigs and goats are kept by some, but in small numbers.¹¹ Foods, work and property are split between genders: men feed and slaughter animals, prepare the fields and build houses and canals, while women are responsible for the collection of firewood, fodder and water, cleaning the homestead and stalls and cooking.¹² Interestingly, women are in charge of the markets; however, in order to trade 'male' foods (such as bananas and beer), permission must be obtained.¹³

In the pre-colonial era, fighting between various Chagga chiefdoms was common. Since the start of multi-party politics in 1992, the Chagga have been more politically active, allowing for increasing cohesion between Chagga peoples along party lines.¹⁴

The Chagga have traditionally practised the betrothal of daughters and the payment of bride-prices, with corresponding elaborate ceremonies, and polygamy; however, Christian traditions are now combined with Chagga ritual, and polygamy is less common. Having a son through which the family lineage will be continued is of great importance.¹⁵



*Chagga women, Moshi
(© 28 Too Many)*

Age and Prevalence

The DHS 2010 found that the prevalence of FGM in Kilimanjaro, where the Chagga mainly reside, is 21.7%; however, this figure is based on a small number of participants and should therefore be treated with caution. Additionally, this figure is likely to be a result of groups who practise more frequently and also live in the area, specifically the Maasai and the Pare.

Two studies report that Chagga girls were traditionally cut relatively late, at the age of 15 or older.¹⁶ 28 Too Many's in-country research, however, found that certain Chagga are now cutting girls between the ages of one month and one year, often without the father's knowledge or consent. The male elders taking part in the study explained that, whereas FGM once took place when girls were between the ages of 14 and 30, pressure from the Government and authorities has caused the practice to go underground and be carried out on babies to avoid detection.

The elders also informed 28 Too Many that, prior to the shift to cutting girls at a younger age, women would often be cut after marriage if they experienced problems conceiving children or if the husband's family faced difficulty or misfortune – believing that their uncut daughter-in-law was responsible for their ill luck.¹⁷

Despite these studies, other in-country researchers report that cutting among the Chagga died out by the 1990s and continues only in isolated pockets. This contradicting information may be a result of the confusion that can occur when groups switch to performing *sunna* (see below), as sometimes this is not seen as being FGM; however, further research would need to be done to confirm this.

Reasons for Cutting

A number of reasons for the practice of FGM have been provided by the Chagga. Responses, in common with other ethnic groups, included the beliefs that FGM is necessary in order to initiate girls into maturity, to prevent pre-marital sexual intercourse and to obtain a higher bride-price when daughters are betrothed. A number of respondents also maintained that many girls wanted to undergo FGM in order to be accepted by their families and communities.

The more atypical responses provided highlighted particular Chagga understandings of human anatomy and preventative healthcare. For instance, one highly unusual response contended that FGM enabled the identification and treatment of girls born with both male and female sex organs, while another claim was that FGM helps girls to avoid contracting HIV/AIDS as it 'removes [the] obsession for sex'.

Some girls understood FGM to serve as a means to prevent them from developing *lawalawa* (see FGM and *Lawalawa* on page 50). It is also believed that uncut girls give birth to disabled children or are unable to conceive once they are married.¹⁸

Type of FGM

Type I is the most common type of FGM found among the Chagga.¹⁹ 28 Too Many found that a number of Chagga, especially from the majority-Muslim districts, are employing *sunna*, suggesting a belief that the practice is an Islamic requirement (see Religion and FGM below). This sunna form of FGM involves the cutting of a small part of the clitoris, followed by the application of salt with a handkerchief. This is considered to reduce the risk of large losses of blood that would require hospital treatment.²⁰

The Traditional Chagga Ceremony

Traditionally, FGM – or *kudinwa*, meaning ‘to be cut’ – within Chagga communities would take place in the month of September, during the harvest, to ensure that enough food would be available to hold feasts for the initiates and for the cooler weather to aid the healing process for the cut girls.

The women responsible for cutting the girls were known as *wakeku* (singular form *mkeku*), highly respected elderly women considered to be the ‘grandmothers’ or ‘guardians’ of the women of the community; they may also have been referred to as *bibi* (‘Grandmother’). The *wakeku* were given gifts for their services, namely goats, clothes, money and other material possessions; it was also believed that if the *wakeku* were not paid, they had the power to prevent the girls’ wounds from healing.

During the ceremony, the girls were cut with a section of iron sheeting, following which they were seated on a traditional ceremonial stone, with women from the community in a circle around them to sing songs and perform traditional dances. The initiates were then given a variety of foods – likely to be considered restorative and strengthening – such as *mlaso* (meat mixed with fermented milk), *kisusyo* (the blood of a slaughtered cow), *kitawa* (a banana-and-milk mixture), *mtori* (banana mixed with cooked meat) and porridge. The new initiates were presented with gifts such as special clothing, money and food. The most important element to be presented to the initiates was a stick along with traditional medicine (*ibangasa*), which was believed to hold magical powers that would protect them from witches and evil. However, respondents claim that girls who were ‘troublesome’ while being cut would not be presented with gifts.

The cut girls underwent a period of seclusion lasting between one and three months, in order to be instructed in their new responsibilities as Chagga women by the *wakeku* and their aunts. Such instructions included how to run a clean and efficient home, how to care for one’s husband and be loyal to him, the best ways to plan the conception of children, how to respect their elders and how to ensure that their households had enough food stored in preparation for famines. Once the girls had undergone FGM and the associated initiation, they were considered ready for marriage (as were boys after circumcision).²¹

Now, however, young infants are more frequently cut indoors in secret, with no ceremony. Interestingly, traditionally, when girls were cut a goat was slaughtered, but now a small part of a goat’s ear is cut and the drops of blood are smeared on the face of the cut infant with the aim of fulfilling the traditional requirements and thus escaping misfortune in the family.²²

Attitudes

The Chagga were able to point to many of the negative impacts of FGM upon women and girls. It has been noted that, despite being aware of the illegal status of FGM, many Chagga have been reluctant to support the authorities in their investigations and to admit to any continuation of the practice within their communities.

A number of respondents reported that girls have started to run away from home in order to escape undergoing FGM. Many believe that this can be attributed to the information and education provided through schools, churches, hospitals, women’s self-help groups and NGOs.

Intermarriage between Chagga and non-Chagga persons has also started to influence the prevalence – or perhaps the visibility – of the practice.²³

Case Study: A Story of Five Sisters in Moshi



My name is Elisabeth*. There are five sisters in my family, of which I am the youngest. My three elderly sisters were cut when they were 15 and 16 years old. The fourth sister refused to be cut. She got married and had two children. Later she had problems in her marriage. My parents believed that these problems were partly due to the fact that she had not been cut and had brought misfortune on her husband's family. She was therefore forced to be cut as an adult.

When I was 16 years old, early one morning, my parents sent me, along with my cousin, to follow my aunt and one of our neighbouring women to an unknown place. One of my nieces asked me, 'Elisabeth, do you know where they are taking you? You're going to be taken to the *Mkeku*!' [Mkeku are Chagga elderly women who perform FGM on Chagga girls.]

I wanted to know more and asked her why they were taking us to the Mkeku. She told me, 'You are going *kudinwa* ["to be cut"]!' We then made a plan to escape. As we walked towards the Mkeku's house, we ran away through banana plants. Those who were sent to take us to the Mkeku returned home alone. When we went back home in the evening, we found them waiting for us. We were severely punished and chased from the family home.

The next day, my grandmother asked me why I refused to be cut when I knew that all my other sisters had already been cut. I replied boldly that I didn't like it. I had confidence to reply in this way because I knew that FGM was being abolished by the Government.

My grandmother rudely cursed me. She said, 'In your life you shall always face problems; you will never get married because you have refused to be cut.' She gave my elder sister as an example, saying, 'Your elder sister refused to be cut, and, when she got married, she brought misfortune to her husband's family, and, as a result, she was cut as an adult, so you shall suffer the same fate.' I replied that it was better never to get married than to be cut.

Some years later, by the will of God, I had a fiancée and got married. We have children and, so far, nothing bad has happened to my family. Even my grandmother's curses could not bear fruit in my marriage.

I would like to advise my fellow Chagga girls to get rid of the FGM tradition. Let them be assured that nothing bad shall happen in their life. All the myths about FGM are flitting dreams and hold no meaning in anyone's life. I strongly advise them to get rid of this lethal practice of FGM.²⁴

*Names have been changed.

Gogo

One of the largest ethnic groups in Tanzania, the Gogo are a Bantu-speaking, patrilineal people with a population of approximately 1.4 million people who reside in the Dodoma region.²⁵ This area is bordered by hills to the south and east and the Bahi Swamp to the west.²⁶

Traditionally, the Gogo have engaged in a pastoralist way of life; however, a growing number of contemporary Gogo are becoming farmers or workers on farms and plantations in other parts of the country.²⁷ As well as herding cattle, sheep and goats to accrue wealth, the Gogo undertake subsistence agriculture, cultivating drought-resistant crops such as sorghum, maize and millet.²⁸



*Gogo women, Dodoma
(© 28 Too Many)*

Although the Gogo were at war with the neighbouring Hehe and Maasai tribes during the pre-colonial era,²⁹ tension between the groups does not appear to be an issue in the present day.

The Gogo practise polygamy and the exchange of bride-wealth prior to marriage. The bride-price due to the bride's family will normally consist of goats, beads, a cow and an amount of money. Girls are considered marriageable once they have started menstruating and have undergone the traditional puberty rites that feature FGM.³⁰

Age and Prevalence

The DHS 2010 found that the prevalence of FGM in Dodoma, where the Gogo mainly reside, is 63.8%.³¹ Based on feedback from community representatives and clinics in Dodoma, however, The AFNET estimates that incidences of FGM have dropped to a 'very low level' among the Gogo (and Rangi). While the Gogo traditionally carried out FGM on girls between 10 and 15 years of age, it is now reportedly performed secretly on infants or has even died out in some communities.³² The reduction in the age at which FGM is performed can, in part, be attributed to the impact of the criminalisation of FGM and the belief in lawalawa (see FGM and *Lawalawa* on page 50).

Reasons for Cutting

Traditionally, FGM was performed as a rite of passage to ensure marriageability – a means of gaining the respect of the community and becoming a 'proper Gogo woman'. The prevailing reasons appear to be the maintenance of tradition and to cure lawalawa.³³

Type of FGM

Both Type I and Type II FGM have been reported among the Gogo.³⁴

The Traditional Gogo Ceremony

FGM among the Gogo shares a number of similarities with the rite practised by the Nyaturu in the Singida region. Girls and boys undergo cutting during the harvest months of June and July, and groups of initiates are trained in being a Gogo man or woman.

The ceremonies are said to take place once a father has decided that he wanted his daughter to be cut. His family and neighbours are notified and an *ngariba* is called. Traditional leaders also consult the gods in order to determine the appropriate time for the ceremony to take place.

The girls are usually unaware that they will be cut before the rite and are often lured into the bush with the promise of honey. Once the girls have been cut, they are covered in oil, dressed in new clothes and given gifts. It is considered appropriate for girls to wait to have intercourse until a year after being cut, as it is believed that children conceived before that time will die.³⁵

Hadza

The Hadza (also known as Kindiga or Hadzabe) are a hunter-gatherer group with a population of approximately 1,100, residing mainly in the areas around Lake Eyasi in the Singida region.³⁶ Of this population, only 300–400 continue to live as traditional hunter-gatherers, while the remainder have become part-time residents of settled villages, supplementing gathered food with store-bought produce.³⁷ Those engaged in the traditional way of life obtain approximately 95% of their subsistence from hunting and gathering; this diet generally consists of tubers, baobab fruit, berries, nuts, seeds, honey, hunted mammals (such as baboons, warthog and impala) and birds.³⁸ Both men and women are actively involved in providing for Hadza camps, with groups of women foraging for plant food (tubers, fruit and berries) and solo or paired males hunting animals and collecting honey and baobab fruit.³⁹

Socially, the Hadza reside in 'camps' of around 29 people, and tend to move site every one to two months.⁴⁰ An egalitarian way of life is followed, and equality is of high priority. There is no political structure within or between camps, and, similarly, there is no apparent hierarchy or set of group leaders. Food and tools are shared, as well as responsibility for caring for younger members of the camps.⁴¹

While there are no official marriage ceremonies, couples who have slept at the same fire for a period of time may consider themselves married.⁴² In addition, it is rare for a man to have more than one partner at a time; however, while some couples may stay in a pairing for life, it is more common for people to change partners a couple of times during their lives.⁴³

Hadza women are widely reported as having a great deal of autonomy and taking part in decision-making with men.⁴⁴ Further illustrating the autonomy of women within Hadza society, Finkel notes that in the changing of partners it is often women who initiate break-ups, particularly if their husbands have treated them badly or are found to be poor hunters.⁴⁵

The practice of FGM by the Hadza is an unusual case because, while FGM is commonly practised by pastoralists, it is rarely part of the culture of hunter-gatherer groups.⁴⁶ It has been suggested that the Hadza may have taken on the practice because the neighbouring Iraqw people – with whom the Hadza are often engaged in purification rituals involving intercourse – practise Type I FGM, and suggestions of a preference for 'clitrectomized women' from males in neighbouring groups have been made.⁴⁷

The Traditional Hadza Ceremony

Hadza girls undergo FGM as part of a puberty ritual, *mai-to-ko*. During *mai-to-ko*, girls who are in the *tlakwenakweko* age-set – that is, teenagers who have experienced their first menstrual cycle – assemble in a camp for three days, where they are dressed in ceremonial beads and feathers and take part in singing, dancing and chasing older boys with fertility sticks.

On the third day of the rite, the girls are segregated from the rest of the camp and males are not allowed to draw near to the area. It is here that an old Hadza woman will cut off part of the clitoris of each initiate (Type I FGM). Once Hadza girls have gone through *mai-to-ko*, they are officially ready for marriage; however, Marlowe has noted that girls will often only marry a year or two after the rite.⁴⁸

Kuria

The Kuria (the spelling 'Kurya' is also used) are a majority-pastoralist group residing in the Mara region of northern Tanzania, near the Kenyan border.⁴⁹ With a population of approximately 524,000,⁵⁰ the Kuria are divided into sub-clans. They have lived mainly as farmers and herders, with Kuria communities living in the Serengeti district remaining almost entirely pastoral.⁵¹

Age and Prevalence

The Kuria practise FGM every two years, on girls who are between the ages of 11 and 16.⁵² While this age range is not unusual in comparison to other practising groups, it is of interest in that the Kuria previously cut girls at 15 to 18, but brought the ceremony forward to counteract the rising number of refusals to being cut from older teenaged girls. The prevalence is particularly high within some districts, such as Tarime.

Reasons for Cutting

As with other groups, FGM among the Kuria marks the transition of girls into womanhood, with girls undergoing FGM in order to gain the respect of the community and avoid stigmatisation. Such is the peer pressure that girls have reportedly cut themselves with razors in circumstances where their parents do not want them to undergo FGM.⁵³

Once girls have been cut, they are rapidly found partners for marriage. Indeed, it is only through being cut that girls are considered eligible for marriage.⁵⁴

While public denunciations of FGM by politicians had caused some Kuria communities to cut girls in secret for a brief period, the lack of enforcement of the law or ramifications upon practitioners has led to a return of FGM being practised openly.⁵⁵ This is unlike many other regions of Tanzania, where the practice has gone underground. Please see the National Laws section below, which discusses the mass mutilations that still take place in the Tarime district and the difficulties faced in enforcing the law.

The Kuria: Traditional Beliefs, Ceremonies and FGM

In the Mara Region, over 95% of the population is Christian or Animist, although there is a small Muslim population, mostly in urban areas.⁵⁶ However, Animist beliefs seem to strongly influence the practice of FGM by the Kuria.

According to Ngowi, FGM among the Kuria is prohibited during July and August and in any year ending in the number seven, as such years are considered to be 'bad'.⁵⁷ Traditional leaders go to the river to ask spirits if it is safe to conduct the FGM ceremony during a particular year. This is done by leaving two empty calabash gourds next to the river overnight; if, when the leaders return, the calabashes are full, it is considered safe – if they are only half full, the ceremony must not take place.

The ceremonies traditionally take place in the open, in a sacred place, with many girls being cut at the same time.⁵⁸ FGM is considered to be a blood sacrifice to appease the ancestors (*mizumi*) and avoid misfortune. The events are accompanied by much celebration.⁵⁹

During the ceremony, the initiates are cut by an *omsali* (*ngariba* in Kiswahili).⁶⁰ Once the girls have been cut, they have a period of confinement and rest for one month, during which they will be cared for. They will then dress up and partake in traditional celebratory dances called *litungu* in order to 'advertise' themselves as being ready for marriage.⁶¹ If a girl dies after being cut or during the period of confinement afterwards, she is considered cursed and cannot be buried in the home. Her body is thrown away secretly like an animal, the mother is not permitted to mourn publicly and any presents received during the ceremony, even cows, must be destroyed.⁶²

There is a link between male circumcision and FGM, and this link, too, is associated with traditional Animist beliefs. Girls feel societal pressure to undergo FGM in order to benefit from the same status, celebration and transition to adulthood that male youths experience from their circumcision ceremonies. Boys and girls undergo circumcision/FGM at the same time, but in different areas. The places where the cutting takes place are considered sacred, and 'outsiders' are not permitted to enter them. Kuria women who have not undergone FGM are not permitted to 'receive' their sons following their circumcision ceremonies. After a boy is circumcised, he is permitted to build the gate of his future homestead. Traditional rites are performed at the homestead gate, and it is for this reason that the homestead gate and the receiving of the son following circumcision have such significance.⁶³

Maasai⁶⁴

The Maasai are one of the most widely-known pastoralist groups of East Africa. They are a semi-nomadic, Maa-speaking group, with an economy that centres on cattle and goat herding. Maasai clans occupy regions in both southern Kenya and northern Tanzania, with the Tanzanian Maasai population of approximately 309,000 people residing in the Manyara and Arusha regions.⁶⁵ There is a high prevalence of FGM within these regions. For instance, Larsen and Yan⁶⁶ found that 90% of women in Arusha have been mutilated. (Although the DHS 2010 reports that only 58.6% of women aged 15–49 are cut in Arusha and 70.8% in Manyara, this regional data should be interpreted with some caution.⁶⁷)

The status of women among the Maasai is low, and there are a number of Maasai cultural practices that reinforce women's position in the community. Fathers alone make decisions regarding the betrothal of daughters, and women do not hold positions of leadership.⁶⁸ Before initiation into womanhood through FGM, girls often go to reside in the residences of the *morani* (adolescent, circumcised males who have become 'warriors') to provide domestic help, during which time they are often expected to engage in sexual activity with the *morani*. In addition, girls and boys who have been circumcised on the same day are said to be age-mates and must develop a strong bond. Many married girls have reported that they have struggled with unwanted sexual advances when accommodating a visiting age-mate at their home and feared that they will be cursed if they refuse their age-mate.⁶⁹

The Maasai also practise polygamy, with men having on average 2.8 wives⁷⁰ and, on occasion, up to 16 wives, according to some studies.⁷¹ There is often competition between co-wives over limited household resources, with 'less-favoured' wives struggling to meet their needs and the needs of their children as a result.⁷²



*Maasai women
(© 28 Too Many)*

Age/Prevalence

28 Too Many's in-country research among the Maasai in Arusha has revealed different findings in relation to the ages of cutting between different groups within the community. This may reflect diverse perceptions or a reluctance to disclose due to the fear of prosecution. Some elders claimed that FGM had been abandoned entirely.

While elders in one community believe that FGM takes place when girls reach 18 years of age, students interviewed from the same community stated that, while, traditionally, the cutting took place when girls reached the age-group of 'maturity', which was between 12 and 20 years, there had been a shift to cutting infants and newborn babies as young as seven days old. The cutting takes place indoors, amidst much secrecy, and a number of infant deaths result from it. It was reported that parents do not take them to hospital as they are afraid of detection. Sometimes, even the father is not aware that the cutting is taking place.

'We were cut when we were 11 years old, up to 20 years old. Many of the Maasai girls are forced into marriage after initiation. Nowadays our young sisters are cut at only seven days old. The cut infants sometimes die. It is not easy to know because it is done in secrecy between the engamuratani ["excisors"] and the mothers and aunts of the baby.'

~ Focus group participant⁷³

Reasons

Girls are often married shortly after being cut and are thus denied an education. Maasai elders, however, stress the importance of the rite in transforming girls into 'complete' women, making them acceptable and prepared for marriage. It is believed that, once a girl has been cut, she has the 'right' to marry and produce a family; an uncut girl will not be afforded this right. The Maasai elders contend uncut girls and women would not be allowed to join the community of adult Maasai women. It is a widely-held belief that uncut girls are not only a disgrace, but bringers of misfortune to their families. For this reason they face discrimination and exclusion within their communities. One elder commented with regard to FGM that 'it is a treasured rite of passage rooted in cultural traditions, embedded in our customs and always signified to us by our oracle's visions for a perfect Maasai society.'

Type of FGM and Traditional Excisors

Traditional excisors called *engamuratani* in Maa (as opposed to the Kiswahili *ngariba*) remove the whole clitoris of the initiates (Type I FGM) using a section of iron sheeting known as *omurunya*. Previously, Type II was performed. Engamuratani are highly respected for their work and – as they can earn per girl cut up to 10,000 Tanzanian Shillings (US\$6) and/or a cow, goats, sheep and a substantial portion of meat from cattle slaughtered for the rite – are considered to be wealthy members of the community. Although the engamuratani are believed to have been educated on the harmful consequences of FGM, including its illegal status, they persist in carrying out the practice. They also reportedly exert pressure on parents who are reluctant to cut their daughters. Many believe that this is due to the benefits they receive from performing the rite. However, student respondents claimed that, in order to conceal the fact that cutting is taking place, ceremonies no longer take place openly, the traditional songs are no longer sung and the oilate tree is not placed in front of the house. These girls noted that cutting now takes place during the time that the boys are being circumcised (diverting attention away from their FGM rite), and girls no longer wear special ceremonial clothing so as not to reveal any differentiation between cut and uncut girls. The reason for this change is



**Male Maasai elders, Arusha
(© 28 Too Many)**

reported to be to avoid prosecution, following the outlawing of FGM. In addition, following sensitisation by NGOs, the current generation has witnessed many enlightened Maasai girls running away to avoid FGM. Therefore, Maasai traditionalists believe that cutting infants will ensure that FGM is perpetuated.

Participants of focus-group discussions said that, currently, some families have decided not to cut their girls and that such families face severe challenges from other community members.

The Traditional Maasai Ceremony

Traditionally taking place during the school holidays in December and the cooler month of June (supposedly to aid the healing of the cut genitalia), the rite is carried out over five days. Over the course of the ceremony, a cow, goat and sheep are slaughtered, and a branch from a special *oloilate* tree is placed in front of the house in which the initiates are undergoing FGM. This tree acts as a sign that girls from the *boma* are being prepared to enter adulthood. The mothers of the girls who are cut will touch the tree while it is held up by a circle of other women. The women also sing traditional songs that celebrate the occasion and praise the girls for being cut.

Once the girls have undergone FGM, their wounds are dressed with fermented milk or Vaseline and they are given protein-rich foods, fatty meats and blood to eat and drink, in order for them to regain their strength. The girls (at least traditionally) were adorned with traditional Maasai ornaments (*shanga*), dressed in ceremonial black clothing known as *kaniki* and presented with money and gifts such as clothes, a cow or a goat. The bone of one of the front legs of the slaughtered cow is cut off and presented to an initiate as part of her naming ceremony, acting as an emblem of grace by which she will have a peaceful marriage and children, and will not be affected by the misfortunes of life.

A period of seclusion is then to take place, sometimes lasting several months. Many girls are unable to continue with their education during this period; others still are quickly married and so must give up school entirely. While in seclusion, the *engamuratani*, mothers and aunts of the initiates are responsible for imparting the knowledge and skills required for the girls to become capable Maasai wives and mothers, including how to care for her in-laws.

Attitudes

Maasai women also reported a shift in preference among boys and young men towards marrying uncut girls; however, the opinions of young Maasai males were not collected to verify this claim. Some participants reported a difference in attitudes between Maasai girls: educated girls 'hated and despised' FGM, while uneducated girls liked it because they thought of getting presented with gifts and bringing honour to their families. However, other participants said that educated girls still want to undergo FGM in order to gain social acceptance as an adult member of the Maasai community. With regards to the right to receive education, one elder commented, '[U]nfortunately, we do not initiate our girls for that purpose.' One study by Equality Now on the Maasai in Kilimanjaro showed that some traditional elders have publicly denounced FGM and are now fully engaged in the campaign against it. One village enacted a by-law against FGM that led to action being brought against the parents of an 18 year old who was cut.⁷⁴

The Maasai: The History of Development and Anti-FGM Campaigns

The Maasai have a long and complicated history of highly politicised interactions with local, national and international organisations that seek to promote 'civilisation', development and modernisation. As one commentator notes, the semi-nomadic pastoralism of the Maasai has been treated by colonial and post-independence governments as being a 'backward' way of life, and their 'stubborn traditionalism' is widely viewed as the principal barrier to school attendance and female empowerment. FGM among the Maasai is often attributed to 'their cultural isolation and ignorance, the stubborn persistence of apparently static customs, and an unwillingness to change'.⁷⁵

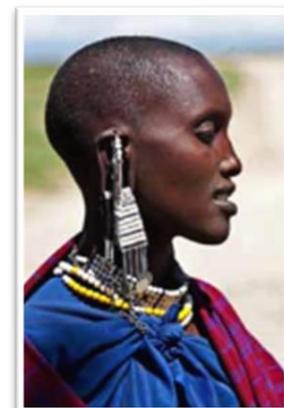
Sometimes, 'development' and 'civilisation' have involved the forcible removal of land in return for no or little tangible benefit. As a result, many Maasai have decided that cultural practices such as FGM, undermined by such development efforts, must be protected at all costs. Attacks on FGM, both historically and today, may therefore politicise FGM as an essential element of Maasai cultural identity.

Winterbottom *et al* argue that the new lexicon of development, with its emphasis on 'culture' and 'tradition', often disguises a continued attack on Maasai culture by civil society organisations (CSOs) as well as schools, religious organisations and the media. Development initiatives and anti-FGM campaigns may be viewed with suspicion by the Maasai, especially where there has been declining service provision and previous development initiatives have had negative consequences. Campaigns that remove Maasai from their land and enforce school attendance have proved particularly controversial and figure centrally in Maasai fears of their cultural and physical destruction. Anti-FGM campaigns must therefore be seen within this troubled historical and political context.

Despite the perception that the Maasai cling to static traditions, the cultural practices of the Maasai do change. Changes are expressed by the Maa concept of *enkisasai* (meaning 'new' or 'modern'). FGM ceremonies have changed – for example, the traditional dress of initiates has changed from the leather robes with bead embroidery of the past to more simple designs made from brown or black cloth. Changes to the FGM ceremony are often expressed in terms of changes to the local environment and ecology, rather than in the language of laws or rights. For example, as cattle and other resources become scarce, a father is no longer expected to slaughter an ox before the ceremony. In addition, the fact that the Maasai appear to be cutting girls at a much younger age, in response to the outlawing of FGM and the perceived need to treat lawalawa and not as part of an initiation into adulthood, illustrates the Maasai's ability to adapt to circumstances.

Winterbottom *et al* conclude that anti-FGM campaigns must:

- be rooted within the Maasai communities;
- use locally appropriate language and terminology;
- make the case for change in the language of *enkisasai*, emphasising the constant adaptation of Maasai cultural practices to change; and
- be accompanied by real improvements in the availability, accessibility and cultural appropriateness of local health and educational services.⁷⁶



Nyaturu

The Nyaturu, a population of approximately 932,000, reside in the central and southern parts of Singida, west of the Wembere river.⁷⁷

Age and Prevalence

According to Larsen and Yan, 27.8% of women have undergone FGM within the Singida region.⁷⁸ The Anti-Female Genital Mutilation Network of Tanzania (AFNET), based on feedback from community representatives and clinics, reports that the current prevalence is between 30% and 40%. In one small-scale study in 2010 at a reproductive health clinic at which girls under the age of two were physically examined, it was found that 84% had been cut (59 girls out of 70).⁷⁹

Traditionally, Nyaturu girls had to be 8–12 years old or found to be tall enough to undergo FGM.⁸⁰ Girls now undergo FGM at an earlier age, often as babies, amidst much secrecy. The lowering of age and prevalence can, in part, be attributed to the impact of the criminalisation of FGM and belief in *lawalawa* (see FGM and *Lawalawa* on page 50).

Reasons

FGM was traditionally performed as a rite of passage, to ensure marriageability and as a means of gaining the respect of the community and avoiding stigmatisation. The prevailing reasons appear to be the maintenance of tradition and to cure *lawalawa*.⁸¹

Type

Both Type I and Type II FGM have been reported.⁸²



*A Nuaturu woman, Singida
(© 28 Too Many)*

The Traditional Nyaturu Ceremony

The Nyaturu call FGM *irongho*, meaning a thing closely related to the gods (the ancestors), who are called *arongo*. It is therefore a sacred matter and a taboo to discuss publicly. Traditionally, the Nyaturu have conducted cutting ceremonies as rites of passage for both boys and girls at the same time. The ceremonies would take place in June and July to coincide with the harvest, ensuring the abundance of food. The communities also believed that the cooler temperature of these months would lessen bleeding and aid the healing of the girls. The rite involved the separation of initiates into camps, where they learned of cultural and community values and sang songs of leaving their childhood behind.⁸³ If a child bled to death during the cutting, this was seen as a curse from the ancestors.⁸⁴

Pare

The Pare (also called Asu) are an Asu-speaking, Bantu people residing in the northeast Kilimanjaro region, in the Pare Mountains, lying along the border with Kenya.⁸⁵ Being situated in a mountainous region, the Pare are engaged in a highland farming system of production. The majority of families also keep cattle, goats and sheep as sources of protein and wealth.⁸⁶ Their population is about 699,000.⁸⁷

While Pare women carry out duties commonly associated with the female domain by many Tanzanian peoples – cooking, washing, planting, weeding and looking after cows – the increase in migration of Pare men from the Ugweno district to urban areas for employment has resulted in a shift in the traditional division of labour between married men and women. Women with migrant husbands have sole responsibility for farming and marketing their produce. Coffee, however, continues to be sold only by men.⁸⁸

The majority of Pare are Muslim.⁸⁹ Hollos and Larsen note that, while there is also a Lutheran Christian presence among the Pare, Muslim and Christian families co-exist peacefully, with some families even containing converts from one religion to the other. Within the Muslim Pare community, there is a persistence of polygamy and, it is argued, ‘a related ethos of male superiority’. However, in recent years the practices of polygamy and marriages arranged by patrilineal elders have been seen to diminish (potentially due to a rise in marriages to women from the neighbouring Chagga ethnic group), and, in the present day, Pare households are most commonly composed of a couple and their unmarried children. Bride-wealth, however, remains an important part of Pare marriages.⁹⁰

Age and Prevalence

One study in 2002 among Pare and Chagga in an urban area of Kilimanjaro, which involved physical examination, found the prevalence of FGM among the Pare to be 35.8%, compared to 4.8% among the Chagga. Pare therefore had a significantly higher prevalence than the other main ethnic group in the same region. The study found an overall prevalence in the region of 16.6%. A study four years earlier found a much higher prevalence in rural Kilimanjaro. This may reflect a selection bias in the study, since the participants were relatively young, or it may reflect an actual lower prevalence in urban areas.⁹¹ The median age at which FGM is carried out is nine years.⁹²

Reasons

Perpetuation of tradition (67%) and the opportunity to teach about marriage and life (40%) were the most common reasons given by the Pare for carrying out FGM.⁹³ While discussing FGM with girls in Moshi, 28 Too Many was able to obtain the views of a number of Pare girls. They stated that the elders within their communities support FGM, claiming that it prevents girls from contracting UTIs (i.e. lawalawa) (see FGM and ‘lawalawa’ on page 50).⁹⁴

Type

Only Type I FGM has been reported among the Pare.⁹⁵ This is supported by 28 Too Many’s in-country research.

The Traditional Pare Ceremony

It appears that, like their neighbours the Chagga, the Pare have a goat slaughtered in order for its meat and blood to be consumed by the girls to regain their strength. Following being cut, Pare girls are provided with special black-and-red clothing to set them apart from girls who have not been cut.⁹⁶

Reasons for Practising FGM

FGM is most commonly practised as a **rite of passage into adulthood**.⁹⁷ In the Singida region of Tanzania, the Nyaturu ceremony of ihongo takes place every four to five years to cut groups of girls between the ages of 8 and 12, or those considered to be tall enough, and initiate them into womanhood.⁹⁸ In other regions, ceremonies are carried out every two years. The WHO has noted that, in many societies, FGM is seen as a 'necessary step' in a girl's journey into womanhood, and those forgoing it are at risk of not being socially accepted as women.⁹⁹

Large groups of girls will go through the rite together during the FGM season. A number of articles have highlighted the sheer scale of the practice in particular regions of the country. Some reports claimed that up to 5,000 girls in the Tarime district of Mara were at risk of being subjected to genital cutting during the school-holiday period at the close of 2012.¹⁰⁰

Reasons for the practice of FGM often vary with national and regional views, ethnicity, beliefs and world-perspectives. The Kuria, and similarly the Maasai, instil ideas of the importance of marriage in girls and socialise them to be able to run a household by the age of ten. Due to this early socialisation to the ideals of marriage, the Kuria are said to use FGM as a means to prepare – or 'validate' – a girl's body for marriage.¹⁰¹ Indeed, **child marriage** and FGM are intrinsically linked for the vast majority of practising communities in Tanzania. For many families within these communities, girls provide the opportunity to obtain wealth through the payment of bride-price. As women are mainly viewed as potential wives and mothers, parents are not motivated to keep girl children in school for longer than is considered necessary, as this would delay marriage, prolonging parental financial responsibility for their daughters. It is therefore within the economic interests of parents for girls to marry early.¹⁰²

The insurance of a bride's **virginity** is extremely important, and, that being so, it is considered that the earlier a girl is married, the more likely she is to be a virgin. As FGM is seen as both initiating girls into womanhood – making them eligible for marriage – and as a means to ensuring female chastity, it is clear that the practices of early marriage and FGM are mutually dependent for validation.¹⁰³

All of this perpetuates FGM as a **social norm**. Families continue to practise FGM as it is a cultural expectation within communities to ensure that girls will be made socially acceptable for full participation in communal activities. In forgoing such an important cultural convention, individuals and families open themselves up to severe social consequences such as marginalisation, mockery and the loss of status. Therefore, some have argued that, although FGM is, by its nature, violent, it is not intended as a violent act but as an obligation to be fulfilled in order to be acceptable to society.¹⁰⁴

Traditional beliefs seem to be a significant driving force behind the continuation of FGM within some practising communities in Tanzania. While some continue the practice out of a sense of duty

to preserve the traditions of their cultures, many also practise FGM to appease their ancestors (*mizimu*). There is a strong belief that ancestors maintain a constant watch over the community. If members of the community displease the ancestors by not continuing traditions, their wrath will be incurred. As it is commonly believed that these ancestors must be 'fed' with the blood from FGM, many Tanzanians fear that ending FGM – both withholding the blood-offering and renouncing tradition – would anger the ancestors, bringing calamity upon the community.¹⁰⁵

There is also a **financial incentive** to continue practising FGM. Traditional excisors give a portion of their earnings to the traditional community leaders (*wazee wa mila*), who themselves plan the FGM ceremonies. Therefore, the negative social influence of traditional community elders can also be driven by their personal financial interests.¹⁰⁶

FGM AND THE TRADE IN BODY PARTS

The Ministry of Gender and Children, in collaboration with AFNET, undertook a study in the Manyara region (Manjoro district). They discovered that FGM was taking place, and the flesh was being dried and sold as charms used in witchcraft (*ngekewa*) to traders of tanzanite and other traders such as taxi drivers in Arusha, vegetable sellers in the market and fishermen. The charms were also found to have been placed in tanzanite mines to bring good fortune. It was discovered that elderly women were undergoing FGM as part of this trade.¹⁰⁷



Uncut, rough and raw Tanzanite (© Imfoto)

FGM and *Lawalawa*

Lawalawa is a relatively new phenomenon arising first among the Nyaturu in 1970, just after the Arusha Declaration of 1968. President Nyere's statement of *unjuuma* ('brotherhood') contained the Bill of Abolishment that banned FGM. During this period there were attempts to create a uniform culture and homogenise different tribal traditions to create a nation in which 'we are all Swahili'.¹⁰⁸

Following the declaration, the Dodoma and Singida regions witnessed outbreaks of genital and urinary-tract infections generally referred to as *lawalawa*, for which FGM was believed to be the only cure. These outbreaks led to mass ceremonies in which many girls were cut. As a result of a heightened visibility of FGM, the semi-military Field Force Unit and police were sent to Singida and Dodoma to forcibly stop the practice. According to the NGO AFNET, in a six-month period, many

people 'were roughly treated, beaten, held in custody in police cells, and ultimately sent to court, where they were convicted and given jail sentences'.¹⁰⁹ AFNET reported that, 'instead of stopping FGM once and for all, the campaign forced it to go underground until today.'¹¹⁰

Lawalawa, meaning 'sweet taste' in Kiswahili, has been confusingly defined in the literature as various diseases:

- 'Lawalawa has been variously identified as thrush, trichomonas vaginalis and candida and is most likely a term encompassing various infections causing vaginal itching.'¹¹¹
- '. . . any of a number of bacterial diseases such as urinary and vaginal infections. This is mainly a result of poor cleaning of the girl child's genital parts due to lack of water as well as the practice of cleansing the genital areas with sand. Sometimes sexually transmitted infections are also found in girls, possibly contracted at birth. Locally these infections are named lawalawa.'¹¹²
- 'To the Nyaturu and Gogo people, lawalawa was and is a mythical curse from the ancestors who are feared by all and at the same time are the protectors of those who have got lawalawa. The clear message from the ancestors is: Have your girl circumcised or she will die.'¹¹³

The consensus of all the available literature is that most of the cases of vaginal and urinary-tract infections that give rise to the symptoms of vaginal swelling, itching and rashes, known locally as lawalawa, are bacterial in nature. As such, they are easily cured with a treatment of antibiotics from a health facility. A local female doctor said,

Actually there is medicine to cure lawalawa, but it does not reach the villages. The hygiene is poor, and poverty plays a role: lack of clean clothes, lack of possibilities to wash properly, etc. But the most important thing is knowledge. If people bring their daughters to hospital, they will get medicines and treatment for lawalawa.¹¹⁴

Sadly, transport is costly, roads are bad and some villages are far away from any medical centre, so when children get lawalawa, the cheapest 'treatment' is FGM.¹¹⁵

In the 1970s the belief spread across central Tanzania to the Gogo, Masaai and Chagga that lawalawa was a curse from the ancestors and FGM was the only way to prevent the death of their children. At that time, FGM began to be performed on baby girls, in secret. Chiku Ali asserts that the Nyaturu invented lawalawa as a pretext under which to continue performing FGM, even though it lost some of its original meaning as a rite of passage:

Strangely, the phenomenon of lawalawa did not exist before the authorities decided that FGM must be banned immediately. The population were under observation and told they must abandon FGM within six months.¹¹⁶

More than 40 years after the Arusha declaration, the belief in lawalawa persists. The belief is not limited to vaginal infections, but is also sometimes declared when girls or boys have a fever or other illness.

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Countrywide Taboos and Mores

The most widespread taboos in Tanzania are associated with sex and sexuality. Sexual behaviour is a highly sensitive subject and is not discussed between adults, children and young people.¹ Writers exploring the social impact of HIV/AIDS in Tanzania have found that the severity of the stigma surrounding the disease – as opposed to that surrounding cancer or other terminal diseases – results from the understanding that the vast majority of HIV/AIDS infections are transmitted through sex.² The implications of having HIV/AIDS are serious, as sexual activity outside of marriage (both pre- and extra-marital) is believed to be immoral. Therefore, the disease is often seen as a just punishment for sexual ‘deviancy’.³

FGM is commonly upheld as a necessary means to secure female virginity, reduce sexual desire and promiscuity, and improve fertility.⁴ Women who have not been cut are subject to social stigma in many communities throughout Tanzania. Girls and women who have not undergone FGM regularly experience discrimination and are often insulted by their peers, and some men are prohibited from marrying into families that do not practise FGM.⁵ If a man does choose to marry an uncut girl, the view is taken that this man has ‘done the girl a favour’. However, within such a marriage, the girl is likely to be discriminated against by her in-laws.⁶

There are numerous taboos surrounding girls who have not undergone FGM, affecting their participation in daily activities within their community. For example, girls who have refused FGM in the Tarime district are prohibited from cooking for their in-laws, washing in the river with girls who have been cut and opening the doors of cow shelters (to prevent their ‘bad luck’ being brought upon anyone who may enter the shelter after them).⁷ The social exclusion faced by girls who reject FGM seriously affects their abilities to marry.

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Sociological Background

Tanzania was ranked 47 out of 86 in the **2012 OECD Social Institutions and Gender Index (SIGI)**.¹

Early marriage is common in Tanzania, although this does appear to be changing. The DHS 2010 found that the median age for the first marriage of women aged 25–49 is 18.8. However, while 44.7% of women aged 45–49 were married by the age of 18, 36.9% of women aged 20–24 were found to be married by 18. Child marriage also appears to be less common. 13% of women aged 45–49 were married by the age of 15, while only 2.8% of women aged 15–19 were married by the same age. The minimum legal ages for marriage are 15 for women and 18 for men.²

Tanzanian law recognises three types of **marriage**: monogamous, polygamous and potentially polygamous. By law, mothers and fathers in Tanzania have equal rights in regard to parental authority, but many traditional practices discriminate against women, and men are very much in control at the household level. However, domestic violence is recognised as grounds for divorce by the courts.

Customary Law (Declaration) Order No. 436/63 discriminates against women as widows and daughters with respect to **inheritance**. Women and girls are unable to inherit clan land, and for other types of property they inherit less, if any at all. The DHS 2010 indicates some preference towards sons in regard to access to education, but not in regard to early childhood care.³

Although **domestic violence** is recognised as grounds for divorce by the courts, there is no law in Tanzania specifically addressing domestic violence. When a woman does seek help from the police, they are generally unwilling to intervene. Domestic violence remains very widespread and is believed to be severely under-reported. Pressure from family and the community to remain silent and the stigma surrounding GBV violence prevents many women from reporting spousal violence. The DHS 2010 found that 43.6% of women who had ever been married had experienced physical or sexual violence at the hands of their partners at some point in their lifetimes.⁴ **Rape** also remains a serious problem.

Women's **freedom of movement** may be restricted on a day-to-day basis: 49.5% of married women aged 15–49 questioned for the DHS 2010 stated that their husbands made the final decision as to whether or not they could travel to visit family.⁵

1 OECD Development Centre (2012) *2012 SIGI Social Institutions and Gender Index: Understanding the drivers of gender inequality*, p.13. Available at <https://www.oecd.org/dev/50288699.pdf>.

2 DHS 2010, pp.95–96.

3 DHS 2010, pp.16–17.

4 DHS 2010, pp.282–283.

5 DHS 2010, p.250.

Healthcare System

The distribution of **health facilities** in Tanzania has a heavy rural emphasis because more than 70% of the population lives in rural areas. In 1977 private health services for profit were banned under the Private Hospitals (Regulation) Act and the practice of medicine and dentistry prohibited as a commercial service. Health services are structured on various levels, including: village health services, which essentially provide preventative services that can be offered in homes; dispensary services, which cater for between 6,000 and 10,000 people and supervise all the village health posts in their wards; health centres, which cater for 50,000 people (approximately the population of one administrative division); district hospitals; regional hospitals; referral/consultant hospitals (presently there are four referral hospitals in the country); and treatment abroad, as, depending on the foreign exchange position, some patients have to be sent for treatment abroad.

There are several **medical-training** schools for various medical cadres. The aim of the Government is to train adequate, qualified and motivated medical personnel at all levels of the healthcare system.

The National Family Planning Programme is the sum total of all **family-planning** activities provided by various agencies, which are coordinated by the Reproductive and Child Health Unit of the Ministry of Health. The Government formally started providing family-planning services as one of its Maternal and Child Health components in the mid-1970s. This Family Planning Unit is responsible for initiating and developing family-planning standards and guidelines on service provision, training and other aspects of quality care.¹

Since 2006, **maternal and child healthcare** have been included as priority components of national health policy. The Government's health-sector strategic plan specifically addresses the midwifery workforce, and the Road Map for Reproductive and Child Health puts an emphasis on the need for skilled birth attendants with life-saving skills and competencies. The plan advocates producing more midwives and providing retention incentives. A pay-for-performance strategy is to be implemented as an incentive for midwives practising in remote areas. Free access to maternal healthcare services is always documented, but implementation appears to be limited by lack of equipment.²

Over the last 15 years, Tanzania has made a number of important achievements in **public health**. These include a rapid decline in childhood deaths (infant mortality was almost halved between 2001 and 2010), HIV prevalence falling from 7.1% to 5.6%, and, in March 2010, the United States and Tanzania signing a Partnership Framework to scale up prevention efforts while maintaining support for care and treatment.³ In addition, there has been a six-fold increase in the number of Tanzanian adults who know their HIV status, and more adults are protecting themselves from HIV infection through condom use. More children are fully immunised and sleep under insecticide-treated nets. Increased numbers of pregnant women are taking intermittent preventive treatment to reduce the consequences of malaria in both themselves and their unborn children.⁴

Problems in **healthcare financing** are being dealt with through prepayment schemes like national health insurance and the Community Health Fund. The majority of Tanzanians do not have health insurance. The DHS 2010 reports that 93.5% of women have no health insurance, 0.5% have social security, 3.7% have employer insurance, 2.1% have community-based insurance and 0.1% have

private care. Similarly, 93.3% of men have no health insurance, 0.5% have social security, 3.1% have employer insurance, 2.7% have community-based coverage and 0.4% have private care.⁵

Reproductive Healthcare

Although 95.9% of women receive **antenatal care** from a skilled provider, only 42.8% make the four (or more) antenatal visits recommended by the WHO (a decline from 61.5% at the time of the DHS 2004–05⁶). There is an inequality in the numbers who make four or more visits between women who live in urban areas and women who live in rural areas (urban: 54.8%; rural: 39.1%).⁷

50.6% of women receive **delivery assistance** from health personnel, but only 30.8% of women receive **postnatal care** from health personnel within the first two days after delivery.⁸

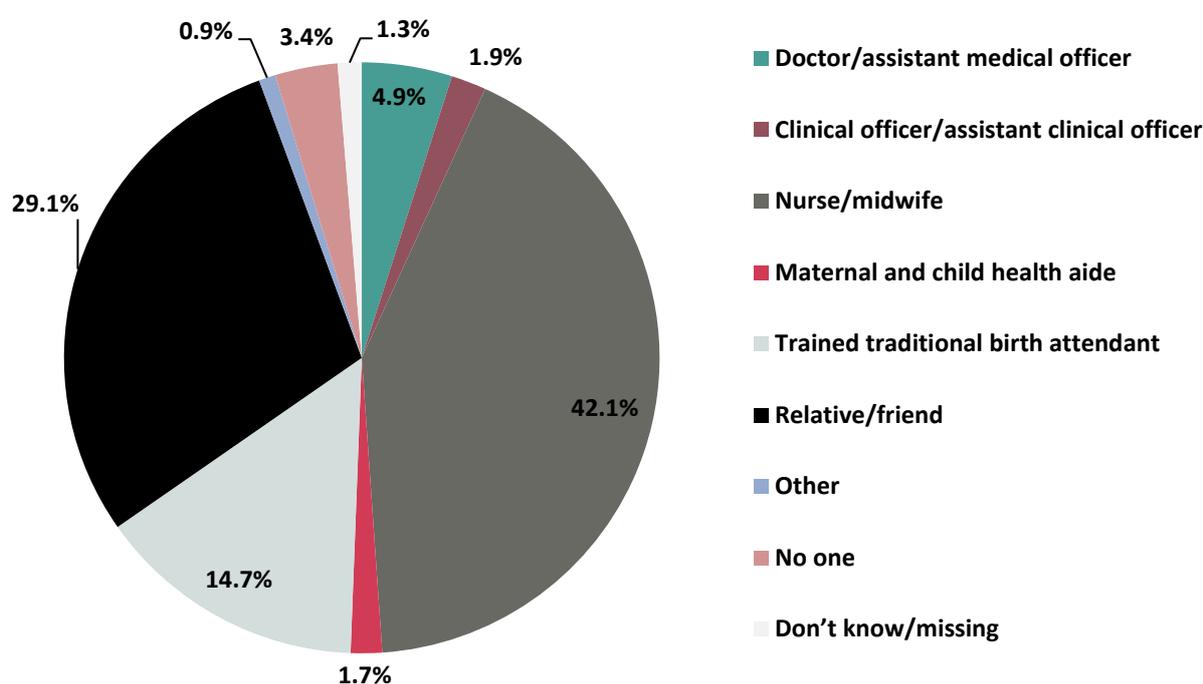


Figure 12: Percentage distribution of women who give birth under the supervision of a skilled provider, according to type of provider⁹

A recent report indicates that Tanzania is unlikely to meet its 2015 **reproductive health targets**, which aim to reduce the estimated one million abortions, 2.9 million unintended births, 18,000 maternal deaths and 500,000 child deaths that occur every year because of poor access to family-planning services. Referring to the poor reputation of Tanzania’s health systems, the authors of one report comment that, ‘[T]he bad birth care experiences of women undermine the reputation of the healthcare system, lower community expectations of facility birth, and sustain high rates of home deliveries.’¹⁰

Place of Delivery

Overall, 50% of births take place in a health facility. The percentage of births taking place in health facilities depends on certain demographic characteristics: births to women who are younger, who live in urban areas and/or who are in the higher wealth quintiles are much more likely to take place in health facilities.

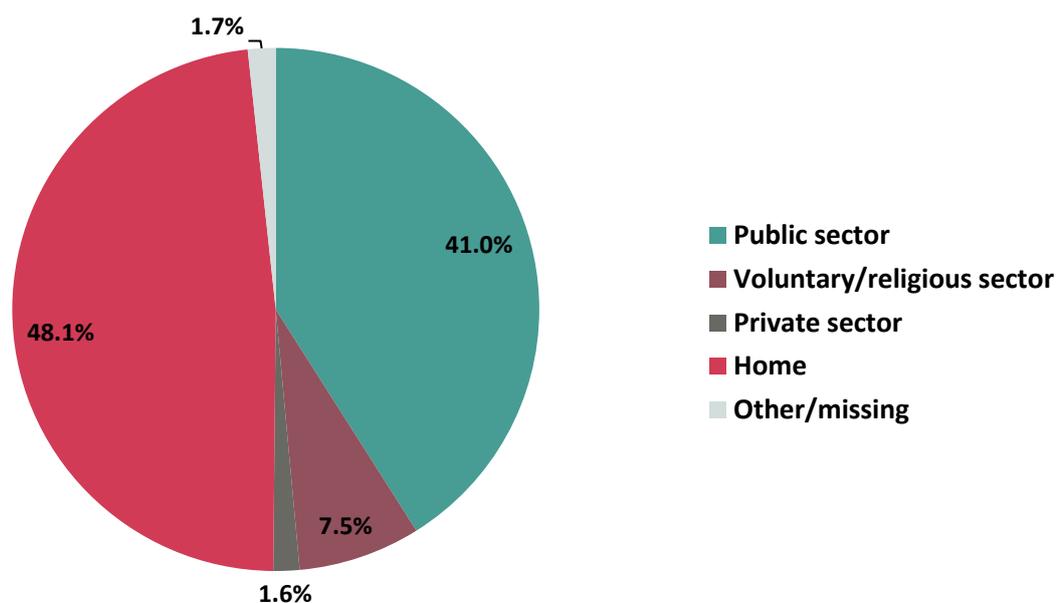


Figure 13: Percentage distribution of women who give birth according to place of delivery¹¹

Women's Health and Infant Mortality

Women's Health

There are numerous health concerns associated with FGM. **Immediate complications** can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection),

One study of the Chagga and Pare ethnic groups in urban Kilimanjaro (who traditionally practised Type I FGM), which involved physical examinations, found the most common gynaecological complication to be keloid formation, supporting other studies that have reported similar findings.¹²

urine retention, open sores in the genital region and injury to nearby genital tissue. **Long-term consequences** can include recurrent bladder and urinary-tract infections; cysts; infertility; an increased risk of childbirth complications and newborn deaths; and a need for later surgeries. For example, women who have undergone Type III infibulation need to be cut open later to allow for sexual intercourse and childbirth.¹³ There are reports that women who have undergone FGM also have reduced sexual desire, pain during intercourse and less sexual satisfaction.¹⁴

In relation to **psychological issues** surrounding FGM, some studies suggests that, following FGM, women are more likely to experience psychological disturbances (have a psychiatric diagnosis or suffer from anxiety, somatisation, phobia and low self-esteem). However, more research is needed to better understand the relationship between FGM and consequential psychological, social and sexual problems.¹⁵

In relation to the increased risk of birth complications, a WHO multi-country study, in which over 28,000 women participated, confirmed that women who have undergone FGM have a significantly increased risk of **adverse events during childbirth**. Higher incidences of caesarean section and postpartum haemorrhage were found in women with Type I, II and III FGM than in uncut women, and the risk increased with the severity of the FGM procedure. The consequences for women not giving birth in a hospital setting are likely to be even more severe.¹⁶ The high incidence of postpartum haemorrhage is particularly concerning where health services are poor or inaccessible.¹⁷

Another WHO-sponsored study is examining the association between FGM and **obstetric fistulae**. The pilot study indicated that there may be an association, but the final results are not expected until the end of 2013.¹⁸ The DHS 2010 indicates that less than 1% of Tanzanian women report having experienced fistula, although a majority (67%) of women have heard of the problem.¹⁹

Infant Mortality

The WHO-sponsored study also shows that the death rate for newborn babies is higher when mothers have had FGM. There is an increased need to resuscitate babies whose mothers have had FGM. The death rate among babies during and immediately after birth is also much higher among those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.

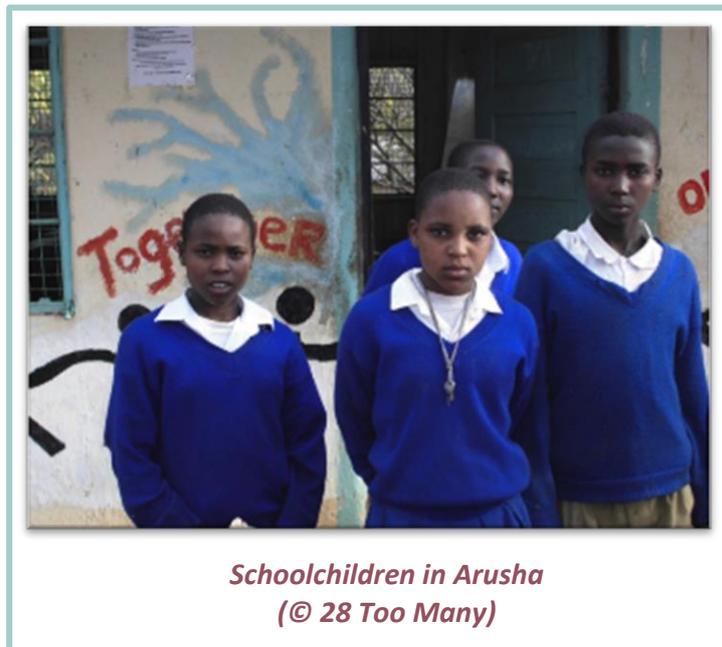
In addition, a multi-country modelling study was set up to estimate the increased costs in obstetric care due to obstetric complications as a result of FGM. The annual cost was estimated to be US\$3.7 million and ranged from 0.1% to 1% of government spending on health for women aged 15–45.²⁰

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- 1 United Republic of Tanzania (2012) *Government Portal*. Available at <http://www.tanzania.go.tz/>.
 - 2 UNFPA (2011) *The State of the World's Midwifery 2011: Delivering Health, Saving Lives*. Available at <https://www.unfpa.org/publications/state-worlds-midwifery-2011>.
 - 3 USAID (2013) *Stories from the Field: Women leaders join in Mara, Tanzania to call for an end to GBV* *Stories from the Field: Women leaders join in Mara, Tanzania to call for an end to GBV*, 1 July. Available at http://www.healthpolicyinitiative.com/index_id_successStories.html.
 - 4 *Tanzania Global Health Initiative Strategy 2010–2015* [no longer available online].
 - 5 DHS 2010, pp.49 & 50.
 - 6 DHS 2004-05, p.134.
 - 7 DHS 2010, pp.129–129.
 - 8 DHS 2010, pp.137–139.
 - 9 DHS 2010, p.137.
 - 10 Mselle *et al* in IRIN (2013) *Tanzania Likely to Fall Short on its Family Planning*, 19 November. Available at <http://www.irinnews.org/report/99159/tanzania-likely-fall-short-its-family-planning-targets>.
 - 11 DHS 2010, p.135.
 - 12 Sia E. Msuya, Elizabeth Mbizvo, Akhtar Hussain, Johanne Sundby, Noel E. Sam and Babill Stray-Pedersen (2002) 'Female genital cutting in Kilimanjaro, Tanzania: changing attitudes?', *Tropical Medicine and International Health* 7(2), pp.159–165.
 - 13 World Health Organization (2011) *An update on WHO's work on female genital mutilation (FGM) Progress report*, pp.3 & 7. Available at http://apps.who.int/iris/bitstream/handle/10665/70638/WHO_RHR_11.18_eng.pdf;jsessionid=B9C59C50B0B821AC81747A9A43644EB8?sequence=1.
 - 14 Rigmor C. Berg, Eva Denison, and Atle Fretheim (eds.) (2010) 'Psychological, Social and Sexual Consequences of Female Genital Mutilation/Cutting (FGM/C): A Systematic Review of Quantitative Studies', *Norwegian Knowledge Centre for the Health Services (NOKC) 2010(13)*, June. Oslo, Norway: Knowledge Centre for the Health Services at The Norwegian Institute of Public Health (NIPH). Available at <https://www.ncbi.nlm.nih.gov/pubmed/29320049>.
 - 15 *Ibid.*
 - 16 World Health Organization (2006) 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries WHO study group on female genital mutilation and obstetric outcome', *The Lancet*, 3 June. Available at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68805-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68805-3/fulltext).
 - 17 World Health Organization (2008) *Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO*. Available at http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.
 - 18 World Health Organization (2011), *op. cit.*, p.7.
 - 19 DHS 2010, p.142.
 - 20 World Health Organization (2011), *op. cit.*, pp.3 & 7.

Education

Pre-school education caters for children aged five to six and lasts two years; attendance is not compulsory. Primary education is compulsory and lasts seven years. At the end of the process, the Primary School Leaving Examination is set, which is used for secondary-school selection. Secondary education is in two cycles, the first lasting four years and preparing students for the Certificate of Secondary Education Examinations, and the second lasting two years and leading to the advanced-level examination. Tertiary and higher education is offered in universities, university colleges and tertiary-level institutions.¹

In mainland Tanzania there has been an improvement in the percentage of pupils **completing primary school** (Standard VII) from 72% in 2009 to 95.1% in 2010. However, the transition from primary Standard VII to secondary school dropped from 56.7% in 2007 to 50% in 2009.² This may be associated with the declining trend in the percentage of pupils passing the Primary School Leaving Examination.



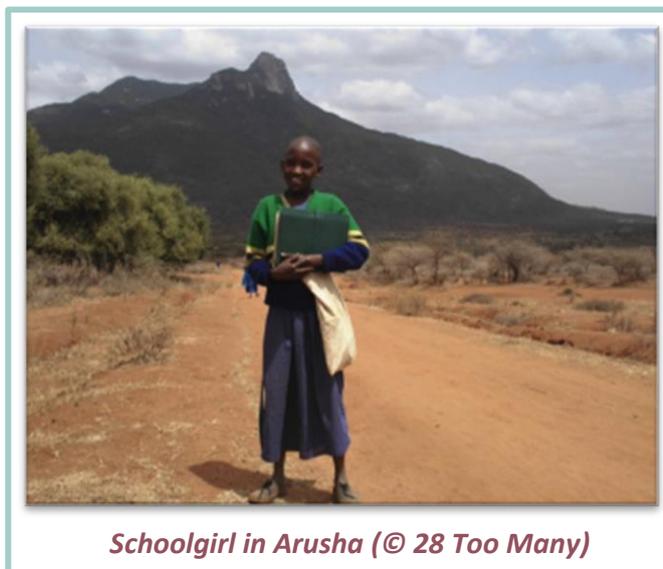
Progress has been made in **gender parity** in education since the early 1990s. Primary-school enrolment ratios for girls and boys are nearly equal, although the gender balance deteriorates with the transition to secondary school and higher levels. MDGs 2 and 3 are both thought to be achievable by 2015.³

The Central Intelligence Agency's World Factbook reports that the adult **literacy** rate in Tanzania is 67.8%.⁴ The literacy rate is higher among men (75.5%) than among women (67.8%), and lower in rural areas than in urban areas. In order to reach an increased level of literacy, more effort is needed to increase enrolments of school children and ensure that they complete primary school and transition to higher levels, supported by adult literacy programmes.

Early pregnancies and marriages at young ages continue to contribute significantly to school dropout among girls in both rural and urban areas.⁵

Education and FGM

In many cases, FGM has a negative impact on girls' educations. Girls are taken out of school to be cut, and the healing time takes several weeks, resulting in further school absence. Moreover, as FGM is considered by many groups to be a rite of passage into womanhood, it is likely that a girl's education will end after she is cut in order for her to be married. Studies have shown that education influences perceptions of FGM and that educated women are more aware of its health consequences.



Schoolgirl in Arusha (@ 28 Too Many)

The DHS data below shows that the prevalence of FGM generally decreases with the level of a woman's education. In addition, the higher a woman's education level is, the less likely she is to be in favour of FGM.

The association between education and FGM may, however, be more complex than it initially appears. The educational background of the parents, integration with other groups that do not practise FGM (such as occurs in urban areas) and access to media may play larger roles than education level.⁶

Education Level	2010
'No' education	20.3%
Primary incomplete	12.9%
Primary complete	16.6%
Secondary and above	3.1%

Table 2: Prevalence of FGM in Tanzanian women (aged 15–49), according to levels of education⁷

Education Level	2004–05	2010
'No' education	8%	5.4%
Primary incomplete	4.6%	3.5%
Primary complete	2.3%	2.9%
Secondary and above	0.7%	0.2%

Table 3: Percentage of Tanzanian women (aged 15–49) with at least one daughter with FGM, according to the mother's level of education⁸

Education Level	2004–05	2010
'No' education	2.8%	4.2%
Primary incomplete	2.8%	2.2%
Primary complete	1.9%	2%
Secondary and above	0%	0.5%

Table 4: Percentage of Tanzanian women (aged 15–49) who intend to have daughter cut, according to the mother's level of education⁹

There is a strong preference for educating boys in Tanzania. Families will even sell their cows to pay boys' school costs. Girls are not so lucky, and parents are often wary of the independence that might result from educating them.¹⁰

In the Tarime district, most girls get married after finishing primary education (up to Standard VII), especially if they do not pass exams for government secondary-school entry. Girls who do not go to school at all get married younger, once they have undergone FGM. Sometimes, if the husband of a girl who has completed primary education continues his education into secondary and beyond, he will abandon his poorly educated wife to marry a more educated girl.¹¹

1 UN Educational, Scientific and Cultural Organization and International Bureau of Education (2010) *World Data on Education* [VII ed.]. Available at www.ibe.unesco.org/en/services/online-materials/world-data-on-education/seventh-edition-2010-11.html.

2 UNDP (2010) *Tanzania: Country Report on the Millennium Development Goals 2010*, p.16. Available at <http://www.undp.org/content/dam/tanzania/Tanzania%20MDG%20Report%202010.pdf>.

3 *Ibid.*

4 Central Intelligence Agency (2013) *The World Factbook: Tanzania*. Available at <https://www.cia.gov/Library/publications/the-world-factbook/geos/tz.html>.

5 UNDP, *op. cit.*

6 Sia E. Msuya, Elizabeth Mbizvo, Akhtar Hussain, Johanne Sundby, Noel E. Sam and Babill Stray-Pedersen (2002) 'Female genital cutting in Kilimanjaro, Tanzania: changing attitudes?', *Tropical Medicine and International Health* 7(2), pp.159–165.

7 DHS 2010, p.296.

8 - DHS 2004–05, p.253

- DHS 2010, p. 299.

9 - DHS 2004–05, p.253

- DHS 2010, p. 299.

10 Children's Dignity Forum and FORWARD (2010) *Voices of Child Brides and Child Mothers in Tanzania: A PEER Report on Child Marriage Tanzania*. Available at <http://www.forwarduk.org.uk/wp-content/uploads/2013/11/Voices-of-Child-Brides-in-Tanzania.pdf>.

11 *Ibid.*

Religion

Religious freedom is protected by the constitution and various laws and policies; it is prohibited to discriminate against anybody based on their religious beliefs, practices or associations.¹

Religious affiliation is not asked in the national census, and consistent data is therefore hard to find. Many religious groups are reluctant to estimate **religious demographics**, but most religious leaders estimate the population to be 50% Christian and 50% Muslim. A Pew Research Center survey conducted in 2010 suggests that approximately 60% of the population is Christian, 36% Muslim, and around 4% adhere to other religions.² The World Factbook 2013 states that on the Tanzanian mainland the religious composition is Christian – 30%, Muslim – 35%, and indigenous beliefs – 35%; and on Zanzibar the population is more than 99% Muslim, of which 80–90% are Sunni and the rest belong to Shia sub-groups.³ Followers grouped under ‘Christianity’ include Roman Catholics, Protestants, Pentecostals, Seventh-Day Adventists, Mormons and Jehovah’s Witnesses. Other religious groups in Tanzania include Buddhists, Hindus, Sikhs and Bahais.⁴

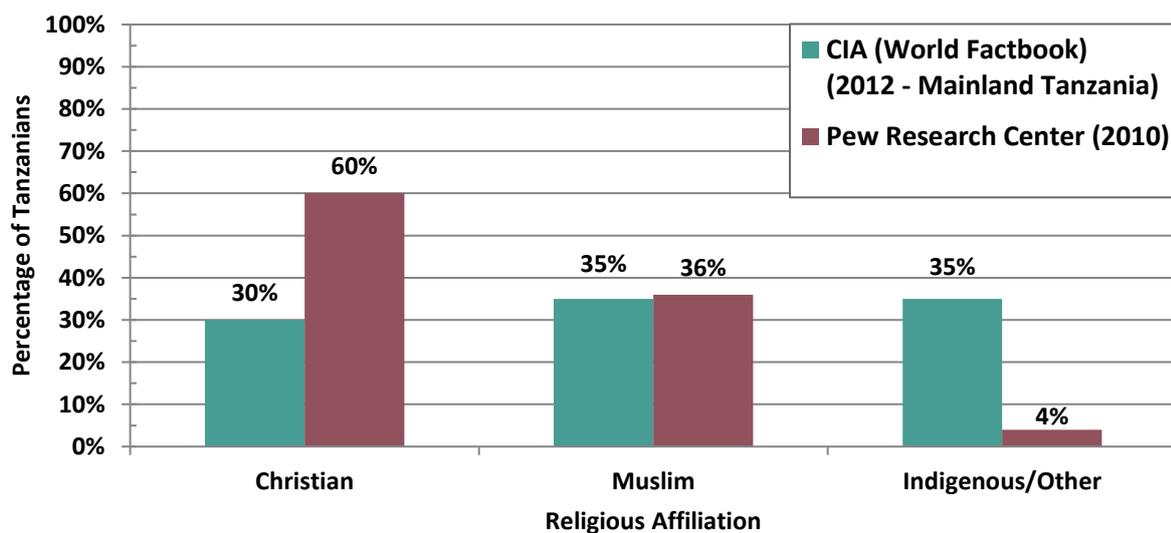


Figure 14: Religious affiliation in Tanzania according to different sources⁵

As in many countries in Africa, many of those who indicate they are deeply committed to Christianity or Islam also incorporate elements of **African traditional religions** in their practices. In Tanzania, more than half the people surveyed (60%) believe that sacrifices to ancestors or spirits can protect them from harm, which is the highest percentage of the 19 sub-Saharan African countries surveyed by Pew Research Center. In addition, 93% of Tanzanians say that religion is ‘very important’ in their lives, which again is among the highest percentages of the countries surveyed.⁶

There are numerous reports of **witchcraft**-based killings, including 71 killings and 28 attempted killings of persons with albinism, and 630 witchcraft-related killings of aged persons in 2012. Many of these were also associated with mob violence. Reasons given by the Legal and Human Rights Centre and the Zanzibar Legal Services Centre for these continued incidents are:

- (a) Economic conflict of interest from one family, within the family[,] or clan to clan has been a source of killings due to witchcraft and mob violence in all the lake zone regions;
- (b) High level of illiteracy and superstitious beliefs;
- (c) The use of witchdoctors has been named as a major factor for killings due to witchcraft beliefs. This is because majority of the people opt to go to witchdoctors for treatment and whenever they die, the witch doctor tends to tell relatives that there is someone behind that death.⁷

The Pew survey indicates that 85% of Tanzanians see others as being very free to practise their faiths.⁸ There are no reports of Government abuses of **religious freedom**, although the Government has imposed restrictions on some religious groups.

In the past Tanzania has earned a reputation for religious harmony, but recently there has been an increase in church-burning and heightened **tensions between Muslims and Christians**. For example, in May 2012, three churches were burned during riots in Zanzibar, following the arrest of a leader of the Islamic group Uamsho, after Uamsho argued that the constitutional review process pushed aside the interests of Zanzibar in favour of the mainland. In predominantly Muslim Zanzibar, churches reportedly symbolise the mainland's influence in Zanzibar: the attacks were apparently, in part, a strike against the mainland because of religious and political differences. Rioting also took place in 2012 in the Mbagala suburb of Dar es Salaam, and more than 100 people were arrested. The riots followed an incident in which a 14-year-old Christian boy was taken to the police for allegedly urinating on a copy of the Koran. After the police transferred the boy to another location, Christian churches were attacked in the area.⁹

43% of Christians see Muslims as violent, as opposed to the 11% of Muslims who see Christians as violent, and 24% say that **conflict between religious groups** is a very big problem.¹⁰

At the end of 2012, the president stated that, in Tanzania, for the first time in its history, there was a possibility of civil strife and division along religious lines. He encouraged religious and political leaders to take seriously their responsibilities to ensure that citizens continue to live peacefully, regardless of religion, ethnicity, colour or place of origin. In addition, some society leaders have taken positive action to promote religious freedom.¹¹

Religion and FGM

As in other countries, the practice of FGM in Tanzania predates the major religions and is not exclusive to one religion. Some people have attempted to justify FGM under Islam, yet many Muslims do not practise FGM and agree it is not in the Koran. The Bible does not mention the issue of FGM, meaning that Christians in Africa who practise FGM do so because of a cultural custom.

Many faith-based organisations (FBOs) and officials are involved in the eradication of FGM. In 2006, Target

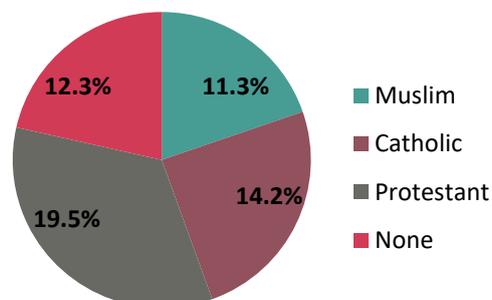


Figure 15: Prevalence of Tanzanian women (aged 15–49) who have undergone FGM, according to their religion (2004/5)¹²

sponsored a conference between Muslim scholars from many nations; they deemed FGM to be against the Islamic faith as it is a harmful attack on women.¹³

The DHS 2004–05 reported the prevalence of FGM in Tanzania according to religion, but the DHS 2010 did not (see Figure 15).

Of the Tanzanian regions that practise FGM, it appears that those that are predominantly **Christian** have the highest proportion of women who have had FGM.¹⁴

According to one study, there is little connection in Tanzania between adherence to **Islam** and the practice of FGM.¹⁵ Moreover, the Muslim Council of Tanzania (A.K.A. BAKWATA) has issued statements condemning FGM on Islamic grounds.

The few Muslims who live in Mara believe that FGM is a violation of Islam. A number of ethnic groups that practise Islam do not practise FGM. Notable is the island of Zanzibar, where 99% of the population are Muslim but the proportion of cut women is less than 1%. Similarly, prevalence is very low in the predominantly Muslim areas of Kigoma and Tabora. The only region where there is a large Muslim population that has a relatively high prevalence is Tanga.¹⁶

28 Too Many did, however, find that in Kilimanjaro some Muslims are practising a ‘lesser’ form of FGM and referring to it as *sunna* (*sunna* is the body of traditional sayings and customs attributed to the Prophet Muhammad and supplements the Koran). This does suggest one possible link between the practice and Islamic belief.

Tanzania has a high level of belief in **animism** alongside the mainstream religions, and such beliefs appear to strongly influence the practice of FGM in some groups, such as the Kuria in the Mara region.

1 US Department of State (2012) Tanzania 2012 International Religious Freedom Report. Bureau of Democracy, Human Rights and Labor. Available at <https://www.state.gov/documents/organization/208416.pdf>.

2 *Ibid.*

3 Central Intelligence Agency (2013) *The World Factbook: Tanzania*. Available at <https://www.cia.gov/Library/publications/the-world-factbook/geos/tz.html>.

4 US Department of State, *op. cit.*

5 - Central Intelligence Agency, *op. cit.*

- Pew Research Centre (2010) *Tolerance and Tension: Islam and Christianity in Sub-Saharan Africa*. Available at www.pewforum.org/2010/04/15/executive-sum-mary-islam-and-christianity-in-sub-saharan-africa/.

6 Pew Research Center, *op. cit.*

7 Legal and Human Rights Centre and Zanzibar Legal Services Centre (2012) *Tanzania Human Rights Report 2012*. Available at http://www.zlsc.or.tz/documents/Tanzania_Human_Rights_Report_2012.pdf.

8 Pew Research Center, *op. cit.*

9 US Department of State, *op. cit.*

10 Pew Research Center, *op. cit.*

11 US Department of State, *op. cit.*

12 DHS 2004–05, p.205.

13 Target (2006) *Newsletter 2006*. Available at http://w3i.target-nehberg.de/pdf/rundschreiben/AnnualReport_2006.pdf.

14 Elizabeth Heger Boyle, Fortunata Songora, and Gail Foss (2001) ‘International Discourse and Local Politics: Anti-Female-Genital-Cutting Laws in Egypt, Tanzania, and the United States’, *Social Problems*, 48(4), November 2001, pp.524-544.

15 *Ibid.*

16 *Ibid.*

Media

Press Freedom

The Committee to Protect Journalists reports that in Tanzania there has been a 'rise in anti-press attacks . . . set against a backdrop of repressive media laws', and that this is 'sowing self-censorship among Tanzanian journalists, especially those working in rural areas.'¹

Freedom House has declared that the media in Tanzania is 'partly free'.²

Despite the guarantee of free speech in the constitution (Article 18), there are examples of the Government suppressing information. The Human Rights Report states that the Government controls the media in Zanzibar, although the political opposition has gained increased access since the 2009 reconciliation; that journalists have been attacked, harassed and intimidated by law-enforcement authorities; and that a permit is required for reporting on police or prison activities, and journalists can be fined 250,000 Tanzanian shillings (US\$158) and/or face three years' imprisonment for not having one. The report also states that the media practises self-censorship to avoid conflict with the Government.³

East African newspapers, including Tanzanian ones, have been reasonably aggressive in their reporting. Exposure of individuals in government is measured. Generally, papers feel safer criticising inefficiency than misconduct. They feel free to complain about bureaucratic inadequacy and social conditions, and they discuss democracy in principle. The press is more careful in questioning election outcomes.

The Government itself is careful of the manner in which it interferes with the freedom of the press. It attempts to appear to be within legal boundaries. One of the more aggressive Swahili papers, *Mtanzania* ('*The Tanzanian*'), was shut down by the Government on the grounds that the publisher was not a Tanzanian national. Such incidents happen with sufficient frequency to remind those still in print to be wary and sensitive.⁴

Access to Media

The most popular **newspapers** in Tanzania are:

- *24 Tanzania (Dar es Salaam)* (English)
- *Arusha Raha* (Swahili)
- *Arusha Times* (English)
- *Business Times* (English)
- *The Citizen* (English)
- *Daily News* (English)
- *East Africa News Post* (English)
- *The Express* (English)
- *Guardian IPP (Dar es Salaam)* (English)
- *In2EastAfrica* (English)
- *Kafoi Online (Dar es Salaam)* (English and Swahili)
- *Kawowo Sports* (English)
- *Mwananchi (Dar Es Salaam)* (Swahili)
- *Raia Mwema* (Swahili)
- *Tanserve* (English)
- *Tanzania Daima (Dar es Salaam)* (Swahili)⁵

The International Telecommunications Union says that approximately 12% of Tanzanians use the **internet** and 5% of households had internet access in 2011.⁶

Men **access** various traditional media platforms more frequently than women (see Table 5), and there are positive correlations between people’s exposure to mass media and their levels of education and wealth. People living in urban areas have much greater access to these forms of media than people living in rural areas.⁷

Medium	Female	Male
Newspaper	18.8%	29.9%
Television	23.6%	39.5%
Radio	57.5%	76.5%
All three	8.6%	19.7%
None	36%	18.8%

Table 5: Percentages of Tanzanian men and women aged 15–49 who access various forms of media at least once per week⁸

1 Tom Rhodes (2013) ‘The Invisible Plight of the Tanzanian Press’, *Committee to Protect Journalists*, 6 August. Available at <https://cpj.org/reports/2013/08/the-invisible-plight-of-the-tanzanian-press.php>.

2 Freedom House (2013) *Tanzania*. Available at <https://freedomhouse.org/country/tanzania>.

3 Legal and Human Rights Centre and Zanzibar Legal Services Centre (2012) *Tanzania Human Rights Report 2012*. Available at http://www.zlsc.or.tz/documents/Tanzania_Human_Rights_Report_2012.pdf.

4 Press Reference (2013) *Tanzania*. Available at <http://www.pressreference.com/Sw-Ur/Tanzania.html>.

5 *Onlinenewspapers.com* (2013) [website]. Available at <http://onlinenewspapers.com/>.

6 Legal and Human Rights Centre and Zanzibar Legal Services Centre, *op. cit.*

7 DHS 2010, pp.39–40.

8 *Ibid.*

Public Attitudes To and Knowledge of FGM

Knowledge of FGM is generally common in Tanzania. In 2010, more than 75% of women across all age groups, levels of education and wealth, and most geographic regions had heard of the practice.¹

Women with higher levels of education are more likely to have heard of FGM (95.9%) than women with no formal education (70.2%). Similarly, women in higher wealth quintiles are more likely to have heard of the practice than those in lower wealth quintiles.

However, widespread knowledge of FGM in any given group does not predict a higher prevalence of FGM.

In urban areas, knowledge of FGM is 94.9%, while in rural areas it is 77.4%. Despite this, cutting is more than twice as prevalent in rural areas (17.4%) than in urban areas (7.8%).²

In Tanzania, **opposition to FGM** is high among women of all levels of education and wealth, but is highest among women who are more highly educated and wealthier.³

The highest levels of opposition to FGM come from the islands adjacent to mainland Tanzania: about 98% of women in Zanzibar believe that the practice should be stopped, and women from Zanzibar are also the least likely to be subjected to FGM (0.2% have been cut). However, it should be noted that these findings are based on only a small number of women.⁴

Table 6 below gives a breakdown of **support for the continuation of FGM** according to certain background characteristics of women aged 15–49, and the changes since the DHS 2004–05.

The continuation of FGM is supported by 5.5% of women aged 15–49 who have heard of the practice. This is broadly the same percentage as in 2004–05 (4.9%).⁵

Women in rural communities are around four times more likely to support the continuation of FGM (7.4%) than those in urban communities (1.8%).⁶ One reason for this difference in attitudes towards FGM is the greater level of awareness-raising by NGOs around the capital.

The strongest level of support by zone comes from Lake, where 10.9% of women support the practice, and the lowest level of support comes from the Southern and Eastern zones. The Lake zone appears to have had the largest increase in support, from 4.7% in 2005–05 to 10.9% in 2020.⁷

A woman's own FGM status appears to be an influence on whether she is likely to support the continuation of the practice. Women who have undergone FGM are much more likely to support its continuation (19%) than those who have not (2.7%).⁸ This is most likely to be as a result of the importance of FGM in changing the status of girls into socially accepted women in their communities. A number of observers have witnessed girls actively pursuing FGM in order to claim the prestige of status, gifts, and avoid the name-calling and social stigma attached to uncut women.⁹

FGM in Tanzania also has a low level of **support among men**. The DHS 2004–05 found that, of men aged 15–49 who have heard of the practice, 8.5% believe it should be continued, while 88.9% believe it should be discontinued.¹⁰ The DHS 2010 did not provide data on the attitudes of men towards FGM. Nevertheless, the majority of men are taught from an early age that cut women are ‘better’ than women who have not undergone FGM, and men can face ridicule from their peers should they marry a woman who has not been cut.¹¹ In its survey of Kuria men and women, the Devine Economic Development Group found that 51% of men would not marry a woman who has not had FGM.¹² Similarly, an elderly Gogo ngariba has testified that male relatives are prohibited from marrying uncut women as they are believed to be impolite and ‘over-sexed’.¹³

Background Characteristic	Attitude towards FGM (DHS 2004–05)		Attitude towards FGM (DHS 2010)	
	Should be continued	Should be discontinued	Should be continued	Should be discontinued
AGE:				
15–19	5%	89.9%	5.9%	91.8%
20–24	4.7%	90.5%	5.6%	91.6%
25–29	4.2%	91.4%	4.4%	92.5%
30–34	5.4%	91.2%	5.8%	92.2%
35–39	4.8%	90.2%	6.3%	91.2%
40–44	5%	91.2%	7.1%	90.7%
45–59	5.5%	89.7%	3.3%	93.8%
FGM STATUS:				
Not cut	1.6%	93.8%	2.7%	95.3%
Cut	18%	77.7%	19%	76.5%
AREA OF RESIDENCE:				
Urban	0.9%	96.9%	1.8%	97.5%
Rural	7%	87.3%	7.4%	89.2%
ZONE:				
Western	6.8%	77.7%	4.3%	92.5%
Northern	9.6%	87.8%	7.9%	88.7%
Central	5.4%	90.7%	7.7%	90.6%
Southern Highlands	5.5%	90.2%	3.7%	91.7%
Lake	4.7%	90.8%	10.9%	87.5%

Background Characteristic	Attitude towards FGM (DHS 2004–05)		Attitude towards FGM (DHS 2010)	
	Should be continued	Should be discontinued	Should be continued	Should be discontinued
Eastern	1.1%	97.7%	2.7%	96.1%
Southern	0.8%	96.5%	2.1%	95.3%
EDUCATION:				
No education	11%	81.4%	12.1%	82.8%
Primary incomplete	4.4%	89.3%	8.5%	88.7%
Primary complete	3.8%	92.6%	4.3%	93.3%
Secondary or above	0.1%	99%	1.2%	98%
WEALTH QUINTILE:				
Lowest	11.6%	83.3%	10.3%	85.7%
Second	7.4%	85.2%	7.7%	88.2%
Middle	6.9%	86.1%	7.9%	88.4%
Fourth	3.3%	92.8%	4.2%	93.5%
Highest	0.6%	97.6%	1.2%	98.5%
TOTAL	4.9%	90.6%	5.5%	91.9%

Table 6: Percentages of women aged 15–49 who have heard of FGM by opinion on whether FGM should be continued, according to selected background characteristics¹⁴

There is a widely-held belief – by both men and women – that FGM is necessary to **curb female sexuality**.¹⁵ Similarly, male Hadza respondents have contended that, unless the clitoris is removed, women will enjoy sex too much; this is seen as a problem because enjoyment causes women to move around and make noise during intercourse. Some men also believe that the clitoris must be removed, otherwise it will obstruct the birth canal during labour, preventing babies from being born successfully.¹⁶

HIV/AIDS and FGM

In academic literature there is a growing recognition of the need to explore the possible links between FGM and HIV/AIDS transmission. However, despite noting the lack of epidemiological studies into the transmission of HIV through FGM in sub-Saharan Africa, Monjok *et al* argue that there is an increased risk for the transmission of any sexually-related viral or bacterial pathogen if the vaginal epithelial has pre-existing lacerations or has suffered trauma. They follow on to

contend that, due to the increased risk of damage to the vaginal epithelial after FGM, the probability of HIV transmission increases.¹⁷

Having found only one under-aged, HIV-positive survey participant who had undergone FGM in their sample from the Kilimanjaro region, Klouman *et al* do not consider that FGM has a direct causal link to the transmission of HIV. However, as the survey data was collected in 1991 and 1992 – during the first phase of the HIV epidemic – the writers recognise a probable increase in cases as a result of more HIV-positive girls being cut along with their peers in FGM-practising communities.¹⁸

In Stallings and Karugendo's review of the relationship between FGM and HIV in Tanzania, a significant correlation between high rates of FGM and HIV was not established, with only four of the ten regions with the highest prevalence of FGM also listed in the ten regions with the highest rates of HIV infection.¹⁹

Msuyu *et al* also found no significant correlation between HIV (and hepatitis B) and FGM.²⁰

The performance of FGM as a collective rite for pre-pubescent children appears frequently in the literature. Due to this common practice, other researchers have found that unmarried respondents who have been cut present more cases of HIV than unmarried respondents who have not been cut, as a result of the transmission of infected blood via unclean instruments and the unwashed hands of the practitioners.²¹

In addition, Manjok *et al* have put forward further suggestions on the possible role of FGM in the transmission of HIV:

- (1) the sharing of blood between sexual partners as a result of vaginal tearing during intercourse;
- (2) an increased need for a blood transfusion (often unscreened) following haemorrhaging as a result of the actual FGM procedure, childbirth, defibulation or intercourse; and
- (3) engaging in anal intercourse in order to avoid the difficulties and pain of vaginal intercourse.²²

Evidence as to the direct impacts of FGM on the transmission of HIV remains inconclusive to date; however, the above shows some support for the notion that the practice of FGM may increase susceptibility to HIV.

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- 1 DHS 2010, p.294.
 - 2 DHS 2010, pp.294 & 296.
 - 3 DHS 2010, p.301.
 - 4 DHS 2010, p.301.
 - 5 - DHS 2010, p.301.
- DHS 2004–05, p.255.
 - 6 DHS 2010, p.301.
 - 7 - DHS 2010, p.301.
- DHS 2004–05, p.255.
 - 8 *Ibid.*
 - 9 - Monica Magoke-Mhoja (2008) *Child-Widows Silenced and Unheard: Human Rights Sufferers in Tanzania*. Author House UK Ltd.
- Children's Dignity Forum and FORWARD (2010) *Voices of Child Brides and Child Mothers in Tanzania: A PEER Report on Child Marriage Tanzania*. Available at <http://www.forwarduk.org.uk/wp-content/uploads/2013/11/Voices-of-Child-Brides-in-Tanzania.pdf>.
- Safeworld International Foundation (2012) *A baby dies from FGM as forum demands better education and an end to 'gifts'*. [No longer available online.]
 - 10 DHS 2004–05, p.256.
 - 11 - Children's Dignity Forum and FORWARD (2010), *op. cit.*
- Jessie Boylan (2009) 'RIGHTS-TANZANIA: 'I Feel Like Less of a Woman'', *Inter Press Service*. Available at <http://www.ipsnews.net/2009/12/rights-tanzania-i-feel-like-less-of-a-woman/>.
 - 12 Devine Economic Development Group (2009) *Male and Female Viewpoints On Female Circumcision in Tarime District Kuria community in Tanzania*, p.6. Available at http://preventgbvafrica.org/wp-content/uploads/2013/10/Viewpoint_on_Female_Circumcision.pdf.
 - 13 Equality Now (2001) *Tanzania: Failing to Enforce the Law Against Female Genital Mutilation*. Available at <https://www.equalitynow.org/action-alerts/tanzania-failing-enforce-law-against-female-genital-mutilation>.
 - 14 - DHS 2004–05, p.255.
- DHS 2010, p.301.
 - 15 - Jessie Boylan, *op. cit.*
- Monica Magoke-Mhoja, *op. cit.*
- Devine Economic Development Group, *op. cit.*
 - 16 Frank W. Marlowe (2010) *The Hadza: hunter-gatherers of Tanzania*. California: The Regents of the University of California, Berkeley and Los Angeles.
 - 17 E. Monjok, E.J. Essien and L. Holmes Jr. (2007) 'Female Genital Mutilation: Potential for HIV Transmission in sub-Saharan Africa and Prospect for Epidemiologic Investigation and Intervention', *African Journal of Reproductive Health*, 11(1), pp.33–42
 - 18 E. Klouman, R. Manongi and K.I. Klepp (2005) 'Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections', *Tropical Medicine & International Health* 10(1), pp.105–15.
 - 19 Rebecca Y. Stallings and Emilian Karugendo (2005) *Female Circumcision and HIV Infection in Tanzania: for Better or for Worse?* Rio de Janeiro: Third International AIDS Society Conference on HIV Pathogenesis and Treatment, 24–27 July. Available at <http://www.tzonline.org/pdf/femalecircumcisionandhivinfectionintanzania.pdf>.
 - 20 Sia E. Msuya, Elizabeth Mbizvo, Akhtar Hussain, Johanne Sundby, Noel E. Sam and Babil Stray-Pedersen (2002) 'Female genital cutting in Kilimanjaro, Tanzania: changing attitudes?', *Tropical Medicine and International Health* 7(2), pp.159–165.
 - 21 - D.D. Brewer, J.J. Potterat, J.M. Roberts Jr. and S. Brody (2007) 'Male and female circumcision associated with prevalent HIV infection in virgins and adolescents in Kenya, Lesotho, and Tanzania', *Annals of Epidemiology* 17(3), pp.217–26.
- E. Monjok, E.J. Essien and L. Holmes Jr., *op. cit.*
 - 22 E. Monjok, E.J. Essien and L. Holmes Jr., *op. cit.*

Laws Relating to FGM

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

- Convention on the Elimination of Discrimination Against Women (*CEDAW*)
- Convention on the Rights of the Child (*CRC*)
- International Covenant on Economic, Social and Cultural Rights (*ICESR*)
- African Charter on the Rights and Welfare of the Child
- Maputo Protocol to the African Charter on Human and Peoples’ Rights on the Rights of the Women in Africa (the *Maputo Protocol*)
- African Charter on Human and People’s Rights (the *Banjul Charter*)

The *CEDAW* and the *CRC* clearly prohibit traditional practices that discriminate against women and harm children. Article 2 of the **CEDAW** directs ‘State Parties . . . (f) to take all appropriate measures, to stop customs and practices which constitute discrimination against women.’ Additionally, Article 5 states:

State Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes

Article 24(3) of the **CRC** states, ‘State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.’ In addition, Article 19(1) provides that ‘State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse.’

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

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

The Maputo Protocol explicitly refers to FGM. Under Article 5, ‘state parties shall prohibit and condemn . . . through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them.’

The **Banjul Charter** includes provisions related to the right to health (Article 16) and the right to physical integrity (Articles 4 and 5).¹

In December 2012, the **UN** passed an historic resolution, calling on countries to eliminate FGM, and in 2013 the 57th UN Convention on the Status of Women agreed conclusions that included a reference to the need for states to develop policies and programmes to eliminate FGM as well as other forms of violence against women.²

Additionally, the African Union declared the years 2010 to 2020 to be the **Decade for African Women**.

National Laws

Age of Suffrage, Consent and Marriage

The legal minimum age for marriage is 15 years for girls and 18 for boys.³ The Penal Code allows for marriage under the age of 15 years, provided the marriage is not consummated before the age of 15 (s.138). Furthermore, under the Law of Marriage Act, a marriage contract can be agreed without the bride's consent, based on agreement between the girl's father and the groom, and polygamy is authorised (although women are forbidden to have more than one husband).

The age of suffrage is 18 years, and any person under the age of 18 is considered to be a minor as determined by the Penal Code. The age of consent for sexual activity is 18, according to the Penal Code; however, the age of consent for sexual activity under the Law of Marriage 1971 is 15.

Constitution

The Constitution of Tanzania guarantees equality between men and women (Articles 12 and 13). There is currently a constitutional reform process underway, and this provides an opportunity to ensure that gender equality and the illegal nature of FGM are adequately enshrined in the new constitution. The Constitutional Review Commission has been holding meetings to gather people's views on what they would like to see changed. Several women have stated that FGM is a particular concern.⁴

Anti-FGM Law

Some commentators have argued that, since most of the population of Tanzania does not practise FGM, it might have been expected that Tanzania would be a forerunner in adopting anti-FGM legislation. However, this did not happen, possibly in part due to the state's policy of neutrality in the face of local diversity. Against this background, an anti-FGM law targeting particular minorities could be problematic.⁵

The adoption of anti-FGM measures across Africa from the 1980s may be attributable primarily to Western pressure.⁶ It may therefore be argued that Tanzania's efforts to criminalise FGM in the 1990s were primarily a response to obligations to international institutions, rather than to local needs.⁷ The Tanzanian authorities then enthusiastically embraced international calls to eradicate FGM, adopting the international discourse on FGM and therefore not appearing biased against minority groups.⁸

Parliament passed the **Sexual Offences Special Provisions Act** in 1998 (which amends the Penal Code) to prohibit FGM on girls under the age of 18. Anyone who has custody, charge or care of a girl under the age of 18 who causes her to undergo FGM commits the offence of child cruelty. Although the maximum sentence is five years' imprisonment and/or a fine of 300,000 Tanzanian shillings (US\$185), there is no minimum sentence, which has often resulted in courts exercising

their discretion to impose marginal sentences on offenders. In addition, there is no definition of FGM in the Act, and it does not explicitly cover all the persons who may be involved in perpetrating FGM, such as medical practitioners.

The CEDAW committee expressed concern with ‘the continued legality of the practice upon women aged 18 years of age, who are usually pressured or forced into undergoing the practice’.⁹

By-Laws

Some communities have passed by-laws against FGM. For example, Equality Now reports that one Maasai village in Kilimanjaro had enacted a by-law to punish the perpetrators of FGM, which led to a court action against the parents of an 18 year old who was cut. The parents were fined and imprisoned. The community no longer practises FGM.¹⁰

Enforcement

‘[O]nly a handful of cases have ever reached the courts and the police are reluctant to arrest and prosecute the perpetrators.’

~ Equality Now¹¹

There is no record indicating the number of suspects convicted of FGM.¹² However, journalists and NGOs report that there have been prosecutions. For example, in 2012, at least one excisor in the Mara region was arrested and charged for cutting two schoolgirls. The excisor was paid Tanzania Shillings 5,000 for the job and was arrested after one of the victims reported her to the police.¹³

Girls are encouraged to report their parents to local authorities or anti-FGM organisations such as AFNET. In addition, girls may also face compulsory inspections at school to check whether or not they have undergone FGM.¹⁴

In response to the trend to cut infants, healthcare workers in Singida are reportedly checking infants when they are presented at clinics for routine check-ups.¹⁵

There are, however, challenges to adequate law enforcement. In 2008, the CEDAW expressed its concern at ‘the continued prevalence of the practice in some parts of the country . . .’ and ‘the weak enforcement of the prohibition of female genital mutilation . . .’¹⁶ Waritay and Wilson found that, in Singida and Dodoma, although research participants reported that they had heard of prosecutions, a number of participants felt that the Government played a passive role and that the level of prosecutions had dropped off.¹⁷

In 2010, there were reports in the press that over 5,000 girls were due to undergo **mass mutilations** in FGM ceremonies in Tarime, in the Mara region. The international NGO Equality Now requested that the Government take action to prevent the cuttings and arrest the perpetrators. The law-enforcement agencies were aware that the mass mutilations were imminent, and, despite having a number of units to specifically tackle GBV, no action was taken to protect the girls or arrest the perpetrators. The Legal and Human Rights Centre (LHRC) reported that, over a ten-day period at the end of November/beginning of December 2010, over 700 girls were cut. The organisation only managed to rescue eight girls who were taken to a rescue centre.¹⁸ In the cutting season in 2012, it was reported that 4,000 girls were at risk. The Government and civil society did attempt to intervene. Although the mass mutilations did go ahead, the interventions raised awareness and led to an increase in the number of girls fleeing their homes and being sheltered at the Masanga Shelter Centre.¹⁹

Mama Maria Nyerere, the former First Lady of Tanzania, called on traditional elders in Tanzania to work within their communities to reduce discrimination against women, including FGM, in an event held in Mara and organised by USAID.²⁰

Women Wake Up (WOWAP) has a unit of community-based paralegals who provide legal aid and help to resolve disputes in the community. Such services can be vital in ensuring access to justice. An interview with the chairperson of WOWAP highlights the key role paralegals can play in rural areas:

The need for paralegals is borne out by the fact that lawyers are not able to adequately provide legal services to the rural and urban populations in the whole country. Further, their geographical distribution is such that the majority of them can only be found in towns. This makes the role of paralegals very crucial.²¹

In a positive move, the Tanzanian Government recently launched an **action plan to establish Gender and Children's Desks** – confidential spaces in police stations where victims of GBV can file their complaints to female officers – and to improve its response to survivors of GBV.²²

Challenges to law enforcement include the following list.

- FGM being undertaken in secret, making detection difficult.
- In Mara, the traditional ceremonies are marred by violence, and anyone attempting to intervene risks physical violence. The area where FGM takes place is also a no-go zone for strangers.
- Cross-border issues between Kenya and Tanzania:
 - In the Tarime and Rorya districts of the Mara region, where the Kuria ethnic group resides on both sides of the border, some girls reportedly cross the border to be cut.²³
 - NAFGEM intends to carry out a joint campaign with villages in the border region and collaborate with Kenyan district leaders and anti-FGM organisations to raise awareness and put a stop to cross-border FGM.²⁴
- Lack of political will in some areas, as MPs rely on supporting FGM in order to be re-elected:
 - Candidates in Tarime, Mara were asked whether they supported FGM; if the answer was 'no', they would not get elected.²⁵
 - Some local leaders have been known to participate in FGM ceremonies. The LHRC reports that, in one FGM ceremony, the local district councillor was the guest of honour.²⁶
- Corruption and poor police investigation – for example, it has been reported that the police, ward executive officers and village executive officers accept bribes not to pursue FGM cases.²⁷
- Lack of capacity of Tanzanian authorities:
 - Inadequate police resources.²⁸
 - It has been argued that the Tanzanian authorities lack the mechanisms to deal with runaway girls and with girls attempting to escape FGM being returned to their communities, leaving them vulnerable to punishment, FGM and early marriage.²⁹
- Lack of confidence in the due legal process or difficulties engaging with process:
 - Insufficient knowledge of the law.³⁰
 - Victims' reluctance to testify against family/community members and fear of reprisals.³¹
 - Most Tanzanians have strong ties to traditional councils, such as Litongo for Kuria communities.³²

- 1 *Unless otherwise stated, all references in this sub-section are to* Chi Mgbako, Meghna Saxena, Anna Cave, Nasim Farjad and Helen Shin (2010) 'Penetrating the Silence in Sierra Leone: A Blueprint for the Eradication of Female Genital Mutilation', *Harvard Human Rights Journal*, Vol. 23. Available at <http://harvardhrj.com/wp-content/uploads/2010/10/111-140.pdf>.
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Interventions and Attempts to Eradicate FGM

Background

Whereas in both Kenya and Sudan the issue of FGM became politicised as part of the independence movements, no such high-profile measures against those practising FGM were recorded in colonial Tanganyika.¹ There were, however, attempts by the British colonial authorities and Christian missionaries to abolish FGM.²

In relation to the Maasai, anti-FGM efforts should be seen within the context of the country's broader historical background, both colonial and post-colonial, and perceived threats to Maasai culture (see inset box 'The Maasai, the history of development and anti-FGM campaigns' in Anthropology).

As discussed (see FGM and *Lawalawa* on page 50), following the Arusha Declaration of 1968, heavy-handed tactics were applied in an attempt to stop FGM in Singida and Dodoma. This led to a backlash from the local Nyaturu ethnic group, who started to practise FGM on infants in secret, under the pretext of preventing *lawalawa*. *Lawalawa* is, in fact, an easily treatable vaginal or urinary tract infection, but many Nyaturu believe it is a curse from the ancestors that could only be cured by FGM. This belief spread to their neighbouring Gogo, Maasai and Chagga ethnic groups.

During the 1980s, under Tanzania's second president, Ali Hassan Mwinyi, there was a move away from *unjamaa* ('familyhood', the basis of Nyerere's development policies) towards economic liberalisation and reduced state bureaucracy. A 'plethora of development organizations emerged, many offering services or education in areas such as literacy, hygiene, sexual health and agriculture.'³

CASE OF THE THREE MAASAI GIRLS IN MOROGORO

The Legal and Human Rights Centre investigated a case in 1999 in which three girls ran away from their father in an attempt to evade FGM.

They fled to a local pastor for protection, who, along with several other pastors, took them to the police. The police, however, arrested the pastor on suspicion of unlawfully taking custody of the girls. He was beaten and asked to confess to rape. The girls were subsequently examined, and it was concluded that they had not been raped. The police returned the girls to their father, who arranged to have them cut the next day and married within a month, one to a man who already had 11 wives.

The case was subsequently brought to court by the LHRC, but the girls changed their minds, telling the court they never wished to pursue a case against their father.⁴

Government Policy and Support

The Government has adopted a **National Plan of Action on the Eradication of FGM/C (2001–2015)**. As of 2008, however, it had 'only implemented several activities, including awareness raising and participation in training, all sponsored by donors.'⁵ It also has a **National Plan of Action for the Prevention and Eradication of Violence against Women and Children (2003)**. Gender equality and women's empowerment also form major components of the **National Poverty Reduction Strategies** under the goals on governance, education and health.

The Deputy Minister for Community Development and Children visited Tarime in December 2012 and commented,

'[A]fter visiting various villages of Tarime, I have to admit that FGM is a big problem and it has deep roots based on the traditions. We must develop strategies to end the practice. The Ministry will now put in place an effective strategy to fight FGM in Tarime district with education on the effects of the malpractice targeting young girls, traditional elders, parents as well as FGM conductors getting top priority.'⁶

The LHRC reports that there is collaboration between the Government and CSOs on the issues of FGM and GBV.⁷ One study, however, commented that the **Ministry of Community Development, Gender and Children** has a wide-reaching mandate, resulting in a lack of capacity and resources to advance issues effectively.⁸

Overview of Interventions

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

- health risk/harmful traditional practice approach;
- addressing the health complications of FGM;
- educating traditional excisors and offering alternative incomes;
- alternative rites of passage;
- religious-orientated approach;
- legal approach;
- rights approach/'Community Conversations';
- promotion of girls' education to oppose FGM;
- supporting girls escaping from FGM/child marriage; and
- media influence.

Health Risk/Harmful Traditional Practice Approach

Convincing people in areas of very high FGM prevalence of the health problems it causes can be a challenge. Difficult childbirths and long post-partum recovery periods, which are often exacerbated

by FGM, are often seen as the norm. Communities may not therefore attribute the complications of FGM to the procedure itself.

This is compounded by the fact that many believe FGM confers health benefits, such as a cure for lawalawa.⁹ In much of Tanzania, the issue of lawalawa needs to be central to any attempts to eradicate FGM, as lawalawa is one of the main drivers behind the continuance of the practice in many areas. Interestingly, in one study, where attitudes were compared between villagers who had been exposed to health messages and control villages where people had not been so exposed, indications were that the health message was more sustainable than merely fear of prosecution.¹⁰

The health-risk approach is just one of the many methods adopted by the **Anti-Female Genital Mutilation Network (AFNET)**, a national NGO. The main method used in fighting FGM is discussions initiated in village meetings and in small groups in religious and community settings. The health risks posed by FGM is one of the topics covered. AFNET prepares information, education and communication materials such as posters, signposts, leaflets, brochures, audio and video cassettes and books (see further AFNET's profile in National Organisations below).



Poster in Moshi: 'Female circumcision is cruel and has big effects on health. Let's join together and stop this cruel thing.'
(Photograph © 28 Too Many)

Addressing the Health Complications of FGM

NAFGEM works with the **Comprehensive Community Based Rehabilitation in Tanzania** to identify and assist women with fistula in FGM-practising areas. There is also a lawalawa clinic in the **Kilimanjaro Christian Medical Centre**. There, mothers who were sensitised could seek antibiotic treatment for their daughters for vaginal/urinary-tract infections. The initiative to open the clinic came from **IAC** members who were also health professionals.¹¹

There is generally a need for more medical care, particularly in relation to women's and maternal health, including more facilities for the treatment of lawalawa and for the complications of FGM.

Problems relating to FGM are compounded by the poor access to health facilities in rural areas. Winterbottom *et al.* note that 'people are suspicious of being told to stop using methods that have apparently proven effective when they are offered no alternative in the form of improved health care facilities.' One of the participants in Winterbottom's research asked, '[H]ave the white people got any medicine for lawalawa, or are they just telling us to stop circumcision?', highlighting this need to offer improved health facilities as well as illustrating the feeling that anti-FGM initiatives are imposed by 'outsiders'.¹²

Educating Traditional Excisors and Offering Alternative Income

Educating traditional excisors about the health risks and providing them with alternative means of income as an incentive to stop practising FGM is a further strategy used by organisations. The work of **SIAC** and **DIAC** (see section on the IAC below) involves working with excisors to encourage them to lay down their tools and advocate against FGM; this is a good way to influence elders, as excisors have high standing in the community.¹³

The **LHRC** reports that, between 2002 and 2007, 380 excisors voluntarily gave up their practice of cutting women and girls, mostly in Arusha, Dodoma, Manyara and Mara, and that this trend continues. The LHRC encourages the Government to fund programmes that can provide alternative means of income for former excisors.¹⁴

Although such initiatives may be successful in supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address the demand for FGM, but alone they do not have the elements necessary to end it.¹⁵

Moreover, there have been reports of excisors declaring that they have ‘put down their tools’, but still secretly performing FGM. In addition, performing FGM may not necessarily be an income-generating activity – in many cases, excisors receive only symbolic payments. Targeting of excisors therefore needs to be done appropriately, and providing an alternative means of income is one of a number of ways of engaging these stakeholders.¹⁶

Alternative Rites of Passage

For those ethnic groups in which FGM is part of a rite of passage initiating girls into adulthood, one approach that has had some success is promoting alternative rites of passage (ARPs). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve the cultural traditions. The success of ARPs depends on the group practising FGM as part of a community ritual. In addition, ARPs will have limited impact unless they are accompanied by education, which engages the whole community in collective reflection and leads to changes in the expectations of community members. The use of ARPs is further limited by the trend for communities to cut girls at a younger age and with less ritual.¹⁷



***Alternative Rite of Passage of Maasai girls,
Kilimanjaro.
(© 28 Too Many)***

The trend in many regions of Tanzania is for FGM to be carried out on girls at a young age, often in secrecy and without any accompanying ritual or ceremony. This suggests that the accompanying ceremonies and rites are not the main motivation behind the continuance of the practice, and therefore ARPs may have limited application overall. They may, nonetheless, be relevant where FGM is still practised as a rite of passage, such as in the Tarime district of Mara.

DIAC and **SIAC** (see section on the IAC below) have introduced ARPs in Dodoma and Singida, although the trend there is towards cutting very young girls. The ARP consists of training followed by a graduation ceremony. The training includes the teaching of traditional songs, dances, values and responsibilities. The ceremonies have been well accepted, and the communities have decided that they should also apply to boys. An evaluation report suggests that the ceremonies provide a venue for sensitising the community to FGM and provide an entry point for engaging elders.¹⁸

ARPs are considered time consuming and relatively expensive, and there is concern that, without sustainable project support, communities will not have the economic means to carry out the ceremonies. Some people expressed relief that the traditional ceremonies had gone, due to the economic burden they placed on the families involved.¹⁹

Religious-Orientated Approach²⁰

A religious-orientated approach refers to an approach that demonstrates that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour.

Religious organisations such as the **Christian Council of Tanzania (CCT)** and the **National Muslim Council of Tanzania (A.K.A. BAKWATA)** are involved in efforts to combat FGM, using various strategies or combinations of strategies. BAKWATA has issued statements condemning FGM on Islamic grounds.

In the Mara region, which is predominantly Christian, religious leaders have been the most frequent source of information on FGM: a study by CCT found that the people receive education from the following sources: 54% from religious leaders, 30% from the media, 8% from NGOs/CBOs and 6% from government officials/political leaders. The high percentage of education received from religious leaders highlights the importance of engaging with FBOs and churches to sensitise and advocate against FGM.

CCT's Women's Development, Children and Gender Programme, through Sunday-school programmes in local churches, has sensitised over 700 children on FGM in the rural Tarime district in Mara. **Churches** in Dodoma and Singida have also raised awareness of FGM, sometimes in collaboration with AFNET. Although churches have been raising awareness of FGM, in general, this appears to be in an uncoordinated manner and not as part of a broader programme.

In addition to providing education, in Mara, several different denominations of the church have provided shelter and refuge to girls fleeing FGM and, in some communities, have been a lone voice speaking out against FGM, sometimes in the face of violent opposition. Girls from these religious groups are still able to marry despite not being cut; they do not seem to face the same discrimination as their peers. This indicates the potential for communities to accept a different view of FGM.²¹

In 2013 there was a meeting of bishops from Singida, Dodoma and Mara, in which there was enthusiasm for developing a church response to the issue. **Tearfund partners** CCT and the African Inland Church of Tanzania (*AICT*) are developing pilots in Mara utilising the Tearfund CCMP (church and community mobilisation process), integrating FGM with community conversations, which is a human-rights-based approach.

Legal Approach

There is a long history of attempts to outlaw FGM in Tanzania. Tanzania has signed several **international human-rights conventions**, which provide a strong basis for the characterisation of FGM as a violation of human rights. Attempted crackdowns following the Arusha Declaration in the early 1970s led to the change in the way FGM was practised in many regions, with it being carried out in secret on babies and infant girls to evade prosecution.

The Tanzanian parliament also passed the **Sexual Offences Special Provisions Act** in 1998, amending the Penal Code, to prohibit FGM on girls under the age of 18. However, this does not include women over the age of 18, and there is no minimum sentence.

There has been some **enforcement** of the law, but overall the number of reported cases is low. NGOs such as the Legal and Human Rights Centre have investigated complaints of FGM leading to prosecutions.

Many challenges remain in law enforcement, including FGM being undertaken in secret, making detection difficult; cross-border issues along the border between Kenya and Tanzania, with girls being taken across the border to be cut; a lack of political will in some areas; corruption and poor police investigation; the lack of capacity of Tanzanian authorities; and the lack of confidence in the due legal process or difficulties engaging with process. In a positive move, however, the Government recently launched an action plan to establish **Gender and Children's Desks** in police stations and improve its response to survivors of GBV (see Laws Relating to FGM above).²²

Human-Rights-Based Approach

A human-rights-based approach acknowledges that FGM is a violation of women's and girls' rights. This approach is sometimes used alongside other strategies based on the social-abandonment theory of FGM (derived from the social-change theory behind foot-binding in China). The components of this theory include (i) a non-judgemental human-rights approach; (ii) community awareness-raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective one by the entire community; (iv) the requirement of public affirmation of abandonment; (v) intercommunity diffusion of the decision; and (vi) a supportive, change-enabling environment, including the commitment of the Government. This approach was pioneered by Tostan in Senegal.²³

Tearfund, working with local partners the **AICT** and the **CCT**, is developing pilots in the Mara Region, utilising the Tearfund's CCMP, integrating FGM with community conversations, which is a human-rights-based approach.

Promotion of Girls' Education to Oppose FGM

The Maasai Women Development Organisation, a UN Women partner organisation, provides education to girls in Arusha at risk of FGM and/or early marriage. At-risk girls are identified and given scholarships, with full board, to ensure they receive a minimum level of education.²⁴

NAFGEM targets both boys and girls in schools in Kilimanjaro and organises youth camps in which boys and girls aged 9–18 participate. Children are educated on their rights and the consequences of FGM. Girls are not simply given information on FGM, but are encouraged to publicly voice their concerns and denounce FGM and sexual abuse. The children produce songs, poems and dramas to highlight the effects of FGM. These are performed monthly and during special events such as the International Day of the African Child and the International Day of Zero Tolerance to FGM. The

children then go on to become peer educators. Such campaigns have reportedly been successful, with many running away or threatening to report their parents to camps.²⁵

The LHRC recommends that the Government, through the Ministry of Education and Vocational Training, integrate a topic on the effects of FGM in primary schools, especially in those regions most affected, in order to protect the next generation from FGM.²⁶ One issue is that the Tanzanian school curriculum does not teach pupils about their ethnic heritage,²⁷ which may be a barrier to properly teaching on the full significance of FGM.

Supporting Girls Escaping from FGM/Child Marriage

There are organisations that aim to protect children from early marriage and/or FGM, as well as sometimes enabling young girls to continue their education, by offering places of refuge. They can also facilitate the reconciliation of girls who have run away with their families, and their reintegration into their communities.

In isolation, however, places of refuge are unlikely to have a significant impact in ending FGM. The CCT, for example, reports that in 2012 in Mara, a total of 336 girls sought refuge at church leaders' homes to escape the December cutting season, which is an increase from those who sought refuge in previous years.²⁸

Media and Communication

'In Africa, wherever there is singing and dancing, people will let go of everything and come.'

~ DIAC village facilitator

DIAC and **SIAC** use participatory methods, due to the low levels of literacy among villagers. 'The villagers like theatre, poetry, singing and dancing, so we use these methods.' They have also had success in showing educational films about FGM. **SIAC** staff contend that the use of film and theatre would lead to more people coming to sensitisation events. Lack of equipment is, however, reported to be an issue.²⁹

The popularity of these media methods was also confirmed by Waritay and Wilson.³⁰ Moreover, people frequently refer to the media, particularly radio and newspapers, as sources of information on FGM.³¹ 28 Too Many's in-country research in Arusha and Kilimanjaro found participants in both regions referred to radio programmes covering the issue of FGM. **NAFGEM** collaborates with Moshi FM radio, which airs weekly programmes covering FGM, with messages being created by grassroots activists. Listeners can call in and participate in the programmes. Moshi FM Radio estimates that more than five million people have been reached through radio messages aired in Kilimanjaro, Arusha, Manyara, Tanga and parts of Kenya.³²

The **LHRC** produced a 'landmark media programme' on FGM covering the work of the LHRC's Gender and Children Unit.³³ **The Tanzanian Media Women's Association (TAMWA)** uses a 'Bang Style' of journalism, which involves the diffusion of information to various media institutions at the same time. TAMWA also trains journalists on how best to cover issues affecting the lives of women and children.

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- 30 Johanna Waritay and Dr Ann-Marie Wilson, *op. cit.*
- 31 Hanne Lotte Moen *et al*, *op. cit.*
- 32 Equality Now, *op. cit.*
- 33 Stefan Dahlgren, Sarah Forti and Jane Magigita (2012) *Evaluation of Legal and Human Rights Centre (LHRC) in Tanzania - Final Report*. Available at <https://www.sida.se/English/publications/110770/evaluation-of-legal-and-human-rights-centre-lhrc-in-tanzania---final-report/>.

International Organisations

Inter-African Committee on Harmful and Traditional Practices Affecting the Health of Women and Children (*IAC*)

The Dodoma Inter-African Committee (*DIAC*) and the Singida Inter-African Committee (*SIAC*) are the Tanzanian chapters of the IAC, an international NGO with national committees in 28 African countries. The IAC advocates for the elimination of harmful traditional practices (*HTPs*), including FGM.

SIAC and DIAC also work to eliminate HTPs by involving local stakeholders. The core of their projects is building capacity of DIAC/SIAC members and other community members to effectively engage in the fight against HTPs such as FGM, early marriage and wife inheritance. DIAC and SIAC target religious leaders, local politicians, excisors, teachers and health workers, emphasising the sensitisation of youth and the provision of ARPs. They work in 24 and 21 villages respectively.

DIAC and SIAC work with existing local structures, building the skills of local village facilitators, who carry out village-level activities on a voluntary basis. Travel by foot, bicycle or public transport is time-consuming and means they cannot visit remote villages, and the very small allowances given to volunteers is problematic. However, according to one evaluation report, the 'DIAC uses few resources yet appears to get quality results and reach many people in remote areas of the Dodoma region'.¹

Tearfund

Tearfund has supported local Christian partners in Tanzania since 1969. They work with seven partners, whose main focuses are church and community mobilisation.

Tearfund's partners work to help the following groups: internally-displaced people, families affected by HIV, subsistence farmers and pastoralists, orphans and other vulnerable children. These people are being helped through a variety of programmes covering community development, primary healthcare, water and sanitation, environmental protection, disaster preparedness and risk reduction, women's empowerment, and HIV care and prevention. A special emphasis is also being placed on strengthening the Tanzanian church to speak out at local and national levels about issues such as HIV, human rights, climate change, food security, disaster preparedness and improving poor communities' access to services.

UN in Tanzania

Tanzania is not yet one of the 15 countries where the UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation is being implemented. From July 2011 to June 2015, the UN in Tanzania will be operating under a single business plan, the UN Development Assistance Plan (*UNDAP*). This plan captures the entire range of activities supported by the UN in Tanzania.

The UN Inter-agency Gender Group (IAGG) is one of the working groups under the United Nations' 'Delivering as One', which contributes to the UNDP outcome 'Strengthen UNCT Gender Mainstreaming and Women's Empowerment across Programme Delivery and Advocacy Campaigns'. The IAGG aims to ensure that mainstreaming of gender equality and women's empowerment in all UN system activities in Tanzania is achieved through effective cooperation, coordination and monitoring.

World Vision Tanzania

World Vision is an Evangelical Christian humanitarian aid, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. World Vision Tanzania was started in 1981 as part of World Vision International Kenya. It has operations in 12 regions in Tanzania, clustered in five zones. Every zone has between 12 and 16 Area Development Programmes managed by programme coordinators.

World Vision is carrying out the Makulat FGM Eradication Project, a three-year programme funded by AUSAID and based in the Arusha Region among the Waarusha ethnic group, who are rooted in Maasai culture. The project's objectives are:

- increased community-leadership voice on FGM prevention;
- communities executing alternative rites of passage; and
- increased capacity of traditional practitioners to undertake anti-FGM work.

Proposed implementation strategies are:

- facilitating dialogue with community members, teachers, government officials, local and church leaders and encouraging them to engage in activities that advocate for FGM eradication;
- conducting training of trainers for identified sets of people, including women of child-bearing age, teachers, community-development officials, youth, children and excisors, and encouraging them to impart the acquired knowledge to their fellow community members; and
- encouraging ARPs for girls.

Specific activities with the aim of achieving these objectives are:

- the formation of youth clubs;
- the formation of an FGM Practitioners Committee (30 practitioners identified and trained);
- the training of trainers;
- the formation of the Anti-FGM Village Advocacy Committee; and
- in collaboration with the Tanzania Media Women's Association (TAMWA) and the Tanzania Networking Gender Forum (TGNP), creating appropriate messages that could be passed through the media.

1 Hanne Lotte Moen, Aggripina Masha, and Hirut Tefferi (2012) *A Comparative Evaluation of FOKUS FGM Projects in East Africa*. Available at <https://www.norad.no/globalassets/import-2162015-80434-am/www.norad.no-nyl/filarkiv/ngo-evaluations/a-comparative-evaluation-of-fokus-fgm-projects-in-east-africa.pdf>.

Local Organisations

African Inland Church of Tanzania (AICT)

Mara Ukerewe Diocese is one of six dioceses of the Africa Inland Church Tanzania (AICT) established in 1993 when the national AICT decided to decentralise into dioceses. The Diocese of Mara Ukerewe is located in the northern part of Tanzania, stretching to Lake Victoria in the north and the Serengeti national park in the south-east. The diocese has experienced tremendous growth since its inception in 1993, growing from 12 pastors and 82 local churches with 5,681 members to 35 pastors, 130 local churches and a membership of over 15,000 Christians.

The diocese, in partnership with Tearfund, is involved in an ongoing CCMP that empowers communities to utilise their local resources in meeting needs holistically. Through the project, the communities have renovated six primary schools; constructed one new secondary school, one health centre and three dispensaries; and contributed to significant improvement of livelihoods. AICT, in collaboration with Tearfund and the CCT, is developing pilot programmes in Mara utilising the Tearfund CCMP and integrating FGM with community conversations, which is a human-rights-based approach.

Afya Bora

Afya Bora is a community-based organisation in Arusha and Manyara. It is run by volunteers who are professionals in public health and hygiene, concerned individuals and institutions. It works particularly among the Maasai community, advocating health.

Afya Bora plans to work with the traditional Maasai institutions (the Council of Traditional Leaders, the spiritual leaders and age-group leaders) and bring them in contact with the formal structures (district, ward and village leadership) to help empower victims of FGM through a sustainable, community-based approach. This will involve forming FGM committees and appointing FGM educators (both of which comprise cutters, elders, victims of FGM and other community members).

In schools the project will work closely with FGM peer-educators (selected by the pupils themselves) and teachers who are also selected by the pupils to serve as their guardians in relation to issues of FGM.

Objectives of the project are:

- to facilitate collaboration with relevant community groups to reduce FGM among the Maasai in Simanjiro district, Manyara region;
- to develop a system for community sensitisation and mobilisation on FGM in a sustainable manner;
- to establish procedures for supporting FGM victims and monitoring FGM activities at the community (village) level;
- to raise awareness on FGM among school populations for informed sexual and reproductive health rights in order to prevent FGM; and

- to enhance positive peer norms and values among school youths and enable them to stand against sexual abuse and gender-based inequality, including FGM.¹

Anti-Female Genital Mutilation Network (*AFNET*)

The Anti-Female Genital Mutilation Network is a national NGO. It is a member of the National Coalition Against Female Genital Mutilation. AFNET is a membership-based organisation with more than 5,000 individual members from villages in the eight regions of Tanzania. It is structured to encompass groups at the village level, which then form networks at the ward level and subsequently ward networks at the district level to enable coordination from the village to the national level. AFNET has 220 facilitators based at ward level, 23 district coordinators, eight regional coordinators and one national coordinator. Members and facilitators based in the villages and wards work on a voluntary basis and pay membership-entrance fees and annual subscriptions.

AFNET uses an integrated approach to addressing FGM that focuses on the rights of children and women and the detrimental health consequences of the practice. AFNET also advocates ARPs for girls that continue to teach girls how to live in communities as young women but exclude FGM. In the Singida region, work against FGM has been integrated into a reproductive health programme that empowers vulnerable groups, especially women.

The main method used in fighting FGM is discussions initiated through village meetings and in small groups in religious and community settings. General discussions are held at these meetings, which are often assisted by the village leadership. Discussions on more sensitive issues are discussed in smaller, more private groups in which women are segregated from men. Singing, role-play and theatre performances are most effective in discussions with children.

AFNET's activities include:

- preparing information, education and communication materials such as posters, signposts, leaflets, brochures, audio and video cassettes and books;
- maintaining a databank and resource centre on FGM issues;
- researching FGM in different communities;
- providing evidence of the health hazards of the practice;
- lobbying for and advocating enforcement of the law against FGM, which has resulted in some parents and cutters being jailed;
- providing support and care for victims of FGM; and
- providing refuge centres for girls fleeing FGM.²

The Christian Council of Tanzania (*CCT*)

The Christian Council of Tanzania is an ecumenical organisation formed by 15 Protestant churches and 14 associates. CCT's vision is to promote Christian unity among member churches. Its programmes focus on education, health, interfaith relations, women's development, children and

gender, and peace and justice. CCT works in partnership with Norwegian Church Aid, and it is a member of the National Coalition Against Female Genital Mutilation.

Its Women Development Children and Gender (*WDCG*) programme has been engaged in promoting women's empowerment and gender equity. The programme also seeks to enhance the capacity of women and children's participation in decision-making processes for their political, socio-economic and cultural well-being. Specifically, the *WDCG* programme has continued to focus more on advocacy against GBV and, in particular, FGM in five districts: Kiteto (Manyara Region), Singida (Singida region), and the Tarime, Serengeti and Rorya districts in the Mara region.

In all the districts FGM issues are being mainstreamed into *VICOBA* (Village Community Banks) programmes for sustainability. *VICOBA* are micro-finance programmes where community members form groups and buy shares after a certain time. Members are allowed to take loans for small entrepreneurial projects, servicing the loan on agreed terms. The scheme is working well so far, and lots of people, mainly women, have benefitted from the scheme. *VICOBA*s have gone further to reduce GBV, especially domestic violence, in some families.

Some other successes have been documented, including hundreds of young girls running away from FGM in the Mara region following CCT's work in selected communities. The girls seek refuge with church leaders, where they stay for the whole month of FGM ceremonies, after which they return home. Some families refuse to take back the girls, while other girls are denied school fees. CCT, in collaboration with Tearfund and AICT, is developing pilot programmes in Mara, utilising the Tearfund CCMP and integrating FGM with community conversations, which is a human-rights-based approach.³

Children's Dignity Forum (*CDF*)

Children's Dignity Forum is a children's-rights-based NGO in Dar es Salaam. *CDF* works on three key issues:

- female genital mutilation/cutting;
- child marriage; and
- the promotion and protection of child rights.

CDF has conducted *PEER* research in the Tarime district on child marriage and FGM, carried out on ward executive officers at a consultative workshop on child marriage and FGM and a National Consultative Workshop to end child marriages. It has also produced educational t-shirts with messages promoting children's rights first and ending FGM, and brochures highlighting the impacts of child marriage and FGM.

The Legal and Human Rights Centre (*LHRC*)

The Legal and Human Rights Centre is a private, autonomous, voluntary, non-governmental, non-partisan and non-profit-making organisation. Since its inception in 1995, the *LHRC* has been growing steadily. It works throughout Tanzania through its outreach services and human-rights-violation monitoring activities. The *LHRC* has the capacity to influence policies, laws and issues of practice at

the national level while obtaining its mandate and support from the grassroots. The LHRC publishes annual Human Rights Reports that include, among other subjects, information on FGM. The LHRC organises the training of paralegals, enlightens communities and police on FGM, conducts advocacy campaigns and is coordinator of the National Coalition Against FGM (see below).⁴

Mkombozi Vocational Training and Community Development Centre (*MVTCDC*)

The Mkombozi Vocational Training and Community Development Centre is a national, community-based organisation, created in 1999, that operates in Moshi. MVTCDC is committed to empowering community members by cultivating skills that will promote individual and community liberation. Its motto is 'quality education for self-reliance', and its objectives include raising awareness of gender-equality issues. It hopes that disadvantaged groups of women and youths will be empowered economically and socially. The centre has grown and developed to welcome 71 students this year.

MVTCDC supports children living in harsh environments, including girls from the Masaai community who are vulnerable to FGM. The centre offers a meeting place, health information and a resource library on different subjects including reproductive health, HIV/AIDS, STDs and FGM.⁵

National Coalition Against Female Genital Mutilation

In 1999, the LHRC conducted research on FGM in Tanzania and thereafter held a national workshop where its findings were released. Members who took part in the workshop decided to form a coalition to fight FGM in Tanzania. A committee was formed, and the LHRC was given a mandate to coordinate the coalition. Members of the committee come primarily from NGOs and government and international organisations, and the committee is supported by the international NGO Equality Now.

The coalition organised a campaign centred on the International Day of Zero Tolerance to FGM. The day was observed in Dodoma in February 2005, where a public rally was held and speeches were delivered by the Minister for Community, Development, Gender and Children Affairs. Testimonies were given by survivors and affected people as well as campaigners.

From then onwards the coalition has been active and meets regularly to organise activities and events. Ever since its establishment, the coalition has been commemorating the International Day of Zero Tolerance to FGM on February 6th. Some organisations have been facilitating the coalition financially to hold regular meetings to plan for activities and events.

The coalition meets four times a year, and one of its major achievements is its successful advocacy for the formulation of an FGM policy.⁶ Other activities include commemorating the African Child Day (16 June 2007) and holding a capacity-building workshop for 30 members of parliament who come from areas with high prevalences of FGM (November 2007). Funding for this workshop was obtained from The Eastern African Sub-regional Support Initiative for the Advancement of Women. In 2007, one activity conducted during the Day of Zero Tolerance to FGM was an ARP graduation ceremony of 100 girls. The girls transitioned from childhood to adulthood without having to undergo FGM.

Members of the Coalition include AFNET, the CDF, the CCT, the DIAC, the LHRC, NAFGEM, the National Muslim Council of Tanzania (A.K.A. BAKWATA), TAMWA, TAWLA and Women Wake Up.⁷

National Muslim Council of Tanzania (also known as BAKWATA)

The National Muslim Council of Tanzania, founded in 1968, provides religious guidance and national representation to the Tanzanian Muslim community. Many Tanzanians considered BAKWATA an extension of the ruling Chama Cha Mapinduzi party; however, the organisation's local legitimacy has since increased. BAKWATA has issued statements condemning FGM on Islamic grounds. In 2007, BAKWATA worked with Norwegian Church Aid to run workshops familiarising Tanzanian religious leaders with publicly available information about government activities. Other projects include support for orphans, HIV/AIDS-prevention education in madrassas and collaboration with The Balm in Gilead on a national interfaith partnership on HIV/AIDS. The organisation also speaks out on political issues such as the Tanzanian Government's 2008 consideration of membership in the Organization of the Islamic Conference.⁸

Network Against Female Genital Mutilation (*NAFGEM*)

The Network Against Female Genital Mutilation is a network of members and community-based groups working towards the elimination of FGM and other forms of GBV. It is a member of the National Coalition Against Female Genital Mutilation. It was founded in late 1998 by a group of human-rights activists in an effort to stage up the fight against FGM in the Kilimanjaro region.

NAFGEM has gradually developed to cover all districts in the Kilimanjaro region and since 2007 has been establishing interventions in the Simanjiro district, Manyara.

The organisation's mission is to eliminate FGM and other forms of GBV by providing anti-FGM/GBV education, networking with grassroots communities and likeminded partners, including the Government and social institutions, with a view towards ending the practice and supporting FGM/GBV victims.

NAFGEM's main activities are focused on community sensitisation and awareness of the health effects of FGM on women and girls. It believes that, with adequate and factual knowledge, community members will change their attitudes towards and practice of FGM. Even though its primary target groups are women and girls, female excisors are also targeted, and so are traditional birth attendants, traditional leaders, youths, school children, religious leaders, men, local government leaders and other CSOs.

The approaches being used are meetings, public-awareness campaigns, seminars, workshops and individual talks. An animation project has also been implemented to ensure the sustainable dissemination of anti-FGM messages and monitoring of the FGM practice in the community.

Its activities include:

- awareness-creation on FGM and GBV through meetings, community campaigns and posters with anti-FGM messages;
- educating communities in trainings, seminars and workshops on human rights and FGM/GBV and the effects of these practices;
- engaging various social groups, including traditional leaders, religious leaders, political leaders, cutters, women, youths and children with anti-FGM/GBV activities;
- developing the Village Animators Program, wherein selected community members are trained to sensitise their communities and facilitate community changes towards the elimination of FGM/GBV;
- implementing youth programs in which school-aged youths (girls and boys) that are both in and out of school are trained and challenged to say no to FGM and other forms of GBV; and
- developing the Anti-FGM Radio Program, which disseminates anti-FGM/GBV messages through local radio stations and other media groups, to ensure that the community is constantly reached with anti-FGM messages.

Tanzania Media Women's Association (*TAMWA*)

TAMWA is a activist media-advocacy organisation started by 12 women from the media industry. Since its inception, its membership has grown to more than 100 female journalists. Its mission is to advocate for women and children's rights by conducting awareness-raising activities for cultural, policy and legal changes in society through the use of media. It is a member of the National Coalition Against Female Genital Mutilation.

A diploma in the profession and three years' experience are the minimum requirements for membership. Members are from the mainland and Zanzibar, and the majority of them work with various electronic and print media. Through experiences and trainings, some have become specialists in gender, human-rights, media-ethics and election reporting, among other things. Others are engaged as public-relations officers or communication consultants in public and private institutions. A few members now hold government offices.

TANWA uses a 'Bang Style' of journalism, which involves the diffusion of information to various media institutions at the same time, and trains journalists how best to cover issues affecting the lives of women and children. It has also established a crisis centre for victims of GBV.⁹

Tanzania Women Lawyers Association (*TAWLA*)

The Tanzania Women Lawyers Association provides legal aid services to women, campaigns for women and children's rights, advocates for good governance and creates forums for female lawyers to build their professional capabilities, in the hopes of ensuring greater representation for women in government.

The founding members comprised a professional group of female lawyers who felt the need for an organisation that could promote an environment that guarantees equal rights and access by focusing

on vulnerable and marginalised groups, especially women and children. TAWLA now has more than 570 members and is a member of the National Coalition Against Female Genital Mutilation.

TAWLA's priorities are:

- providing legal aid services to vulnerable women and children;
- undertaking policy research, advocating for legal reform and campaigning for women and children in relation to issues of equality and human rights;
- educating the public by raising awareness on gender and legal-rights issues through the media, seminars, community conversations, publications and drama groups;
- raising awareness of sexual- and reproductive-health rights at the grassroots level and advocating for advancement of these rights as human rights in Tanzania;
- campaigning for good governance and accountability and advocating for respect for human rights and gender equality; and
- supporting the professional development of female lawyers in Tanzania, and building and developing TAWLA's membership services for female lawyers.¹⁰

Tanzania Education and Micro-Business Opportunity

Trust (*TEMBO*)

The Tanzania Education and Micro-Business Opportunity Trust was established in 2007 to carry out Project TEMBO'S mandate of providing education and empowerment for Maasai girls and women in Arusha. It has a Canadian sister fundraising organisation. TEMBO's mission is to provide opportunities for the girls from Longido and Kimokouwa to succeed in secondary school, teacher training school and/or vocational school, and to provide opportunities for women in Longido and Kimokouwa to succeed in micro-business initiatives. It is also responsible for the oversight of the TEMBO Guesthouse, which provides offices and meeting spaces for TEMBO as well as comfortable and safe lodgings for the TEMBO volunteers and other visitors to Longido.¹¹

In 2012–2013, TEMBO supported more than 60 girls through secondary school, six girls to attend teacher-education college and 21 girls through vocational training. They have also given micro-loans to 130 women. During in-country research conducted by 28 Too Many, TEMBO Trust reported that it had founded a club called Sara and Juma for girls in primary and secondary schools and in the community.

TEMBO has developed lesson plans around a series of books put out by the United Nations. This series, also called Sara and Juma, is designed to teach girls to know their rights, value education, be proactive, have good relationships with boys and avoid FGM and HIV/AIDS. Classes are delivered four days a week at primary and secondary schools in Longido and Kimokouwa. Since boys have requested to be included, the materials were adapted to include information important for boys. TEMBO believes that it is crucial that adults know what is being taught, and sessions are conducted with the parents of TEMBO-sponsored students. It also reaches more families through the women in the micro-finance groups. As a result, some families agree to practise ARPs. TEMBO also uses every opportunity to include village and tribal leaders in the classes.¹²

Women's Legal Aid Centre (*WLAC*)

The Women's Legal Aid Centre is a voluntary, non-governmental, non-partisan and non-profit-making organisation. WLAC was registered in 1994. It is a member of the National Coalition Against Female Genital Mutilation.

WLAC takes a rights-based approach, trains paralegals and raises awareness within communities and the police on the anti-FGM law. They have lawyers that are trained in the area of FGM. They were the instigators of a test case in Morogoro, together with the LHRC, which, although it was lost, generated a lot of publicity.

WLAC jointly runs advocacy campaigns with the LHRC, raises awareness on FGM in the context of HIV/AIDS, produces national and local radio programmes, and provides publications, legal research and human resources in terms of attorneys for court cases involving the LHRC.¹³

Women Wake Up (*WOWAP*)

Women Wake Up is an NGO based in the Dodoma region, with branches in the Singida and Iringa regions, working in both rural and urban areas. WOWAP is determined to be a catalyst of positive change towards women's participation in social and economic issues, and promote a positive social attitude towards women and children through cultural means and consciousness raising.

WOWAP empowers women by educating them on their rights and mobilising them to fight traditional practices that discriminate against women.¹⁴ Muslim and Christian religious leaders, teachers, ward- and village-government officials have been mobilised to fight for the elimination of FGM. WOWAP addresses FGM holistically, taking a community-development strategy, using culturally sensitive and non-judgmental approaches and engaging a wide variety of participants and stakeholders.

WOWAP has trained facilitators to start community-based activism. The programme contained various modules, including ones on human rights, the right to health, the right to protection against all forms of violence and the right to education. These modules provided a foundation for the remaining ones and were constantly referred to throughout the programme. They were followed by modules on problem-solving and better hygiene, in which participants weighed certain positive traditional practices (for example, breastfeeding) against harmful ones (for example, FGM and early marriage). In the end, participants formed grassroots advocacy committees and developed personal and committee advocacy plans for changing FGM practices within their families, workplaces and communities.¹⁵

WOWAP also has a unit of community-based paralegals that provides legal aid and helps to resolve disputes in the community,¹⁶ and it has reached out to members in the rural Dodoma district and the Kondoa district who have come together as a result of the training done in primary schools.¹⁷

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- 1 Afya Bora (2013) [website]. Available at www.afya-bora.com.
 - 2 The Anti-Female Genital Mutilation Network (undated) *AFNET, Models of Good practice*. [No longer available online.]
 - 3 28 Too Many (2013a) *Correspondence with the CCT*.
 - 4 - Legal and Human Rights Centre (2013) [website]. Available at www.humanrights.or.tz.
- Tonje Bentzen and Aud Talle (2007) *The Norwegian International Effort Against Female Genital Mutilation*. Norad. Available at <https://www.norad.no/en/toolspublications/publications/2009/the-norwegian-international-effort-against-female-genital-mutilation/>.
 - 5 28 Too Many (2013b) *Correspondence with the MVT CDC*.
 - 6 Dr Angelina Dawa and World Vision (2013) *Mukalat FGM Eradication Project 2012-2014, Baseline Survey Report*. World Vision Tanzania, Mukalat ADP, September–November 2013.
 - 7 Legal and Human Rights Centre, *op. cit.*
 - 8 Berkley Center (2013) *National Muslim Council of Tanzania*. Available at <http://berkeleycenter.georgetown.edu/resources/organizations/national-muslim-council-of-tanzania>.
 - 9 Tanzania Media Women's Association (2013) [website]. Available at www.tamwa.org.
 - 10 Tanzania Women Lawyers Association (2013) [website]. Available at <http://www.tawla.or.tz/index.php?limitstart=24>.
 - 11 Tanzania Education and Micro-Business Opportunity Trust (2013) [website]. Available at www.projectembo.org.
 - 12 - *Ibid.*
- 28 Too Many (2013c) *Correspondence with TEMBO*.
 - 13 Tonje Bentzen and Aud Talle, *op. cit.*
 - 14 Foundation for Civil Society (2012) *Foundation for Civil Society Newsletter*, July–September 2012. Available at www.thefoundation.or.tz/index.php/en/.
 - 15 Women Wake Up (2006) *Interim Report, Grassroot activism against FGM in Mombasa, Makorongo and Donsee villages, Farkwa divisions, Kondo district*. Available at www.wowap.org.
 - 16 Foundation for Civil Society, *op. cit.*
 - 17 Unless otherwise noted, all references are to Women Wake Up (2012) [website]. Available at www.wowap.org.

Challenges Faced by Anti-FGM Initiatives

There are many challenges faced by anti-FGM initiatives, such as:

- FGM is often undertaken in secret on newborn babies and infants, making detection difficult;
- attitudes are entrenched, particularly among elders;
- people living in remote areas are hard to reach, and a lack of transport hampers efforts by NGOs;
- getting people to attend sensitisation discussions is difficult because of the time that farming and collecting water takes and the expectation among participants that they will receive something in return for attending;¹ and
- there is a lack of reliably accurate data on prevalence, due partly to the fact that FGM is now more frequently performed in secret and on infants, and also because people are reluctant to disclose FGM for fear of prosecution. Therefore, not all cases are captured by the most recent DHS data.

1 Hanne Lotte Moen, Aggripina Moshia, and Hirut Tefferi (2012) *A Comparative Evaluation of FOKUS FGM Projects in East Africa*. Available at <https://www.norad.no/globalassets/import-2162015-80434-am/www.norad.no-ny/filarkiv/ngo-evaluations/a-comparative-evaluation-of-fokus-fgm-projects-in-east-africa.pdf>.

Conclusions

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

Adopting Culturally Relevant Programmes

Tanzania is a country of significant geographical, cultural, ethnic and religious diversity. FGM is practised, to varying degrees, across much of the country. Strategies for eliminating FGM need to be at both the national level and the community level, with particular care being taken by organisations to tailor anti-FGM initiatives and strategies to take into account particular regional circumstances. In particular, the underlying reasons that FGM is practised and how the practice has changed in some regions needs to be considered. Despite the fact that Tanzania does not record the ethnicity or religion of its citizens, understanding ethnic identity and religions and the impact these have on the practice of FGM is crucial.

Sustainable Funding

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. Continued publicity of current FGM practices at a global level, particularly through the UN and the WHO, is crucial for ensuring that NGOs and charities are given support and resources long term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as is discussed in this report, FGM is a focal issue connected to these crises and directly relates to several of the MDGs.

FGM and The Millennium Development Goals

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

FGM and Education

Education is a central issue in the elimination of FGM. The lack of basic education perpetuates social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM hinders girls' abilities to obtain basic education and prevents them from pursuing higher education and employment opportunities. This lack of education directly relates to issues surrounding child marriage.

It is, however, concerning that primary-school retention rates have dropped from 78% in 2006 to 62.5% in 2008¹, and moves to reverse this trend are to be encouraged. Anti-FGM programmes need to be focused on educating girls; however, educating boys and the wider community on FGM is equally important. We concur with Equality Now's suggestion of the need for continued campaigning on the importance of educating girls, as well as creating child-friendly clubs for anti-FGM education and peer support in schools and in the community.²

FGM, Medical Care and Health Education

FGM should be integrated into reproductive-healthcare clinic programmes because these are highly attended by women of childbearing age.³ Healthcare providers need to be better trained to manage complications resulting from FGM. Given the possible trend towards medicalisation in some areas (for example, Kilimanjaro), this should also be addressed through education for healthcare providers on the consequences of their role in FGM. There needs to be improved access to healthcare through the FGM complications referral programme to ensure women are receiving appropriate care quickly. The lack of access to and utilisation of adequate healthcare generally is also an issue that needs to be addressed, particularly in remote areas. This is especially the case in light of the recent report indicating that Tanzania is unlikely to meet its 2015 reproductive health targets.⁴ More resources are needed for sexual- and reproductive-health education.

In addition, among the Kuria ethnic group in Mara, girls feel societal pressure to undergo FGM in order to benefit from the same status, celebration and transition to adulthood as male youths experience in their circumcision ceremonies. Encouraging male circumcision in hospitals will not only protect boys from the health risks posed by traditional circumcision, but also remove the practice from the community, therefore breaking the strong cultural link between male circumcision and FGM.

Lawalawa

The issue of lawalawa needs to be central to any attempt to eradicate FGM in many areas, as this is one of the main drivers behind the continuance of the practice. Many myths surrounding lawalawa persist, and many people are unaware that lawalawa is a vaginal or urinary tract infection that can be easily treated with antibiotics. One NGO in Singida reported that 'the community promised that they would stop performing FGM if there was another cure for lawalawa' and that, after sensitisation on health and hygiene, villagers started to seek medical treatment for such infections.⁵

One study in Arusha indicated that even basic education could make a difference to the perception of lawalawa: over 60% of respondents who had 'no' education said that lawalawa was a reason to

carry out FGM, compared to 40% of respondents who had a primary-school education.⁶ Health education in relation to lawalawa and FGM is therefore crucial in combating FGM in those areas where it is a driver, as well as providing access to medical treatment for vaginal and urinary tract infections. In general, however, access to health services needs to be improved.

FGM, Advocacy and Lobbying

Advocacy and lobbying is essential to ensure that the law, including the Constitution, properly covers FGM and that the Government's National Plan of Action on the Eradication of FGM/C is adequately implemented.

FGM and the Law

Subsequent to the amending of the Tanzanian Penal Code in 2006, progress has been made to stop FGM; however, reports suggest that the law is not being implemented to its fullest extent. The law should contain a comprehensive definition of FGM and explicitly cover all those persons who may be involved in perpetrating FGM, such as medical practitioners. Crucially, it should specifically outlaw FGM performed on women over the age of 18.

As far as other laws are concerned, given the link between FGM and child marriage, we recommend that the Law of Marriage should be reformed to raise the legal age of marriage of girls and achieve equality between the sexes, and to conform to international human-rights standards, as also recommended by Equality Now.⁷ Furthermore, the current constitutional review process provides an opportunity to ensure that gender equality and the illegality of FGM are adequately enshrined in any new constitution.

There needs to be increased sensitisation of law-enforcement officials and judicial authorities about FGM and the importance of strictly enforcing the law.⁸ We welcome the recent government action plan to establish Gender and Children's Desks and improve its response to survivors of GBV.

The Government should increasingly anticipate mass mutilations during FGM seasons in the Mara region and allocate the necessary resources to ensure adequate law enforcement, as well as take measures to protect at-risk girls.⁹

FGM in the Media

Media have proven to be useful tools against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on FGM and encourages these projects to continue. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level.

FGM and Faith-Based Organisations

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are major agents of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision. They can also work with global bodies such as the UN and its agencies. Given that 93% of Tanzanians say religion is 'very important' in their lives (among the highest percentages of those African countries surveyed by the Pew Research Centre)¹⁰, this approach is particularly relevant in Tanzania.

Communication and Collaborative Projects

There are a number of successful anti-FGM programmes currently operating in Tanzania, with the majority of the progress beginning at the grassroots level. There is an existing National Coalition Against Female Genital Mutilation. We recommend continued efforts to communicate their work more publicly and encourage collaborative projects. A coalition against FGM is a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success.

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

Further Research

There is a need for further research and up-to-date data on the prevalence of FGM that includes infants and girls under 15 years old, so as to capture recent trends. It would also be advantageous to collect data along ethnic lines, given the strong link between FGM and ethnicity and the lack of available official data on this in Tanzania. Data collected using anthropological interviewing techniques and physical gynaecological examinations would be especially valuable, given the secret nature of the practice and the disparity between women's self-reported FGM statuses and clinically observed signs of FGM in previous studies. More research and funding is also needed on the psychological consequences of FGM and the prevalence of fistulae.

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- 2 Equality Now (2011a) *Protecting girls from undergoing Female Genital Mutilation: The experience of working with the Maasai communities in Kenya and Tanzania*. Available at https://www.equalitynow.org/sites/default/files/Protecting%20Girls_FGM_Kenya_Tanzania.pdf.
- 3 Sia E. Msuya, Elizabeth Mbizvo, Akhtar Hussain, Johanne Sundby, Noel E. Sam and Babill Stray-Pedersen (2002) 'Female genital cutting in Kilimanjaro, Tanzania: changing attitudes?', *Tropical Medicine and International Health* 7(2), pp.159–165.
- 4 IRIN (2013) *Tanzania Likely to Fall Short on its Family Planning*, 19 November. Available at <http://www.irinnews.org/report/99159/tanzania-likely-fall-short-its-family-planning-targets>.
- 5 Hanne Lotte Moen, Agripina Moshia, and Hirut Tefferi (2012) *A Comparative Evaluation of FOKUS FGM Projects in East Africa*. Available at <https://www.norad.no/globalassets/import-2162015-80434-am/www.norad.no-ny/filarkiv/ngo-evaluations/a-comparative-evaluation-of-fokus-fgm-projects-in-east-africa.pdf>.
- 6 Dr Angelina Dawa (2013) *Mukalat FGM Eradication Project 2012-2014: Baseline Survey Report*. World Vision Tanzania.
- 7 Equality Now (2011b) *Tanzania: Submission to the UN Universal Periodic Review, Twelfth Session of the UPR Working Group of the Human Rights Council*. Available at <http://lib.ohchr.org/HRBodies/UPR/Documents/session12/TZ/EN-EqualityNow-eng.pdf>.
- 8 Legal and Human Rights Centre and Zanzibar Legal Services Centre (2008) *Tanzania Human Rights Report 2008*.
- 9 Alicia Erickson (2012) *Peace in Tanzania: an island of stability in Sub-Saharan Africa*. Available at <http://depts.washington.edu/jsjweb/wp-content/uploads/2012/04/JSJWEBv3n1.Erickson.A.pdf>.
- 10 Pew Research Centre (2010) *Tolerance and Tension: Islam and Christianity in Sub-Saharan Africa*. Available at www.pewforum.org/2010/04/15/executive-sum-mary-islam-and-christianity-in-sub-saharan-africa/.

Appendix I

Selection of International and National Organisations Contributing to Efforts for the Abandonment of FGM in Tanzania

28 Too Many

Aang Serian

African Inland Church of Tanzania, Diocese of Mara and Ukewere (AICT)

African Medical Research Foundation (AMREF)

Afya Bora

The Anti-Female Genital Mutilation Network (AFNET)*

AUSAID

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

Children's Dignity Forum (CDF)

Christian Council of Tanzania (CCT)*

Department of International Development (DiFD)

Dodoma Inter African Committee (DIAC)*

Equality Now

Envirocare

Fokus

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

Friedrich Ebert Foundation

Hanang Women Counseling and Development Association (HAWOCDA)

Humankind Foundation

Kamilika

Koshuma

HIVOS

Kivulini Women's Rights Organisation

Legal and Human Rights Centre (LHRC)*

Masanga Shelter Centre, Mara

Maasai Women Development Organisation (MWEDO)

Medical Missionaries of Mary (MMM)

Ministry of Community Development, Gender and Children

Ministry of Constitutional and Legal Affairs
National Coalition Against Female Genital Mutilation
National Anti-FGM Network (*NAFGEM*)*
National Muslim Council of Tanzania (Bakwata)*
Norwegian Embassy
Norwegian Church Aid
PACT
Save the Children Fund
Singida Inter African Committee (*SIAC*)
Tanzania Interfaith Partnership
Tanzanian Media Women's Association (*TAMWA*)*
Tanzanian Woman Lawyers Association (*TAWLA*)*
Tanzania Interfaith Partnership
TAWLA website: www.tawla.or.tz/index.php/priorities-and-mission
Tearfund
Tembo
University of Dar es Salaam, the Department of Fine and Performing Arts
Women and Legal Aid Centre (*WLAC*)
Women's Front of Norway
Women in Law and Development in Africa (*WILDAF*) – Tanzania
Women's Research and Documentation Project Association (*WRDP*)
Women Wake-Up (*WOWAP*)*
Women Promotion Center (*WPC*)
World Health Organization (*WHO*)
World Vision Tanzania*
United Nations Children's Fund (*UNICEF*)
United Nations Development Programme (*UNDP*)
United Nations Entity for Gender Equality and Empowerment of Women
United Nations Population Fund (*UNFPA*)
UN Tanzania Inter-Agency Gender Group
USAID

(* Denotes organisations that are members of the National Coalition Against Female Genital Mutilation.)

