

1. Female genital mutilation/cutting

1.1 Introduction

Female genital mutilation/cutting (FGM/C)¹ is a traditional cultural practice involving the 'partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons'.² FGM/C is classified into four types depending on the extent of the cutting.

Definition: Types of FGM/C

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: Other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

Source: World Health Organisation (WHO)

FGM/C is associated with a number of significant short-term health effects including pain, bleeding and risk of infection following the procedure. FGM/C is also associated with many long-term consequences which include chronic pain, infections, decreased sexual enjoyment, psychological problems and a significantly increased risk of complications during childbirth (WHO, 2008).³

1.2 Tanzania country context

Tanzania's Demographic Health Survey (DHS) in 2010 found that, across the country, 14.6 per cent of females aged 15 to 49 had undergone FGM/C. Eighty-four per cent of Tanzanian females and 79 per cent of Tanzanian males believe that FGM/C should be stopped in the communities where it is practised (Unicef, 2011).⁴

Since the Tanzania Sexual Offences Special Provision Act (1998), FGM/C has been illegal in Tanzania. A number of communities have reported that high-profile political statements condemning FGM/C have led to fear of prosecution on the part of its practitioners. This has led to the practice of FGM/C being carried out in secret, putting young women at even greater risk of complications. However, prosecution and enforcement have been minimal and as a result the practice still continues in a number of communities.

2. Research overview

2.1 Location

Tearfund, a Christian international NGO, commissioned research in 22 rural communities across three districts of Tanzania: Mara, Dodoma and Singida. The prevalence of FGM/C in these three districts was found to be significantly higher than the national average, which is 14.6 per cent of women.⁵ In Mara, 39.9 per cent of women had undergone FGM/C, while the figure was 51 per cent in Singida and Dodoma. (DHS 2010)

2.2 Objectives

The aims of the research were to:

- Understand the current extent of FGM/C and the key drivers behind the practice
- Explore the current responses of local churches to FGM/C
- Document any expectations communities and FGM/C survivors had about church participation in this issue.

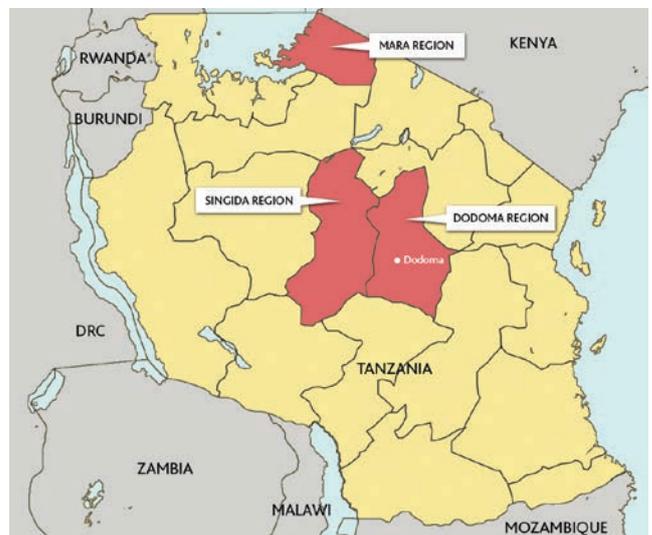


Figure 1: Districts involved in the research study

- 1 This report uses the term FGM/C to reduce negative associations and stigma related to the term 'mutilation', that may hinder the process of social change.
- 2 WHO definition, 2006
- 3 WHO (2008) *Eliminating female genital mutilation: an interagency statement*, by OCHR, UNAIDS, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem and WHO
- 4 Unicef (2011) *Violence against children in Tanzania: findings from a national survey 2009*, United Republic of Tanzania
- 5 Aged between 15 and 49

2.3 Partners

Tearfund commissioned 28 Too Many (a charity which aims to eradicate FGM/C in the 28 countries where it is still practised) to conduct this research with local Tearfund partners. The partners involved were: Christian Council of Tanzania (CCT), Africa Inland Church of Tanzania (AICT) Diocese of Mara Ukerewe, and Anti-FGM Network (AFNET).

The main partner involved in the research was CCT, which is an ecumenical organisation comprising 14 member churches and ten associate members. CCT's vision is one of promoting Christian unity among member churches. Its programmes include: education, health, interfaith relations, women's development, children and gender, peace and justice. CCT has been working for more than ten years to educate and train communities on FGM/C and its consequences.

3. Summary of findings

Key points

- A legal framework opposed to FGM/C is in existence in Tanzania, providing opportunity for prosecution and reduction in practice.
- Prosecution of FGM/C is minimal, and government intervention has been limited.
- Since the laws⁶ were passed the practice is being conducted increasingly on younger girls (sometimes infants) and in secret, for fear of prosecution.
- Community members practising FGM/C are found in both church congregations and the wider community.
- Traditional leaders play a critical role in perpetuating FGM/C – acting as 'gatekeepers of the cultural practice'.
- Social pressure to undergo FGM/C is high, linked with marriage opportunities, peer pressure and the economic benefits for practitioners of the cutting ceremonies.

Participants were asked to estimate the prevalence of FGM/C, the age range in which the practice occurred and the most prominent type of FGM/C that occurred within their communities. These estimates were also compared with the Tanzania Demographic Health Survey (DHS) in 2010.

In Mara region (prominently comprised of Luo and Kurya tribes):

- Prevalence: Community estimates ranged from ten per cent (Luo tribe, Rorya district) to 99 per cent (Kurya tribe, Tarime district) and varied significantly from DHS 2010 levels (39.9 per cent of women).
- Age of practice: Varied estimates between communities, most estimating 8–10 years or 11–16 years, depending on the community.
- Most prominent type of FGM/C: Type II

In Singida and Dodoma regions (prominently comprised of Nyaturu and Gogo tribes):

- Prevalence: Community estimates were that 54 to 57 per cent of women (Nyaturu tribe) and 60 to 70 per cent of women (Gogo tribe) underwent FGM/C. These were broadly in keeping with the findings of the DHS2010 (51 per cent women (Nyaturu tribe) and 63.8 per cent women (Gogo tribe). The community estimated that, historically, prevalence was 100 per cent within Gogo communities.

- Age of practice: Estimated between eight and 13 years (Nyaturu tribe) and between five and seven years/ten and 12 years depending on the community (Gogo tribe). However, increasingly, FGM/C has been practised on babies and younger children in this area.
- Most prominent type of FGM/C: Both Type I and Type II were practised in the Nyaturu tribe and Type II was more prominent in the Gogo tribe.

3.1 Key drivers

The drivers of FGM/C varied between communities, but key themes emerged in discussions with community members. These drivers were seen to be a critical part of any response to FGM/C in Tanzania.

Preparation for marriage and/or childbirth

- 'Uncut' women have to be cut 'to become a proper woman'
- FGM/C marks the transition from childhood to adulthood

Prevention of promiscuity/ prostitution

- Controlling sexual desire to prevent prostitution/promiscuity

Traditional beliefs and practices

- FGM/C as a blood offering to appease ancestors (*mizimu*)
- 'Uncut' women are seen as a 'curse' and are segregated and stigmatised as a result

Social norms and social pressures

- Pressure to undergo FGM/C brought to bear by traditional leaders, parents, wider community and even peers
- Some girls resort to cutting themselves in response to peer pressure, if their parents oppose the practice

Source of income

- A 'business issue' for *ngaribas* (circumcisers) – traditional elders and community members who participate in FGM/C ceremonies benefit financially from FGM/C
- The cost of cutting (paid to *ngaribas*, with a share for traditional elders) ranges from 5,000 Tsh (Tanzanian shillings – approximately £2 or \$3) to 10,000 Tsh (approximately £4 or \$6)

Link with male circumcision

- Girls seek similar social acceptance and transition into adulthood as boys

Lawalawa

- Communities in Singida and Dodoma reported that FGM/C is believed to cure a disease (*lawalawa*) of the female (and male) genitalia, which is thought to be a punishment from the local gods. This has, however, been found to be vaginal and urinary tract infections that can be cured with conventional medicine.



Gogo women near Dodoma, in a community that has seen a decline in FGM/C.

3.2 Current response of the church

The research sought to document current church activities in response to FGM/C, as well as to investigate the potential of local churches to build a more sustainable church-based response to FGM/C. This involved documenting community and survivor expectations of how the church could work to end FGM/C.

Mara region

Churches in Mara have adopted a range of positive approaches to combat FGM/C. Churches are working to sensitise congregation and community members on the impacts and consequences of FGM/C, and to engage traditional leaders within these discussions.

CCT has partnered with Norwegian Church Aid for more than ten years (in Tarime district) to coordinate advocacy campaigns, and to educate and train community members and traditional leaders on FGM/C and its consequences. CCT has also worked to disseminate advocacy materials to churches and schools, with a total of 332 young people participating in the school advocacy programmes to date. This has resulted in improved knowledge and understanding of FGM/C and its consequences. Through local church Sunday School programmes, CCT has sensitised more than 700 children on FGM/C practices to date. In 2012, a total of 336 girls sought refuge at pastors' homes to escape the December cutting season, which represents an increase in the number of those seeking refuge compared with previous years.

The Christian Council of Tanzania believes that the local church can be a driving force for change on the issue of FGM/C in local communities.

Some churches have provided places of refuge for girls who are fleeing FGM/C and who are at risk of violence as a result. Other churches have initiated alternate rites of passage for young girls who want to avoid FGM/C, but who still want to participate in a ceremony that marks the beginning of adulthood. Successes were reported with these approaches; however, some initiatives did face opposition from communities. Some programmes appeared to be small-scale and not part of a broader coordinated response.

Singida and Dodoma regions

Local churches have been one of a number of community actors working to eradicate FGM/C, there have been more government and local NGO interventions in these regions than in Mara, particularly by the Anti-FGM/C Network (AFNET).

The church has worked to raise awareness, often through addressing the issue of FGM/C in sermons and preaching. Working in collaboration with AFNET, churches will host information sessions facilitated by someone from AFNET to discuss in further detail the impact and consequences of FGM/C.

A number of churches have worked to integrate FGM/C into their work on HIV. AFNET has produced an integrated training manual which has been used by churches; this has led to women with HIV and/or fistulae coming forward for medical treatment.

The Anglican Diocese of Tanganyika has facilitated training with different social groups on the effects of FGM/C and related issues (including HIV). As part of this response, they have included entrepreneurship training for former *ngaribas* (circumcisers) to help them find alternate sources of income.



Photo: 28 Too Many

Tools of the trade laid down by former *ngaribas* (circumcisers)

3.3 Challenges

Many local churches are ideologically opposed to FGM/C and are actively taking a stand against it, challenging traditional and cultural practices in their communities. In some communities, church members had been asked to leave the church because of their participation in FGM/C, which has led to violence. However, this has had significant consequences for the church in a number of ways. Lower attendance, smaller congregations and hostility towards the church were found to be common. One church pastor explained that he had, in the past, conducted seminars at primary schools on FGM/C but had stopped doing so, because he had faced opposition from within the community.

One pastor explained that in some areas the church was the only body within the community taking any action against FGM/C. As a result, the church has faced hostility and resistance to change.

4. Key recommendations for churches

4.1 The potential of the church

Survivors of FGM/C and those who believe the practice must be eradicated felt it was critical for churches to be an integral part of the response to FGM/C in Tanzania.

A baseline study (CCT, 2010) showed that people in Mara region received education from different sources: **54 per cent by religious leaders**, 30 per cent by media, eight per cent by NGOs/Community based organisations (CBOs) and six per cent from government officials/political leaders.

The church is an integral part of its community, present in both rural and urban areas. The local church is well situated to scale up current work and see an end to FGM/C through the influence and respect it has in communities.

Engaging with religious leaders is essential in order to engage whole communities on the issue of FGM/C and its consequences.

It was said that the government speaks half-heartedly on FGM/C and does not take an aggressive approach to end the practice. It was also said that 'the church needs to take the lead in showing compassion'. In another community, a village opinion-leader commented, 'The church is the right place to start, in that one could weigh traditions in terms of what is and is not acceptable to God.'

4.2 Recommendations for action

The following recommendations are made to help build a broader church-based response, ending FGM/C in Tanzania:

Raise awareness and provide information by facilitating community-driven discussion sessions on:

- Harmful consequences of FGM/C
- Health issues related to FGM/C (including dispelling myths such as *lawalawa*)
- Tanzanian anti-FGM laws (including knowledge and reporting)

Discussions should be organised to include a variety of community members, including: schools, church congregations, Sunday School, youth groups, and community meetings.

Create alternative rites of passage

- Facilitate the development of alternative rites of passage for girls through community participation
- Break the link between FGM/C and male circumcision by encouraging male circumcision to take place in hospitals
- Provide incentives and alternative ceremonies for girls refusing FGM/C

Become a 'safe' space

- Facilitate 'safe' discussion spaces for community members to discuss openly issues relating to FGM/C in a non-judgemental way
- Provide places of refuge for young women who are facing pressure to be cut in their community

Support the development of alternative sources of income for *ngaribas* (traditional circumcisers)

- Facilitate entrepreneurial activities and support business development of *ngaribas* willing to discontinue the practice of FGM/C

Challenge harmful effects of cultural traditions

Ensure key local stakeholders are all engaged fully in discussion groups:

- Men, women, boys and girls from the community
- Traditional leaders
- Community and religious leaders (including teachers, doctors, youth leaders)

Promote changed views among young men, and other community members, on what constitutes an 'acceptable wife'.

Facilitate broader partnerships and collaboration

Engage and coordinate partnerships both nationally and locally to achieve:

- A nationally coordinated church response
- Interfaith collaboration between Christians and Muslims
- A community response (engaging schools, churches, mosques and community leaders)

Enable advocacy and promote effective lobbying

- To amend the Sexual Offences Special Provisions Act 1998 to ban FGM/C on women over 18 years and to increase fines for violations
- To ensure adequate law enforcement and prosecution of cases
- To ensure that gender equality and the illegality of FGM/C are adequately enshrined in any new constitution (under the current constitutional reform process)
- To strengthen national capacity for improving the quality of health delivery systems and the level of education for women and girls (UNFPA, 2007)
- To strengthen the National Plan of Action on the Eradication of FGM/C

5. Next steps

Tearfund and its partners will share these research findings with a wide range of stakeholders in Tanzania, including church leaders, government officials and other organisations committed to ending FGM/C.

A context-specific action plan for a church-based response to eliminating FGM/C will be developed with faith groups, building on their experience and core competencies. It is hoped that church leaders will demonstrate their commitment to speak out and mobilise their communities to address the priority needs identified by survivors and community members. Survivors will play a key role in shaping this response.

In order to see Tanzania free of the practice of FGM/C, the church must play a central role in working alongside communities to critically analyse the impact and consequence of cultural practices, and to discern which elements to retain and which to abandon. Tearfund seeks to build models of good practice in focus communities that can be shared in other communities and countries involved in the practice of FGM/C.



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