Persistence of Female Genital Mutilation in Tarime District, Tanzania

Rygon John Magata[1], Raphael Jettah Ndaro[2] and Immaculate Gillo[2]*

[1]University of Dodoma, P.O.Box 259, Dodoma, Tanzania
[2]Institute of Rural Development Planning, P.O. Box 138, Dodoma, Tanzania

[*]Corresponding author's email:rndaro@irdp.ac.tz

Abstract

The study aimed at assessing the reasons for the persistence of the Female Genital Mutilation (FGM) in Tanzania. The specific objectives of the study were to identify the actual status of FGM in the study area, to identify the efforts done in the study area to eradicate the situation, to explore the major barriers hindering eradication of FGM and to determine the perception of people towards mitigating FGM in the study area. The methods employed to collect data for this study were interview using questionnaires and Focus Group Discussion (FGD) using the FGD guide. Data analysis was done using a Statistical Package for Social Science (SPSS). Descriptive statistical analysis was used in data analysis. Data presentation was done using tables, charts (graphs) and logical statements. The findings from the study indicated that, the campaign against FGM is facing some challenges. Major challenges are the influence of traditional leaders, community influence, influence of traditional circumcision practitioners (commonly known as Ngariba in Swahili) and the parents; the status of traditional circumcision is very high; FGM is supported by households; only few organisations are involved in fighting this problem in the study area. Basing on such finding it is recommended that effective legal measures should be applied by legal authorities to people perpetuating FGM; education to various age groups should be given by all stakeholders; the central government should support the organisations involved in FGM eradication campaign and traditional leaders should be involved in the campaign.

Key words: Female Genital Mutilation, circumcision

1. Introduction

The estimates by World Health Organisation (WHO) and other major united nations agencies shows that about 100 million to 140 million girls and women worldwide have undergone Female Genital Mutilation (FGM) and more than three million girls are at risk of cutting each year on the African continent alone (Harris, 2011; PRB,2010). FGM is generally performed to girls between 4 to 15 years, although it is practiced in some cultures as early as a few days after birth or as late as just prior to marriage (Morjoria, 2010).The practice of FGM is so serous to the extent that there are approximately 6000 new cases every day or five girls in every minute (Morjoria, 2010). Such practices have no reasonable advantages and effectively hinder the full empowerment of women in all areas of society (Amnesty International, 2010). According to UNICEF(2006), FGM is still predominantly performed by traditional female circumcisers using sharp stones, broken glasses, scissors or unsterilized razor blades without anesthesia (Reymond *et al*., 2010). Health officers such as nurses, doctors and mid wives are also increasingly performing FGM (Morjoria, 2010).

In Africa, the FGM is deeply embedded in the culture of many FGM practicing communities and often considered as part of women's identity and as symbol of her membership within the community (Adams and Adam, 2001). In some cultures, for example in Benin; Burkinafaso; Cameroon and Central Africa Republic, FGM is performed as part of girls "coming of age" celebration and it indicates her readiness for her adulthood and marriage (Adams and Adam, 2001; WHO, 2006). In Tanzania, this practice is performed in Arusha, Kilimanjaro, Dodoma, Singida, Morogoro, Iringa, Mbeya and Mara regions where it is estimated that about 18% of the females in these regions are affected by FGM (Mwambasalwa, 2011). The situation is more serious in Mara region especially in Tarime district where the prevalence rate is about 85% (Sengu, 2010; IPPF, 2008). Sengu (2010) found that, between November and December 2010 alone, over 700 girls were mutilated in

Tarime district.

The government has taken some measures to address this problem in the study area through programmes and campaigns. Various initiatives and various groups such as Anti-FGM network(AFNET), Ministry of Community Development Gender and Children Affairs (MCDGC),Tanzania Women Lawyers (TAWLA), Children Dignity First (CDF), Women Woke up (WOWAP) and many other have been formulated in the study area but yet the problems do persist. This study therefore aims at identifying the actual status of Female Genital Mutilation (FGM) in the study area; identifying the efforts done in the study area to eradicate the situation; exploring the major barriers hindering eradication of FGM and determining the perception of people towards mitigating FGM in the study area. It is expected that, the findings from this study will enable decisional makers to improve the strategies against the problem in the study area.

2. Study Area and Methodology

The study was conducted in four selected villages of Tarime district namely Getenga, Nyabitocho, Itiryo and Mangucha. This area was preferred for the study because it is the area in this district where the situation is so serous despite the various intervention carried out to eradicate the problem (Squaire, 2009; Amnesty International, 2010).A cross sectional survey study design was employed to collect data on households using structure and unstructured interview using questionnaires which collected data to 80 respondents. A Focus Group Discussion (FGD) was also used to collect data to some groups of community. Not only that but also, some information were obtained from the secondary source by extraction from official information. Both quantitative and qualitative data were collected from both primary and secondary sources. The respondents were selected by the means of simple random sampling using the Village Registration Book and then the selected respondents were looked for and interviewed.Data analysis was done using a Statistical Package for Social Science (SPSS). Descriptive

statistical analysis was used in data analysis. Data presentation was done using tables, charts (graphs) and logical statements.

3 Results and Discussion

3.1 Demographic Characteristics of Respondents

The results in Table 1 show that, (40.1 %,) of the respondents were of the ages ranged from 14 to 34 years old. About 33.8% of respondents had ages between 35 and 55 and the rest 26.3% had the ages above 55. An equal amount of respondents from either sex (that is 50% males and 50% females were used in this study. In terms of education, the results showed that 35% of respondents had no formal education and the rest had a primary level education and above. For marital status, the results showed that 50% of respondents used in this study were married and the rest 50% were not married.

Table 1: Demographic characteristics of respondents

	Merge				
Characteristics	Gatenga n=20	Nyabitocho n=20	Itiryo n=20	Mangucha n=20	Total
Age					
15-34	10(12.5%)	6(7.5%)	11(13.8%)	5(6.3%)	32(40.1%)
35-44	5(6.3%)	9(11.3%)	5(6.3%)	8(10%)	27(33.8%)
55+	5(6.3%)	5(6.3%)	4(5%)	7(8.8%)	21(26.3%)
Gender					
Male	10(12.5%)	10(12.5%)	10(12.5%)	10(12.5%)	40(50%)
female	10(12.5%)	10(12.5%)	10(12.5%)	10(12.5%)	40(50%)
Education level					
No formal education	7(8.8%)	8(10%)	6(7.5%)	7(8.8%)	28(35%)
Primary	5(6.3%)	6(7.5%)	8(10%)	2(2.5%)	21(26.3%)
Secondary	3(3.8%)	1(1.3%)	2(2.5%)	6(7.5%)	12(15%)
Above secondary	5(6.3%)	5(6.3%)	4(5%)	5(6.3%)	19(23.8%)
Marital status					
Not married	7(8.8%)	9(11.3%)	11(13.8%)	13(16.3%)	40(50%)
married	13(16.3%)	11(13.8%)	9(11.3%)	7(8.8%)	40(50%)

3.2. Status of FGM in the Study Area

3.2.1 Respondent's view on the trend of FGM

Respondents were asked about the assessment on the trend of FGM in the study area. Answers were limited to increasing, decreasing, same and do not know. The results showed that majority of respondents (53.8%) said FGM is still increasing. 31.3%) were of the opinion that the FGM among residents were decreasing; 7.5% were of the opinion that FGM remained the same and 7.5% did not know. The findings further revealed that many of the respondents who reported the increasing rate of FGM are from Gatenga and

Itirya both being villages which are close to kuryas of Kenya who also practice FGM. This tend to correlate with the argument by WHO (2010) which said that geographic vicinity are correlated to the practice or non practice of FGM. It is probable that these communities influence each other in practicing FGM.

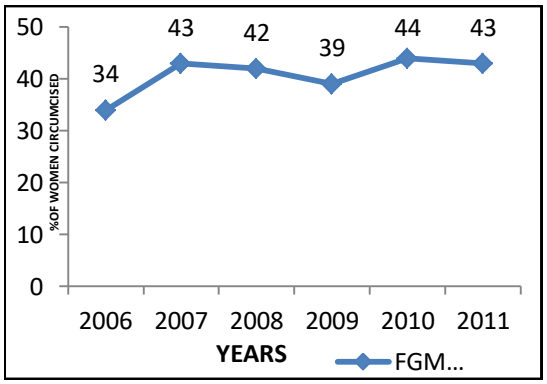

Figure 1: Trend of FGM

Table 2: Respondent's view on the trend of FGM

Response	Village: Gatenga n=20	Nyabitocho n=20	Itiryo n=20	Manguc ha n=20	Total
Increasing	16(19.7%)	8(10%)	11(13.8%)	8(10%)	43(53.8%)
Decreasing	3(3.8%)	7(8.8%)	6(7.5%)	9(11.3%)	25(31.3%)
Same	1(1.3%)	1(1.3%)	3(3.8%)	1(1.3%)	6(7.5%)
Don't know	0(0%)	4(5%)	0(0%)	2(2.5%)	6(7.5%)

These results were also supported by secondary data extracted from Children's Dignity First (CDF) which revealed that, the percentage of women circumcised per year increased from 34% in 2006 to 43% in 2011. The data also reveal that the trend of FGM slightly declined from 43% in 2007to 42% in 2008 and 39% in 2009 and then increased rapidly to 44% in 2010 (Figure1)

The results above confirm the findings by Sengu, 2010 who said, in Mara region, Tarime district has the highest prevalence rate of FGM. Also, the International Planned Parenthood Federation argued that openly and defiantly practiced over among the rural female population in the region (IPPF, 2008)

3.2.2. Reasons for the increasing trend

The researcher was interested to know the reason for the increasing trend of FGM practice in the study area. In this case, key informants were asked to use their experiences in the study area to state the probable reasons which may have led to such trend. The reasons mentioned were marriage prospects,

receiving rewards, preserving virginity, preserving traditions, fear of divorce, weak laws and gaining respects from the people. That is, some people decided to undergo FGM because they were promised to receive rewards from their parents or other relatives in case they succeed in undergoing FGM. This was also discovered during a FGD by victims of FGM where one victim was quoted saying;

> *'Many girls and women who are uncircumcised have no access to resources, status or a voice in their community that is why they submit themselves to undergo FGM.'*

Others performed FGM to secure prospects of marriage. This is because a person who has not undergone through this ritual is considered as a prostitute and hence very difficult to be married. It is believed in the study areas that marriage to a woman who has undergone FGM takes place within two years after FGM. This supports Otoo-Oyortey, (2011) argument that, it is believed to be a bad lack for girls who have undergone FGM not to get married before the next season of FGM

Preserving virginity was also a factor mentioned to lead to FGM. Virginity is believed to be the base of marriageability in the study area and enforces the prohibition of sexual relationships outside marriage. In kurya tribe, a man may refuse to marry a woman who has not been mutilated because it is believed that a woman who has not been mutilated will not be faithful to her husband. During the interview, one of the traditional leader in Nyabitocho said "*a girl is expected to bring honor to her family though the preservation of virginity".* Talle (1993), argue that people in regions that practice FGM believed that FGM ensures fidelity and adds value to bride price.

During interview with one of traditional circumcision practitioner, she mentioned that, "a girl must be mutilated in 7 to 14 years old or just before the onset of menstruation and just before marriage according to the tradition." Furthermore, one of the elder said that an uncircumcised girl has no chance of having a suitor as far as the Kurya tradition is concerned, thus, she must pass through initiation.

According to Moges, (2003) before the initiation through mutilation, girls are kept in seclusion for a period of time (at least 2 weeks) and given instructions on morality, tribal law, social codes, being a good wife, behaviour and their interaction with elders and other age group.

Furthermore, gaining respect was also mentioned as one of the factors that reinforce girls to undergo FGM. Respect of a woman in Kurya tribe is recognized when passed through FGM, marriage and reproduction. This was confirmed by a girl who was a victim of FGM quoted during the FGD who said

> *"Many girls and women who are uncircumcised have no access to resources, status or a voice in their community that is why they submit themselves to undergo FGM."*

This supports the statement by Moges, (2003) who found that respect guarantee a woman to gain economic security and social status and therefore a woman who is not mutilated, without children or unmarried will not be respected and will have very difficult life and devastated old age especially one without any support from their relatives or community.

3.2.3. Campaigns on FGM mitigation

Over years, there have been major efforts in the study area to eradicate FGM. The study identified different organisations in the study area dealing with fighting FGM. Organisations such as African Medical Research Foundation (AMREF) and Child Dignity Fist (CDF) are currently in operation in the study area and have been operating since 2005 and 2007 respectively. The study wanted to know the kinds of activities that are done to ensure that the FGM is eradicated.Table3 shows their responses.

Table 3: Campaigns on FGM

Name of NGO	*Coverage*	*Activities*
AMREF	*District level and study area*	• *Fight against FGM through promoting gender equality* • *Educating and counseling FGM D victims*
CDF	*District level and study area*	• *create awareness on FGM impacts and legal aspects* • *Provide information on FGD magnitude and effects* • *Provide counseling to FGM victims* • *Strengthen cooperation with FGM stakeholders.*

During the interview, one of the AMREF-TUIMARISHE staff, was quoted saying,

> *"Our campaigns have awakened other parties to start campaigns against FGM like peer groups, women organisations and others. However, traditions and customs contribute to unequal gender roles where men are seen as the dominant figure and a women as the inferior part."*

Such statements were also given CDF staff about the performance of a house-to-house campaignthat was quoted saying that;

> *"The house to house campaign was expected that the campaigners should reach every individual in the house, however many people lacked response to campaigns in fearing of social isolation."*

Concerning campaigns on FGM eradication, the study wanted to know from residents the kinds of campaigns conducted in the study area. The study identified three kinds of campaigns namely peer education, village meeting and house-to-house campaign. However, the kind of complain differed from village to village where some kinds of campaigns were more dominant in one are than another (Figure 2)

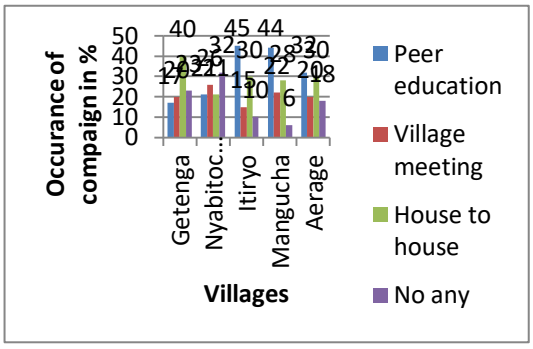

Figure 2: Different types of campaign against FGM in the study area

3.3 Barriers to FGM Eradication

The available secondary data from the study area revealed that, there are some organisations involved in FGM mitigation in the study area. These organisations include African Medical ResearchFoundation (AMREF) operating in the area since 2005 and the Children's Dignity First operating in the study area since 2007. The specific activities performed by these organisations include fighting FGM through promoting gender equality, educating and counseling FGM victims, creating awareness on the nature, effects and magnitude of FGM, enabling women to know their legal rights and strengthening cooperation with FGM stakeholders. Some of the activities are organized through community meeting campaigns.

However, these ca*m*paigns are facing a lot of challenges one most important challenge being poor response from the community. Speaking during interview about one of the campaign organized by CDF and AMREF-TUIMARISHE, one of the CDF staff was quoted in the interview saying *"there is low response from the community in attending our campaigns."*

The study was interested in knowing from the respondents the major barriers to FGM eradication in the study area. The results from the study revealed that 32.5% of respondents said that the people in their community have great influences on other people to involve in FGM. This correlates to what UNICEF (2006) found where they said girls sometimes desire themselves to undergo the procedure as a result of social pressure. Apart from community influence, there was also a substantial percent of people who said their parents influence them to undergo FGM(28.8%) and 27.5% who said the traditional leaders influence people to under goFGM.Traditional circumciser practitioners were also voted as the cause of FGD though with relatively low respondents (11.3%). The presence of traditional circumcision practitioner's influence was also supported by Draege (2007) who found that, the traditional circumcision practitioners claimed that FGM enhances fertility, controls and prevents disobediences of girls and

makes a woman faithful to their husband (Table 4).

Table4: Major barriers to eradication of female genital mutilation eradication

Factor	Village				TOTAL
	Gatenga n=20	Nyabitocho n=20	Itiryo n=20	Mangucha n=20	
Parent's influence	7(8.8%)	5(6.3%)	7(8.8%)	4(5%)	23(28.8%)
Community influence	6(7.5%)	7(8.8%)	5(6.3%)	8(10%)	26(32.5%)
Traditional Circumciser Practitioner's influence	3(3.8%)	2(2.5%)	3(3.8%)	1(1.3%)	9(11.3%)
Traditional leaders influence	4(5%)	6(7.5%)	5(6.3%)	7(8.8%)	22(27.5%)

In a Focus Group Discussion conducted to FGM, victim, some expressed that they engaged in FGM because they saw other peers being mutilated. Others stated that they were influenced by already mutilated women and older women to engage in FGM by being told that, once mutilated, they would be more suitable for marriage, respectable in the village and socially accepted.This correlates to the study by Draege (2007) which found that older women are more likely to support the practice and tend to see effort to combat the practice as an attack on their identity and culture.

In a face-to-face interview with one of the community leader, he expressed his disagreement with the modern views on women dignity and rights where he was quoted saying;

"No one tradition is better than the other, therefore, we would not accept to see any interference from other traditions which would distort the Kuryan culture, the FGM should be a sustained culture. In maintaining the family stabilities the kuryan tradition should start from mutilating a woman."

3.4. Perceptionof People towards FGM Mitigation

The research was also interested in knowing the perception of the community towards FGM mitigation. With regard to this, respondents were asked about their opinion on FGM. The responses were limited into three categories namely; "should be continued," "should be discontinued" and "do not know." The results showed that, majority of respondents (57%) supported the continuation of the practice. However, there was a substantial amount of respondents (39%) who hated this unlawful practice

who said the practice should be discontinued. The rest did not show their position instead they said they do not know what should be done

In village level, the views varied from one village to another. The results showed that many respondents (70%) in Gatenga village were in the views that the practice should continue. In the other hand, many respondents in Nyabitocho village compared to other villages hate the practice and prefer that the practice be discontinued. Other results are as indicated in Figure3.

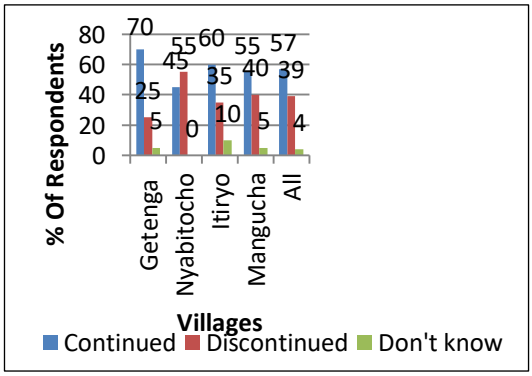

Figure3: Perception towards FGM mitigation

The respondents were asked to judge whether there is a possibility of the people to change because of the existing initiatives. The options were limited to strongly agree, agree, undecided, disagree and strongly disagree. The results revealed that, majority of the people41.3% were of the opinion that the initiatives will not be able to change the attitude of people in the study area. However, there was a substantial number of people 37.5% who argued that there is a possibility of people to change as a results of the current initiatives.Otherresults are as indicated in Table 5.

Table 5: Possibility of people to change

	Villages				
Responses	Gatenga n=20	Nyabitocho n=20	Itiryo n=20	Manguch a n=20	Total N=80
Strongly agree	0	0	2(10%)	0	2(2.5%)
Agree	7(35%)	11(55%)	8(40%)	2(10%)	28(35%)
Undecided	4(20%)	4(20%)	2(10%)	7(35%)	17(21.25 %)
Disagree	9(45%)	5(25%)	7(35%)	11(55%)	32(40%)
Strongly disagree	0	0	1(5%)	0	1(1.25%)
	20(100 %)	20(100%)	20(100 %)	20(100%)	20(100%)

These results reveal that the current initiatives in the area need to be strengthened so that they can bring rapid desirable impacts in the study area. the findings corresponds to the study done by Aliwho said although the government of Tanzania prohibits the practice of FGM under sexual offences special provision Act 1998, its effects in preventing mass mutilation taking place in practicing communities has been low (Ali, 2010)

4. Conclusionand Recommendation

To sum up, the current status of genital FGM in the study area is very high is very high. The FGM is increasing despite being opposed seriously by different individuals and humanitarian organisations.The opinion of many people from the study area is that the current initiatives will not succeed to eradicate female genital mutilation in the study area; Marriage prospects, preserving traditions, and demand of respect in the community are major factors identified as being responsible for the observed status of FGM;The available campaign against FGM in the study area receives several challenges which hinder the eradication of the problem. These challenges include the influence of community, low support from parents, traditional leaders and criticism traditional circumcision practitioners.

In view of this, it is recommended that; basic education could be an effective instrument for eliminating the practice of FGM. Ministry of Education and Vocational Training (MOEVT) should develop instruction units and teaching materials on the issue of various age groups and they should see that FGM; becomes integrated into national curricula and teacher training programmes. Experienced educators and researchers should be involved in drafting issues on FGM; strict legal measures should be applied by legal authorities where necessary in order to give lessons to the culprits who undermine women's right. The authority concerned should stand firm in implementing the laws against FGM; The Central Government should increase itscommitment to support organisations responsible for FGM campaigns with strong policies, funds and relevant resources needed; Campaigns should involve key people like traditional leaders, traditional circumcision practitioners, elders and village leaders in decision making because these people are regarded as the key agents in influencing development in the community; The stakeholders should cooperate, starting from family level (parents and guardians), schools, peer groups, religions, media, and the community at large. The stakeholders should observe that FGM has no positive impact to family, women, the

community and the country at large.

References

Adams, J and Adam, M. (2001). Mama and Nuru (Mother and baby) Pregnancy Care for African women: An Information manual for service providers, Women's Health West, Melbourne.

Amnesty International. (2010), Ending Female Genital Mutilation to promote the achievement of the Millennium Development Goals. Amnest International Ireland rue de Treves,Brussels.

Draege, T.L. (2007). The role of men in the maintenance and change of female Genital cutting inEritrea. Thesis, University of Bergen

Harris, D.M. (2011). Ethics in health services and policy: A Global approach. John Wiley and Sons, North Carolina.

International Planned Parenthood Federation. (2008). Female Genital Mutilation (FGM), IPPF, London.

Moges, A. (2003). FGM-Myths and Justifications, Caldaria Co. Ltd, Vienna.

Mwambasalwa, S (2011). Female Genital Mutilation practices in Tanzania, Mzumbe University, Morogoro.

Otoo-Oyortey, N. (2011). FGM and Child marriage in Tanzania through the Lens of Child Brides, 7th edition). ECT, Madrid.

Reymond,L., Mahamud, A and Ali, N. (2010). Female genital mutilation-the facts. WGF,Nairobi.

Sengu, H. (2010). Report on FGM Fact Finding Mission Conducted in Tarime District. Legal and Human Rights Centre. Dar es Salaam.

Squaire, C (2009). The Social Context of Birth, Radcliffe Publishing, New York.

Talle, A. (1993). Transforming women into "pure" agnates: Aspects of female infibulationin Somalia"In Broch-DUE., Rudie, I and Bleie, T. (Eds). Carved Flesh, Cast Selves: Gender symbols and Social Practices, Oxford, Berg, Vol.15 No83-106

UNICEF. (2006). Tanzania female genital mutilation/cutting: overview of female genitalmutilation/ cutting, UNICEF, NewYork.

WHO. (2006).Female Genital Mutilation. Women in the Middle East, No.43, May and June 2006, Sana'a cited from http://www.angelfire.com/female_fenital_mutilation.html on Nov4, 2012.

WHO. (2010). Science mystery-female Genital Mutilation. Cited from http://www.who.int/mediacentre/factsheets/fs241/en/ on Nov4, 2012