

## Working to end female genital mutilation and cutting in Tanzania The role and response of the church



### Report commissioned by Tearfund

Researchers: Johanna Waritay & Dr Ann-Marie Wilson from 28 Too Many

### In partnership with:

Christian Council of Tanzania  
African Inland Church of Tanzania  
Anti Female Genital Mutilation Network



**Tearfund is a Christian relief and development agency building a global network of local churches to help eradicate poverty**

Justin Nyamoga, Country Representative  
Email: Justin.nyamoga@tearfund.org

**Christian Council of Tanzania aims to promote the spiritual unity of the church, express a common voice on issues of interest and promote welfare services**

Mary Shuma, Programme Officer for Women Development, Children and Gender  
Email: wdg@cct-tz.org

**Africa Inland Church of Tanzania is committed to preaching the Gospel and planting and cultivating maturing local churches. Through ministries it meets the spiritual, educational, social and physical needs of the Tanzanian people**

Peter Ngwili, Development Programme Coordinator, Diocese of Mara and Ukerere  
Email: ngwilip@yahoo.com

**Anti Female Genital Mutilation Network works with education officers across the Serengeti to increase awareness about the negative effects of FGM**

Mbiki Mumba, Deputy Director  
Email: mbikimumba@yahoo.com; afnetdodoma@yahoo.com

**28 Too Many is a values-based charity working to end female genital mutilation (FGM). Its primary focus is on research and enabling local initiatives to end FGM in the 28 African countries where it is practised and across the diaspora**

Dr Ann-Marie Wilson, Executive Director  
Email: annmarie@28toomany.org

## Contents

1. Introduction	3
2. Guide to acronyms and key wording	5
3. Research overview and objectives	6
4. Research findings in Mara Region: communities 1-8	8
Nature and extent of FGM/C in:	
4.1 Kurya, Simbiti, Sweta and Hacha tribes in Rorya District (communities 1-4)	8
4.2 Kurya tribe in Tarime District (communities 5-8)	9
5. Research findings in Singida Region: communities 9-16	10
Nature and extent of FGM/C in:	
5.1 Nyaturu tribe of Singida District (communities 9-12, 15)	11
5.2 Gogo tribe in Manyoni District (communities 13, 14 & 16)	13
6. Research findings in Dodoma Region: communities 17-22	14
6.1 Nature and extent of FGM/C in the Gogo tribe	14
7. Key drivers of FGM/C	16
7.1 Preparation for marriage and/or childbirth	16
7.2 Prevention of promiscuity/prostitution	16
7.3 Traditional beliefs and practices	17
7.4 Link with male circumcision	17
7.5 Social norms and pressures	18
7.6 Source of Income	19
7.7 Myths (lawalawa)	19
8. What is the church doing to end FGM/C?	20
9. Recommendations for a church response to end FGM/C	24
9.1 Awareness-raising	24
9.2 Training	24
• Myths (lawalawa)	
• Harmful consequences of FGM/C	
• Breaking links between male circumcision	
• Tanzanian National Laws on FGM/C	
9.3 Facilitating alternative rites of passage	25
9.4 Becoming a safe space	26
9.5 Providing alternative sources of income	26
9.6 Challenging community attitudes	26
9.7 Working alongside others	27
9.8 Advocacy	28
10. Conclusion	29
Bibliography	30

## 1. Introduction

Throughout this report the term FGM/C is used instead of FGM (female genital mutilation) or FGC (female genital cutting). The preference for this terminology is out of respect for survivors of FGM/C who find the negative association attached to the term mutilation stigmatising and have expressed concern that this wording hinders the process of social change.

Although UN agencies and WHO use the terminology FGM/C, many international agencies still use the term FGM, choosing to use the word mutilation to establish a clear linguistic distinction from male circumcision and emphasising the gravity and harm of the act. Use of the word mutilation reinforces the fact that the practice is a violation of girls' and women's rights, is medically dangerous and a painful and humiliating process. So the word promotes national and international advocacy for the prevention and end of FGM/C. Affected communities prefer the term 'female genital cutting or circumcision' so we are referencing both within the term FGM/C.

### What is FGM/C?

Female genital mutilation/cutting is a cultural practice involving the "partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons."<sup>1</sup>

WHO groups FGM/C into four types depending of the extent of the cutting:

- **Type 1:** Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- **Type 2:** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type 3:** Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
- **Type 4:** All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

FGM/C is generally carried out on 4- to 14-year-old girls. It is also performed on infants, women who are about to be married, and even women who are pregnant with their first child or who have just given birth.<sup>2</sup>

FGM/C has been documented in 28 countries in Africa and a few countries in Asia and the Middle East. It is estimated that 140 million girls and women worldwide have undergone such procedures and 3 million girls are estimated to be at risk of undergoing FGM/C each year.<sup>3</sup>

FGM/C is associated with a number of health risks and consequences, including pain, bleeding and infection as a consequence of the procedure. Long-term consequences include: chronic pain, infections, decreased sexual enjoyment and psychological consequences such as post-traumatic stress disorder. Women who have undergone FGM/C also experience an increased risk of problems during childbirth, including higher incidences of post-partum haemorrhage and higher infant-death rates.<sup>4</sup>

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<sup>1</sup> WHO

<sup>2</sup> Unicef, 2005

<sup>3</sup> WHO, 2008

<sup>4</sup> Ibid

The Tanzania Demographic Health Survey in 2010 found that 14.6% of 15- to 49-year-old females had undergone FGM/C and 84% of Tanzanian females and 79% of Tanzanian males believe that FGM/C should be stopped.<sup>5</sup>

Although the Tanzania Sexual Offences Special Provision Act of 1998 banned the use of FGM/C, it is still widely practised in some communities.

A statistical study showed that Christian groups in Tanzania are more likely to practise FGM/C than other faith groups and that FGM/C is higher among daughters of Christian women than Muslims. This could be attributed to other factors such as ethnicity and the distribution of religious groups within the country.<sup>6</sup>

## Worldwide, an estimated 140 million girls and women have undergone FGM/C procedures

### 3 million girls are estimated to be at risk of FGM/C each year



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<sup>5</sup> Unicef 2011

<sup>6</sup> Unicef 2005

## **Guide to acronyms and key wording**

AFNET	Anti Female Genital Mutilation Network of Tanzania
AICT	African Inland Church of Tanzania
Baseline study	Data collected on behaviour patterns in a population, prevalence of practices and past and present public attitudes
CBO	Community-based organisation
CCT	Christian Council of Tanzania
Cutting season	Ceremony (either in public or secret) where girls are circumcised or cut. The season is either in July or December in Tanzania
FGC	Female genital cutting or circumcision
FGM/C	Female genital mutilation/cutting
Kiswahili	The national language of Tanzania
Lawalawa	Believed to be a genital disease which is cured by undergoing FGM/C – a myth perpetuated by witchdoctors. It is in fact a bacterial infection caused by lack of washing with clean water.
Mizimu	The Kiswahili word for ancestors
NGOs	Non-government organisations
Ngariba	The Kiswahili word for circumciser or traditional healer
UNFPA	The United Nations Population Fund
UNICEF	The United Nations Children’s Fund
WDCG	CCT’s Women’s Development, Children and Gender Directorate
WHO	World Health Organisation

### 3. Research overview and objectives

The research consisted of a situation assessment in October 2012 and used both qualitative and quantitative research methodologies focusing on 22 communities in three regions: Mara Region in the north-west and Dodoma and Singida Regions in central Tanzania. Data was collected in eight communities in Mara Region (communities 1-8), eight in Singida (communities 9-16) and six in Dodoma (communities 17-22). The research was conducted in collaboration with the Christian Council of Tanzania (CCT), Mara Ukerewe Diocese of the African Inland Church of Tanzania (AICT) and the Anti Female Genital Mutilation Network of Tanzania (AFNET). Interviews were also carried out with representatives of each organisation.

Communities were approached through the local church, due to the sensitive nature of the subject and potential hostility from those who practise FGM/C as a cultural tradition. In Mara Region, a broad mixture of church denominations was selected, including Evangelical (AICT and Salvation Army), Mennonite, Pentecostal, Roman Catholic, and Seventh Day Adventist. It was the first time communities had been visited by AICT so it was only feasible to conduct mixed-gender sessions as it was felt that it could pose problems to request single-gender sessions. The sessions were facilitated by two facilitators (one female) and an interpreter and lasted over an hour each.

The majority of communities chosen were in remote locations where no known FGM/C sensitisation had taken place. The participants were made up of church leaders and male and female adult members of the congregations and communities. Although female-only sessions were not feasible and some women seemed reluctant to contribute, in each community women made valuable contributions and in communities 7 and 8 there was a better gender balance. Due to the fact that the sessions were of mixed genders, intimate questions such as the type of FGM/C practised, could not always be asked.

Table 1: Details of participants in Mara Region

<b>Gender and age</b>	<b>Number of participants</b>	<b>Church and community leaders participating</b>
Women >18 years	58	1 community executive officer and 4 church leaders. <sup>7</sup>
Men >18 years	58	13 church leaders and 1 teacher

In Singida and Dodoma Regions, the sessions were arranged by AFNET. Most of the communities who participated had previously experienced sensitisation by AFNET. This meant that both mixed and female-only sessions could be conducted and there was more time. Although women were generally more forthcoming in the single-sex session, in a number of communities there was still a reluctance to speak openly. In Singida and Dodoma Regions fear of prosecution was frequently voiced as the reasons for the decline in FGM/C. Fear of prosecution may have also led to reluctance to openly answer questions and the data may underestimate the true prevalence of the situation. The questionnaire was adapted to take into account the fact that there was evidence of ending FGM/C in these regions.

<sup>7</sup>Included in this category are the wives of male church leaders, although they may not all have church leadership positions.

Table 2: Details of participants in Singida Region

Gender and age	Number of participants	Church and community leaders participating
Women >18 years	37	1 youth representative, 1 nurse, 4 traditional birth attendants
Men >18 years	58	7 church leaders, 3 Muslim leaders, 7 community executive officers, 5 community chairman, 3 opinion leaders and 1 teacher

Table 3: Details of participants in Dodoma Region

Gender and age	Number of participants	Church and community leaders participating
Women >18 years	38	6 church leaders, 1 traditional birth attendant, 1 former ngariba/traditional healer
Men >18 years	45	10 church leaders, 3 community executive officers , 2 community chairman and 1 opinion leader

### Research objectives:

- To understand the current extent of FGM/C in the churches and communities of Mara, Singida and Dodoma Regions, including the nature and extent of the practice. (These regions were selected by Tearfund because they had a past prevalence of FGM/C)
- To understand the key drivers behind FGM/C
- To have a greater understanding about what the church in Tanzania is doing to end FGM/C
- To document any expectations communities and FGM/C survivors had about church participation in this issues
- To understand the potential of the church to end FGM/C at the local, regional and national level and how Tearfund can mobilise and support churches and leaders to end the practice of FGM/C in their churches and communities

### Limitations of the research

The research was a qualitative and quantitative sampling of the situation. A large number of communities and people were reached in a limited timeframe. It should be noted that not all the participants actively participated in the questions and answer sessions and their reluctance to talk could be due to fear and inhibition. Language may also have been a barrier.



#### 4. Research findings in Mara Region: communities 1- 8

Mara Region is located in the north-west of the country on the shores of Lake Victoria. Musoma is the region's capital. The neighbouring regions are Mwanza and Shinyanga (south), Arusha (south-east) and Kagera (across Lake Victoria). To the north-east, the Mara Region borders Kenya.<sup>8</sup>

Over 95% of the population is Christian or Animist with a small Muslim population mostly in urban areas.<sup>9</sup> The main ethnic groups are Kurya, Jita and Luo. The Kurya are the main ethnic group in the Tarime highlands and in the midlands and account for roughly 50% of the population.<sup>10</sup>



Figure 1: Location of Mara Region in Tanzania (Wikipedia)

##### 4.1 Kurya, Simbiti, Sweta and Hacha tribes in Rorya District (communities 1-4)

The nature and extent of FGM/C within the church and communities varied.

In community 1, FGM/C was still performed at a rate of approximately 80%. However, FGM/C is decreasing and the practice is now conducted in a secretive manner because of government opposition. Previously, people would have used ngariba from their clan, but now people use any ngariba they can find. Previously girls would have been cut together in public, but now the ngariba is brought secretly to the home at night. There has also been a decrease in the age at which girls are cut from 12-years-old to between 8- and 10-years-old. A grandmother had even undergone FGM/C in the last cutting season due to intense social pressure. It was reported that the pressure on girls from within their peer group to undergo FGM/C is so great that some have resorted to cutting themselves with razorblades if parents are opposed to the practice. These issues affect both Christian and non-Christians within the communities.

In community 2, FGM/C is performed at a rate of 80-90%. As with community 1, it is now conducted more secretly on 8- to 10-year-old girls. It was reported that the type of FGM/C has changed with a smaller amount of flesh being cut to avoid profuse bleeding. FGM/C is practised both within and outside church communities. Many people are reported to leave the church during cutting season to participate in the cutting ceremony.

<sup>8</sup>The Planning Commission, Dar es Salaam, and The Regional Commissioner's Office, Mara. December 1998

<sup>9</sup>Ibid

<sup>10</sup>Ibid

In Community 3, which is composed of the Simbiti, Sweta and Hacha tribes, FGM/C practices have changed and during the last cutting season there weren't many cases of neither male nor female circumcision. However, survey results showed a strong link between male circumcision and FGM/C. FGM/C used to be practised on 15- to 18-year-old girls, now it now happens at a younger age and highly secretly. The reduction was attributed to the new law banning FGM/C, government announcements and the fear of being caught and fined, as well as steps taken by the church. In addition, research participants said that because new people had moved into the area and intermarried, bringing with them new traditions and customs, the practice of FGM/C had been weakened. One participant said that FGM/C is now "out of fashion."

In Community 4, of the predominant Kurya tribe, female community leaders indicated that the situation had "cooled down", with one person saying that only 30% get cut. Even so, the last time there was a cutting season in 2009 a lot of women participated, including married women.

According to the Christian Council of Tanzania's (CCT) baseline study for Rorya in 2010 overall FGM/C prevalence is low in the district – 359 participants said it is less than 10% and 107 participants between 10-20%. This is because the Luo tribe occupy a large part of this district and do not practice the tradition. Discussions from the stakeholder meetings for CCT's baseline study revealed that communities occupied by the Simbiti and Kurya tribes have a higher rate of FGM/C at about 80%.

#### **4.2 Kurya tribe in Tarime District (communities 5-8)**

In communities 5- 8, all of which are inhabited by the Kurya tribe, the current prevalence of FGM/C is estimated between 68-100%. All communities reported that FGM/C is practised every two years and the last cutting season was December 2012. It is practised on 11- to 16-year-old girls.<sup>11</sup> Previously 15-to 18-year-old girls would be cut, but as these girls started to disagree with being cut, the age has reduced.<sup>12</sup> Christians and non-Christians both practise FGM/C, although the prevalence may be slightly less among Christians.

The circumcision of boys and girls is accompanied by much celebration, with drinking, dancing and music and invitation cards handed out for the event (similar to wedding invitations). Boys are circumcised in one area (which is considered sacred), the girls in another.

One community started cutting in secret following the high-profile political announcements condemning FGM/C. However, there was a lack of any law enforcement and prosecutions and the local MP, wanting to get re-elected, told the community to retain their traditional beliefs. The community publically resumed the practice of FGM/C. It was also found that sometimes girls ask the ngaribas to cut only a small bit of flesh or their parents pay them not to cut at all.

A low percentage of the population is actively practising Christian. According to CCT's baseline study for Tarime District in 2009, FGM/C is still practised at a rate of more than 75%. They also reported that only type 1 was practised, whereas previously types 1 and 2 were practised.

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<sup>11</sup>communities 5 and 7

<sup>12</sup>community 7

The Tanzania Demographic Health Survey in 2010 found that 39.9% of woman in Mara Region had been circumcised, with 2% of those reporting being “cut, no flesh removed” (type 1) and 94.2% being “cut, flesh removed” (type 2).

The age at which FGM/C takes place on girls within the Lake Zone area was as follows:

>1 year	1-4 years	5-6 years	7-8 years	9-10 years	11-12 years	13+ years	Unknown
1.3%	0%	0.5%	3.8%	10.2%	16.2%	66.4%	1.5%

The view that FGM/C should continue is highest across the Lake Zone (11%) and within Mara Region (16%). Of those surveyed in Mara Region, 82.5% of women thought that FGM/C should be discontinued.<sup>13</sup>

### 5. Research findings in Singida Region: communities 9-16

Singida Region is located in central Tanzania. The main tribe is Nyaturu. In Iramba District the main tribe is the Nyiramba. In Manyoni District, the Gogo and a few Nyaturu tribes. Historically the Nyaturu and Gogo have practised FGM/C.



Figure 2: Location of Singida Region in Tanzania

#### Nature and extent of FGM/C in Manyoni District

Christian Council of Tanzania’s (CCT) baseline study for the Singida Region in 2008 found that although FGM/C/ is still practised, it is now done at a rate of less than 10% showing the efforts to abolish the practice are bearing fruit.

The past study showed that 54% of research participants<sup>14</sup> thought that FGM/C was still being practised; 23% of individual participants did not think it was being practised and 23% of individuals did not know. 72% of leaders thought that it was practised on 1- to 5-year-old children.

It also found that 51% of woman in Singida Region had been circumcised (compared with 43.2% in 2004), with 1.7% of those reporting being “cut, no flesh removed”; 95% being “cut, flesh removed” and 3.3% unknown.

<sup>13</sup>TDHS, 2010

<sup>14</sup>1072 out of 1999 people

Only 4.7% of women surveyed thought that FGM/C should be continued with 94.2% discontinued.<sup>15</sup>The report also found the age at which FGM/C takes place on girls within the central zone as follows:

>1 year	1-4 years	5-6 years	7-8 years	9-10 years	11-12 years	13+ years
18.9%	18.8%	13.4%	17.2%	17%	8.2%	6.4%

**5.1 Nyaturu tribe of Singida District (communities 9-12 and 15)**

The nature and extent of FGM/C was similar in other communities in the region with historical rates of FGM/C of 100% irrespective of whether women were Christian or Muslim. In community 9, one participant stated, “everyone did it.”<sup>16</sup> Another community said that if someone married into the tribe who was not cut, they would not have to be cut.<sup>17</sup>



A Nyaturu woman in Singida © Johanna Waritay/28 Too Many

Historically within the Nyaturu tribe, the practice of FGM/C is linked with the circumcision of boys. The cutting of both boys and girls happened every June and July. This coincided with harvest time, so food for the celebrations would be plentiful. It is also cooler at this time of year and it was believed that the cooler weather would lessen the bleeding and aid healing. There would be much celebration, eating and drinking. The boys and girls would be cut on the same day having received training in a special place on how to live well, such as how to care for their family and community. This would take place in a special camp where they would have white soil smeared on their bodies, which was changed daily. They would sing special uplifting and encouraging songs that would remind them they are no longer children. The boys would receive gifts such as a cow.

<sup>15</sup>TDHS 2010  
<sup>16</sup>Yet another participant in this community stated that the prevalence used to be 50%  
<sup>17</sup>community 10

FGM/C used to be performed on 8- to 13-year-old girls in communities 9-12. In community 15, 5- to 6-year-old girls were cut. In community 11, if a 5-year-old girl went along to the cutting celebrations she would sometimes spontaneously join her friends for cutting.

All the communities reported that during the 1970s a belief in lawalawa arose which led to babies being cut. Lawalawa was believed to be a disease of the male and female genitalia, which could only be cured by performing FGM/C. It was believed to affect babies as well as older children and adults. One participant said that it was considered a punishment from the local gods and that the only way to cure it was to appease them through FGM/C, otherwise babies would die. According to the Anti Female Genital Mutilation Network, the belief may have arisen through stories told by witchdoctors. But participants and even a nurse from a dispensary clinic shared that lawalawa is now thought to be a bacterial infection caused by poor hygiene that can be easily cured using conventional medicine. Women said it was sometimes difficult to wash due to lack of access to clean water.

One community reported that the government had started to intervene before the outlawing of FGM/C.<sup>18</sup> A combination of the belief in lawalawa and the government announcement outlawing FGM/C in 1998 have reportedly reduced the age at which FGM/C is carried out, with 4 out of the 5 communities reporting that FGM/C is still practised on babies, but at a much lower rate. One community reported that FGM/C had ceased completely.

Estimates of the current prevalence of FGM/C range from 0-30% (see table 4). One community could not estimate the current prevalence and another acknowledged that it was difficult to estimate given the secrecy of the practice.<sup>19</sup> One participant admitted that the prevalence might be higher in remote communities.<sup>20</sup> The drop in the rate of FGM/C was mainly attributed to the government announcement and fear of prosecution. One participant said, “the government announcement led to fear – everyone was very afraid.”<sup>21</sup> One participant said that the government had told dispensaries and clinics to report cases. A number of communities reported that they had heard of prosecutions.

Table 4 below summarises the prevalence and type of FGM/C among the Nyaturu tribe.

	<b>Prevalence of FGM/C</b>	<b>Age</b>	<b>Type of FGM/C</b>
<b>community 9</b>	1-2%	Newborn	2 (labia majora and minora)
<b>community 10</b>	1%	Newborn	2 (labia majora and minora)
<b>community 11</b>	Not specified	0-1 years	1
<b>community 12</b>	30%	Babies <sup>22</sup>	1
<b>community 15</b>	0%	n/a	n/a

<sup>18</sup>community 12

<sup>19</sup>community 9

<sup>20</sup>community 10

<sup>21</sup>community 11

<sup>22</sup>unspecified whether newborn or baby

Both FGM/C types 1 and 2 were reported to have been performed in the past as well as both types being currently being performed on babies. In two communities, the type of cutting had changed from type 2 (or type 1 or 2) to type 1 with one community reporting that just a small portion of flesh is now cut (as opposed to the entire clitoris).

A number of traditional birth attendants reported differences in the experiences of cut and uncut women during childbirth – with cut women experiencing many difficulties such as blood loss.

## **5.2 Gogo tribe in Manyoni District (communities 13, 14 & 16)**

In some of these communities there was a reluctance to share and participants gave conflicting reports as to whether FGM/C is still practised. No estimates were given for current prevalence.

Historically, FGM/C was practised at varying ages, from 5-6 years,<sup>23</sup> 5-7 years,<sup>24</sup> and 10+ years.<sup>25</sup> Prior to the government announcement outlawing FGM/C, it used to be practised a rate of 51% in Singida Region. One community reported the past prevalence rate as 100%. FGM/C was practised irrespective of religion. Historically type 2 was practised in all communities (except one where type 1 was practised).

In communities 13, 14, 16, either all or some of the participants reported that FGM/C is no longer practised, and estimated the prevalence rate as 0.5 to 3%.<sup>26</sup>

However, in two of these communities some participants stated or implied that it is still practised in secret on babies.<sup>27</sup> In community 13, one participant said FGM/C was not practised, but a female nurse who worked at a clinic said that she had seen babies coming into the clinic who had been cut. In the same community one man also referred to it being done secretly without a husband's knowledge.

The Anti Female Genital Mutilation Network (AFNET) representatives interviewed estimated the current rate of FGM/C in Singida Region as between 30-40%, with greater prevalence in rural areas. To avoid prosecution, the age of girls undergoing FGM/C has reduced from 9- to 12-year-olds to newborns. These results are based on feedback from community representatives and data gathered from clinics. In one community AFNET conducted a small-scale study in 2010 at a reproductive health clinic at which girls aged from 0-1.5 and two-years-old were physically examined. It found that 84% had been cut (59 girls out of 70).

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<sup>23</sup>community 13

<sup>24</sup>community 14

<sup>25</sup>community 16

<sup>26</sup>communities 13 and 14

<sup>27</sup>Ibid

## 6. Research findings in Dodoma Region: communities 17-22

Dodoma Region is also located in central Tanzania and bordered by four regions: Manyara in the north, Morogoro in the east, Iringa in the south and Singida in the west. Historically the Gogo are the principle tribe and practise FGM/C.



Figure 5: Location of Dodoma Region in Tanzania (Wikipedia)

### 6.1 Nature and extent of FGM/C in the Gogo tribe

Similar to the communities of the Gogo tribe in Singida Region, participants were reluctant to share and gave conflicting reports into the practice of FGM/C. No estimates were given for current prevalence.

The traditional practice of FGM/C among the Gogo tribe is linked to male circumcision, just as within the Nyaturu tribe in the Singida Region. In the past, boys and girls would both be cut in June/July accompanied by great celebrations with food, music and the slaughtering of cows and goats. Boys and girls would receive training on what it meant to be a Gogo man and woman. A father wanting to get his daughter cut would tell his wider family and neighbours, the ngariba would be called and all the girls would be cut together. The traditional leaders had a significant role to play and would consult the local gods to determine whether the time was acceptable for cutting to take place. The girls would be covered with oil afterwards, dress in new clothes and walk with a stick. When she met a male relative, she would put the stick down and not smile until the male relative gave her a present. Boys would similarly receive presents from female relatives. Girls were not supposed to have sex for one year after being cut and told that any babies conceived as a result would die. Girls would receive gifts, such as clothes, shoes, money and beads, which would reach the jaw line. Without knowing they were to undergo FGM/C, girls used to be lured to the bush with the promise of honey, which was very attractive.

Historically, FGM/C was practised at varying ages, from 10+ years,<sup>28</sup> 12+ years<sup>29</sup> and 14-15 years.<sup>30</sup> Prior to the government announcement outlawing FGM/C, it used to be practised a rate of 63.8% in Dodoma.<sup>31</sup> One community reported the historical prevalence rate as 100% and stated that FGM/C was practised irrespective of religion. Historically, type 2 was practised in all communities (except one where type 1 was practised).

In communities 19 and 22, most of the participants reported that FGM/C is no longer practised.

In community 18, research participants reported that the government announcement outlawing FGM/C was the main driver behind the people stopping the practice. They mentioned a government announcement that encouraged parents to take their children to the clinic if they had lawalawa, but if it was discovered they had performed FGM/C they would be prosecuted and could go to prison. There had also been migration into the area and this had an impact as uncut girls could get married outside of the Gogo tribe.

In communities 17, 20, 21 research participants said that FGM/C was not often practised, but mainly on babies<sup>32</sup> or older girls.<sup>33</sup> Two communities estimated the prevalence at between 0.5% and 3%.

In community 17, research participants said that the small minority still practising FGM/C was made up of those who either did not go to school or had very little formal education and were not churchgoers. Traditional leaders tell parents that their child has lawalawa. In communities 20 and 21 participants reported older girls being taken far away, escorted by ngariba, to undergo FGM/C secretly. In community 22, this also used to happen in the past, but with 16-year-old girls and older so that it would be easier to explain their absence. In community 20, girls would receive presents and there would be big celebrations at Christmas or birthdays, but the real reason was to celebrate the girls undergoing FGM/C. In community 20, it was reported that sometimes mothers would even lie to their husbands and take their babies to be cut on the pretence they had lawalawa.

The Anti Female Genital Mutilation Network representatives that were interviewed said the rate of FGM/C in Dodoma had dropped to a “very low level” among the Gogo (and Warangi tribes in Kondoa District). The Tanzania Demographic Health Survey in 2010 found that 63.8% of 15- to 49-year-old women in Dodoma Region had been circumcised, with 0.5% of those reporting being “cut, no flesh removed” and 99.5% being “cut, flesh removed.” 9.6% of women surveyed in Dodoma Region thought FGM/C should be continued, and 88.3% discontinued.<sup>34</sup>

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<sup>28</sup> communities 18 and 19

<sup>29</sup> communities 17, 20, 21

<sup>30</sup> community 22

<sup>31</sup> TDHS 2010

<sup>32</sup> communities 17 and 21

<sup>33</sup> communities 20 and 21

<sup>34</sup> TDHS 2010



## 7. Key drivers of FGM/C across the communities

The following section will discuss the key drivers of the practice of FGM/C in the three regions of Tanzania covered by the research.

The Christian Council of Tanzania's (CCT) baseline study for Rorya District in 2010 and Tarime District in 2009 found the following reasons for continuing the practice of FGM/C:

- Lack of awareness of the risks associated with FGM/C
- Resistance to change behaviour among community leaders
- Threats from traditional leaders and practitioners
- Fear of wrath from spirits and ancestors (Mizimu)
- Continuance of traditions and practices

Following the most recent research in 2012, key themes emerged through discussions with community members. The issues raised should inform any future response to FGM/C in Tanzania.

### 7.1 Preparation for marriage and/or childbirth

In all but one of the 22 communities, it was believed that FGM/C was a necessity if women wanted to get married as it was seen as a sign of maturity,<sup>35</sup> and it afforded you respect in the community.<sup>36</sup> In one community, one of the women commented that, "if you didn't have FGM, forget about having a husband!" If a woman had not been cut, when getting married she would have to be cut.<sup>37</sup> One woman in the same community said that there was pressure on girls to get married soon after they were cut. She also said that if you are pregnant and uncut, you would be cut during childbirth. In Tarime District, one woman stated that if a woman is not cut she will not attract a dowry and get married.<sup>38</sup>

In another community, it was believed that the clitoris would obstruct the view of the baby during childbirth and would hinder penetration during sexual intercourse.<sup>39</sup>

### 7.2 Prevention of promiscuity/prostitution

In nine of the communities, FGM/C was seen as a way to prevent promiscuity and prostitution. In community 4, a church elder explained how in the past girls were not permitted to have sex before undergoing FGM/C and if they did they would be killed. He said FGM/C ensured the morality of women and prevention of prostitution. In community 20, FGM/C was intended to decrease women's sexual desire and there was a belief that eventually all uncut women would become prostitutes. In community 22, women stated that FGM/C was performed to decrease women's sexual desires and that historically men did not want women to have pleasure during sexual intercourse.

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<sup>35</sup>community 7

<sup>36</sup>communities 9-21

<sup>37</sup>communities 2-3

<sup>38</sup>community 8

<sup>39</sup>community 22

### **7.3 Traditional beliefs and practices**

In a third of the communities FGM/C was viewed as a traditional practice and a sign that a girl had transitioned from childhood to adulthood.

In two thirds of communities<sup>40</sup> the practice of FGM/C continued because it was viewed as a traditional 'norm'. In community 14, one participant said people still want to 'cling to tradition.'

In community 1, it is believed that FGM/C is a blood offering to the ancestors (Mizimu) to ensure good rains and prevent disease and in the past it was believed that if there was no blood sacrifice through FGM/C, the Mizimu will bring bad luck on the community. In community 3, historically it was believed that FGM/C would lead to women bearing many children, but they now see that uncut women are more fertile. In community 5, it is considered a curse if a woman is not cut. If a woman dies during the cutting or in the one month period of confinement afterwards during which she is cared for, she cannot be buried in the home and is thrown away secretly like an animal. The mother is not allowed to publicly mourn and any presents that were received during the ceremonies (even cows) are destroyed. In community 7, they referred to an abandoned traditional practice among the Kurya of wearing bracelets on their upper arms and cutting their ears. If you were to do this now, you would be stigmatised.

The influence of traditional leaders (ngaribas) was also mentioned in two communities.<sup>41</sup> The traditional leaders used to lead the cutting and would announce when it would take place after they had consulted the local gods. Traditional leaders would do everything to persuade parents to get their babies cut. These leaders were both Christian and Muslim and would also participate in local traditional beliefs such as talking to the spirits of ancestors (Mizumi).

### **7.4 Link with male circumcision**

The traditional practice of male circumcision and FGM/C appear of significant importance in both Mara and Singida Regions. In community 1, it was stated that the girls see the boys "becoming men" after being circumcised and being accepted into the community and want the same social acceptance themselves. It was stated that women who have not undergone FGM/C cannot "receive" their sons into the homestead after the traditional male circumcision ceremony.<sup>42</sup> After a man has been circumcised, he is permitted to build the homestead gate, and traditionally many rites are performed at the gate. It is for this reason that the homestead and receiving a son from circumcision has such significance.<sup>43</sup> In community 5, boys and girls of the same age are circumcised together and become age-mates, which is a term to describe how children view each other as brother and sister after the ceremony and visit each other's homes.

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<sup>40</sup> communities 9-22

<sup>41</sup> communities 15 and 22

<sup>42</sup> communities 1, 2 and 4

<sup>43</sup> community 3

## 7.5 Social norms and pressures

In a third of the communities in the Mara and Singida Regions women underwent FGM/C to avoid stigmatisation within their tribe and community.<sup>44</sup> Two thirds of communities said that you are likely to be respected more if you had undergone FGM/C.<sup>45</sup>

A woman who has not undergone FGM/C is segregated from the wider community and cannot participate in many domestic chores, such as collecting water. There is a belief that the wells are sacred places and will dry up if an uncut woman goes there. An uncut woman cannot collect firewood or open the gates of the homestead or cook food for community celebrations. In community 3, it was said that the husband of a woman who has not undergone FGM/C cannot eat certain cuts of meat at the circumcision celebration and cannot perform certain community rites. A participant in community 1 said, “all the time, the community will look upon you as a child,” and an uncut woman will also be verbally abused and called derogatory names. Only community 3 reported that the stigma had reduced.

In four communities,<sup>46</sup> peer pressure was so high amongst young girls to undergo FGM/C that in community 1 girls had resorted to cutting themselves with razor blades. In community 2, a church elder said, “men do not like FGM, the women do not like it, but they get it done because of peer pressure.”

In five of the communities traditional elders were the main reason that community members participated in FGM/C.<sup>47</sup> In community 1 in Rorya District, a participant stated that the traditional elders are “pushing everyone to do it.” A pastor from community 2 said, “the traditional elders are behind it, they are very powerful.” A woman from community 5 said, “the elders are worshiped and the community believes that they can curse people.” However, elsewhere traditional elders are not actively persuading girls and women to undergo FGM/C.<sup>48</sup>

In just over half of the communities<sup>49</sup> (almost all in Singida and Dodoma Regions) parental pressure was referred to as a reason for FGM/C. In particular, some participants mentioned the fact that it is often the mother under pressure from the baby's grandmother.<sup>50</sup> Parents in community 14 wanted to show that their child is a “proper Gogo.” A number of communities stressed that in Gogo culture, “there is no room for a daughter to argue with her mother.”<sup>51</sup> In some communities, the parental desire to secure a dowry for their daughter was a contributing factor.<sup>52</sup>

In community 1, a woman said that she wanted her daughter to be cut because she herself had been cut. Yes in community 2, a mother opposed to her daughters undergoing FGM/C was left with “no choice” after her husband gave her the option of circumcising the girls or leaving home.

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<sup>44</sup> communities 1-2,4,6-8

<sup>45</sup> communities 9-21

<sup>46</sup> communities 1,2,6,8

<sup>47</sup> communities 1,2,5,7 and 8

<sup>48</sup> community 3

<sup>49</sup> communities 1,2,7-9,11,12,14-22

<sup>50</sup> communities 9, 11-12, 21-22

<sup>51</sup> communities 21-22

<sup>52</sup> communities 10, 12 -14, 18

## 7.6 Source of Income

In four communities in Mara Region FGM/C and traditional male circumcision was considered a “business issue.” The ngaribas are paid 5,000 Tanzanian Shillings (TZS)<sup>53</sup> and 3,000 for a boy. In another community the cost was 10,000 TZS for girls and 9,000 for boys.<sup>54</sup> A portion of this is paid to the traditional elders according to Christian Council for Tanzania’s (CCT) baseline study for Tarime District in 2009. Male musicians forego the income from their normal professions during the cutting season.<sup>55</sup> Only one community felt that the source of income for ngaribas from FGM/C was insignificant, as they had other sources of income.

## 7.7 Myths (lawalawa)

The ongoing belief in lawalawa was mentioned as a reason for FGM/C in half the communities.<sup>56</sup>

Lawalawa was believed to be a disease of the male and female genitalia, which could only be cured by performing FGM/C – this was also a myth perpetuated by witch doctors. It is in fact a bacterial infection of the genitalia most probably caused by a lack of access to clean water.

In two communities,<sup>57</sup> participants mentioned that FGM/C was thought to prevent lawalawa, but also that it helped prevent illnesses caused by a lack of hygiene showing that there is still much confusion and a need for education and awareness-raising.

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<sup>53</sup> approximately US\$3

<sup>54</sup> community 6

<sup>55</sup> community 2

<sup>56</sup> communities 9-13, 16-22

<sup>57</sup> communities 11,12

## **8. What is the church doing to end FGM/C?**

A key objective of this study is to get a better idea of the current role of the church in Tanzania in responding to and preventing FGM/C.

The research results show that many churches are in principle opposed to FGM/C, stating it to be 'against the Bible' and 'not a practice acceptable as a Christian.' This has led churches to challenge traditional beliefs within their congregations and communities. Many churches have spoken out about FGM/C. However, in a number of cases this has led to negative consequences and church leaders have reported violence and threats to those who were speaking out against FGM/C. Girls who are refusing to be cut are forced. Traditional leaders within the church have accused church members of being witch doctors after church anti-FGM/C campaigns. However, despite the hostility faced the church has also achieved success.

### **Christian Council of Tanzania – supporting the church to respond to FGM/C**

The Christian Council of Tanzania (CCT) is an ecumenical organization formed by 14 member churches and 10 associates. CCT's vision is one of promoting Christian unity among member churches. Its programmes include: education, health, interfaith relations, women's development, children and gender, and peace and justice.

In partnership with Norwegian Church Aid, CCT has been working for more than 10 years in the Mara Region to coordinate advocacy campaigns, educate and train community members and traditional leaders on FGM/C and its consequences.

CCT has also distributed advocacy materials to churches to engage congregations with the issue of FGM/C.

CCT's Women's Development, Children and Gender (WDCG) programme has been promoting women's empowerment in social justice with an emphasis on gender equity. The programme seeks to enhance women and children's participation in decision-making processes for their political, socio-economic and cultural well-being. Specifically, the WDCG programme has focused on advocacy against gender-based violence and in particular FGM in five districts: Kiteto (Manyara Region), Singida (Singida Region), Tarime, Serengeti and Rorya Districts in Mara Regions

CCT has worked on advocacy programmes within schools, reaching 332 young people. This has resulted in improved knowledge and understanding of FGM/C and its consequences. In 2012, a total of 336 girls sought refuge at pastors' homes to escape the December cutting season, which is an increase in those who have sought refuge in previous years. Through Sunday school programmes in local churches, CCT's WDCG programmes have sensitized over 700 children on FGM/C practices in rural Tarime District.

## **A summary of the churches impact**

Local churches have been involved in a number of ways in working to eradicate FGM/C in their communities. The main focus of this work is as follows:

### **Sensitisation and advocacy**

Churches have sensitised their members on FGM/C as a result of the work done by Christian Council of Tanzania (CCT) to promote awareness. One community found that because of the work of the church there has been a gradual acceptance of the message and a greater awareness of the implications of FGM/C. CCT and church leaders held a community meeting in which ngaribas attended and committed to ending the practice. Community members felt that FGM/C had decreased in prevalence since.

CCT conducted a baseline study for Rorya and Tarime Districts in 2010 and 2009. These studies revealed that a large area of Rorya District does not have organisations sensitising against FGM/C, with 82% of participants saying that they have no such organisations in their area, 8% reporting they do and 10% not knowing.

The CCT baseline study on Tarime District showed that 94% of the people had not been properly educated on FGM/C, with only 6% having received sensitisation education.

The study also showed that people in Mara Region received education from different sources: 54% by religious leaders, 30% by media, 8% by NGOs/CBOs and 6% from government officials/political leaders. The percentage of education conducted by religious leaders emphasises the critical nature of engaging with faith-based organisations and churches to sensitise and advocate against the practice of FGM/C. Churches in Dodoma and Singida Regions have raised awareness of FGM/C through sermons. Several communities referred to post-sermon awareness sessions. These sessions were sometimes instigated and facilitated by Anti Female Genital Mutilation Network representatives (AFNET).

Previously, AFNET's community-based facilitators have conducted focus-group discussions for elders, traditional leaders, young men and women and uncut girls, and facilitated peer education for girls and boys with different messages for different groups. Nearly all the communities reported an impact.

### **Training and integration with health programmes**

In community 18 The Anglican Diocese of Tanganyika has trained different groups within the community on the effects of FGM/C and on related issues such as HIV. It has also conducted entrepreneurship training for former ngaribas so they could find alternative sources of income. Community members agree this has helped inform people of the effects of FGM/C and changed attitudes. Information has been distributed at clinics and via newspapers in communities 10 and 14.

The effectiveness of combining the message against FGM/C with that of HIV was seen as positive by communities 14 and 17. In community 17, participants commented that AFNET's training, which covered both FGM/C and HIV, has led to women with fistulae or HIV coming forward and getting medical treatment. In two other communities, FGM/C had been covered as part of HIV programmes by different NGOs such as Health Action Promotion Association and the Agricultural Development Project.

### **Alternate rites of passage**

Community 8 received FGM/C sensitisation and training by the Christian Council of Tanzania (CCT) and a Kenyan NGO. They had undertaken joint seminars with other churches to which parents, girls, ngaribas and community elders were invited. The girls were taken to a camp and given bibles and clothes to increase involvement (similar to the receiving of gifts during the FGM/C ceremony). This was successful and many girls decided not to be cut and instead formed their own peer group. One of the most feared traditional elders was engaged in the alternative rites of passage and as a result promised to stop his involvement in the practice.

### **Safe havens for girls**

In Community 6, there has been extreme hostility towards the church for speaking out against FGM/C. The pastor explained that the church was the only organisation taking any action within the community. He conducted seminars at primary schools, but had ceased due to the community's opposition. The church had also provided refuge for girls escaping FGM/C and had conducted an awareness and prayer campaign.

In Community 7, the pastor explained that another church in the community had taken a stance against FGM/C and as a result there were many uncut girls in that church. They would chase people out of church if they underwent FGM/C. The pastor and church leaders also reported cases of the church sheltering girls fleeing FGM/C ceremonies.

### **Partnership and collaboration**

In contrast to Mara Region, in Singida and Dodoma Regions there has been more government intervention and action by local NGOs – in particular AFNET, as well as by the church. The church remains one of a number of key organisations taking action to eradicate FGM/C.

### **Limitations to the church's response**

Local churches, particularly those in Mara Region, have raised awareness of FGM/C, but in an uncoordinated manner and not as part of a broader programme.<sup>58</sup> Through sermons and single-sex group discussions people were urged to stop the practice. A couple of communities said that coordination with some denominations was impossible because of theological differences. Community 22 had expelled members of the church because of their participation in FGM/C.

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<sup>58</sup>communities 9-22

A number of communities reported that they had heard of prosecutions relating to FGM/C.<sup>59</sup> One participant stated that the police could not deal with the matter locally and would say the matter should be settled informally out of court.<sup>60</sup> In another community the police had not followed through on prosecutions, arresting and then immediately releasing people. Another participant thought the government had played a passive role,<sup>61</sup> although FGM/C had been a special agenda item at government meetings.<sup>62</sup> One participant stated that it seemed to have “fallen off the agenda.”<sup>63</sup>

In terms of effectiveness, it is difficult to draw firm conclusions on what has worked. The overwhelming reason for the reduction in the prevalence or end of FGM/C was thought to be government law and fear of prosecution. However, a number of communities said that awareness-raising by the government, church and NGOs (particularly the Anti Female Genital Mutilation Network) had also contributed.

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<sup>59</sup> communities 9 and 14

<sup>60</sup> community 9

<sup>61</sup> community 12

<sup>62</sup> communities 9, 10, 14 and 16

<sup>63</sup> community 9



## 9. Recommendations for a church response to end FGM/C

What is the best course of action for churches in Tanzania in continuing to deal with FGM/C - taking into account the current work of the church in these communities as well as the gaps in response that were identified?

### 9.1 Awareness-raising

Many communities said that people still need to be made aware of the consequences of FGM/C and that awareness-raising should target remote communities.

#### *Sensitisation and Outreach*

Various methods for awareness-raising through sensitisation and outreach were suggested by research participants, including: information sessions in churches, community meetings targeting different groups (especially traditional leaders)<sup>64</sup> education in schools (including ensuring FGM/C is dealt with more thoroughly in the curriculum) and delivering special sessions to girls at Sunday school.<sup>65</sup> Two communities suggested that FGM/C should be raised alongside education on HIV.<sup>66</sup>

#### *Community meetings*

It was proposed that FGM/C is on the agenda of any community and regional meetings. One community suggested that at such meetings, chairmen from other communities should attend and “diffuse” the message to their own communities.<sup>67</sup>

#### *Sensitisation by role play, music or theatre*

Over half the communities in Singida and Dodoma Regions suggested that awareness of FGM/C should be raised by way of cinema/theatre/DVDs – particularly good for reaching out to non-churchgoers. As literacy levels were low, leaflets were of limited value.<sup>68</sup> Music and choirs were also mentioned in a number of communities and creating social groups and producing caps and T-shirts with anti-FGM messages for members.

### 9.2 Training

Due to the lack of information that communities have on FGM/C, education and training was raised a key recommendation and opportunity for the church. A number of women said that they would not have undergone FGM/C if they had fully appreciated the harmful consequences of it.

In Singida and Dodoma Regions, many participants thought that communities needed to be reminded about the effects of FGM/C, even in those areas with a low prevalence or where it no longer happens.

A key recommendation was to conduct seminars for women and men in single-sex sessions, and for traditional leaders, on the impact of FGM/C and emphasising the consequences in childbirth.

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<sup>64</sup> community 12

<sup>65</sup> *Ibid*

<sup>66</sup> communities 18 and 20

<sup>67</sup> community 17

<sup>68</sup> community 14

It was also felt that peer training would be an effective type of training, allowing community members to learn from those who understand their cultural practices. This provides an opportunity to bring back the training elements of the former FGM/C ceremonies and the positive elements of the Nyaturu or Gogo culture.

Training on the following issues needs to be prioritised:

#### *Myths (lawalawa)*

In Singida and Dodoma Regions, one of the reasons for the continuance in the practice of FGM/C is traditional beliefs and myths, especially the belief that FGM/C can cure a disease called lawalawa. Support of this belief is imposed by mothers, grandmothers and local spiritual leaders. Lawalawa is in fact a bacterial infection that can easily be cured with conventional medicine.

Training must incorporate discussion of this issue, targeting women in particular and dispelling the lawalawa belief that perpetuates the practice of FGM/C. It was also recommended to link initiatives to end the FGM/C practice to community initiatives that improve the reproductive health of women and girls through education and HIV programmes.<sup>69</sup>

#### *Breaking the link between male circumcision and FGM/C*

Male circumcision and FGM/C are linked through the social pressure felt by girls to undergo FGM/C in order to benefit from the same status, celebration, and transition into adulthood than male youths experience in their circumcision ceremonies. Encouraging male circumcision in hospitals not only protects the health of the boys involved, but removes the practice from the community and thus potentially reducing the social pressure for girls to undergo FGM/C.

#### *Tanzanian National Laws on FGM/C*

There appears to be a low level of enforcement by the government. One community stated: “the government was not a strong force locally and although we have heard about the ban on the radio, it appears that the government is saying and not doing” (although in this community the government had tried to gather data in schools on the issue). There were no prosecutions reported. A participant in another community said: “the government only makes announcements, but is very weak.” In another community, a participant said people, “ignore the law.”

There is an opportunity for the church to take steps to ensure that people are informed about the law and its consequences and extent of the penalties. This will improve the government enforcement of the law.

### **9.3 Facilitating alternative rites of passage**

In Mara Region, participants referred to the ritualised nature of FGM/C. It was considered a coming of age ceremony as girls are considered ready for marriage afterwards. Creating alternative rites of passage would preserve the positive socio-cultural aspects of the ritual, but not require girls to undergo FGM/C. The potential of this strategy is limited to those communities where FGM/C is associated with such rites of passage.

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<sup>69</sup>UNFPA, 2007

However, there is a trend in some communities to cut girls at a younger age with less ritual so this would be of less benefit in Singida and Dodoma Regions.

Developing alternative rites of passage may contribute to a reduction in the incidence of FGM when it is accompanied by community awareness and discussion. In isolation it has limited impact since it does not address the underlying social values associated with FGM/C and therefore, does not provide assurance that a girl will not be cut at a later date.<sup>70</sup>

#### **9.4 Providing a safe space**

The church could adopt education programmes where communities are encouraged to define the problems and solutions themselves.<sup>71</sup> This should be non-judgmental, non-directive public discussion and reflection.<sup>72</sup> By creating appropriate spaces and opportunities in communities for discussion – where individuals feel safe and confident to share their views – community members can control their own development rather than be the passive recipients of communication messages.

Safe houses enable young girls to receive protection from FGM/C as well as an opportunity to continue their education. They also facilitate a process of reconciliation and reintegration between girls and their families and the community.<sup>73</sup> In isolation, safe houses are unlikely to have a significant impact on ending the practice of FGM/C.

#### **9.5 Providing alternative sources of income**

In several countries, there have been initiatives to educate those who perform FGM/C about the health risks involved and support them in developing alternate sources of income. This can be followed by a public or private ceremony, which may involve circumcisers denouncing the practice and symbolically surrendering their instruments. Although these initiatives have been successful in supporting cutters in ending their involvement in the practice, they do not change the social norms that encourage families to continue to seek out individuals who are willing to perform the practice. Such initiatives may complement approaches that address demand for FGM/C, but alone it does not end FGM/C.<sup>74</sup>

#### **9.6 Challenging community attitudes**

##### *Engaging men*

It is important to work with both men and women to examine their own beliefs and values related to the FGM/C practice in an open and non-threatening way.

Approaches to eradicating FGM/C often target women, but should also include men who may not always have the opportunity to discuss the issue, but have a significant role in the perpetuation of the practice.<sup>75</sup>

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<sup>70</sup>Unicef, 2005b

<sup>71</sup> WHO, 2008

<sup>72</sup> Unicef, 2005b

<sup>73</sup> UNFPA

<sup>74</sup> Unicef, 2005b

<sup>75</sup> Ibid

### *Engaging traditional leaders*

Christian Council of Tanzania believes that traditional leaders act as 'gatekeepers of the practice of FGM/C.'

It is therefore recommended that approaches to address FGM/C target traditional elders so they can change attitudes and help to shape new social norms.

Engaging charismatic local leaders is a key to mass ending of FGM/C.<sup>76</sup>

This is particularly important in Mara Region where local traditional elders are very influential. Former ngaribas, acting as peer educators, can also be powerful agents of change.<sup>77</sup>

### *Gender equity*

As FGM/C is a manifestation of gender inequality, the empowerment of women is of key importance to eradicating the practice. Programmes which foster women's economic empowerment are likely to contribute to progress as they can provide incentives to change patterns of traditional behaviours. Gainful employment empowers women in various spheres of life, influencing sexual and reproductive choices, education and healthy behaviour.<sup>78</sup> Holistic programmes that provide support for a wide variety of community needs, including addressing broader gender issues, are more credible than ones which address only FGM/C or a narrow range of sensitive topics.<sup>79</sup>

## **9.7 Working alongside others**

A number of communities referred to the need for churches to work together. Some communities thought that it was the church's job to take a lead in combating FGM/C. One participant thought it was the job of the church, government and the community to stop FGM/C collaboratively, but it was the church that should lead this response.

It was said that government speaks half-heartedly and does not take an aggressive approach and that, "the church needs to take the lead in showing compassion to these girls." In another community, an opinion leader commented, "the church is the right place to start in that one could weigh traditions in terms of what is and is not acceptable to God."

Many communities referred to the fact that there should be joint efforts by various community groups, including coordination with the government, NGOs and schools. Also emphasised was the importance of interfaith collaboration between Christians and Muslims; their churches and mosques.

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<sup>76</sup>Mackie, 2009

<sup>77</sup>Feed the Minds, 2011

<sup>78</sup>WHO, 2008

<sup>79</sup>Mackie, 2009

## 9.8 Advocacy

Success in promoting the end of FGM/C also depends on the commitment of government, at all levels, to introduce appropriate social measures and legislation, complemented by effective advocacy and awareness. Civil society forms an integral part of this enabling environment. The church should consider working with the media in advocating for the end of FGM/C.<sup>80</sup>

At a national level the church has a role in lobbying for the following changes:

- To amend the Sexual Offences Special Provisions Act 1998 to prohibit FGM/C on women over 18-years-old and to increase the fines. Currently the law applies only to girls under 18-years-old.
- To ensure adequate law enforcement
- Under the current constitutional reform process, ensure that gender equality and the illegality of FGM/C are adequately enshrined in any new constitution
- To strengthen national capacity for improving the quality of health delivery systems and level of education for women and girls, which are needed for sustained change<sup>81</sup> and to strengthen the National Plan of Action on the Eradication of FGM/C. In 2008, the government had “only implemented several activities, including awareness-raising campaigns and participation in training – all sponsored by donors.”<sup>82</sup>



Africa's children need to be released from harmful FGM/C practices.  
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<sup>80</sup>UNFPA, 2007

<sup>81</sup>Ibid

<sup>82</sup>USAID, 2008

## **10. CONCLUSION**

Working to end the practice of FGM/C is clearly sensitive in nature and deeply embedded in cultural practices, beliefs and local community structures.

Any attempts to challenge social norms and support the prevention and end to FGM/C must operate with respect to people and cultures and maintain the dignity of those who have practised it for many years.

The local church is an institution rooted within its community and holds the potential to influence beliefs and attitudes and support behaviour change. In many communities, the church is a trusted entity where people turn to for advice and support.

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

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

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

From the abolition of slavery to the current global call to end extreme poverty, this research evidence has presented a radical new opportunity for the church to once again fulfil its biblical mandate to serve the most vulnerable and to promote social justice in communities.

While FGM/C still humiliates, denigrates and put women's lives at risk on a daily basis, there is an urgent need to unify the local, national and international church to come together to work to end this dangerous traditional practice.

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