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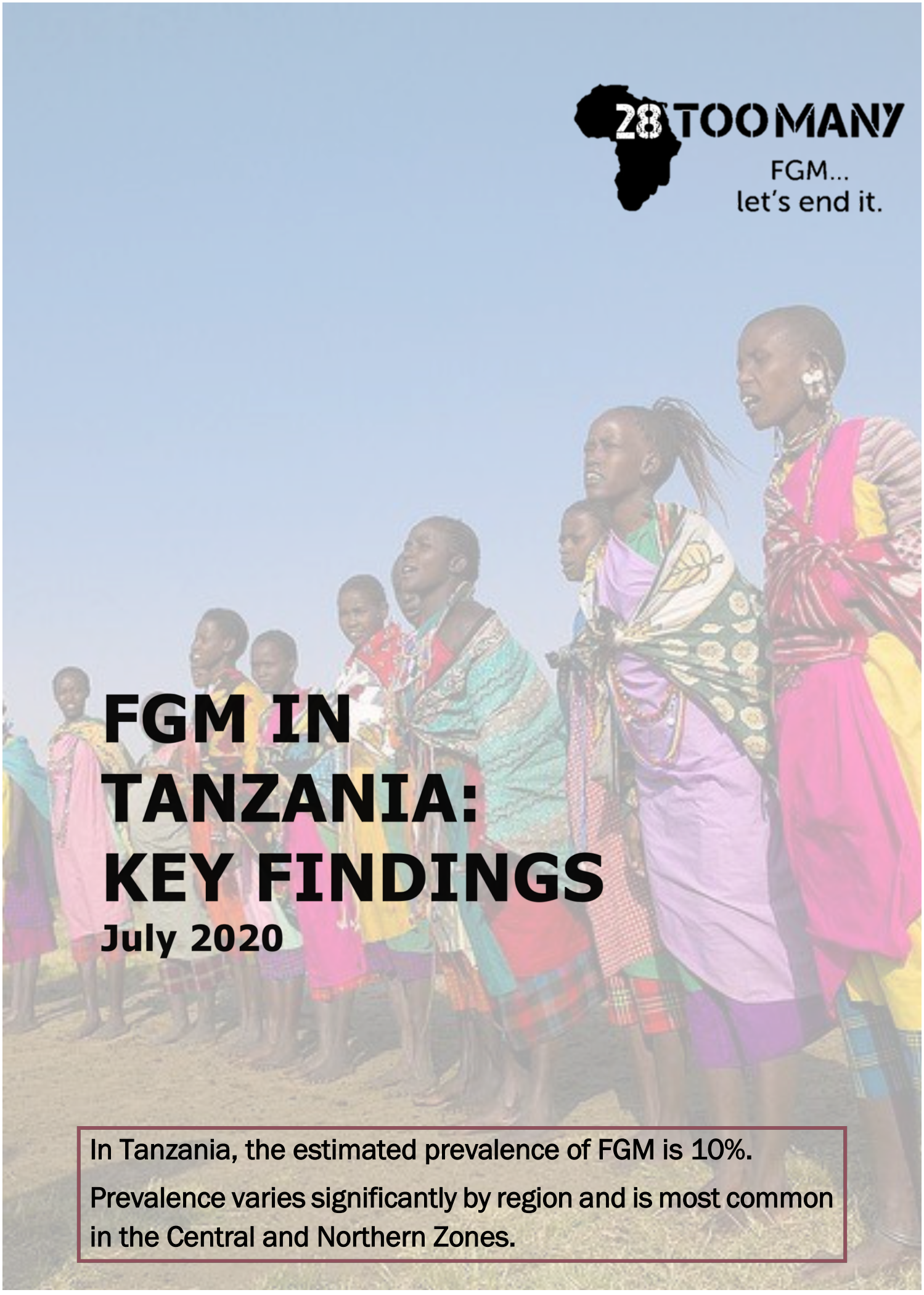
FGM...
let's end it.



FGM IN TANZANIA: KEY FINDINGS

July 2020

In Tanzania, the estimated prevalence of FGM is 10%.

Prevalence varies significantly by region and is most common in the Central and Northern Zones.

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FGM Prevalence

Refer to Country Profile pages 19–22 and Country Profile Update pages 12–13.

There is a downward trend in the **prevalence of FGM in Tanzania among women aged 15–49,** as recorded in the DHS survey reports from 1996 to 2015/2016[1]. Currently, the prevalence is 10%, whereas it was 17.9% in 1996[2]. This suggests a greater-than-40% drop in that period. Although it is likely that, in part, this reflects a true decrease in the practice, in part it may also be due to under-reporting of FGM by the women surveyed, especially since the practice became illegal in 1998.

Breaking down the most recent data by age group shows that the prevalence for women aged 45-49 is 18.7%, while for the youngest age group this has fallen to 4.7%[3]. Despite the fact that a small proportion of women may be cut after the age of 15, the data demonstrates a clear trend towards lower prevalences among younger women.

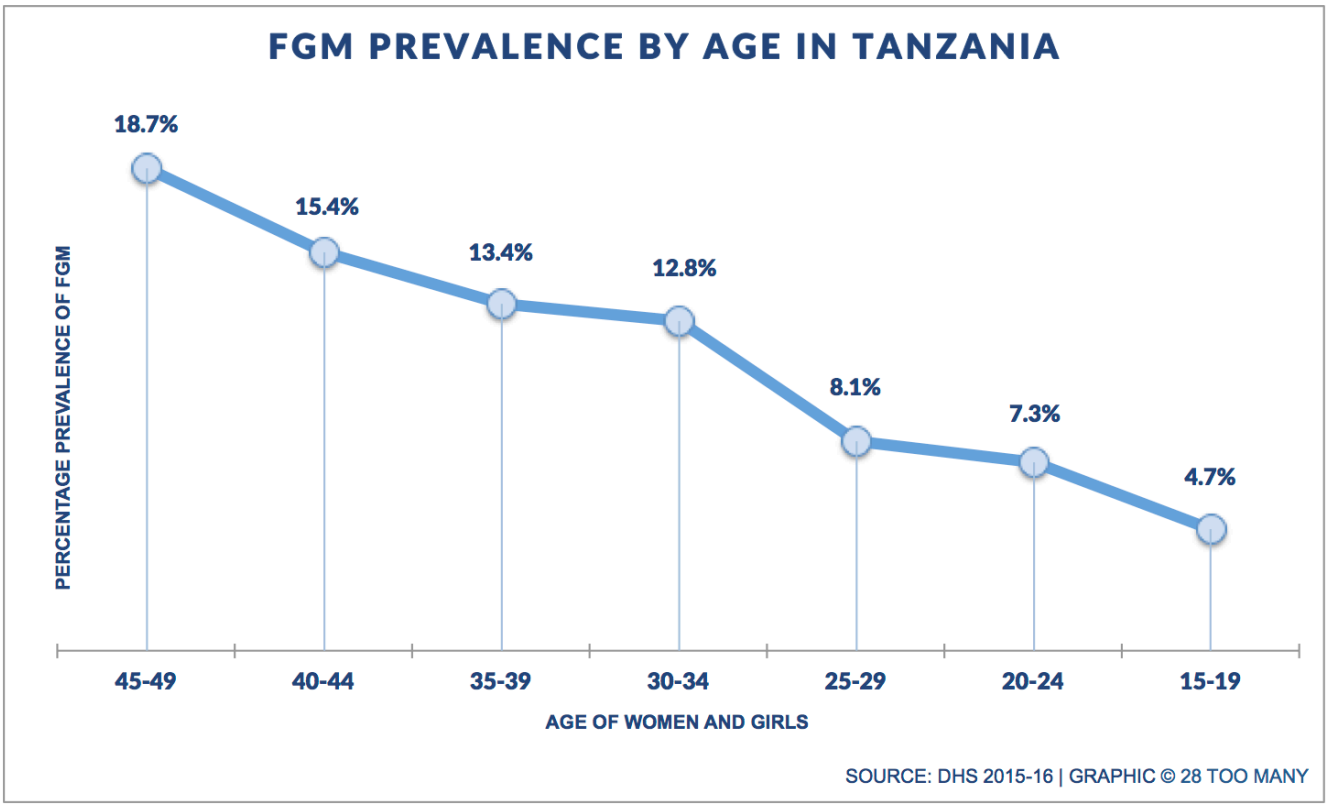


Figure 1: Prevalence of FGM in women aged 15-49, broken down by age-group[4]

Why

Refer to Country Profile page 50–52 and Country Profile Update pages 19.

In Tanzania, both the practice and the abandonment of FGM are intrinsically linked with economics.

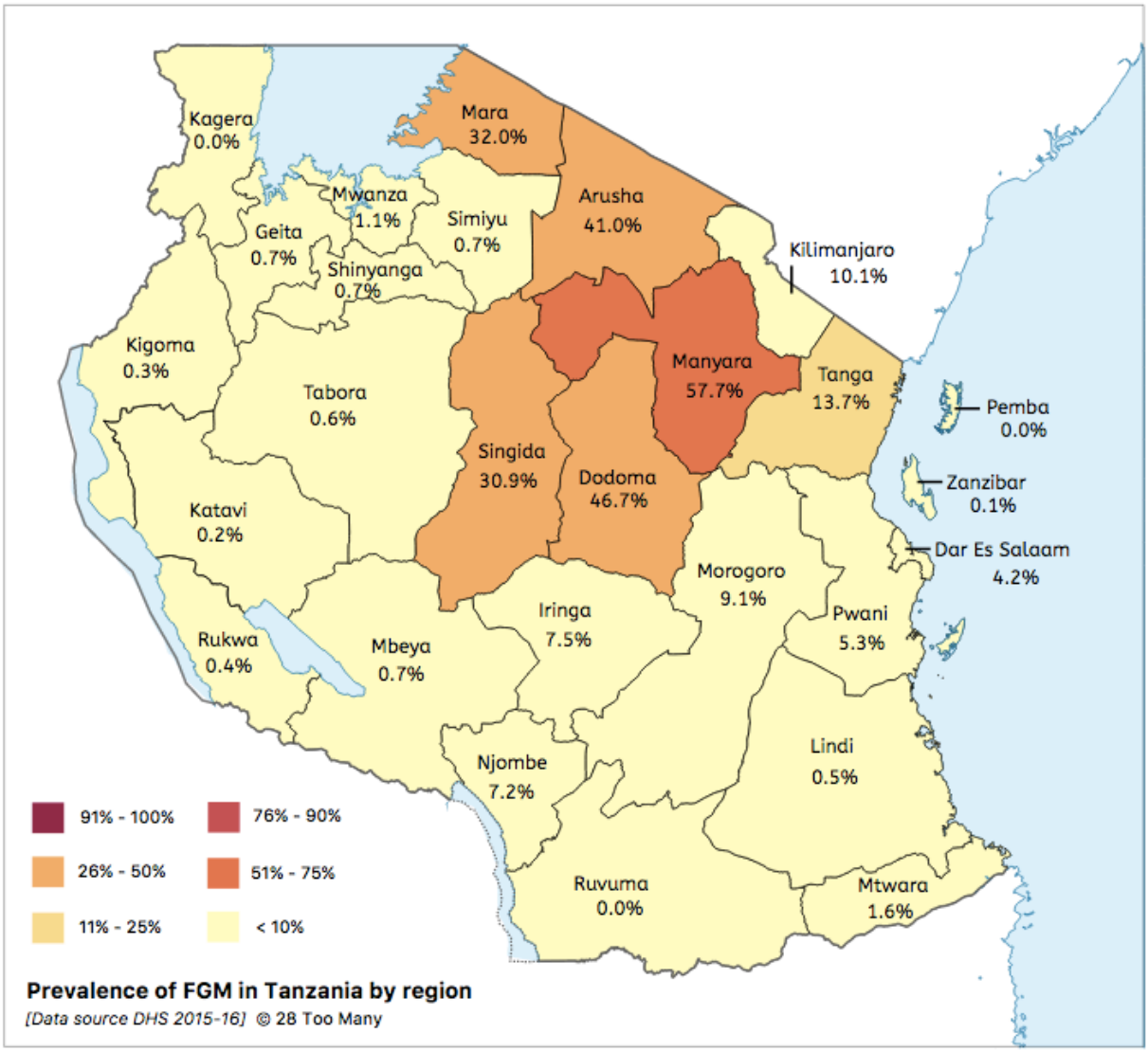
Money is believed to be one of the driving factors behind FGM in Tanzania[5]. In other countries in Africa where FGM is practised, it has been found that a necessary part of any movement towards the abolition of FGM is the provision of alternative income means for cutters. However, it is not just the cutters who profit financially from cutting ceremonies. The girls' families also benefit from the (usually monetary) gifts they receive when their daughters are cut. Additionally, in certain ethnic groups, the parents of a girl who has been cut will also receive a higher bride price, although often this is used to pay for the cutting ceremony.

Traditionally, FGM was performed as a rite of passage to ensure marriageability – a means of gaining the respect of the community and becoming a 'proper woman'. The prevailing reasons appear to be the maintenance of tradition and to cure lawalawa[6]. ▪ 'Lawalawa has been variously identified as thrush, trichomonas vaginalis and candida and is most likely a term encompassing various infections causing vaginal itching.[7]' As such, they are easily cured with a treatment of antibiotics from a health facility.

Where

Refer to Country Profile pages 21–22 and Country Profile Update pages 14–15.

FGM is most prevalent in the rural areas of the mainland, followed by the urban areas of the mainland. The practice is uncommon in Zanzibar. The prevalence appears to have become less common on the mainland since 1996, the biggest drop in prevalence being in rural areas, from 20.8% in 1996 to 13.1% in 2015[8]. It should be noted that migration to urban areas may have influenced these statistics. The Central and Northern zones continue to have the highest prevalence of FGM.



Law

Refer to Country Profile pages 76–79 and Country Profile Update pages 21–22.

The main law criminalising FGM in Tanzania is the Sexual Offences Special Provisions Act 1998 (*SOSPA*), which amended Section 169 of the Penal Code and prohibits FGM on girls under the age of 18 years[10].

The SOSPA prohibits the performance and procurement of FGM on children under the age of 18 years and sets out associated fines and/or prison sentences, but failure to report FGM that has taken place or is planned is not directly addressed under this law.

In addition, the Law of the Child Act 2009[11] protects persons under the age of 18. Article 13(1) makes it a criminal offence to 'subject a child to torture, or other cruel, inhuman punishment or degrading treatment including any cultural practice which dehumanizes or is injurious to the physical and mental well-being of a child' and sets out associated fines and/or prison

sentences. As a child protection law, Article 18 also allows the court to issue a care order or an interim care order to remove the child from any harmful situation.

Understanding and Attitudes

Refer to Country Profile pages 71–75 and Country Profile Update pages 28–29.

There has been a general upward trend in the **percentage of women in Tanzania who have heard of FGM**, suggesting that awareness campaigns are working, albeit slowly. In 2004-2005, 73.1% reported having heard of FGM, which had increased to 86.1% in 2015-16[12].

Knowledge of FGM is more common among women living in urban areas (95.1%) than among women in rural areas (80.9%) and increases with their levels of education and wealth. In the Western and Southwest Highlands regions, only around two-thirds of women have heard of FGM. This is considerably lower than in other regions, where knowledge of the practice is around 80% or higher[13]. The percentage of women who have heard of FGM and **believe that it should not be continued** increased from 91.9% in 2010 to 95% in 2016[14].

The percentage of women aged 15–49 who have heard of FGM and who believe that **FGM is required by their religion** is 3.1%, and the percentage who believe that it is not required is 95.1%. However, there is a substantial difference between the understanding of women who have undergone FGM and those who have not: 15.3% of women who have been cut believe that it is a requirement of their religion, as opposed to 1.5% of those who have not been cut.

Women who are less wealthy and/or have received less education are more likely to believe that it is a requirement of their religion, as are women who reside in the Northern and Central Zones[15].

Age & FGM Types

Refer to Country Profile pages 25–27 & Country Profile Update pages 16–18.

The data reveals a decrease since 2010 in the percentage of women aged 15–49 who have undergone FGM and have been 'cut, no flesh removed', and increases in the percentages who have been 'cut, no flesh removed' and 'sewn closed' (Type III/infibulation). In particular, the prevalence of Type III FGM shows a potentially concerning increase from 0.7% in 2010 to 6.6% in 2015–16[16]. However, due to the known issues with self-reporting of FGM types and the small numbers of women involved, more data would ideally be required to form firm conclusions.

Across all datasets, there are clear age-groups within which girls are at a higher risk of being cut, namely below the age of one year and above the age of 13.

The data shows a rise in the percentage of women who were cut before the age of one year (from 28.4% in 2004–05 to 35.4% in 2015–16), while the percentage of women who were cut at aged 13 and above appears to have stayed roughly the same over that period[17].

Practitioners of FGM

Refer to Country Profile pages 24–25.

In Tanzania, FGM is most frequently carried out by traditional practitioners ('excisors') within communities, called ngariba in Kiswahili. The DHS 2010 reports the person who performed FGM on the most-recently-cut daughter of the women surveyed. Three out of every four instances of FGM (73%) were reported to have been carried out by traditional excisors (ngariba), while 21.9% had been carried out by traditional birth attendants and 4.4% by other traditional cutters. Only 0.4% had been carried out by nurses/midwives[18].

The DHS data does not appear to suggest a trend towards **medicalised FGM***: 1% of instances were carried out by health professionals in 2004–05[19]. There are, however, indications that, in urban areas, wealthier families prefer to use the services of health personnel such as midwives and doctors[20]. Such indications include reports of midwives performing FGM at hospitals in Kilimanjaro during deliveries.

Work to end FGM

Refer to Country Profile pages 81–87 & Country Profile Update pages 24–25..

The Ministry of Health, Community Development, Gender, Elderly and Children is responsible for issues relating to violence against women and girls in Tanzania. The strategy to tackle harmful practices, such as FGM and child marriage, is set out in The National Plan of Action to End Violence against Women and Children 2017–2022[21]. It sets out the measures to be taken to end FGM, including the development of a communication strategy and advocacy campaigns involving religious and influential leaders and policy-makers 'to promote positive norms and values and address gender inequalities' through community dialogue, data collection and training across ten regions. Regarding the law, the Plan aims to engage police forces and local government authorities to respond sensitively and appropriately to cases of FGM.

The Government also works in partnership with a range of international and national non-governmental organisations, carrying out various interventions including awareness campaigns and training workshops in practising communities, providing safe shelters for girls escaping FGM and training local police and magistrates[22].

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

- health risk/harmful traditional practice approach;
- addressing the health complications of FGM;
- educating traditional excisors and offering alternative incomes;
- alternative rites of passage;
- religious-orientated approach;
- legal approach;
- rights approach/'Community Conversations';

- promotion of girls' education to oppose FGM;
- supporting girls escaping from FGM/child marriage;
- media influence.

**For detailed information about the medicalisation of FGM, please see 28 Too Many's report, which is available at http://28toomany.org/fgm-research/medicalisation-fgm/.*

Challenges Moving Forward

Refer to Country Profile page 100.

What challenges remain for Tanzania in eliminating FGM?

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

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

1 '**DHS 2015-16'** - Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF (2016) *Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015–16*. Dar es Salaam, Tanzania, and Rockville, Maryland, USA: MoHCDGEC, MoH, NBS, OCGS, and ICF. Available at **https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf**. , p. 363

2 '**DHS 1996' -** Bureau of Statistics [Tanzania] and Macro International Inc. (1997*) Tanzania Demographic and Health Survey 1996*. Calverton, Maryland: Bureau of Statistics and Macro International. Available at **https://dhsprogram.com/pubs/pdf/FR83/FR83.pdf**., p. 168

3 DHS 2015-16, p. 363

4 *ibid*

5 Gayle Tzemach Lemmon (2017) 'How to Fight Female Genital Mutilation with Economics', *CNN*, 4 December. Available at https://edition.cnn.com/2017/12/04/opinions/stopping-female-genital-mutilation-opinion-lemmon/index.html.

6 Johanna Waritay and Dr Ann-Marie Wilson/28 Too Many (2012) Working to end female genital mutilation and cutting in Tanzania: The role and response of the church. Tearfund.

7 AFNET (2004) Report on the Situation of Female Genital Mutilation in Tanzania: A Study of Five Regions.

8 DHS 1996, p.168.
- DHS 2004–05, p.250.
- DHS 2010, p.296.
- DHS2015–16, p.363.

9 *Ibid.*

10 The United Republic of Tanzania (1998) *The Sexual Offence Special Provisions Act 1998*. Available at http://tanzania.go.tz/egov_uploads/documents/The_Sexual_Offence_Special_Provisions_Act,_4-1998_en.pdf.

11 *The Law of the Child Act* (2009). Available at http://mcdgc.go.tz/data/Law_of_the_Child_Act_2009.pdf.

12 '**DHS 2004–05'** - National Bureau of Statistics (NBS) [Tanzania] and ORC Macro (2005) *Tanzania Demographic and Health Survey 2004–05*. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro. Available at **https://dhsprogram.com/pubs/pdf/FR173/FR173-TZ04-05.pdf**. , p.248.
- '**DHS 2010' -** National Bureau of Statistics (NBS) [Tanzania] and ICF Macro (2011) *Tanzania Demographic and Health Survey 2010*. Dar es Salaam, Tanzania: NBS and ICF Macro. Available at https://dhsprogram.com/pubs/pdf/FR243/FR243[24June2011].pdf., p.294.
- DHS 2015–16, p.362.

13 DHS 2004–05, p.248.
- DHS 2010, p.294.
- DHS 2015–16, p.362.

14 DHS 2010, p.301.
- DHS 2015–16, p.295.

15 DHS 2015–16, p.365.

16 DHS 2010, p.296.
- DHS 2015–16, p.363.

17 DHS 2004–05, p.252.
- DHS 2010, p.298.
- DHS 2015–16, p.364.

18 DHS 2010, p. 300.

19 DHS 2004-05, p.254.

20 Sosthenes Mwita (2013) 'Tanzania: FGM Remains Quite Dangerous to Health', Tanzania Daily News, 28 October. Available at https://allafrica.com/stories/201310280010.html.

21 The United Republic of Tanzania (2016) *National Plan of Action to End Violence Against Women and Children in Tanzania 2017/18 – 2021/22*. Available at http://www.mcdgc.go.tz/data/NPA_VAWC.pdf.

22 The Network against Female Genital Mutilation (2017) *Law Enforcers Ending FGM & Abuse*. Available at http://www.nafgemtanzania.or.tz/index.php/what-we-do/law-enforcement.