

# COUNTRY PROFILE: FGM IN TANZANIA

DECEMBER 2013



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



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## FOREWORD

Collection, documentation and sharing of systematically checked data are vital if we are to effectively tackle harmful traditional practices, 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 support those at risk and survivors. This is so for female genital mutilation (FGM) where data is central to enabling governments and civil society to safeguard the rights of children and improve their lives to enable them to fulfil their potential.

The magnitude and persistence of FGM continues to shock those who come across it, as it affects vulnerable girls by violating their child 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. It affects women and girls in 28 African countries, and some of the Middle East and Asia. Due to international migration, it also affects diaspora communities in Europe, North America and Australasia.

This Country Profile into FGM across Tanzania shows new research from our research study visits and helps to understand why despite surveys showing that the overall prevalence of FGM in girls/women aged 15-49 years remained static at 14.6% between 2004 and 2010 (DHS), in the regions with the highest prevalence, four have seen an increase over six years.

New evidence from our research shows girls are having FGM at a younger age – with those cut before age one year increasing from 28.4% to 31.7% in 2010, with FGM often done in secret. A change in the law has brought fear of prosecution and is driving the practice underground. Another reason for FGM being practised includes the belief that a bacterial infection ‘lawalawa’ is cured by FGM (which only took hold after laws against FGM were introduced) is still much in evidence and

needs addressing through teaching and retraining.

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 it is changing in different communities, due to social dynamics and influencers. This data can then inform government policy and legislative change; enhance innovative programme design and implementation; improve monitoring of progress towards abandonment; sharing of good practice and successful models of change.

FGM affects both the physical and psychological health of girls, directly impacting their attendance and performance at school by up to 25%. This then impacts their right to equality, economic potential and security. Girls often have lower literacy rates and are pressurised into early marriages. They are vulnerable to HIV/Aids transmission, and childbirth complications such as obstructed fistula, yet often have poor access to healthcare.

Since my first trip to Africa in 2001, I have made visits to 7 African countries, and communities in Asia, the Middle East, USA and Australia that have migrant communities that practise FGM. Over 10 years working to end FGM I have never met a girl who was pleased she was cut, everyone 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 minimize

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

One of the highlights for me this year is to hear how FGM research we undertook for the International NGO Tearfund has led to sharing with a wide range of 75 stakeholders, including government, NGOs, activists and 25 faith leaders. Through an Action Plan building on their experience, it is hoped that communities can now speak out and support survivors in shaping their response to ending FGM. This will directly impact FGM being abandoned in Tanzania by sustainable changes in knowledge, attitude and practice.

This new research, Mary’s story and Tearfund’s Action Plan, give hope in some areas, and enable focused attention on the areas that still have 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**



Mary Laiza with Maasai women © 28 Too Many

## BACKGROUND

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

## PURPOSE

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

## USE OF THIS COUNTRY PROFILE

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

## ACKNOWLEDGEMENTS

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

## THE TEAM

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

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**Lisa Glass** is a Research Volunteer for 28 Too Many and is a freelance writer, editor and blogger on various issues, with a focus 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 the 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 practised 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 its Executive Director. She published her paper this year on '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' in the Journal of Gender Studies.

**Rooted Support Ltd** for donating their time through its Director Nich Bull in the design and layout of this Country Profile, [www.rootedsupport.co.uk](http://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 on '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 Waritay and Wilson, 2012).

Photograph on front cover: Maasai women in line  
© [www.lafforgue.com](http://www.lafforgue.com).



## LIST OF ABBREVIATIONS

**AIDS – Acquired Immunodeficiency Syndrome**

**ARP - Alternative Rites of Passage**

**CBO – Community Based Organisation**

**CC – Community Conversations**

**CCM - Chama Cha Mapinduzi (Political party)**

**CCMP - Church and Community Mobilisation Process**

**CEDAW - Convention on the Elimination of Discrimination Against Women**

**CHF - Community Health Fund**

**CPJ- Committee to Protect Journalists**

**CRC - Convention on the Rights of the Child**

**CSW – Commission on the Status of Women**

**DaO - United Nations Delivering as One**

**DHS – Demographic Health Survey**

**DRC – Democratic Republic of Congo**

**EASSI - Eastern African Sub-regional Support Initiative for the Advancement of Women**

**FBO – Faith Based Organisation**

**FGC – Female Genital Cutting**

**FGM – Female Genital Mutilation**

**FPU – Family Planning Unit**

**GBV – Gender Based Violence**

**HTP - harmful traditional practices**

**GDP – Gross Domestic Product**

**HIV – Human Immunodeficiency Virus**

**IAC – Inter-African Committee on Traditional Practices**

**IAGG - UN Inter-agency Gender Group**

**ICESR - International Covenant on Economic, Social and Cultural Rights**

**IEC - Information, Education, and Communication**

**IPT - Intermittent Preventive Treatment**

**ITNs - Insecticide-Treated Nets**

**LHRC - Legal and Human Rights Centre**

**MCH – Maternal and Child Health**

**MDG – Millennium Development Goal**

**MICS - Multiple Cluster Indicator Survey**

**MP – Member of Parliament**

**NGO – Non Governmental Organisation**

**NHI - National Health Insurance**

**OECD - Organisation for Economic Co-operation and Development**

**PEER – Participatory Ethnographic Evaluation and Research**

**PPP – Public Private Partnership**

**SIGI - Social Institutions and Gender Index**

**SOSPA - Sexual Offences Special Provisions Act**

**STD – Sexually Transmitted Disease**

**TANU - Tanganyika African National Union**

**TDHS - Tanzania Demographic and Health Survey**

**UN – United Nations**

**UNDAP - UN Development Assistance Plan**

**UNDP – United Nations Development Programme**

**UNFPA – United Nations Population Fund**

**UNICEF – United Nations Children’s Fund**

**UTI - Urinary Tract Infection**

**VICOBA - Village Community Banks**

**WDCG - Women Development Children and Gender**

**WFP – World Food Programme**

**WHO – World Health Organisation**

## 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 practice to create positive, sustainable change.

It is estimated that 7.9 million women and girls in Tanzania have undergone FGM (UNICEF, 2013). According to the Demographic Health Survey (DHS), the estimated prevalence of FGM in girls and women (15-49 years) is 14.6% (DHS, 2010). The overall rate has not changed from the 2004-05 DHS which recorded the same rate, but has decreased by 3.3% from 17.9% in 1996 (DHS, 1996). Like many African countries that practise FGM, there are significant regional variations in prevalence. The regions of Arusha, Dodoma, Kilimanjaro, Manyara, Mara and Singida all have rates of FGM prevalence between 20-70%. According to the DHS, of the nine regions with the highest prevalence, five have seen a decrease, and the remaining four an increase between 2004-05 and 2010. Percentages of cut women have increased in Arusha and Mara regions, with the largest increase occurring in Singida from 43.2% in 2004-5 to 51% in 2010. The prevalence rates may vary widely between different ethnic groups within the same region; for example in Mara, FGM 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. Furthermore, the practice of FGM by the small Hadza ethnic group presents an unusual case in that, while FGM is commonly practised by pastoralists, it is rarely part of the culture of hunter-gatherer groups.

Of those women who have undergone FGM, 90.9% have experienced Types I and II 'cut, flesh removed'. Less common, Type IV is recorded at 2.2% and Type III infibulation at 0.7% (DHS, 2010). With respect to the age at which FGM is performed in Tanzania, the DHS data show that the older a woman is, the more likely she is to have undergone FGM. Comparing the data for 1996, 2004-05 and 2010, there has been a decline in the rate of FGM. The DHS 2010 reports that the cutting of young girls is increasingly carried out at an earlier age, with girls cut before their first birthday increasing from 28.4% in 2004-5, to 31.7% in 2010. 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). This coincided with the emergence of lawalawa, a disease believed to be a curse from

the ancestors, which could only be cured by FGM. This disorder is in fact an easily treatable vaginal or urinary tract infection but became a pretext among the Nyaturu ethnic group under which to continue performing FGM, but now on babies and infants amidst much secrecy. The belief in the need to perform FGM to cure lawalawa (and other diseases) spread to Gogo and Maasai ethnic groups and persists to this day.

Of the regions that practise FGM, those that are predominantly Christian have the highest proportion of women who have had FGM. 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 and referring to it as 'sunna' ('sunna' meaning the body of traditional sayings and customs attributed to the Prophet Muhammad and supplementing the Qur'an), suggesting a possible link between the practice and the belief that it is an Islamic requirement. 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 appear to suggest a trend towards medicalisation, there are reports that in urban areas, FGM is sometimes performed by health personnel such as midwives and doctors. While traditionally FGM was often carried out as a rite of passage into womanhood, and linked to bride price, the trend among some ethnic groups (e.g. the Nyaturu, Gogo and Maasai) is towards cutting much younger girls, often newborn babies. This reflects how the practice of FGM evolves to adapt to modern circumstances, including legislation and changing social perceptions.

In one region in Manyara (Manjaro district), it was discovered that FGM was taking place, with the flesh was being dried and sold as charms to traders of tanzanite and other traders. It was found that even old women were undergoing FGM as part of this trade.

The continuation of FGM is supported by 6% of all women who know about the practice, with the majority of support coming from rural areas. The highest proportion of support for the continuation of FGM comes from Mara region, with 16% of women supporting the practice. This is followed by Mwanza and Manyara regions with support from 13.3% and 12.8% of women respectively. Opposition to FGM tends to be found in the wealthier, more educated, sections of Tanzanian society and, overall, 92% of women believe that the practice should be discontinued.

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. The government also has a National Plan of Action to Combat FGM 2001-2015. There have been prosecutions of persons found carrying out FGM. However, evidence suggests that the fear of prosecution is driving the practice under-ground in some regions and in some areas such as Mara, mass FGM still takes place with little or no law enforcement. There are a number of NGOs working to combat FGM and undertaking a variety of strategies, including the health risk approach, human rights approach, women's empowerment and providing alternative sources of income for traditional excisors, 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 old, so as to capture recent trends, especially given the trend of cutting infants.

We propose measures relating to:

- Adopting culturally relevant programmes
- Sustainable funding
- Considering FGM within the Millennium Development Goals and post-MDG framework
- Facilitating education
- Improvements in access to health facilities and in managing health complications of FGM and lawalawa
- Increased advocacy and lobbying
- Increased law enforcement
- Maintain effective media campaigns
- Encouraging FBOs to act as agents of change and be proactive in ending FGM
- Increased collaborative projects and networking
- Further research

## INTRODUCTION

***'It is now widely acknowledged that FGM functions as a self-enforcing social convention or social norm. In societies where it is practised 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' (UN Generally Assembly, 2009)***

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

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

The WHO classifies FGM into four types:

<b>Type I</b>	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
<b>Type II</b>	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.
<b>Type III</b>	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).
<b>Type IV</b>	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. (WHO 2008)

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

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

needs to be cut open later to allow for sexual intercourse and childbirth. (WHO, 2013)

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

In Tanzania approximately 14.6% of women have undergone FGM and this rate has stayed consistent between 2004-05 and 2010 (DHS). FGM customs differ along geographic and ethnic divides. Not all regions practise FGM, but of those that do, the highest rates of FGM occur in Manyara, Dodoma, Arusha, Singida, Mara and Kilimanjaro at rates between 20-70%. Some of the ethnic groups most associated with practising FGM are the Nyaturu, Gogo, Maasai, Pare, Kuria, Hadza, Barabaig and Iraqw. There has recently been a trend in cutting young girls at an early age (many before their first birthday) and a rate of 31.7% in 2010 (DHS). This is possibly due to rapid government attempts to abolish FGM through legislation. FGM is primarily carried out by traditional practitioners known as ngaribas; it is traditionally carried out as a rite of passage into womanhood and is related to bride price. However, there is also a belief amongst some community groups that FGM can cure lawalawa, a vaginal or urinary tract infection, but this may have been a pretext under which to carry on the practice. Currently FGM is only supported by 6% of all Tanzanian women who know about the practice, the majority of whom live in rural areas. The Tanzanian government has a National Plan of Action to Combat FGM from 2001-2015 and there are a number of NGOs working to support this initiative.

The vision of 28 Too Many is a world where every

woman is safe, healthy and lives free from FGM. A key strategic objective is to provide detailed, comprehensive country reports for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well as providing more general information relating to the political, anthropological and sociological environments in the country to provide a contextual background within which FGM occurs. It also offers some analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound knowledge base from which to determine the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

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

## INTRODUCTION TO FGM

See Introduction above for details of types of FGM.

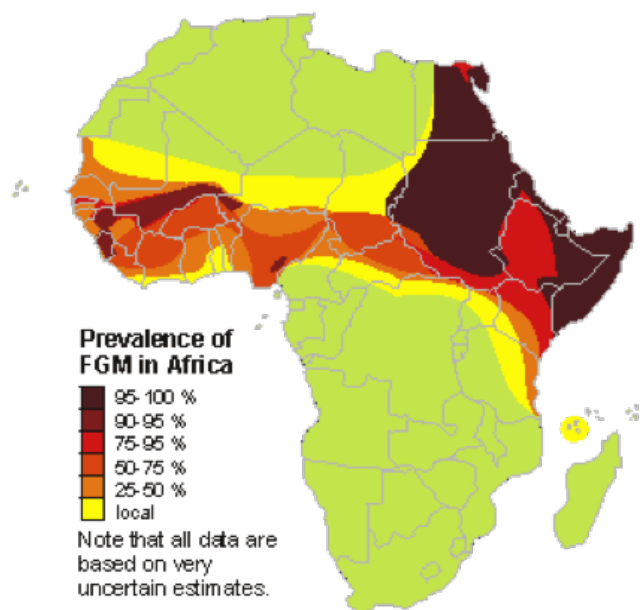
## HISTORY OF FGM

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

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

## FGM – GLOBAL PREVALENCE

FGM has been reported in 28 countries in Africa, as well as in some countries in Asia and the Middle East and among certain migrant communities in North America, Australasia, Middle East and Europe.



Prevalence of FGM in Africa (Afol News)

## NATIONAL STATISTICS

### GENERAL STATISTICS

#### Population

48,261,942 (July 2013 est.)

Median age: 17.3 years

Growth rate: 2.82% (2013 est.) (World Factbook)

#### Human Development Index

Rank: 152 out of 186 in 2012 (UNDP)

#### Health

Life expectancy at birth (years): 58.9 (UNDP) or 60.76 years (World Factbook)

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

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

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

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

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

HIV/AIDS – deaths: 86,000 (2009 est.) (World Factbook)

#### Literacy (age 15 and over that can read and write)

Total population: 67.8%

Female: 60.8%; male: 75.5% (2010 est.) (World Factbook)

Total Youth Population: 77.3%

Female youth (15-24 years): 76.5%; male youth: 78.2% (2013) (World Bank)

#### 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.) (World Factbook)

#### Urbanisation

Urban population: 26.7% of total population (2011)

Rate of urbanisation: 4.77% annual rate of change (2010-15 est.) (World Factbook)

#### 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 (World Factbook)

#### Religions

Mainland - Christian 30%, Muslim 35%, indigenous beliefs 35%; Zanzibar - more than 99% Muslim (see section on Religion below) (World Factbook)

#### 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), many local languages (World Factbook).



## MILLENNIUM DEVELOPMENT GOALS

The eradication of FGM is pertinent to a number of the UN's eight Millennium Development Goals (MDGs).



### GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

According to the World Food Programme (WFP), Tanzania is a least developed and low-income country. The country's GDP has grown in the last decade but this increase has not translated to improved living standards for most ordinary Tanzanians. More than 40% of the population live

in chronic food-deficit regions. Tanzania is among the African countries with the highest levels of malnutrition. Some 42% of children under five are stunted and 80% of children under one year old are anaemic. In addition, more than 50% of pregnant women are anaemic and 10% of women are undernourished (WFP, undated). This MDG is relevant given the correlation between food insecurity and education, and education and FGM respectively. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity (Burchi and Muro, 2007). Education is also important in tackling FGM, as discussed in FGM and Education. This illustrates the links between MDGs and the key role education can play in combating not only FGM but another important development issue for Tanzania, namely food insecurity.

### GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

The aim of this MDG is to provide universal primary education with the target to ensure that by 2015 all boys and girls complete a full course of primary schooling. This is relevant in the context of FGM as the chances of girls undergoing FGM are reduced if they complete their schooling. See section on FGM and Education.

### GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

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

### 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 death rates

among newborn babies are higher to mothers who have had FGM. See section on Women's Health and Infant Mortality.

**GOAL 5: IMPROVE MATERNAL HEALTH**

This MDG has the aim of reducing maternal mortality by three quarters between 1990 and 2015. In addition to the immediate health consequences arising from FGM, it is also associated with an increased risk of childbirth complications. See section on Women's Health and Infant Mortality.

**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 section on HIV/AIDS and FGM. In addition, combating vaginal and urinary tract infections will also combat FGM, given the mistaken belief that FGM cures such infections (see FGM and lawalawa).

**POST-MDG FRAMEWORK**

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

there has been a growing call for the post-MDG agenda to include a distinct focus on ending violence against women (Harper, 2013). Though it is unlikely that FGM will be eliminated in Tanzania by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM (see above). The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the decade for African women will certainly assist in promoting gender equality and the eradication of gender violence in Tanzania.

**A note on data**

UNICEF highlights that self-reported data on FGM needs to be treated with caution since women may be unwilling to disclose having undergone FGM due to the sensitivity of the subject or its illegal nature. In addition, they may be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age. Studies in Tanzania which have compared women's self-reported FGM status to clinically observed signs of FGM found discrepancies in more than 20% of women (Msuya et al, 2002 and Klouman et al, 2005, referred to in UNICEF, 2013).

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

**NATIONAL STATISTICS RELATING TO FGM**

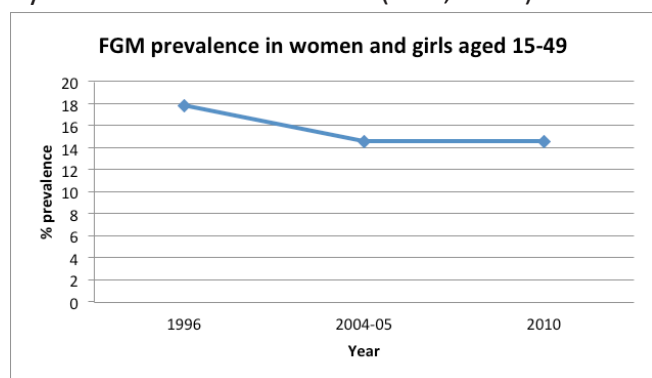
Statistics on the prevalence of FGM are compiled through large scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Cluster Indicator

Survey (MICS). The principal statistics relating to FGM in Tanzania are the Tanzanian DHS of 2010, 2004-05 and 1996.

UNICEF calculates that 7.9 million women and girls in Tanzania have undergone FGM (UNICEF, 2013).

Tanzania is classified as a Group 4 country, according to the UNICEF classification, with a low prevalence. Group 4 countries have a prevalence of between 10% and 25% (UNICEF, 2013).

The estimated prevalence of FGM in girls and women (15-49 years) is 14.6% (DHS, 2010). The overall rate has not changed from the 2004-05 DHS which recorded the same rate, but has decreased by 3.3% from 17.9% in 1996 (DHS, 1996).



Prevalence of FGM in women and girls aged 15-49 (%) (DHS, 1996, 2004-05 and 2010)

### PREVALENCE OF FGM IN TANZANIA BY AGE

The estimated prevalence of FGM in girls and women by age is set out below. These data show

that the older a woman is, the more likely she is to have undergone FGM and, comparing the data for 1996, 2004-05 and 2010, there has been a decline in the rate of FGM.

### PREVALENCE OF FGM IN TANZANIA BY EDUCATION

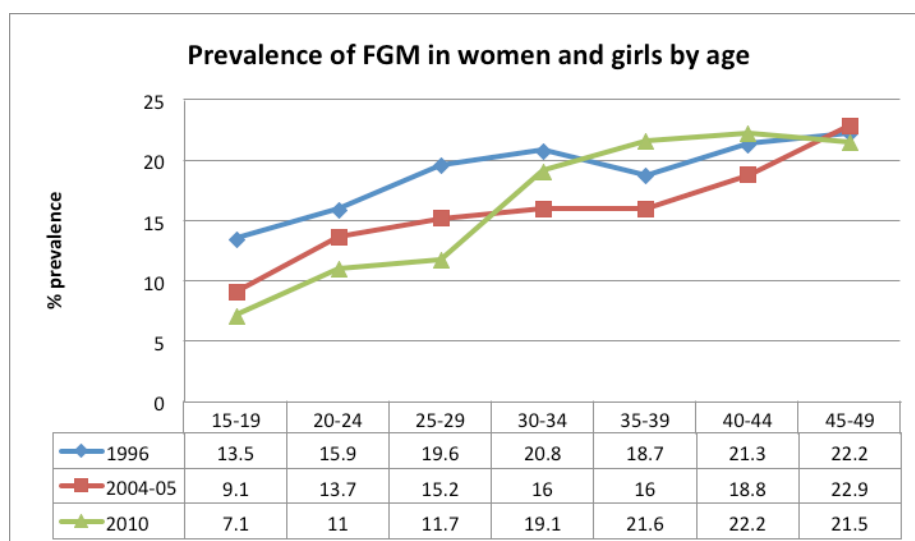
The prevalence of FGM decreases in accordance with the level of education. See further section on FGM and Education below.

Education	2010
No education	20.3
Primary incomplete	12.9
Primary complete	16.6
Secondary +	3.1

Prevalence of FGM by education (%) (DHS, 2010)

### PREVALENCE OF FGM IN TANZANIA BY PLACE OF RESIDENCE

The DHS have consistently shown that prevalence rates among women residing in rural areas is much higher than in urban areas. While both rural and urban areas have seen a reduction in prevalence rates since 1996, the percentage of women who have undergone FGM in rural areas has continued to be at least twice that of urban women. These findings correspond to the fact that FGM is most commonly practised by pastoralist and agrarian groups (see section on FGM by Ethnicity).



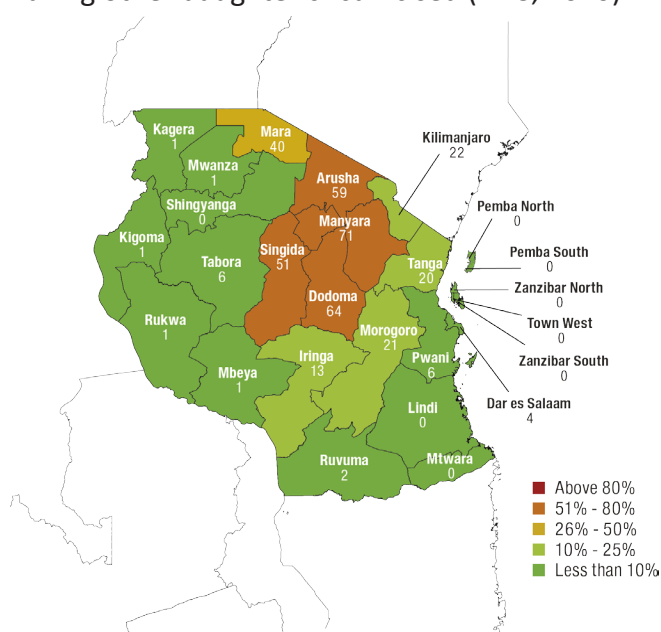
## PREVALENCE OF FGM IN TANZANIA BY HOUSEHOLD WEALTH

Lowest	Second	Middle	Fourth	Highest
24.5	16.7	15.7	13.0	6.3

Prevalence of FGM by household wealth quintile (%) (DHS, 2010)

## REGIONAL STATISTICS

FGM is most prevalent in the Northern and Central zones of Tanzania. Women in these areas are more likely to already have at least one circumcised daughters and would also consider having other daughter circumcised (DHS, 2010).



Prevalence of FGM by region (DHS, 2010)

	% of women with FGM(2004-05)	% of women with FGM(2010)	% decrease/increase
<b>Zone</b>			
Western	1.2	1.7	+0.5
Northern	43.2	37.8	-5.4
Central	57.6	58.8	+1.2
Southern Highlands	6.9	5.3	-1.6
Lake	8.3	8.9	+0.6
Eastern	7.1	9.1	+2.0
Southern	0.8	0.9	+0.1
<b>Region</b>			
Manyara	81.0	70.8	-10.2

Dodoma	67.8	63.8	-4
Arusha	54.5	58.6	+4.1
Singida	43.2	51.0	+7.8
Mara	38.1	39.9	+1.8
Kilimanjaro	25.4	21.7	-3.7
Morogoro	18.1	21.1	+3
Tanga	23.0	19.9	-3.1
Iringa	22.7	13.3	-9.4
Pwani	2.4	5.7	+3.3
Tabora	2.8	5.6	+2.8
Dar es Salaam	3.2	3.5	+0.3
Ruvuma	1.4	2.1	+0.7
Mbeya	0.5	0.9	+0.4
Mwanza	1.0	0.9	-0.1
Kagera	0.0	0.8	+0.8
Rukwa	0.7	0.5	-0.2
Kigoma	0.7	0.5	-0.2
Lindi	0.6	0.4	-0.2
Shinyanga	0.6	0.3	-0.3
Town West	0.4	0.3	-0.1
Unguja North	0.4	0.3	-0.1
Unjuga South	0.2	0.0	-0.2
Pemba North	0.2	0.0	-0.2
Pemba South	0.0	0.0	0.0
Mtwara	0.3	0.0	0.0

Prevalence of FGM by zone and region (DHS, 2004-05 and 2010)

According to some reports, FGM is more widely practiced in approximately seven of the regions of mainland Tanzania (Mella, 2002; Ali and Strøm, 2012). According to the DHS, 2010 the percentages of cut women from the Manyara, Dodoma, Arusha, Singida, Mara and Kilimanjaro regions with range between 20-70%.

According to the DHS, of the nine regions with the highest prevalence, five have seen a decrease, and the remaining four an increase between 2004-05 and 2010. Percentages of cut women have increased in Arusha and Mara regions, with the

largest increase occurring in Singida from 43.2% in 2004-5 to 51% in 2010. The prevalence rates may vary widely between different ethnic groups within the same region. This is not reflected in the DHS, which does not collect data by ethnicity in Tanzania. This is exemplified by evidence from studies in various districts in Mara by the Christian Council of Tanzania, in which respondents were asked to estimate the prevalence of FGM, which show the prevalence rates below. The rates are high in those districts where the Kuria and Simbiti ethnic groups are located but lower in the region where the non-practising Luo ethnic groups reside. (It should be noted that this survey had a different methodology to the DHS and is therefore not directly comparable).

Singida	10%
Mara (Tarime)	75%
Mara (Serengeti)	<75%
Mara (Rorya)	<10%

Prevalence of FGM, estimated by survey respondents, Christian Council of Tanzania baseline studies (Waritay and Wilson, 2012).

Since the DHS prior to 2010 does not survey the FGM status of girls under the age of 15, these data will not reflect most recent trends. Therefore, despite the relatively high figures for Singida and Dodoma, the Anti-Female Genital Mutilation Network of Tanzania (AFNET), based on feedback from community representatives and clinics, estimates that in Dodoma, the rate of FGM had dropped to a 'very low level' among the Gogo (and Rangi) ethnic groups and that in Singida the current rate is between 30-40% (Waritay and Wilson, 2012).

## POLITICAL BACKGROUND

### HISTORICAL

The world's earliest human remains were found in Tanzania. The area now within the national borders of Tanzania has over the millennia been 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 govern the Republic of Tanzania, respect and power is still afforded locally 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 and 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 took 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 with headquarters 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. Subsequent years witnessed Tanganyika moving 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 and 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. A one-party state would allow collaboration and unity without any suppression of opposing views he stated. TANU was now the only legal political party in Tanganyika.

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 (The Tanzania National Website, 2012).

All references in this section are to the US Department of State, 2012, unless otherwise indicated.

## CURRENT POLITICAL CONDITIONS

Since independence, Tanzania has held general

elections every 5 years , although until 1992 there was 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 (The Tanzania National Website, 2012).

Tanzania has been spared the internal strife that has blighted many African countries. Though 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 contrasted 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. But 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 the rise 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 a planned highway threatens the Serengeti game park, Tanzania's biggest draw for tourism (BBC, 2012). Self-governing Zanzibar (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 (US Department of State, 2012).

## ANTHROPOLOGICAL BACKGROUND

### ETHNIC GROUPS

The ethnic make-up of Tanzania is vast, with 130 Bantu tribes representing 95% of the overall population (1% consists of Asian, Arab and European peoples) (World Factbook 2012). A number of sources, however, refer only to the approximately 120 ethnic groups based on socio-linguistic lines (US Department of State 2011; Minority Rights Group International, 2012; EISA, 2012). The largest of these groups are the Sukuma and Nyamwezi peoples (EISA, 2012). Other socio-linguistic groups include the Barabaig, Hadza/Hadzabe, Shirazi, Maasai, and Tatoga (Minority Rights Group International, 2012).

Although surrounded by nations whose instability has often resulted from ethnically-motivated conflict, Tanzania has remained relatively peaceful. This is possibly because no ethnic group has been large enough to have a significant amount of influence within the country or to make a considerable impact upon the nation's politics (Erickson, 2012). A more commonly cited suggestion argues that the 'nation-building' initiatives of the 1960s – the spread of Socialism and anti-colonial nationalism, banning of the use 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. Please refer to section on FGM by Ethnicity for more details on ethnic groups that practise FGM.

## 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 and children and young people (Mwambete and Mtaturu, 2006). 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 of cancer or other terminal diseases – results from the understanding that the vast majority of HIV/AIDS infections are transmitted through sex (Nyblade et al, 2003; Lugalla et al, 2008). 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' (Nyblade et al, 2003).

FGM is commonly upheld as a necessary means to secure female virginity, reduce sexual desire and promiscuity, and to also improve fertility (Mwabalasa, 2006). 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 which do not practise FGM (Equality Now, 2001). If a man does choose to marry an uncircumcised 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 (Children's Dignity Forum/FORWARD, 2010).

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 Tarime district are prohibited from cooking for in-laws, washing in the river with girls who have been cut and opening the doors of the cow shelters to prevent their bad luck being brought upon anyone who may enter the shelter after them (Children's Dignity Forum/FORWARD, 2010).

The social exclusion faced by girls who reject FGM seriously affects their ability to marry.

## SOCIOLOGICAL BACKGROUND

### ROLE OF WOMEN

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

There is a high incidence of early marriage in Tanzania that has remained unchanged over the last fifteen years. The minimum legal age for marriage is 15 years for women and 18 years for men. Between 1996 and 2004, between 23.5% and 27.8% of girls between 15 and 19 years of age were married, divorced or widowed. 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 at all. DHS data for 2010 indicate some preference towards sons in regard to access to education, but not in regard to early childhood care (Gender Index, 2012).

Although domestic violence is recognised as grounds for divorce by the courts, there is no law in Tanzania specifically addressing domestic violence. When women do seek help from the police, they are generally unwilling to intervene. Domestic violence remains very widespread and is severely under-reported. Pressure from family and the community to remain silent, and stigma surrounding gender-based violence prevents many women from reporting spousal violence. A 2005 study found that 15% of women who have ever been married had been physically assaulted in the previous 12 months, while 33% had ever

experienced violence at the hands of their partner. Rape also remains a serious problem. Women's freedom of movement may be restricted on a day-to-day basis: 48.9% of married women aged 15-49 questioned for the 2010 DHS said that their husbands made the final decision as to whether or not they could travel to visit family (Gender Index, 2012).

### HEALTHCARE SYSTEM

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. The distribution of health facilities has a heavy rural emphasis because more than 70% of the population live in rural areas. The health services are structured at various levels, including: village health services, which essentially provide preventive services which can be offered in homes; dispensary services, which cater for between 6,000 to 10,000 people and supervise all the village health posts in its ward; health centres, which cater for 50,000 people which is approximately the population of one administrative division; district hospitals; regional hospitals; referral/consultant hospitals, presently there are four referral hospitals in Tanzania; 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 health care system. The National Family Planning Programme is the sum total of all Family Planning activities provided by various agencies – and coordinated by the Reproductive and Child Health Unit of the Ministry of Health. The Government formally started providing Family Planning Services (FPS) as one of the Maternal and Child Health (MCH) components in the mid-70s. This Family Planning Unit (FPU) is responsible for initiating and developing family planning standards and guidelines on service provision, training and other



aspects of quality care (The Tanzania National Website, 2012).

Since 2006, maternal and child health care has been included as a priority component of national health policy. Its 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 health care services is always documented but implementation appears to be limited by lack of equipment (The State of the World's Midwifery, 2011).

Over the last 15 years, Tanzania has made a number of important achievements in public health. These include a continuing rapid decline in childhood deaths with infant mortality cut almost in half and between 2001 and 2010, HIV prevalence fell from 7.1% to 5.6% and in March 2010, the United States and Tanzania signed a Partnership Framework to scale up prevention efforts while maintaining support for care and treatment (USAID, 2012). 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 (ITNs). Increased numbers of pregnant women are taking intermittent preventive treatment (IPT) to reduce the consequences of malaria in both the woman and her unborn child (Tanzania Global Health Initiative Strategy 2010-2015, 2012).

Problems in health care financing are being dealt with through prepayment schemes like National Health Insurance (NHI) and the Community Health Fund (CHF). The majority of Tanzanians do not have health insurance.

The 2010 DHS reported that 93.5% of women

had no health insurance, 0.5% had social security, 3.7% had employer insurance, 2.1% had community-based insurance and 0.1% had private care. Similarly, 93.3% of men had no health insurance, 0.5% had social security, 3.1% had employer insurance, 2.7% had community-based coverage and 0.4% had private care (DHS, 2010).

### REPRODUCTIVE HEALTH CARE

Although 95.9% of women received antenatal care from health personnel, only 43% made the 4+ antenatal visits as recommended by the WHO (a decline from 62% in the DHS 2004-05), with a difference between urban and rural areas (urban: 55%; rural: 39%).

54.5% of women received delivery assistance from health personnel, but only 28% of women received postnatal care from health personnel within the first two days since delivery (DHS, 2010).

<b>% total of women receiving antenatal care</b>	95.9
<b>Doctor/AMO</b>	3.5
<b>Clinical officer</b>	4.8
<b>Nurse/midwife</b>	79.5
<b>MCH aide</b>	8.2
<b>Trained TBA</b>	0.0
<b>Village health worker</b>	2.0
<b>No one</b>	1.8
<b>Missing</b>	0.3

### Access to antenatal care from health care providers (%) (DHS, 2010)

A recent report indicated 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 of access to family planning services. Referring to the poor reputation of Tanzania's health systems, the authors of one report comment that, 'the bad birth care experiences of women undermine the reputation of the health care system, lower community expectations of facility birth, and

sustain high rates of home deliveries' (IRIN, 2013, referring to Mselle et al, 2013).

### PLACE OF DELIVERY

Overall, 50% of births take place at a health facility. The percentage of births taking place in health facilities depends on the child's characteristics. Births to younger women, births in urban areas and low-order births are much more likely to take place in a health facility.

Place of Delivery		Total %
Health facility	Public Sector	41.0
	Voluntary/Religious Sector	7.5
	Private Sector	1.6

### EDUCATION

Pre-school education caters for children aged 5 to 6 years and lasts two years; attendance is not compulsory. Primary education is compulsory and lasts 7 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 4 years and preparing students for the Certificate of Secondary Education Examinations. The second cycle lasts 2 years and leads to the Advanced-level examination. Tertiary and higher education is offered in universities, university colleges and tertiary-level institutions. (UNESCO, 2010).



Schoolchildren in Arusha © 28 Too Many

In Mainland Tanzania there has been an improvement in the percentage of the 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. 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 transition to secondary school and higher levels. MDGs 2 and 3 are both stated to be achievable by 2015 (UNDP Tanzania 2010).

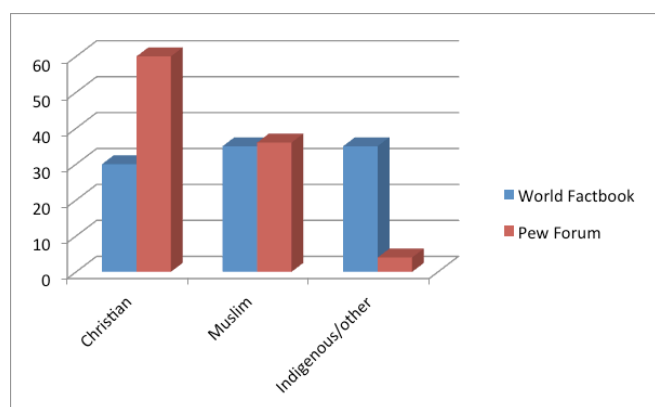
The Household Budget Survey of 2007 shows that on the mainland, the literacy rate among those aged 15+ is 72.5% (89.5% for men and 66.1% for women) (cf. World Factbook and World Bank figures in National Statistics above). Literacy is greater among men than among women, and lower in rural areas compared to urban areas. In order to reach an increased level of literacy, more effort is needed to increase enrolments of school children, ensuring 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 (UNDP Tanzania 2010).

### 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 (Report on International Religious Freedom, 2012).

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 Forum survey conducted in 2010 suggests that approximately 60% of the population is Christian, 36% Muslim, and around 4% adhere to other religions (International Religious Freedom Report, 2011). The World Factbook 2013 states that on the Tanzanian mainland the religious composition is Christian 30%, Muslim 35%, indigenous beliefs 35%; Zanzibar - more than 99% Muslim of which 80-90% are Sunni, the rest consisting of Shia sub groups. Christianity followers include Roman Catholics, Protestants, Pentecostals, Seventh-Day Adventists, Mormons, and Jehovah's Witnesses. Other religious groups in Tanzania include Buddhists, Hindus, Sikhs, and Bahais (Report on International Religious Freedom, 2012).



**Religious composition (%) (World Factbook; Pew Forum)**

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 into their daily lives. 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 of the 19 countries surveyed. In addition, 93% of Tanzanians say that religion is 'very important' in their lives, which again is among the highest of those African countries surveyed (Pew Forum, 2010).

There has a huge reported increase in witchcraft based killings with 71 killings and 31 injuries of persons with albinism and 630 witchcraft related killings in 2012, many associated with mob

violence. Reasons for continued incidents of witchcraft killings include: 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 witch doctors has been named as a major factor for killings due to witchcraft beliefs. This is because a majority of the people opt to go to witch doctors for treatment and whenever they die, the witch doctor tends to tell relatives that there is someone behind that death (LHRC Report, 2012).

One survey indicates that 85% of Tanzanians see others as being very free to practise their faith (Pew Forum, 2010). 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 increase in church burning and heightened tensions between Muslims and Christians. For example, in May 2012, three churches 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 symbolised mainland influence in Zanzibar, with the attacks apparently partly a strike against the mainland due to a combination of religious and political differences. Rioting also took place in 2012 in the Mbagala suburb of Dar es Salaam with more than 100 people being arrested. The riots followed an incident in which a 14 year old Christian boy was taken to police for allegedly urinating on a copy of the Qur'an. After the police transferred the boy to another location, Christian churches were attacked in the area (International Religious Freedom Report, 2011). 43% of Christians see Muslims as violent (median is 43%), as opposed to 11% of Muslims seeing Christians as violent (median is 20%) and 24% say that conflict between religious groups is a very big problem (Pew Forum,

2010).

At the end of 2012, the President stated that in Tanzania, for the first time in its history, there was possibility of civil strife and division along religious lines. He encouraged religious and political leaders to take seriously their responsibility to ensure that citizens continue to live peacefully regardless of the religion, ethnicity, colour or place of origin. In addition, some prominent society leaders have taken positive action to promote religious freedom (International Religious Freedom Report, 2011).

## MEDIA

### PRESS FREEDOM

There has been a rise in anti-press attacks, set against a backdrop of repressive media laws, and this promotes self-censorship among Tanzanian journalists, especially those working in rural areas (Committee to Protect Journalists, 2013).

Freedom House has declared that the media in Tanzania is only partly free. Despite the guarantee of free speech in the constitution, there are examples of the government repressing information. The Human Rights Report states that the government controls media in Zanzibar, although political opposition has gained increased access since the 2009 reconciliation; that journalists are 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. The report states that the media practises self-censorship to avoid conflict with the government (Human Rights Report, 2012).

East African papers, 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 in the manner it interferes with the freedom of the press. They attempt 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 things happen with sufficient frequency to remind those still in print to be wary and sensitive. (Press Reference, 2013)

### MAIN NEWSPAPERS IN TANZANIA

24 Tanzania (Dar es Salaam), Arusha Raha\*, Arusha Times, Business Times, The Citizen, Daily News, East Africa News Post, The Express, Guardian IPP (Dar es Salaam), In2EastAfrica, Kafoi Online (Dar es Salaam)\*\*, Kawowo Sports, Mwananchi (Dar Es Salaam)\*, Raia Mwema\*, Tanserve, Tanzania Daima (Dar es Salaam)\* (onlinenewspapers.com, 2013)

Unmarked are in English, \* Swahili, \*\* English and Swahili

### ACCESS TO MEDIA

International Telecommunications Union says that approximately 12% of Tanzanians use the Internet and 5% of households had Internet access in 2011 (Human Rights Report, 2012).

Men have greater access to media and there is a positive correlation between exposure to mass media and level of education and wealth (with the highest access being in urban areas, as expected)

Gender	Female	Male
Reads a newspaper at least once a week	18.8	29.9
Watches television at least once a week	23.6	39.5
Listens to radio at least once a week	57.5	76.5
All three media at least once a week	8.6	19.7
No media at least once a week	36.0	18.8

**Exposure to Mass Media % of Population (DHS, 2010)**

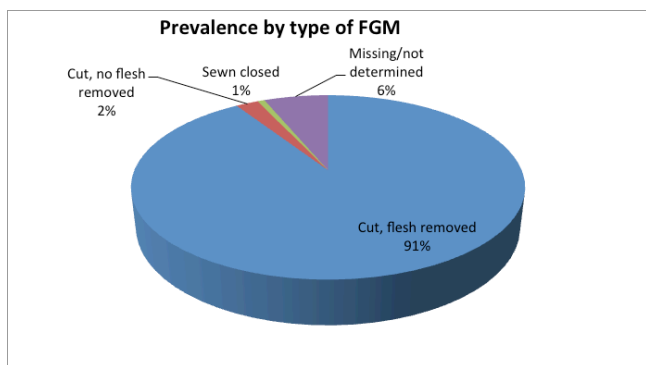
## FGM PRACTICES IN TANZANIA

### TYPE OF FGM

#### Terminology:

*Different terms are used in Kiswahili. In the past 'tohara' was used but later the right term became 'ukeketaji' and sometime the two are used interchangeably.* (LHRC Report, 2011)

The following data from DHS shows the prevalence of FGM by type performed. The most common type is 'cut, flesh removed', which equates to Types I and II, at 90.9%, followed by 'cut, no flesh removed' (Type IV) at 2.2% and 'sewn closed' (Type III) at 0.7%. Overall, the incidence of Type III is low, with it being found mainly in Mara. In Tanga, 10.7% of women who have been cut have undergone 'cutting, no flesh removed' which may indicate a trend towards a ritual 'nicking' with no flesh removal in order to reduce harm.



Prevalence of FGM by type among those women who have undergone FGM (%) (DHS, 2010)

Region	Cut, removal of flesh (Type I & II)	Sewn Closed (Type III)	Cut, no removal of flesh (Type IV)
Manyara	80.5	0.3	0.9
Dodoma	99.5	0.0	0.5
Arusha	81.3	0.0	1.5
Singida	95.0	0.0	1.7
Mara	94.2	3.6	2.0

Kilimanjaro	93.7	1.3	1.8
Morogoro	94.9	1.8	0.0
Tanga	86.3	0.0	10.7
Iringa*	95.0	0.0	2.6

Types of cutting by region (DHS, 2010) [\* figures based on 25-49 unweighted cases]

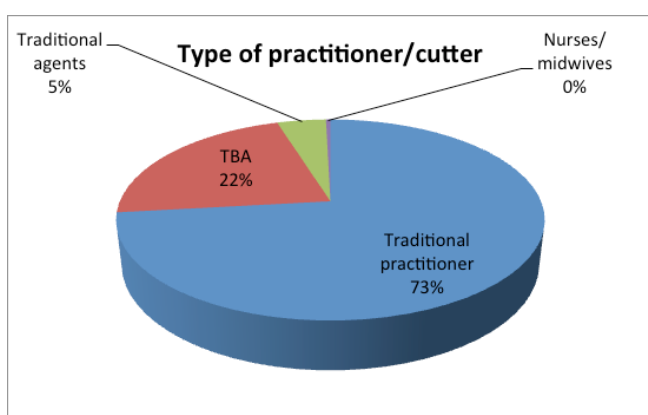
### PRACTITIONERS OF FGM

In Tanzania, FGM is most frequently carried out by traditional practitioners (excisors) within communities, called ngariba in Kiswahili. The DHS, 2010 surveyed the person who performed the FGM of the most recently cut daughter of women surveyed. Three out of every four instances of FGM (73%) were reported to have been carried out by a traditional excisors (ngariba), while 21.9% had been carried out by traditional birth attendants and 4.4% by other traditional community agents. Only 0.4% had been carried out by nurses/midwives (DHS, 2010). The DHS data does not appear to suggest a trend towards medicalisation, with 1.0% of instances being carried out by health professionals in 2004-05 (DHS, 2004-05). There are, however, reports that in urban areas, wealthier families prefer to use the services of health personnel such as midwives and doctors (Mwita, 2013). This has included reports of midwives performing the practice at hospitals in Kilimanjaro during delivery (NAFGEM, 2010).



Cutting tools and other paraphernalia from excisors who had laid down their tools, collected by AFNET © 28 Too Many

Although medicalisation decreases the negative health effects of the procedure, this has led to a misconception that FGM within a hospital/clinic 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 (UNICEF, 2005). 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 (Shell-Duncan et al, 2000). Furthermore, there is concern from older and more traditional members of communities that performing the surgery in a health facility with anaesthetic takes much of the meaning out of the ritual (i.e., the need for the strength to endure the pain) (Christoffersen-Deb 2005).



**Distribution of most recently cut daughters, according to person who performed FGM (%) (DHS, 2010)**

Traditional excisors , ngaribas, often inherit the position, with the right to being an ngariba being passed down from mother to daughter through the generations within a particular clan (Children’s Dignity Forum/FORWARD, 2010 and Ngowi, 2011). Ngariba are held with high regard in their communities. In Singida region ngariba are thought by some communities to possess supernatural powers (Christian Council of Tanzania, 2008). They are also reported to be feared in Tarime district, as community members recognise that if they provoke an ngariba she may cut their daughter

badly and cause even more harm (Children’s Dignity Forum/FORWARD, 2009).

Ngariba receive payment for performing FGM ceremonies, earning between 5,000 – 10,000 Tanzanian Shillings (US\$3-6) per initiate (Waritay and Wilson, 2012). 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 generation. This has meant that while there is widespread knowledge of the illegal status of FGM (92% of practitioners in Singida and 70% of those in Tarime are aware of the law against 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 (Christian Council of Tanzania, 2008 and 2009).

Traditional birth attendants also perform FGM. A number of excisors are reported to have started out as traditional birth attendants before becoming an ngariba. 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, with many cases of excisors receiving only symbolic payments. For example, 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 (World Vision, 2013).

## FGM BY ETHNICITY

**In many settings, FGM/C derives much of its meaning and tenacity from its intimate association with ethnic identity. (UNICEF, 2013)**

As referred to in the Anthropology section above, Tanzania does not record the ethnicity of its citizens. Neither does the DHS breakdown prevalence of FGM by ethnicity. However, variations in the prevalence of FGM across regions are best understood in terms of ethnicity (UNICEF, 2013).

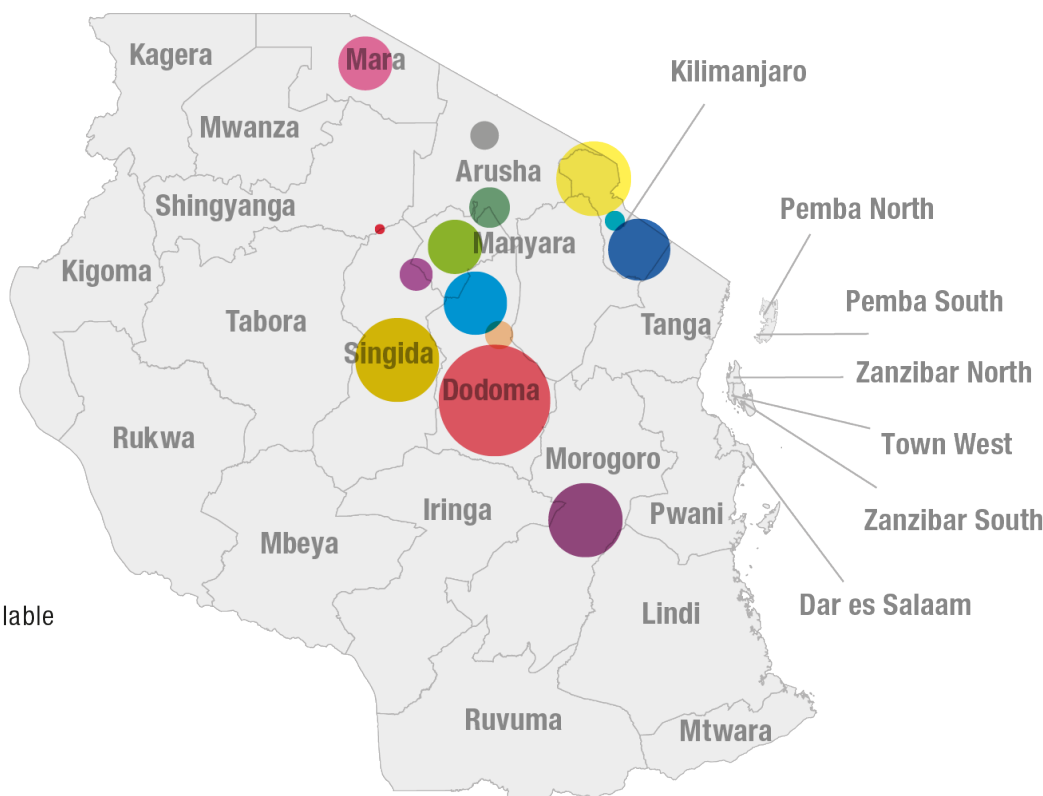
As highlighted above, there are six regions within which FGM is most practised at a rate of over 20% (Manyara, Dodoma, Arusha, Singida, Mara and Kilimanjaro). It has not been possible to profile all of the ethnic groups that practise FGM, however, some of the main ethnic groups within these regions with a higher prevalence of FGM are focused on below. Others include the Rangi and

Sandawi (Dodoma region); the Waarusha (Arusha region), the Luguru (Morogoro region), 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

Representing the third largest group in Tanzania, the Chagga are a Bantu-speaking group of approximately 834,000 people residing in the Kilimanjaro region of northern Tanzania (University of Pennsylvania, 2013; Joshua Project, 2013d). 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 slope of Mount Kilimanjaro (University of Missouri, undated (b); Fernandes et al, 1985). 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 (Fernandes et al, 1985). Foods, work and property are split between

- Nyaturu – 1 million
- Hazda – 1,000
- Maasai – 300,000
- Barabaig – 300,000
- Gogo – 1.4 million
- Chagga – 800,000
- Pare – 700,000
- Kahe – 5,500
- Kuria – 700,000
- Iraqw – 500,000
- Rangi – 500,000
- Sandawi – 40,000
- Luguru – 700,000
- Waarusha – Data unavailable



Approximate distribution and size of practising ethnic groups (Various data)

genders, with men feeding and slaughtering animals, preparing the fields, and building houses and canals, while women are responsible for collection firewood, fodder and water, cleaning the homestead and stalls, and cooking (Every Culture, 2007). Interestingly, women are in charge of the markets, however in order to trade 'male' foods (such as bananas and beer) permission must be obtained (Every Culture, 2007; University of Missouri, undated (a)).

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 (University of Missouri, undated (b)).

The Chagga have traditionally practised the betrothal of daughters and the payment of bride-price, with its 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 to the Chagga (University of Missouri, undated (b)).

**Age and prevalence**

The latest DHS found that the prevalence in Kilimanjaro, where the Chagga mainly reside, was 21.7% (DHS, 2010). Two studies report that the Chagga cut girls relatively late, with the age of girls undergoing FGM being 15 years old or older (Msuya et al, 2002 and Klouman et al, 2005). 28 Too Many's in-country research among the Chagga of Huru, Hai, and Moshi districts, however, found that the Chagga are now cutting girls between the ages of 1 month to 1 year old, 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 years old, pressure from the government and authorities has caused the practice to go underground, and to be carried out on babies to avoid detection. However, the

age of FGM initiates more generally has reduced by a lesser extreme to 8-9 years old. The elders informed 28 Too Many that prior to the shift to cutting girls at a younger age, women could often be cut after marriage if they experienced problems conceiving children, or if the husband's family faced difficulties or misfortune – believing that their uncut daughter-in-law to be responsible for their ill fate (28 Too Many, in-county research, 2013).



Chagga women, Moshi © 28 Too Many

**Reasons**

A number of reasons for continuing 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 health care. 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 claims 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’ in section on Reasons below). It is also believed that uncut girls give birth to disabled children, or are unable to conceive once they are married (28 Too Many, in-country research, 2013).

### Type

Type I is the most common type of FGM (Msuya et al, 2002). 28 Too Many found that a number of Chagga, especially from the majority Muslim districts of Huru and Namuru, are employing sunna, suggesting a possible link between the practice and the belief that it 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 (28 Too Many, in-country research, 2013).

### 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 are 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 be referred to as bibi (grandmother). The wakeku are given gifts for their services, namely goats, clothes, money and other material possessions; it is also believed that if the wakeku are not paid, they have the power to prevent the girls’ wounds healing.

During the ceremony the girls are cut with a section of iron sheeting, following which they will be seated on a traditional ceremonial stone, with women from the community formed in a circle around them to sing songs and perform traditional dances (28 Too Many, in-country research). The initiates are then given a variety of foods – likely to be considered restorative and strengthening – such as mlaso (meat mixed with fermented milk), kiskusyo (the blood of a slaughtered cow), kitawa (a banana and milk mixture), mtori (banana mixed with cooked meat) and porridge. The new initiates are presented with gifts such as special

clothing, money, and food. The most important element to be presented to the initiates is a stick along with traditional medicine (ibangasa) that is believed to hold magical powers that will protect them from witches and evil. However, respondents claimed that girls who were ‘troublesome’ while being cut would not be presented with gifts.

The cut girls undergo a period of seclusion lasting between 1-3 months, in order to be instructed in their new responsibilities as Chagga women by the wakeku and their aunts. Such instructions include 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, to respect their elders, and how to ensure that their households have enough food stored in preparation for famines. Once the girls have undergone FGM and the associated initiation, they are considered ready for marriage (as are the boys after circumcision) (Every Culture, 2007).

Now, however, young infants are 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.

(All references are to 28 Too Many, in-country research, 2013, unless otherwise indicated).

### Attitudes

Although the Chagga were able to point to many of the negative impacts of FGM upon women and girls, they contended that it would be difficult (even impossible) for an uncut women to be respected within her community. 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 the 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. Inter-marriage between Chagga and non-Chagga persons has also started to influence the prevalence – or perhaps the visibility – of the practice (28 Too Many, in-country research, 2013).

## Case Study - A story of five sisters in Moshi



My name is Elisabeth\*. There are five sisters in our 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!' [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 elderly sister as an example saying, 'your elderly 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'.

\*Names have been changed.

(28 Too Many, in-country research, 2013)

## 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, residing in the Dodoma region in the centre of the country (Lewis et al, 2013). This area is bordered by hills in the south and east, and the Bahi Swamp to the west (Encyclopaedia Britannica, 2013). Traditionally, the Gogo have engaged in a pastoralist way of life, however a growing number of contemporary Gogo people are becoming farmers or workers on farms and plantations in other parts of the country (Ndembwike, 2009). 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 (Rigby, 1967; University of Missouri, undated (a)).



Gogo women, Dodoma © 28 Too Many

Although the Gogo have been at war with the neighbouring Hehe and Maasai tribes in the pre-colonial era (University of Missouri, undated (a)), ethnic tension between the groups does not

appear to be an issue in the present day.

The Gogo practise polygamy and the exchange of bridewealth 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 (University of Missouri, undated (a)).

### Age and prevalence

The latest DHS found that the prevalence in Dodoma, where the Gogo mainly reside, was 63.8% (DHS, 2010). The Anti-Female Genital Mutilation Network of Tanzania (AFNET), however, based on feedback from community representatives and clinics, estimates that in Dodoma, the rate of FGM had dropped to a ‘very low level’ among the Gogo (and Rangi) ethnic groups. While the Gogo traditionally carried out FGM on girls between 10-15 years of age, it is now reportedly performed secretly on infants or has in some communities even died out (Waritay and Wilson, 2012). The reduction in the age at which FGM is performed can, in part, be attributed to the impact of the criminalisation of FGM and belief in lawalawa (see FGM and ‘lawalawa’ in section on Reasons below).

### Reasons

Traditionally, FGM was performed as a rite of passage, to ensure marriageability, a means of gaining the respect of the community and to become a ‘proper Gogo woman’. The current prevailing reasons appear to be the maintenance of tradition and to cure lawalawa (Waritay and Wilson, 2012).

### Type

Both Type I and Type II FGM have been reported (Waritay and Wilson, 2012).

## Traditional Gogo ceremony

FGM among the Gogo shares a number of similarities with the rite practised by the Nyaturu in Singida region, with girls and boys undergoing circumcision during the harvest months of June and July, and groups of initiates being trained in being a Gogo man or woman. The ceremonies were said to take place once a father had decided that he wants his daughter to be cut, his family and neighbours notified, and an ngariba 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 have intercourse a year after being cut, as it is believed that children conceived before this time will die (Waritay and Wilson, 2012).

## HADZA

The Hadza (also known as Kindiga or Hadzabe) are a hunter-gatherer group with a population of approximately 1,100 people, residing mainly in the areas around Lake Eyasi in Singida region (Joshua Project, 2013b; Crittenden, 2013). 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 locally store-bought produce (Eede, 2013; Crittenden, 2013). 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, and hunted mammals – such as baboons, warthog, and impala – and birds (Crittenden, 2013; Marlowe, 2003; Eede, 2013). Both men and women are actively involved in providing for Hadza camps, with groups of women foraging plant food (tubers, fruit and berries), and solo or paired males hunting animals and collecting honey and baobab fruit (Crittenden, 2013; Marlowe, 2003).

Socially, the Hadza reside in ‘camps’ of around 29 people, and tend to move site every 1-2

months (Marlowe, 2003). An egalitarian way of life is followed and equality is of high priority among the Hadza. There is no political structure within or between camps, and similarly there is no apparent status hierarchy or set of group leaders; food and tools are shared, as well as responsibility for caring for younger members of the camps (Marlowe, 2003; Crittenden, 2013; Finkel, 2013). Hadza women are widely reported as having a great deal of autonomy and take part in decision making with men (Finkel, 2013; Crittenden, 2013). While there are no official marriage ceremonies, couples who have slept at the same fire for a period of time may consider themselves married (Finkel, 2013). In addition, it is rare for a man to have more than one partner, 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 (Finkel, 2013; Marlowe, 2003). 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 (2013).

### Traditional Hadza ceremony

Hadza girls undergo FGM as part of the 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 3 days, where they are dressed in ceremonial beads and feathers, and take part in singing, dancing, and chasing older boys with a fertility stick. On the third day of the rite the girls are segregated from the rest of the camp, 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). Once Hadza girls have gone through mai-to-ko they are officially ready for marriage, however Marlowe (2010) has noted that girls will often only marry a year or two after the rite (Marlowe, 2010).

The practising of FGM by the Hadza presents an unusual case in that, while FGM is commonly practised by pastoralists, the procedure is rarely part of the culture of hunter-gatherer groups

(Marlowe, 2010). It has been suggested that the Hadza may have taken on the practice since the neighbouring Iraqw people – with whom the Hadza are often engaged in Iraqw purification rituals involving intercourse – also practise Type I FGM; similar suggestions of a preference for ‘clitorectomized women’ from males of neighbouring groups have also been made (Mattiessen and Porter, 1974, and Hames n.d., cited by Marlowe, 2010).

## KURYA

The Kurya (the spelling Kuria is also used) are a majority-pastoralist group residing in the Mara region of northern Tanzania, near the Kenyan border (Lawrence, 2009). With a population of approximately 524,000 people (Joshua Project, 2013g), the Kurya are divided into sub-clans, and have lived mainly as farmers and herders, with the Kurya communities living in Serengeti district remaining almost entirely as pastoralists (Lawrence, 2009; Ndembwike, 2009).

### Age and prevalence

The Kurya practise FGM on girls who are between the ages of 11-16 years old every two years (Waritay and Wilson 2012; Children’s Dignity Forum/FORWARD, 2009). While this age range is not unusual in comparison to other practising groups, it is of interest that the Kurya had previously cut girls at 15-18 years old but brought the ceremony forward to counteract the rising disagreement to being cut from older teenage girls. The prevalence is particularly high within some districts, such as Tarime (see Regional Statistics above).

### Reasons

As it is for other groups, FGM among the Kurya 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

(Waritay and Wilson, 2012). 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 (Children’s Dignity Forum/FORWARD, 2009).

### The Kurya: Traditional beliefs, ceremonies and FGM

In the Mara Region, over 95% of the population is Christian or Animist with a small Muslim population mostly in urban areas (Planning Commission of Tanzania, 1998). Animist beliefs, however, seem to strongly influence the practice of FGM among the Kurya.

According to Ngowi (2011), FGM among the Kurya is prohibited during July, August, and any year ending in the number seven, as such years are considered to be ‘bad’. 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 over night; if when the leaders return the calabashes are full, it is considered safe – if 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 (Waritay and Wilson, 2012). FGM is considered to be a blood sacrifice to appease the ancestors (mizumi), in order to avoid misfortune. The events are accompanied by much celebration (Waritay and Wilson, 2012). During the ceremony, the initiates are cut by an omsali (ngariba in Kiswahili) (Ngowi 2011). 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 dress up and partake in traditional celebratory dances called litungu in order to ‘advertise’ themselves as being ready for marriage (Children’s Dignity Forum/FORWARD, 2010). 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, with the body being thrown away secretly like an animal, and the mother is not permitted to mourn publicly, and any presents received during the ceremony, even cows, must be destroyed (Waritay and Wilson, 2012).

There is a link between male circumcision and FGM, and this link too is associated with traditional animist beliefs. Boys and girls undergo circumcision/FGM at the same time, but in different areas. 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 the circumcision ceremonies. The places where the cutting take place are considered sacred and ‘outsiders’ are not permitted to enter them. Kurya women who have not undergone FGM are not permitted to ‘receive’ their sons following their circumcision ceremony. 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 has such significance (Waritay and Wilson, 2012).

While public denunciations of FGM by politicians had caused some Kurya 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 (Waritay and Wilson, 2012). This is unlike many other regions of Tanzania, where the practice has gone underground. Please see section below on National Laws, which discusses the mass mutilations which still take place in Tarime district and the difficulties faced in enforcing the law.

### MAASAI

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 (Joshua Project, 2013c). There is a high prevalence of FGM within these regions. For instance, Larsen and Yan (2000) found that 90% of women in Arusha have been mutilated however official statistics report that only 58.6% of women have been cut in Arusha, and 70.8% of women in Manyara (DHS, 2011). This compares to 54.5% in Arusha and 81% in Manyara in the DHS 2004-05.



Maasai women, Arusha © 28 Too Many

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 (Mbugua, 2007). 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, fearing that they will be cursed if they refuse their age-mate (Mbugua, 2007).

The Maasai also practise polygamy, with men having on average 2.8 wives (Coast, 2005), and on occasion up to sixteen wives, according to some studies (Mbugua, 2007; Höschele, 2006). 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 (Mbugua, 2007).

### Age/Prevalence

28 Too Many's in-country research among the Maasai in Arusha has revealed different findings

between different groups within the community. This may reflect diverse perceptions or may reflect a reluctance to disclose due to the fear of prosecution. Some elders claimed that FGM had been abandoned entirely.

While elders 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 sangito (the age group of girls of 'maturity', between 12-20 years), there had been a shift to cutting infants and newborn babies as young as 7 days old. The cutting takes place indoors, amidst much secrecy, with a number of infant deaths resulting from FGM. 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 7 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 Discussion participant, 28 Too Many, in country research).

### Reasons

There was consensus among all Maasai respondents that FGM is intended to prevent girls from engaging in pre- and extra-marital intercourse, and particularly to prevent pregnancies prior to marriage. Girls who undergo FGM attract a higher bride price and 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



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

‘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. In the eyes of the Maasai community, uncut girls are called *endito* – literally ‘rubbish’, ‘useless’ women. The Maasai elders contend that such women would not be allowed to join the community of adult Maasai women and would not be able to participate in an honoured traditional greeting of having one’s head touched by an elder or honoured adult. 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 and traditional excisors**

Traditional excisors called *engamuratani* in Maa (as opposed to the Kiswahili *ngariba*) remove the whole clitoris of the initiates (Type I), 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 up to 10,000 Tanzanian Shillings (US\$6) per girl cut, and/or a cow, goats, sheep, along with 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.

### **Traditional Maasai ceremony**

Traditionally taking place during the school holidays of December and the cooler month of June (supposedly to aid the healing of the cut genitalia), the rite was carried out over 5 days. Over the course of the ceremony, a cow, goat, and sheep are slaughtered, and a special *ololate* 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 for marriage. 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 been cut, 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 initiates as part of their naming ceremony, acting as an emblem of grace by which they will have a peaceful marriage, children, and will not be affected by the misfortunes of life.

A period of seclusion is then to take place, sometime 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. Whilst 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.

However, student respondents claim that 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, in order to conceal the fact that cutting is taking place. The 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 will no longer wear special ceremonial clothing so as not to reveal any differentiation between cut and uncut girls. The reason for this change is reported to be to avoid prosecution, following the out-lawing of FGM. In addition, following sensitisation by NGOs, the current generation has witnessed massive running away of enlightened Maasai girls. Therefore, Maasai traditionalists believe that cutting infants can 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 the community members.

### Attitudes

The women also reported a shift in preference amongst 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 between Maasai girls who choose not to be cut and those who do based on the level of education: educated girls 'hated and despised' FGM while uneducated girls like it because they think 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 education and the right to receive it, one elder commented, 'unfortunately, 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 FGM. His village enacted a by-law against FGM which led to action

being brought against the parents of an 18 year old who was cut (Equality Now, 2011).

All references in this section are to 28 Too Many, in-country research, unless otherwise indicated.



Maasai woman, Serengeti, Tanzania © Pal Teravagimov

### 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 government as being a 'backward' way of life, with their 'stubborn traditionalism' widely viewed as the principal barrier to school attendance and female empowerment. FGM among the Maasai is often attributed to their 'their cultural isolation and ignorance, the stubborn persistence of apparently static customs, and an unwillingness to change' (Hodgson, 2005, referred to by Winterbottom et al, 2009).

Sometimes, 'development' and 'civilisation' has involved the forcible removal of land in return for no or little tangible benefit. As a result, the Maasai have often decided that the 'cultural practices' such as FGM, undermined by such development efforts, must be protected at all costs. Attacks on FGM, both in the colonial period 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 institutions, including 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 provisions 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, expressed by the Maa concept of *enkisasai* (meaning new or modern). The FGM ceremonies have changed, for example, the traditional dress of initiates has changed from 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 (see FGM and 'lawalawa' in section on Reasons below).

Winterbottom et al conclude that anti-FGM campaigns must:

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

(Winterbottom et al, 2009)

## NYATURU

The Nyaturu reside in the central and southern parts of Singida region, west of the Wembere river, with a population of approximately 932,000 people (Joshua Project, 2013a).

### Age and prevalence

According to Larsen and Yan, 27.8% of women have been circumcised within Singida region (2000). The DHS records the prevalence as being 51% (DHS, 2010). The Anti-Female Genital

Mutilation Network of Tanzania (AFNET), based on feedback from community representatives and clinics, report that the current rate is between 30-40%. However, in one small-scale study in 2010 at a reproductive health clinic at which infants girls under the age of 2 years were physically examined, it was found that 84% had been cut (59 girls out of 70) (Waritay and Wilson, 2012). Traditionally, girls had to be 8-12 years old or found to be tall enough (Ali and Strøm 2012). Girls now undergo FGM at an earlier age, often as babies, amidst much secrecy. The reduction in age and prevalence can, in part, be attributed to the impact of the criminalisation of FGM and belief in *lawalawa* (see FGM and 'lawalawa' in section on Reasons below).



Nyatutu woman, Singida © 28 Too Many

### Reasons

Traditionally, FGM was performed as a rite of passage, to ensure marriageability and a means of gaining the respect of the community and to avoid stigmatisation. The current prevailing reasons appear to be the maintenance of tradition and to cure *lawalawa* (see FGM and 'lawalawa' in section on Reasons below) (Waritay and Wilson, 2012).

### Type

Both Type I and Type II FGM have been reported (Waritay and Wilson, 2012).

### 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 circumcision ceremonies as a rite 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 learn of cultural and community values, and sing songs of leaving their childhood behind (Waritay and Wilson 2012). If a child bled to death during the cutting, this was seen as a curse from the ancestors (Ali and Strøm 2012).

### 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 (Joshua Project, 2013e; Hollos and Larsen, 2004). Being situated in a mountainous region, the Pare are engaged in a highland farming system of production. The majority of families will also keep cattle, goats and sheep as sources of protein and wealth (Hollos and Larsen, 2004)

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 the marketing of their produce. Coffee, however, continues to be sold only by men (Hollos, 2002).

With a population of approximately 699,000 people, the Pare are a majority Muslim group (Joshua Project, 2013e). Hollos and Larsen (2004) 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 has 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. Bridewealth, however, remains an important part of Pare marriages (Hollos and Larsen, 2004).

### Age and prevalence

The DHS found a prevalence of 21.7% in Kilimanjaro (DHS, 2010). One study among Pare and Chagga in an urban area of Kilimanjaro, which involved physical examination, found the prevalence 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 region. The study found an overall prevalence of 16.6%. This may reflect a selection bias in the study since the participants were relatively young or it may reflect a true lower prevalence in urban areas. Another study found a much higher prevalence in rural Kilimanjaro (Chugulu, 1998, cited by Msuyu et al, 2002). The median age at which FGM was carried out was 9 years (Msuyu et al, 2002).

### Reasons

Perpetuation of tradition (67%) and the opportunity to teach about marriage and life (40%) were the most common reasons given for carrying out FGM (Msuyu et al, 2002). 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 urinal tract infections (UTIs) (i.e. *lawalawa*) (see FGM and 'lawalawa' in section on Reasons below) (28 Too Many, in-country research).

**Type**

Only Type I FGM was reported (Msuyu et al, 2002). This was supported by 28 Too Many's in country-research.

**Traditional Pare ceremony**

It also appears that, like the neighbouring Chagga, the Pare have a goat slaughtered in order for its meat and blood to enable cut 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 (28 Too Many in-country research).

**REASONS**

FGM is most commonly practised as a rite of passage into adulthood (Brewer et al 2007; Magoke-Mhoja, 2008). In the Singida region of the country, the Nyaturu ceremony of Ihongo takes place every four to five years to circumcise groups of girls between the ages of 8-12 years old, or those considered to be tall enough, in order to initiate them into womanhood (Ali and Strøm 2012:69). In other regions, ceremonies are carried out every two years. Indeed, the WHO has argued that in many societies, FGM is seen as a 'necessary step' in a girl's journey into womanhood, with those forgoing circumcision at risk of not being socially accepted as a woman (WHO, 2010). 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, with reports claiming that up to 5,000 girls in the Tarime district of Mara were at risk of being subjected to genital cutting during school holiday period at the close of 2012 (Nyakeke, 2012; Jacob, 2012).

The reasons for the practice of FGM can often vary in relation to national and regional views, ethnicity, beliefs and world views. The Kurya, and similarly the Maasai, instil ideas of the importance of marriage in girl children, and socialise them to be able to run a household by the age of 10. Due to this early socialisation to the ideals of marriage,

the Kurya are said to use FGM as a means to prepare – or 'validate' – a girl's body for marriage (Magoke-Mhoja, 2008). Indeed, child marriage and FGM are intrinsically linked for the vast majority of practising communities in Tanzania. For many families within these communities, girl children 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 (Children's Dignity Forum, 2008).

**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 flesh 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 (LHRC Report, 2008 and 28 Too Many, in-country research).



Uncut, rough and raw Tanzanite © Imfoto

The insurance of a bride's virginity is extremely important and as such 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 a means to ensuring female chastity, it is clear that the practices of early marriage and FGM are mutually dependent upon each other for validation (Children’s Dignity Forum, 2008).

The above 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. As such, 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 (WHO, 2010).

Traditional beliefs seem to be a significant driving force behind the continuation of FGM within some practising communities in Tanzania. While some continue the practise 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 people fear that ending FGM – both withholding the blood-offering and renouncing tradition – would anger the ancestors, bringing calamity upon the community (Christian Council of Tanzania 2009, 2008).

### FGM and ‘lawalawa’

Lawalawa is a relatively new phenomenon arising first among the Nyaturu peoples in 1970, just after the Arusha Declaration of 1968. President Nyere’s statement of ‘Unjuuma’ (brotherhood), contained the Bill of Abolishment which banned FGM. During this period there were strong attempts to create a uniform culture and the homogenization of different

tribal traditions, to create a nation in which ‘we are all Swahili’ (Winterbottom et al, 2009).

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 circumcisions with many girls 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’ (Winterbottom et al, 2009). AFNET reported that, ‘instead of stopping FGM once and for all, the campaign forced it to go underground until today’ (Winterbottom et al, 2009).

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

1. Lawalawa has been variously identified as thrush, trichomonas vaginalis and candida and is most likely a term encompassing various infections causing vaginal itching (AFNET, 2004);
2. 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 (Moen et al, 2012).
3. 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 (Ali and Strøm, 2012).

It would appear from all available literature that the consensus is that most of the cases of vaginal and urinary 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.

‘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' says a local female doctor (Ali and Strøm 2012). Sadly the 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. (Ali and Strøm 2012)

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. Chiku Ali (2012) 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. FGM began to be performed on baby girls, in secret.

'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' (Chiku Ali, co-author). More than 40 years after the Arusha declaration, the belief in lawalawa persists. The belief is not limited to vaginal infections, but sometimes also when girls or boys have a fever or other disease.

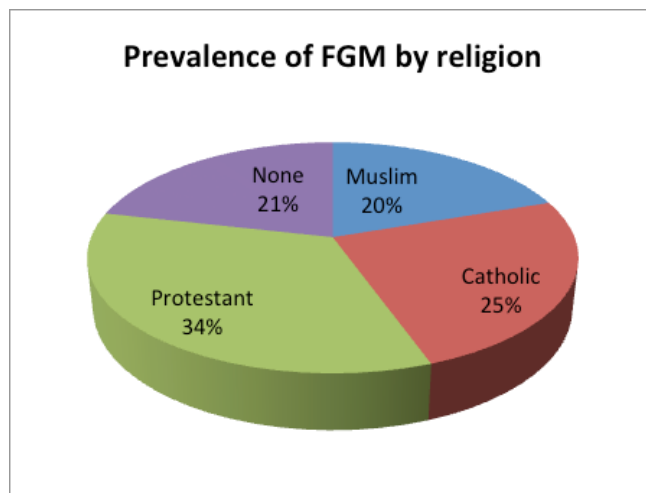
As noted above there is also a financial incentive to continue practising FGM. Traditional excisors give a portion of their earnings to the traditional community leaders (wazee wa mila), who themselves plan the FGM ceremonies. As such, the social influence held by traditional community elders can also be vested with personal financial interests. (Children's Dignity Forum/FORWARD, 2010; Christian Council of Tanzania, 2009).

## RELIGION AND FGM

As in other countries, FGM predates religion and is not exclusive to one religion. FGM has been justified under Islam yet many Muslims do not practise FGM and many agree it is not in the Qur'an. Within Christianity, the Bible does not mention the issue of FGM, meaning that Christians in Africa who practise FGM do so because of a cultural custom. FBOs and officials are involved in the eradication of FGM. In 2006, Target sponsored a conference between Muslim scholars from many nations; they deemed FGM to be against the Islamic faith as it is a harmful attack on women (Target, 2006).

As stated above, religious affiliation is not asked in the national census, and consistent data is therefore hard to find and many religious groups are reluctant to estimate religious demographics.

The DHS 2004-05 surveyed prevalence according to religion, but not the most recent DHS in 2010:



**Prevalence of women with FGM by religion (DHS, 2004-05)**

According to one study, in Tanzania, there is little connection between Islam and FGM (Boyle et al, 2001). Moreover, the Muslim Council of Tanzania (BAKWATA) has issued statements condemning the FGM on Islamic grounds. Of the regions that practise FGM, those that are predominantly Christian have the highest proportion of women who have had FGM. 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, there 99% of the population are Muslim, but the proportion of cut women is less than 1%. Similarly, the predominantly Muslim areas of Kigoma and Tabora have very low prevalence (0.8% and 0.5% respectively). The only region where a large Muslim population has relatively high rates of FGM is Tanga (19.9%) (Boyle et al, 2001, with updated DHS, 2010 prevalence figures). 28 Too Many did, however, find that in Kilimanjaro some Muslims were practising a lesser form of FGM and referring to it as 'sunna' ('sunna' meaning the body of traditional sayings and customs attributed to the Prophet Muhammad and supplementing the Qur'an), suggesting a possible link between the practice and the belief that it is an Islamic requirement.

Tanzania has a high belief in animism, alongside the mainstream religions, with more than half the people surveyed (60%) believing that sacrifices to ancestors or spirits can protect them from harm, the highest of 19 African countries surveyed (Pew Forum, 2010). Such beliefs appear to strongly influence the practice of FGM among some groups such as the Kurya in Mara Region (see FGM by Ethnicity above).

## 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), 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; the need for later surgeries. For example, Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

**One study of the Chagga and Pare ethnic group (who practise Type I FGM) in urban Kilimanjaro, which involved physical examinations, found the most common gynaecological complication to be keloid formation, supporting other studies that have reported similar findings. (Msuya et al, 2002)**

There are reports that women who have undergone FGM have reduced sexual desire, pain during intercourse, and less sexual satisfaction (Berg and Denison, 2011). In relation to psychological issues surrounding FGM, data suggests that following FGM, women were more likely to experience psychological disturbances (have a psychiatric diagnosis, suffer from anxiety, somatisation, phobia, and low self-esteem) (Berg and Denison, 2010). More research is needed to understand better the relationship between FGM and consequential psychological, social and sexual problems (Berg and Denison, 2011).

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 had undergone FGM had a significantly increased risk of adverse events during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III FGM compared to uncut women and the risk increased with the severity of the procedure. The consequences for women not giving birth in a hospital setting are likely to be even more severe (WHO, 2006). The high incidence of postpartum haemorrhage is particularly concerning where health services are poor or inaccessible (WHO, 2008) 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 (WHO, 2011).

The DHS 2010 indicate that less than 1% of women reported having experienced fistula, although a majority (67%) of women had heard of the problem. Although these findings suggest that fistula is not a public health concern, in order to draw meaningful conclusions on the occurrence of fistula in the population, a very large sample is required as well as more detailed methods of probing (DHS, 2010).

## INFANT MORTALITY

The WHO also showed that death rates among newborn babies are higher to mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had had FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra 1 to 2 perinatal deaths per 100 deliveries (WHO, 2006). In addition, a multi-country modelling study was set up to estimate the increased costs in obstetric care due to increased obstetric complications as a result of FGM. The annual costs was estimated to be US\$3.7 million

and ranged from 0.1% to 1% of government spending on health for women aged 15-45 years (WHO, 2011).

**EDUCATION AND FGM**



Schoolgirl in Arusha © 28 Too Many

In many cases, FGM has a negative impact on a girl's education. 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 in order for her to be married. Moreover, studies have shown that education influences perceptions of FGM and that educated women are more aware of the health consequences. The DHS data below shows that the prevalence of FGM 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 in urban areas) and access to media may play a larger role than education in itself (Msuyu et al, 2012).

Education	2010
No education	20.3
Primary incomplete	12.9
Primary complete	16.6
Secondary +	3.1

**Prevalence of FGM by education (%) (DHS, 2010)**

Education	2004-05	2010
No education	8.0	5.4
Primary incomplete	4.6	3.5
Primary complete	2.3	2.9
Secondary +	0.7	0.2

**Percentage of women with at least one daughter with FGM (DHS, 2004-05 and 2010)**

Education	2004-05	2010
No education	2.8	4.2
Primary incomplete	2.8	2.2
Primary complete	1.9	2.0
Secondary +	0.0	0.5

**Percentage of women who intend to have daughter cut (DHS, 2004-05 and 2010)**

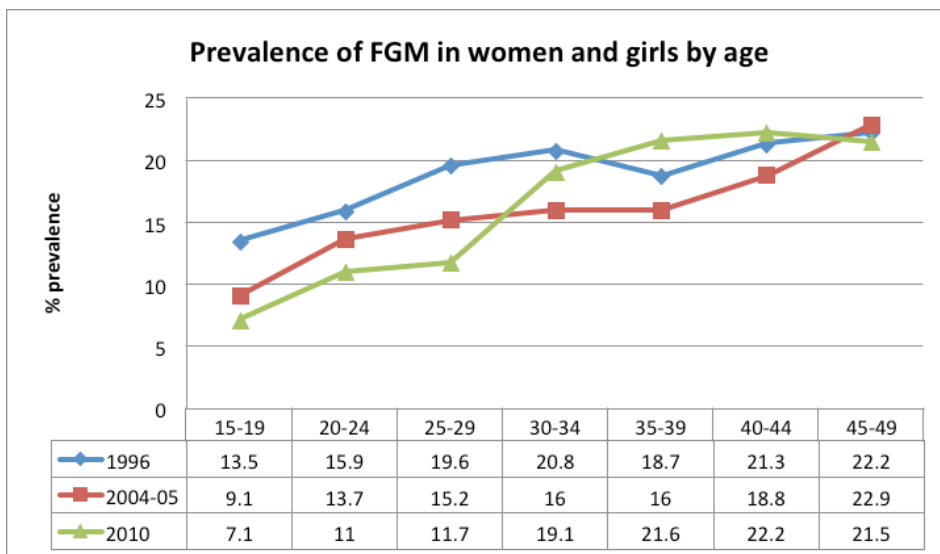
There is a strong preference for educating boys in Tanzania, with families even selling their cows to pay their school costs. Girls are not so lucky, and parents are often wary of the independence that might result from educating them (Children's Dignity Forum/FORWARD, 2010).

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 tends to abandon his poorly educated wife to marry a more educated girl (Children's Dignity Forum/FORWARD, 2010).

**AGE AND FGM**

The estimated prevalence of FGM in girls and women by age is set out below. These data show that the older a woman is, the more likely she is to have undergone FGM and, comparing the data for 1996, 2004-05 and 2010, there has been a decline in the rate of FGM.

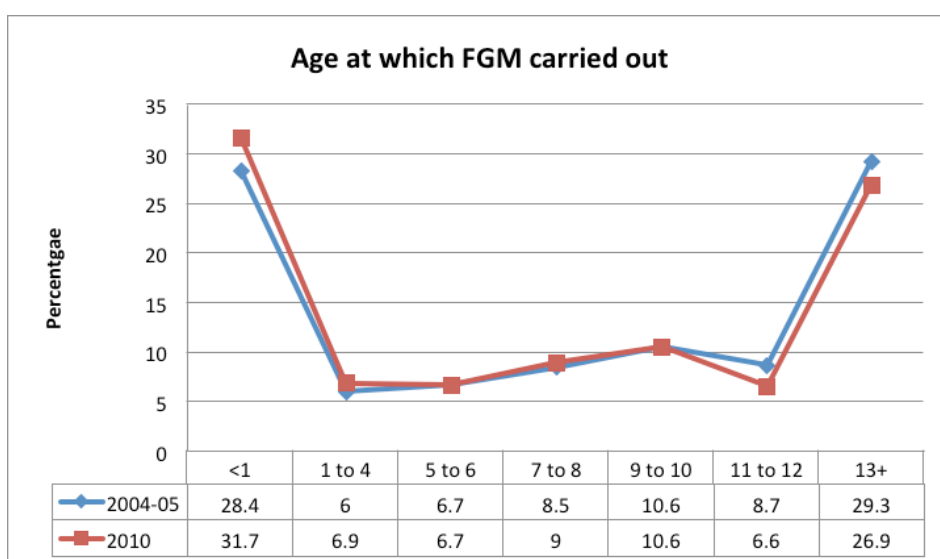




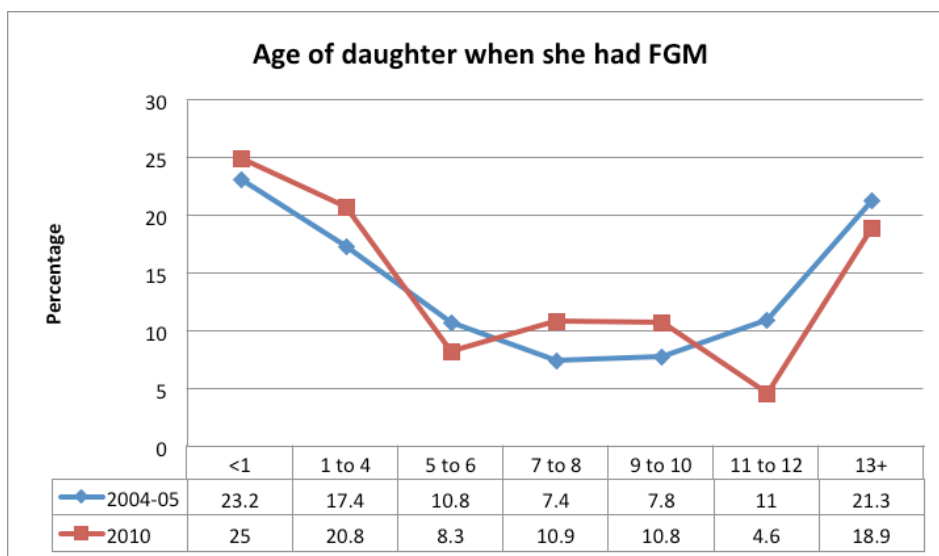
Prevalence of FGM in women and girls by age (%) (DHS 1996, 2004-05 and 2010)

Zone	Age at which FGM carried out (in years)							Don't know/missing
	<1	1-4	5-6	7-8	9-10	11-12	13+	
Western	77.0	0.0	0.0	0.0	3.1	0.0	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	17.0	8.2	6.4	0.0
Southern Highlands	10.0	3.6	5.9	6.5	2.4	1.3	68.3	2.0
Lake	1.3	0.0	0.5	3.8	10.2	16.2	66.4	1.5
Eastern	23.0	0.0	3.0	9.1	10.8	8.6	45.5	0.0
Southern	9.6	0.0	11.8	11.8	23.5	0.0	43.4	0.0

Percentage distribution of cut women by age at which they had FGM by Zone (DHS, 2004-05 and 2010)



Percentage distribution of cut women by age at which they had FGM (DHS, 2004-05 and 2010)



**Percentage distribution of daughters by age at which they had FGM (DHS, 2004-05 and 2010)**

A study of HIV prevalence rates in relation to FGM has reported that in Tanzania FGM generally takes place before puberty (Brewer et al, 2007). The DHS shows that a mean average of 71.5% of women aged 15-49 were cut between the ages of 0-12 years old (DHS, 2011), however the ages at which girls are circumcised can often vary from region to region. For example, data collected in three separate districts in Mara has shown that the majority of girls are subjected to FGM between the ages of 13-18 (no percentages available), whereas approximately 94% of respondents in Singida reported that girls undergo FGM before the age of 5 years (Christian Council of Tanzania 2009 and 2008).

While FGM in Tanzania continues to take place throughout childhood, the DHS 2010 reports that cutting of young girls is increasingly carried out at an earlier age, with girls circumcised before their first birthday increasing from 28.4% in 2004-5, to 31.7% in 2010. Ali and Strøm (2012) have suggested that this increase can, at least in part, be attributed to the abrupt nature of attempts to abolish FGM through the Arusha Declaration in 1968. They have noted that a number of parents from the Gogo and Nyaturu tribes have preferred to circumcise girls before they can speak in order to 'avoid harassment from the authorities'. Refer to FGM by Ethnicity for further details of specific ethnic groups.

Interestingly, the young age at which FGM now takes place can lead to girls not even being aware 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 (see inset box).

***'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 sometime'*** (AFNET coordinator in Manyoni).

There was also a reported trend in 2008 for elderly women in Manyara to undergo FGM to sell the flesh as part of a trade in body parts to be used in witchcraft (see inset box on page 43).

## PUBLIC ATTITUDES TO AND KNOWLEDGE OF FGM

The DHS, 2010 has shown a negative correlation between the levels of knowledge of FGM and the practice of cutting itself. Those with higher levels of education (at least to secondary education) have been found to be “more aware” or have “more knowledge” about FGM than those with lower levels of educational attainment. While 95.9% of women educated to secondary level and above had heard of FGM, much fewer women who had complete and incomplete primary education, or no education at all, were reported as knowing about FGM, at a mean average of 75.73%. However, the report has also shown that the prevalence of FGM decreases as the levels of education and wealth increase. Similarly, knowledge of FGM amongst women is higher in urban areas than in rural areas and more than twice the amount of cutting takes place in rural populations than in urban areas.

Background characteristic	Attitude towards FGM (2004-05)		Attitude towards FGM (2010)	
	In favour	Against	In favour	Against
<b>Age</b>				
15-19	5.0	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	5.0	91.2	7.1	90.7
45-49	5.5	89.7	3.3	93.8
<b>FGM status</b>				
Not cut	1.6	93.8	2.7	95.3
Cut	18.0	77.7	19.0	76.5
<b>Residence</b>				
Urban	0.9	96.9	1.8	97.5
Rural	7.0	87.3	7.4	89.2
<b>Region*</b>				
Manyara	16.5	81.8	12.8	78.2
Dodoma	5.3	91.5	9.6	88.3

Singida	5.7	89.5	4.7	94.2
Arusha	15.1	82.0	11.1	84.6
Kilimanjaro	0.8	96.7	2.1	96.4
Morogoro	2.9	95.9	5.6	91.3
Tanga	7.7	89.3	7.7	90.4
Iringa	12.6	85.8	5.3	90.2
<b>Education</b>				
No education	11.0	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 +	0.1	99.0	1.2	98.0
<b>Wealth quintile</b>				
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
<b>TOTAL</b>	4.9	90.6	5.5	91.9

Percentage distribution of all women who have heard of FGM by opinion on whether FGM should be continued, according to selected background characteristics (DHS, 2004-05 and 2010)

The continuation of FGM is supported by 6% of all women who know about the practice, with the majority of support coming from rural areas. The strongest support comes from Mara region, with 16% of women supporting the practice, followed by Mwanza and Manyara regions with support from 13.3% and 12.8% of women respectively. Opposition to FGM tends to be found in the wealthier, more educated, sections of Tanzanian society.

Mwanza region has perhaps the most notable increase in support for FGM, from 0.8% in 2004-5 to 13.3%, corresponding to rising support across the Lake zone. Only three of the above

regions have shown an increase in support for the discontinuation of FGM – Arusha, Singida and Mara. As these regions lay within three different zones – Lake, Northern and Central – an overarching theme relating to this increase cannot be inferred from the data.

The highest levels of support for the discontinuation of FGM comes from the islands adjacent to mainland Tanzania, with between 97.9% and 98.6% of women from regions on Pemba and Zanzibar believing that the practice should be stopped (DHS, 2011). Incidentally, women from the same regions were the least likely to have been subjected to FGM. No women were recorded as undergoing FGM in Unguja South, Pemba North, and Pemba South, while Unguja North and Town West regions were both shown to have a prevalence of 0.3% (DHS, 2011). On the mainland, a higher proportion of women from urban areas (97.4%) are against the continuation of FGM than those from rural areas (88.9%). One reason for this difference in attitudes towards FGM is the greater level of awareness-raising from NGOs around the capital (DHS, 2011).

FGM is supported by both men and women in Tanzania. Although the findings of the 2010 TDHS show that 92% of women who had heard of FGM believed the practice should be discontinued, women who had undergone FGM showed the most support for its continuation (DHS, 2011). 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 to avoid the name-calling and social stigma attached to uncircumcised women (Magoke-Mhoja, 2008; Children's Dignity Forum/FORWARD, 2010; Safeworld International Foundation, 2012). Men's attitudes towards FGM are often influenced by those of the wider community, with the majority of men being taught from an early age that circumcised women are 'better' than women who have not undergone FGM, and can

even face ridicule from their peers should they marry a woman who has not been cut (Children's Dignity Forum/FORWARD, 2010; Boylan, 2009). In its survey of Kuria men and women, the Devine Economic Development Group (2009) found that 51% of men would not marry an uncircumcised woman (2009:6). Similarly, an elderly Gogo ngariba has testified that male relatives are prohibited from marrying uncircumcised women as they are believed to be impolite and 'over-sexed' (Equality Now, 2001).

There is a widely held belief – by both men and women – that FGM is necessary to curb female sexuality (Boylan, 2009; Magoke-Mhoja, 2008; Devine Economic Development Group, 2009). 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 cause women to move around and make a lot of 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 (Marlowe, 2010).

### 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 (2007) 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, FGM increases the probability of HIV transmission.

Finding only one under-aged, HIV-positive survey participant who had undergone FGM in their sample in Kilimanjaro region, Klouman et al (2005) do not consider the FGM procedure as a direct causal link to the transmission of HIV. However, as

the survey data was collected in 1991-92 – during the first phase of the HIV epidemic – the writers recognise a probable increase in cases, with more HIV positive girls being circumcised along with their peers in FGM-practising communities. In Stallings and Karugendo’s (2005) 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 4 of the 10 regions with the highest prevalence of FGM also listed in the 10 regions with the highest rates of HIV infection. Msuyu et al (2002) also found no significant correlation between HIV (and hepatitis B) and FGM.

The performance of FGM as a collective rite for pre-pubescent children appears frequently in the literature. Due to this common practice, researchers have found that unmarried respondents who had been circumcised presented more cases of HIV than non-circumcised, unmarried respondents as a result of the transmission of infected blood via unclean circumcision instruments and unwashed hands of the practitioners (Brewer et al, 2007; Manjok et al, 2007). 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 blood transfusion (often unscreened) following haemorrhaging, either 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 (Manjok et al, 2007).

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

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

The CEDAW and the CRC clearly prohibit traditional practices that discriminate against women and harm children. Article 2 of CEDAW directs ‘State Parties...(f) To take all appropriate measures, 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 that, 'State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'. In addition, Article 19(1) provides that 'State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse'.

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

The African Charter on the Rights and Welfare of the Child requires 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), right to physical integrity (Articles 4 and 5).

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

## NATIONAL LAWS

### AGE OF SUFFRAGE, CONSENT AND MARRIAGE

The legal minimum age for marriage is 15 years for girls and 18 for boys (Law of Marriage Act 1971). 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).

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

The age of suffrage is 18 years.

### 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 (CRC) has been holding meetings to gather people's views on what they would like to see changed, with several women stating that FGM is a particular concern (FIGO, 2012).

### 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, and this may explain why Tanzania was not at the forefront of efforts to combat FGM (Boyle et al, 2001).

The adoption of anti-FGM measures across Africa from the 1980s may be attributable primarily to Western pressure (Boyle and Preeves, 2000, cited by Winterbottom et al, 2009). It may therefore be argued that Tanzania's efforts to criminalise FGM in the 1990s were designed primarily to respond to obligations to international institutions rather than responding to local needs (Winterbottom et al, 2009). 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 (Boyle et al, 2001).

The Parliament passed the Sexual Offences Special Provisions Act (SOSPA) in 1998, amending the Penal Code, to prohibit FGM of 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 a lack of definition of FGM in the Act and 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' (Equality Now, 2011a).

### BY-LAWS

Some communities have passed by-laws against FGM. For example, Equality Now reports that one Maasai village in Kilimanjaro where the village 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 girl who was cut, and the parents fined and imprisoned. The community no

longer practises FGM (Equality Now, 2011b).

### ENFORCEMENT

***'[O]nly a handful of cases have ever reached the courts and the police are reluctant to arrest and prosecute the perpetrators'*** (Equality Now, 2011a)

There is no record indicating the number of suspects convicted of FGM (LHRC, 2009). However, journalists and NGOS report that there have been prosecutions. For example, in 2012, at least one excisor in Mara region was arrested and charged for cutting two school girls. The excisor was paid Tanzania Shillings 5,000 for the job and was arrested after one of the victims reported her to the police (LHRC Report, 2012). Girls are encouraged to report their parents to local authorities or anti-FGM organisations such as AFNET. In addition, girls can also face compulsory inspections at school to check whether or not they have undergone FGM (Winterbottom et al, 2009). In response to the trend to cut infants, health care workers in Singida are reported to check infants when they are presented at clinics for routine check-ups (LHRC Report, 2008). There are, however, challenges to adequate law enforcement.

In 2008, 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...' (Equality Now, 2011a). Waritay and Wilson (2012), 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. In 2010, there were reports in the press that over 5,000 girls were due to undergo mass mutilations in FGM ceremonies in Tarime district in the Mara region. The international NGO, Equality Now, requested the government to 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 gender-based violence, including enforce then anti-FGM law, no action was taken to protect the girls or arrest the perpetrators. The Legal and Human Rights Centre (LHRC) reported that in a 10 day period at the end of November, beginning of December of 2010, over 700 girls were cut. They only managed to rescue eight girls who were taken to a rescue centre (Equality Now, 2011a). 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 (LHRC Report, 2012).

Interestingly, Mama Maria Nyerere, 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, organised by USAID (USAID, 2013).

WOWAP has a unit of community-based paralegals which provides legal aid and helps 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' (Foundation for Civil Society, 2012).

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 gender violence can file their complaints to female officers - and

improving its response to survivors of GBV (Thomson Reuters Foundation, 2013).

**Challenges to enforcement include:**

- 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 along the border between Kenya and Tanzania
  - In the Tarime and Rorya districts of the Mara region, with the Kurya ethnic group residing both sides of the border. Some girls reportedly cross the border to be cut (LHRC Report, 2012).
  - NAFGEM intend 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 (Equality Now, 2011b).
- Lack of political will in some areas as MPs rely on supporting FGM in order to be re-elected.
  - For example, candidates in Tarime, Mara being asked whether they supported FGM; if the answer was 'no', they would not get elected (Boyle et al, 2001). Some local leaders have been known to participate in FGM ceremonies, with the LHRC reporting that in one FGM ceremony, the local district councillor was the guest of honour (LHRC Report, 2012).
- 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 (LHRC Report, 2008).
- Lack of capacity of Tanzania authorities.
  - Inadequate police resources (LHRC Report, 2008).
  - It has been argued that the Tanzania authorities lack the mechanisms to deal with runaway girls, with girls attempting to escape FGM being returned to their communities, leaving them vulnerable to punishment, FGM and early marriage (Winterbottom et al, 2009).
- Lack of confidence in the due legal process or difficulties engaging with process
  - Insufficient knowledge of law (LHRC Report, 2008).
  - Victim's reluctance to testify against family and community members and fear of reprisals from excisors (LHRC Report, 2008).
  - Most Tanzanians have strong ties to traditional councils such as Litongo for Kuria communities (LHRC Report, 2009).

## INTERVENTIONS AND ATTEMPTS

### TO ERADICATE FGM

#### BACKGROUND

Whereas in both Kenya and Sudan, where the issue of FGM became politicised as part of the independence movement, no such high profile measures against those practising FGM was recorded in colonial Tanganyika (Winterbottom et al, 2009). There were, however, attempts by the British colonial authorities and Christian missionaries to abolish FGM (Mwaipopo, 2004). In relation to the Maasai, anti-FGM efforts should be

### Case of the three Maasai girls in Morogoro

The Legal and Human Rights Centre (LHRC) 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 for protection. 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 confirmed 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 eleven 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 (LHRC, 2004).

seen within the broader context of the historical background, both colonial and post-colonial, of perceived threats to Maasai culture (see inset box 'The Maasai, the history of development and anti-FGM campaigns' in FGM by Ethnicity above). As discussed above (see FGM and 'lawalawa' in Reasons section above), following the Arusha Declaration of 1968, there were heavy-handed tactics involved in an attempt to stop FGM in Singida and Dodoma. This led to a backlash among 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 which many Nyaturu believe is a curse from the ancestors, which could only be cured by FGM – this belief has spread to neighbouring Gogo, Maasai and Chagga ethnic groups.

Since the 1980s, under Tanzania's second president, Ali Hassan Mwinyi, there was a move away from unjamaa towards economic liberalization 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' (Winterbottom et al, 2009).

## GOVERNMENT POLICY AND SUPPORT

The Government has adopted a National Plan of Action on the Eradication of FGM/C (2001-2015). In 2008, however, the government had 'only implemented several activities, including awareness raising and participation in training, all sponsored by donors' (USAID, 2008). 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 forms a major component 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, 'after 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' (Tanzania Daily News, 2012). The LHRC reports that there is collaboration between the government and CSOs on the issue of FGM and GBV (LHRC Report, 2010). One study, however, previously 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 (Norad, 2007).

## OVERVIEW OF INTERVENTIONS

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

- Health risk/harmful traditional practice approach
- Addressing the health complications of FGM

- Educating traditional excisors and offering alternative income
- Alternative rites of passage
- Religious-oriented approach
- Legal approach
- Human rights approach/'Community Conversations'
- Promotion of girls' education to oppose FGM
- Supporting girls escaping from FGM/child marriage
- Media influence

### 1. HEALTH RISK APPROACH

Convincing people in areas of a very high FGM prevalence of the health problems can be a challenge. Difficult childbirth and long post-partum recovery periods, which are often exacerbated by FGM, are often seen as the norm. Communities may not therefore attribute the complications of FGM to the procedure itself. This is compounded by the fact that many believe FGM confers health benefits, such as a cure for lawalawa (Winterbottom et al, 2009). In much of Tanzania, the issue of lawalawa needs to be central to any attempt to eradicate FGM, with lawalawa being one of the main reported 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 the villagers who had not been so exposed, seemed to indicate that the health message was more sustainable than merely fear of prosecution (Moen et al, 2012).

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 through village meetings, 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 (IEC) 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’ © 28 Too Many

## 2. ADDRESSING THE HEALTH COMPLICATIONS OF FGM

NAFGEM works with the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) 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 (Ali and Strøm 2012).

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, ‘have 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’ (Winterbottom et al, 2009).

## 3. 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 involve working with excisors to make them lay down their tools and advocate against FGM, commenting that they can be a good way to reach the elders as they have high standing in the community (Moen et al, 2012). The LHRC report 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 such former excisors (LHRC Report, 2008).

Although such initiatives may be successful in supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address demand for FGM but alone it does not have the elements necessary to end FGM. (UNICEF, 2005). Moreover, there have been reports of excisors declaring that they have ‘put down their tools’, but who still secretly perform FGM. In addition, performing FGM may not necessarily be an income generating activity, with many cases of excisors receiving only symbolic payments. Targeting 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 (Moen et al, 2012).

#### 4. ALTERNATIVE RITES OF PASSAGE

Alternative Rite of Passage of Maasai girls, Kilimanjaro ©



##### 28 Too Many

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

The trend in many regions of Tanzania is for FGM to be carried out on girls at a very young age, often in secrecy 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 ARPs may have limited application overall. They may, however, still be relevant where FGM is still

practised as a rite of passage, such as in the Tarime district of Mara.

DIAC and SIAC have introduced ARPs in Dodoma and Singida, although the trend here is towards cutting very young girls. They consist of a series 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 about FGM and provide an entry point for engaging elders (Moen et al, 2012).

ARPs are considered time consuming and relatively expensive and there is concern that without sustainable project support, the communities will not have the economic means to carry out the ceremonies. Some people expressed relief that the traditional ceremonies have gone, due to the economic burden they posed to the families involved (Moen et al, 2012).

#### 5. RELIGIOUS-ORIENTED APPROACH

A religious oriented approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour. Religious organisations, such as the Christian Council of Tanzania (CCT) and the National Muslim Council of Tanzania (BAKWATA), are involved in efforts to combat FGM, using various strategies or combinations of strategies.

The National Muslim Council of Tanzania BAKWATA has issued statements condemning FGM on Islamic grounds. In Mara region, which is predominantly Christian, religious leaders have been the most frequent source of information on FGM, with a study by CCT finding that the people receive education from the following sources: 54% from religious leaders, 30% from the media, 8% by NGOs/CBOs and 6% from government officials/political leaders. The percentage of education

carried out by 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 rural Tarime district in Mara. Churches in Dodoma and Singida have also raised awareness of FGM, sometimes in collaboration with the Anti-Female Genital Mutilation Network (AFNET). Although the church has 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 mutilated; they do not seem to face the same discrimination as their peers. This indicates the potential for the community to accept a different view of FGM (Forward, 2010).

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 through community conversations, which is a human rights-based approach.

All references are to Waritay and Wilson, 2012 unless otherwise indicated.

## 6. LEGAL APPROACH

There is a long history of attempts to outlaw FGM. Tanzanian has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international 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 has also passed the Sexual Offences Special Provisions Act (SOSPA) in 1998, amending the Penal Code, to prohibit FGM of girls under the age of 18. However, this does not include women over the age of 18 years 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; lack of political will in some areas; corruption and poor police investigation, lack of capacity of Tanzanian authorities, and 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 improving its response to survivors of GBV (Thomson Reuters Foundation, 2013) (see further section on Laws Relating to FGM above).

## 7. HUMAN RIGHTS-BASED APPROACH

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

of the decision and (vi) a supportive change-enabling environment, including the commitment of the government. This approach was pioneered by Tostan in Senegal (UNICEF, 2005). Tearfund, working with local partners the African Inland Church of Tanzania (AICT) and the Christian Council of Tanzania (CCT) are developing pilots in the Mara Region, utilizing the Tearfund's CCMP (Church and Community Mobilisation Process), integrating FGM through community conversations, which is a human rights-based approach.

### 8. PROMOTION OF GIRLS' EDUCATION TO OPPOSE FGM

The Maasai Women Development Organisation (MWEDO), a UN Women partner organization, provides education to girls at risk of FGM in Arusha and/or early marriage. At risk girls are identified and given scholarships with full board to ensure they receive a minimum level of education (UN Women, 2012).

NAFGEM also targets both boys and girls in schools in Kilimanjaro and organise youth camps in which boys and girls aged 9-18 years participate. Children are educated on children's 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 event 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 (Equality Now, 2011b).

The LHRC recommended that the government through the Ministry of Education and Vocational Training should 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 (LHRC Report, 2011). One

issue is that the Tanzanian school curriculum does not teach pupils about their ethnic heritage (Thus 2007, cited by Winterbottom et al, 2009), which may be a barrier to properly teaching on the full significance of FGM.

### 9. 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 the girls who have run away and their families and their reintegration in the community. In isolation, however, places of refuge are unlikely to have a significant impact in ending FGM. The Christian Council of Tanzania (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 in those who sought refuge in previous years

*'In Africa, wherever there is singing and dancing, people will let go of everything and come' (DIAC village facilitator).*

(Waritay and Wilson, 2012).

### 10. MEDIA AND COMMUNICATION

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 films and theatre plays would lead to more people coming to sensitisation events. Lack of equipment was, however, reported to be an issue (Moen et al, 2012). The popularity of these media methods was also confirmed by Waritay and Wilson (2012). Moreover, people frequently referred to the media, particularly radio and newspapers as sources of information on FGM (Moen et al, 2012).

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 5 million people have been reached through radio messages, aired in Kilimanjaro, Arusha, Manyara, Tanga and parts of Kenya (Equality Now, 2011b).

The Legal and Human Rights Centre (LHRC) produced a 'landmark media programme' on FGM, covering the work of the LHRC's gender and children unit (Dahlgreen et al, 2012). 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. TANWA also trains journalists on how best to cover issues affecting the lives of women and children.

## 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. IAC advocates for the elimination of harmful traditional practices (HTPs) including FGM.

SIAC and DIAC work to eliminate HTPs, including FGM, through the involvement of local stakeholders. The core of the 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 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' (Moen et al, 2012).

### TEARFUND

Tearfund has supported local Christian partners in Tanzania since 1969. They work with seven partners whose main focus is 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 fifteen countries where the UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change is being implemented. From July 2011 to June 2015, the UN in Tanzania is 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

(DaO), 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 (ADPs), managed by programme coordinators.

World Vision is carrying out the Makulat FGM Eradication Project, a 3 year programme funded by AUSAID 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;
- Community executing alternative rites of passage (ARPs); and
- Increased capacity of FGM practitioners on anti-FGM for children.

The proposed implementation strategies are:

- Facilitating dialogue with the community members, teachers and 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, excisors and encouraging them to impart the acquired knowledge to their fellow community members; and

- Encouraging ARPs for girls.

Specific activities towards the achievement of these objectives are:

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

## **LOCAL ORGANISATIONS**

### **AFRICAN INLAND CHURCH OF TANZANIA (AICT)**

Mara Ukerewe Diocese is one of the 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 in 1993, to the current 35 pastors, 130 local churches and a membership of over 15,000 Christians to date.

The Diocese, in partnership with Tearfund, is involved in an ongoing church and community mobilisation process (CCMP project) which 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, three dispensaries and have contributed to a significant improvement of livelihoods. AICT, in collaboration with Tearfund and CCT, is developing pilots in Mara utilising the Tearfund CCMP, integrating FGM through community conversations, which is a human rights-based approach.

### AFYA BORA

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

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) and help empower victims of FGM through a sustainable community-based approach. This will involve forming FGM committees and village FGM educators (both comprising of circumcisers, elders, victims of circumcisions and other community members).

In schools the project will work closely with teachers selected by pupils themselves to serve as their guardians for issues of FGM and FGM peer educators (selected by pupils among themselves).

#### Objectives of the project:

- 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 of FGM activities at community (village) level.

- To raise awareness on FGM among school population for informed sexual and reproductive health rights in order to prevent FGM.
- To enhance positive peer norms and values among school youth and enable them to stand against sexual abuse and gender based inequality including FGM.

(Afya Bora, 2013)

### ANTI-FEMALE GENITAL MUTILATION NETWORK (AFNET)

The Anti-Female Genital Mutilation Network (AFNET) 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 co-ordination from the village to the national level. AFNET has 220 facilitators based at ward level, 23 district co-ordinators, 8 regional co-ordinators and one national co-ordinator. 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 in addressing FGM, which focuses on the rights of children and women and the detrimental health consequences of the practice. AFNET also advocates alternative rites of passage for women and girls that continue to teach girls how to live in communities as young women, but that exclude FGM. In the Singida region, work against FGM has been integrated into a reproductive health programme which empowers vulnerable groups, especially women.

The main method used in fighting FGM is discussions initiated through village meetings, 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 the most effective in discussions with children.

Activities include:

- Preparation of Information, Education, and Communication (IEC) materials such as posters, signposts, leaflets, brochures, audio- and video-cassettes and publication of books.
- Maintenance of a databank and resource centre on FGM issues.
- Research into FGM in different communities.
- Providing evidence of the health hazards of the practice.
- Lobbying and advocacy activities advocating enforcement of the law against FGM, which has resulted in some parents and circumcisers being jailed.
- Provision of support and care for victims of FGM.
- Provision of refuge centres for girls fleeing FGM.

(AFNET, undated)

### **THE CHRISTIAN COUNCIL OF TANZANIA**

The Christian Council of Tanzania (CCT) is an ecumenical organisation formed by fifteen Protestant Churches and fourteen associates. CCT's vision is to promote Christian unity among member churches. Its programmes include: education, health, interfaith relations, women's development, children and gender, and peace and justice. CCT works in partnership with Norwegian Church Aid. It is a member of the National

Coalition Against Female Genital Mutilation.

Women Development Children and Gender (WDCG) programme has been engaged in promoting women empowerment in social justice with emphasis on 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 Gender Based Violence (GBV) and in particular FGM in five districts: Kiteto (Manyara Region), Singida (Singida region), Tarime, Serengeti and Rorya districts in Mara regions.

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 entrepreneurship projects, servicing the loan on agreed terms. The scheme is so far working well 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 Mara region, following CCT's work in selected communities. The girls seek refuge from church leaders where they stay for the whole month of FGM ceremonies after which they return home. Some girls are refused back by their families while others are denied school fees. CCT, in collaboration with Tearfund and AICT, is developing pilots in Mara utilizing the Tearfund CCMP, integrating FGM through community conversations, which is a human rights-based approach.

(28 Too Many Questionnaire, 2013)

### **CHILDREN'S DIGNITY FORUM**

Children's Dignity Forum (CDF) is a child rights based NGO based in Dar es Salaam. CDF works on

three key issues:

- Female Genital Mutilation/cutting or women circumcision (FGM)
- Child Marriage
- Promotion and Protection of Child Rights

CDF has conducted PEER research in Tarime district on child marriage and FGM; carried out a consultative workshop with ward executive officers on child marriage and FGM and a National Consultative Workshop to end child marriages; produced educative T-shirts with a message promoting children’s rights first and ending FGM and brochures highlighting impact of child marriage and FGM.

### THE LEGAL AND HUMAN RIGHTS CENTRE

The Legal and Human Rights Centre (LHRC) 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 and works throughout Tanzania through its outreach services and human rights violation monitoring activities. 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 which includes, 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).

(LHRC website, 2013 and Norad, 2007).

### MKOMBOZI VOCATIONAL TRAINING AND COMMUNITY DEVELOPMENT CENTRE

The Mkombozi Vocational Training and Community Development Centre (MVTCDC) is a national a community-based organisation, created in 1999, that operates in Moshi Municipality. 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. The centre has grown and developed to welcome 71 students this year (MVTCDC, 2013).

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 resource library on different subjects including reproductive health, HIV/AIDS, STDs and FGM. MVTCDC strives to empower its members to cultivate skills that will promote individual and community liberation. Disadvantaged groups of women and youths will be empowered economically and socially.

(28 Too Many in-country research and questionnaire)

### NATIONAL COALITION AGAINST FEMALE GENITAL MUTILATION

In 1999, LHRC conducted research on Female Genital Mutilation (FGM) in Tanzania and there after 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 Centre was given a mandate to coordinate the coalition. Members of the committee come primarily from NGOs, 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 meet 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 its major achievements was its successful advocacy towards the formulation of an FGM Policy (World Vision, 2013). Other activities include the commemoration of the African Child Day (16th June 2007), holding a capacity building workshop for 30 members of parliament who come from areas with high prevalence of FGM (November 2007). Funding for this workshop was obtained from EASSI (The Eastern African Sub-regional Support Initiative for the Advancement of Women). In 2007, one of the activities conducted during the Day of Zero Tolerance to FGM was a graduation ceremony of 100 girls through an alternative rite of passage (ARP), with the girls passing through the transition from childhood to adulthood without having to undergo FGM.

Members of the Coalition include the Anti-Female Genital Mutilation Network (AFNET), Children's Dignity Forum (CDF), the Christian Council of Tanzania (CCT), the Dodoma Inter African Committee (DIAC), the Legal and Human Rights Centre (LHRC), the National Anti-FGM Network (NAFGEM), the National Muslim Council of Tanzania (Bakwata), the Tanzanian Media Women's Association (TAMWA), the Tanzanian Woman Lawyers Association (TAWLA) and Women Wake-Up (WOWAP).

(LHRC website, 2013)

### **NATIONAL MUSLIM COUNCIL OF TANZANIA (ALSO KNOWN AS BAKWATA)**

The National Muslim Council of Tanzania (also known as BAKWATA) provides religious guidance and national representation to the Tanzanian

Muslim community. Founded in 1968, 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 organization also speaks out on political issues, such as the Tanzanian government's 2008 consideration of membership in the Organization of the Islamic Conference (Berkley Center, 2013).

### **NETWORK AGAINST FEMALE GENITAL MUTILATION (NAFGEM)**

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

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

The organisation's mission is to eliminate FGM and other forms of GBV by providing anti-FGM/GBV education, networking with grass roots communities and likeminded partners including the government and social institutions in 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 to women and girls.

It believes that with adequate and factual knowledge, community members will change their attitude 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 civil society organisations. The approaches being used are meetings, public awareness campaigns, seminars, workshops and individual talks. An animator project has also been implemented to ensure sustainable community dissemination of anti-FGM messages and monitoring of the FGM practice in the community.

Activities include:

- Awareness creation on FGM and GBV through meetings, community campaigns and posters with anti-FGM messages.
- Educating communities on human rights, FGM, GBV and effects associated with the practice. This is done through trainings, seminars and workshops.
- Engaging various social groups including traditional leaders, religious leaders, political leaders, the circumcisers, women, youths and children into anti-FGM/GBV activities.
- Village Animators Program: Selected community members are trained to sensitise their communities and facilitate community changes towards elimination of FGM/GBV.
- Youth Programs: In and out of school youths (girls and boys) are trained and challenged to say 'no' to FGM and other forms of GBV.
- Anti-FGM Radio Program: Dissemination of anti-FGM/GBV messages through local radios and other media groups to have the community constantly reached with anti-FGM messages.

(NAFGEM, 2013)

### **TANZANIA MEDIA WOMEN'S ASSOCIATION (TAMWA)**

TAMWA is an activist's media advocacy organisation, started by 12 media women. Since its inception, its membership has grown to more than 100 women journalists. Its mission is to advocate for women and children's rights by conducting awareness raising activities for cultural, policy and legal changes/transformations in the 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 of experience are the minimum requirements for membership application. Members are from Tanzania 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, etc. Others are engaged as public relation officers or communication consultants in public institutions 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. TANWA also trains journalists on how best to cover issues affecting the lives of women and children. It has also established a crisis centre for victims of GBV.

(TAMWA website, 2013)

### **TANZANIA WOMEN LAWYERS ASSOCIATION (TAWLA)**

The Tanzania Women Lawyers Association (TAWLA) provides legal aid services to women, campaigns for women and children's human rights, advocate for good governance, and create forums for women 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 women lawyers who felt the need for an organization that could promote an environment guaranteeing equal rights and access to all by focusing on vulnerable and marginalised groups especially women and children. TAWLA now has more than 570 members. It is a member of the National Coalition Against Female Genital Mutilation. TAWLA's key priorities are:

1. Provide legal Aid services to vulnerable women and children
2. Undertake policy research and advocacy for legal reform and campaign for women and children on issues of equality and human rights
3. Educate the public by raising awareness on gender and legal rights issues through the media, seminars, community conversations, publications and drama groups.
4. Raise awareness of Sexual and Reproductive Health rights at the grass roots level and advocate for advancement of these rights as human rights in Tanzania
5. Campaign for good governance and accountability and advocate for the respect and adherence to the principles of good governance and respect for human rights and gender equity
6. Support the professional development of women lawyers in Tanzania, build and develop TAWLA's membership services for women lawyers

(TAWLA website)

### **TANZANIA EDUCATION AND MICRO-BUSINESS OPPORTUNITY TRUST (TEMBO)**

The Tanzania Education and Micro-Business Opportunity (TEMBO) 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 sister Canadian 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 office and meeting space for TEMBO as well as comfortable and safe lodging for the TEMBO volunteers and other visitors to Longido (TEMBO, 2013).

In 2012-2013, TEMBO has supported over 60 girls through secondary school, 6 girls to attend teacher education college and 21 through vocational training. They have also given micro-loans to 130 women. Following 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, called 'Sara and Juma', is designed to teach girls to know their rights, value education, be pro-active, have good relationships with boys, and avoid FGM and HIV/AIDS. These classes are delivered four days a week at primary and secondary schools in Longido and Kimokouwa. Since the 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 and reaches more families through the women in the micro-finance groups. Some families agreed to practise Alternative Rites of Passage (ARPs) as a result. TEMBO also uses every opportunity to include the village and tribal leaders in the classes.

(TEMBO website and 28 Too Many in-country research)

## WOMEN'S LEGAL AID CENTRE (WLAC)

The Women's Legal Aid Centre (WLAC), 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 has 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 was lost, generated a lot of publicity. WLAC jointly run advocacy campaigns with the LHRC, raises awareness on FGM in the context of HIV/AIDS, produces national and local radio programmes, provides publications and legal research and human resources in terms of attorneys for court cases involving the LHRC (Norad, 2007).

## WOMEN WAKE-UP

Women Wake Up (WOWAP) is an NGO based in the Dodoma Region, with branches in Singida and Iringa Regions, working in both rural and urban areas. WOWAP is determined to be a catalyst of positive change of women 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 (Foundation for Civil Society, 2012). Muslim and Christian religious leaders, teachers, ward and village government officials have been mobilised to fight for the elimination of FGM. They address FGM holistically, with a community development strategy, using culturally sensitive and non-judgmental approaches and engaging a wide variety of participants and stakeholders.

WOWAP trained facilitators to start community-based activism. The programme contained various modules, including one on human rights,

the right to health, the right to protection against all forms of violence and the right to education. The new understanding in this module provided a foundation for the remaining themes and was constantly referred to throughout the programme. This was followed by modules in problem solving and better hygiene, in which participants weighed the certain positive traditional practices (e.g. breastfeeding) with harmful ones (e.g. 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 (WOWAP, 2006).

WOWAP also has a unit of community-based paralegals which provides legal aid and helps to resolve disputes in the community (Foundation for Civil Society, 2012).

WOWAP has reached out to members in Dodoma Rural District and Kondo District who have come together as a result of the training done in primary schools.

All references are to WOWAP, 2012 unless otherwise indicated.

## CHALLENGES FACED BY

### ANTI-FGM INITIATIVES

There are many challenges faced by anti-FGM initiatives:

- FGM is often undertaken in secret on newborn babies and infants, making detection difficult.
- Entrenched attitudes particularly amongst elders.
- Reaching remote areas, with people living in remote areas being hard to reach, and lack of transport hampering efforts by NGOs to reach them.
- Challenges in getting people to attend sensitisation, with the farming and time taken collecting water taking people's time and the expectation that participants will receive something in return for attendance (Moen, 2012).
- Lack of data on current prevalence due partly to the fact that FGM is now performed in secret and on babies and infants, meaning that such cases are not captured by the most recent DHS data, and a reluctance by people to disclose for fear of prosecution.

## CONCLUSIONS

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. We propose the following general conclusions many of which are applicable within the wider scope of international policy and regulation and some specific to 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 a community level, with particular care being taken by organisations to tailor anti-FGM initiatives and strategies to take into account the particular regional circumstances. In particular, the underlying reasons for which 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 religion and the impact these both 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 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. FGM is connected to promoting the eradication of extreme poverty and hunger, the promotion of universal primary education, gender equality, reducing child mortality, improving maternal health and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research for broader social change. There has been a momentum for change, with the UN global ban on FGM in December 2012 and the UN CSW 57 focusing on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, and FGM, are reflected in the post-MDGs agenda.

### FGM AND EDUCATION

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM hinders girls' ability to obtain basic education and prevents them from 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 2008 (UNDP Tanzania 2010) 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 school and in the community (Equality Now, 2011b).

### FGM, MEDICAL CARE AND HEALTH

#### EDUCATION

FGM should be integrated into reproductive health care clinics because these are highly attended by women of childbearing age (Msuya, 2002). Health providers need to be better trained to manage complications surrounding FGM. Given the possible trend towards medicalisation in some areas (e.g. Kilimanjaro), this should also be addressed through education to health 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. Lack of access to and utilisation of adequate health care 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 (IRIN, 2013, referring to Mselle et al, 2013). More resources are needed for sexual and reproductive health education.

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

#### LAWALAWA

In much of Tanzania, the issue of lawalawa needs to be central to any attempt to eradicate FGM, with this being one of the main reported drivers behind the continuance of the practice in many areas. Many myths surrounding lawalawa persist, with many people being unaware that

lawalawa is a vaginal or urinary tract infection that can be easily treatable 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 (Moen et al, 2012). One study in Arusha indicated that even basic education could make a difference to the perception of lawalawa, with over 60% respondents who had no education saying that lawalawa was a reason to carry out FGM, compared to 40% among respondents who had a primary school education (World Vision, 2013). Health education in relation to lawalawa and FGM is therefore crucial in combating in FGM in those areas where this is a driver behind the continuance of FGM, as well as providing access to medical treatment for vaginal and urinary tract infections . However, access to health services generally needs to be improved.

### FGM, ADVOCACY AND LOBBYING

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

### FGM AND THE LAW

With 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 the 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 years.

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 (Equality Now, 2011a). 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 (LHRC Report, 2008). We welcome the recent government action plan to establish Gender and Children's Desks and improving its response to survivors of GBV.

The government should increasingly anticipate mass mutilations during FGM seasons in Mara region and allocate the necessary resources to ensure adequate law enforcement as well as taking measures to protect at risk girls (Equality Now, 2012).

### FGM IN THE MEDIA

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

### FGM AND FAITH-BASED ORGANISATIONS

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision regarding issues such as FGM. They can also work with global bodies such as the UN and its agencies. Given that 93% of Tanzanians say that religion is 'very important' in their lives (among the highest

of those African countries surveyed (Pew Forum, 2010)), this approach has particular relevance to 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 effort 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 girl's rights, integrating anti-FGM messages into other development programmes, sharing best practice, success stories, operations research, training manuals and support materials, advocacy tools, providing links/referrals to other organisations will all strengthen the fight against FGM.

### FURTHER RESEARCH

There is a need for further research and up-to-date data on the prevalence of FGM that includes infants and girls under 15 years old, so as to capture recent trends. 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 that combines 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 status to 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 fistula.

**APPENDIX I – LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO EFFORTS FOR THE ABANDONMENT OF FGM IN TANZANIA**

\* denotes organisations that are members of the National Coalition Against Female Genital Mutilation.

28 Too Many

Aang Serian

African Inland Church of Tanzania, Diocese of Mara and Ukwere (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 (NAF-GEM)\*

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](http://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 Organisation (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

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