

Community Awareness and Prevalence of Female Genital Mutilation in Ikungi District, Tanzania

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Abstract

Female genital mutilation is a deeply rooted tradition in many countries, including in some Tanzanian communities despite the various advocacy and legal interventions to stop it. This study examines community awareness and prevalence of female genital mutilation in selected villages of Ikungi District using the behavioural change perspective. The specific objectives of the study were 1) to analyse the levels of awareness on the existence of FGM, and 2) to examine prevalence of FGM in the study area. Data were collected from 150 adolescent school girls and 150 parents/caregivers school teachers, local government officials, traditional birth attendants and religious leaders using questionnaire survey, semi-structured interviews and documentary review. Data analysis techniques included descriptive statistics, chi-square test, independent samples t-test and qualitative content analysis. The study findings revealed that community awareness on female genital mutilation was generally high (98%) among both adults and school girls. Female genital mutilation was still being practiced secretly in the area (specifically on girl doddgers), for spiritual, sociological and hygienic reasons. Prevalence rate of female genital mutilation among young girls was estimated at 12% although could be higher in more remote rural villages. It is recommended that the government and other actors should use the available community radio stations to disseminate information to change current cultural notions and practices favoring female genital mutilation in the district. The voice of religious leaders should also be enhanced and supported to strengthen peer group discussions at church and mosque levels because female genital mutilation was not reported to be a religious requirement.

Keywords

Female Genital Mutilation, Awareness, Prevalence, Behavioural-Change

1. Introduction

This paper examines community awareness and prevalence of female genital mutilation (FGM) in selected villages of Ikungi District in Tanzania using the behavioural change perspective. FGM, defined by the World Health Organisation as 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”, is a deeply rooted tradition in many communities [1]. Having its origins in the 5th century B.C. in traditional societies and cultures with patriarchal structures such as ancient Greece, Rome, Egypt and Pre-Islamic Arabia [1] [2] [3], FGM is practiced in many parts of the world, particularly in Africa, Middle East and Asia, mainly for spiritual and religious, sociological and hygienic reasons [1] [4]. It is estimated that about 140 million women globally have experienced FGM and 3 million girls are estimated to be at risk of undergoing FGM each year [5] [6] [7]. FGM has been documented in 28 African countries and a few countries in Asia and the Middle East [5] [8].

FGM is widely considered as an act of gender-based violence as well as a human rights violation [9], a practice which is typically performed on young girls (and, occasionally, female infants or teenagers) in a variety of cultures. It is also performed on women who are about to be married, and even women who are pregnant with their first child or who have just given birth [1] [5] [6]. In Africa, FGM is motivated by beliefs about sexual behaviour and virginity. It is believed to reduce a woman’s libido and, therefore, helps her resist “illicit” sexual acts [10]. In some cultures, FGM is practiced to increase family’s dignity, and bring glory and respect to parents. And after FGM the girl will gain higher status and recognition in the community and be able to marry a rich, respected and caring husband [1] [5] [6]. However, as WHO states, the practice has no health benefits, and it harms girls and women in many ways [10].

Over the last few decades, FGM has gained increased attention in policy and research due to its impact on women’s health, including severe violation of human rights. FGM affects both the physical and psychological health of girls. It is associated with several short-term health risks and consequences, including pain, bleeding, bacterial infection and urine retention. Long-term consequences include: recurrent bladder and urinary tract infections, decreased sexual enjoyment, an increased risk of childbirth complications, newborn deaths and high possibilities of HIV/AIDS transmission [5] [6] [11]. This practice can also impact on the girls’ school attendance and performance, which may ultimately increase the rate of early marriages while reducing the ability of women to acquire high administrative positions, participate in decision making and control/own potential resources.

Tanzania is one such country where FGM is a deeply-entrenched cultural practice in at least 20 of the country’s 120 ethnic groups, especially in the lake, northern and central zones [9]. Studies show that many women in these areas have undergone FGM and are likely to already have at least one mutilated

daughter and would also consider having other daughters mutilated [7] [12]. The 2010 national demographic health survey estimated FGM prevalence in girls and women (aged 15 - 49 years) to be 14.6% [7]. UNICEF shows that Tanzania has FGM prevalence rate of between 10% - 25% [13]. Other estimates show that about 7.9 million women and girls in Tanzania have undergone FGM [14]. However, as WHO correctly observes, because of the sensitivity of the issue, comprehensive data on the number of girls and women affected by FGM are extremely scarce and vary greatly in quality and reliability [6].

At international level, eradication of FGM is considered as pertinent to the achievement of some Sustainable Development Goals (SDGs): SDG 3—Ensure healthy lives and promote well-being for all at all ages; SDG 4—Ensure inclusive and equitable quality education and promote lifelong opportunities for all; SDG 5—Achieve gender equality and empower all women and girls [15]. Since women and girls are the main actors in production, reproduction and family nurturing, in 2012 the UN passed an historic resolution, calling on countries to eliminate FGM [16]. Tanzania has also ratified several international human rights conventions, which provide a strong basis for characterization of FGM as a violation of international human rights. They include: the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; the African Charter on Human and Peoples' Rights; the African Women's Protocol; the African Charter on the Rights and Welfare of the Child [9]. This suggests that Tanzania has a legal obligation, derived from international and regional human rights instruments, to put in place measures to safeguard the rights of women against FGM. Further, the Sexual Offences Special Provision Act of 1998 states that FGM constitutes cruelty to children and therefore, it is a punishable offense [9] [17].

Despite these interventions and legal provisions that criminalize FGM, the practice is still undertaken in many Tanzanian communities. Even though there is a lot of advocacy activities by government and non-state actors to stop FGM in Tanzania, community awareness and prevalence of FGM have not been clearly documented in the academic literature. Studies on FGM in Tanzania have mainly focused on the reproductive health of mutilated women using clinical examinations [12], and legal and human rights issues associated with the practice [9] [17], leaving a gap between theory and practice. This study was, therefore, conducted to examine community awareness and prevalence of FGM in selected villages in Ikungi District in Tanzania. Specifically, the study aimed at: i) analysing the levels of awareness on the existence of FGM in the area, and ii) examining prevalence of FGM in the study area. The study adopted the behavioural-change perspective because FGM is a deeply embedded cultural practice influenced by the “mental maps” which provide people with the direction and the boundaries between men and women, younger and elder, powerful and powerless within a culture [6]. The remainder of the paper is structured as follows. The next section describes the study area and methodology used in this study,

including the design, sample size and sampling procedures, data types, sources, collection methods and analysis techniques. Then, we present and discuss the findings of the study. In the last section, we draw the key conclusions and recommendations emerging from the study.

2. Study Area and Methodology

The data presented in this paper are based on an empirical study which was conducted in Ikungi District in Singida Region. The district was purposively selected because it is one of the areas where FGM is practiced in the country and has been a focus of various advocacy interventions by different organisations including the Christian Council of Tanzania and AFNET to raise community awareness and eradicate FGM in the area. Previous studies have identified the ethnic groups living in Ikungi District and other parts of the Region as among the ethnic groups practicing FGM in Tanzania [9] [12]. Thus, it was important to establish the implications of such interventions on community awareness and prevalence of FGM in the area. The survey was conducted in five selected wards of Mang'onyi, Mungaa, Ntuntu, Makiungu and Siuyu. The study adopted a cross sectional design using mixed methods of data collection, which included household survey, semi-structured interviews and documentary review. Data were collected at a single point in time, which is one of the characteristic features of a cross sectional design [18]. The target population for the study was parents/guardians, adolescent school girls, school teachers, local government officials (Ward Education Coordinators, Health Officers, Police Gender Desk Officers, Ward and Village Executive Officers), traditional birth attendants and religious leaders.

The study employed multistage sampling techniques using a combination of purposive, random and convenient sampling techniques. Purposive sampling was used to select five wards in the district based on prevalence of FGM practice and their location within the district. Within each ward, one village was randomly selected where 30 households and one primary or secondary school was included in the sample. Within each school, 30 adolescent girls/pupils aged between 10 and 21 years were selected. This was because FGM has been integrated in primary and secondary school extra-curricular activities. Purposive sampling was used to select key informants who provided detailed information regarding the study issues as were knowledgeable on the subject matter.

To enhance validity and reliability of the findings, mixed methods of data collection from multiple sources of evidence were used. A survey was conducted among 150 adolescent school girls and 150 parents/caregivers at household level to capture both qualitative and quantitative data using structured questionnaires with both closed- and open-ended questions. Two separate questionnaires were designed and administered school girls and parents/care givers to solicit information on socio-demographic characteristics of respondents, awareness about the existence of FGM and its effects, and perceived prevalence of the phenome-

non in their areas. Semi-structured interviews were held with police gender desk officers, village and ward executive officers, school teachers, health attendants, religious leaders, traditional birth attendants and traditional female circumcisers. The key issues explored in the semi-structured interviews included the extent to which FGM was practiced in the area, type of FGM performed, where, by whom and instruments used, and the available legal, medical or psychosocial support in relation to FGM practice. In addition, relevant documents related to FGM such as previous studies on FGM in study district and elsewhere were reviewed to provide secondary data.

Data analysis techniques involved descriptive statistics (*i.e.* percents, frequencies, minimum and average values, and means), chi-square tests to establish association between variables, and independent samples t-test to test variation on the means. The qualitative data obtained from semi-structured interviews were transcribed and analyzed using qualitative content analysis technique. This involved transcribing the field notes from interviews and reading through the transcripts to identify key themes and patterns relevant to study objectives and questions. Because quantitative and qualitative data are mutually dependent and tend to complement each other, the presentation and discussion of the findings weaves together the quantitative and qualitative data.

3. Results and Discussion

3.1. Socio-Demographic Characteristics of Respondents

The socio-demographic characteristics of respondents and household heads examined in this study survey were sex, household headship, age, household size, education, tribe and religious affiliation. These characteristics were considered important in influencing people's perceptions and practices on FGM. The findings in **Table 1** show that more than half of the household respondents (54%) were females whereas males accounted for 46% of the respondents. Although the plan was to have an equal representation of male and female respondents, it turned out that in many of the households surveyed, it was the adult female members who were found at home at the time their households were visited for the survey, possibly due to the gender roles which mainly confine women to the domestic sphere. Over two thirds of the surveyed households were male headed (69%) and less than one third were female headed (31%). The proportion of female headed households in the study area is closer to the national

Table 1. Sex of respondents and household headship (n = 150).

Variable	Categories	Frequency	Percent (%)
Sex	Male	68	45.0
	Female	82	55.0
Household headship	Male headed	103	68.7
	Female headed	47	31.3

average of 33.5% reported in the 2012 national housing and population census [19], confirming the patriarchal nature of most rural communities in Tanzania.

The average household size in the study villages was 6.5, with male headed households being significantly ($p = 0.008$) larger (household size of 6.9) than female headed counterparts (household size of 5.6). This variation was explained by the fact that more than half of male headed households had more than 7 members (53%) whereas a similar proportion of female headed households (53%) were composed of between 4 to 6 members. Most of the household heads belonged into the 45 - 60 years' age bracket (39%), followed by those with 36 - 44 years and 26 - 35 years (21%). The mean age of household heads was 46 years, although male heads were relatively older (47 years) than female heads (44 years). Further, 63% of the school girls lived with both parents, 17% with single parents (either mother or father), and about 12% with their guardians and/or other relatives.

A large majority of household heads had primary education: 94% males and 85% females. However, more than one tenth of the female household heads (11%) had no formal education, indicating low education attainment among female household heads. This shows that a substantial proportion of women in the study villages were illiterates. In principle, one's level of education has potential impact on his/her decisions, including those related to FGM practices. In Nigeria, for example, WHO reported that 99% of those with secondary education were more likely to have refused FGM for their own daughters than those with less education [4]. In Sudan, Almroth *et al.* found that the level of education played an important role as more of those with higher education (secondary and university) did not want to let their daughters undergo FGM [20].

Almost all household heads belonged into the Nyaturu ethnic group (98%), which is the major ethnic group in the district. Other ethnic groups were Nyiramba, Rangi and Pogoro (Table 2). Impliedly, having most of the household heads belonging into the same ethnic group could mean that have similar social values, traditions and cultural practices as shaped and influenced by society ties and connections. This could have implications on decisions about FGM since communities and families are key players on continuation of FGM as they exert strong pressure on women and girls [1]. Indeed, as the WHO states, decisions about FGM greatly depend on the tribe one belongs to [11]. Previous studies have identified the Nyaturu and Rangi as among the ethnic groups practicing FGM in Tanzania [9] [12].

Further, 45% of the household heads were Catholics, about one quarter were Pentecostals (15%), just over one fifth were Muslims (27%) and 12% were Protestants. This shows that community members in the study area had diverse religious affiliations, thus, were likely to have varied perceptions, opinions and practices about FGM. This is particularly so because religious affiliation is among the sources of information and it builds one's strong beliefs that are unchangeable in any community. In Sudan, Almroth *et al.* established that religious interpretation of FGM was of vital importance in decisions on whether daughters

Table 2. Socio-demographic characteristics of household heads by age.

Variable	Categories	Male headed household	Female headed household	All
Household size	1 - 3 members	9 (8.7)	9 (19.1)	18 (12.0)
	4 - 6 members	39 (37.9)	25 (53.2)	64 (42.7)
	7+ members	55 (53.4)	13 (27.7)	68 (45.3)
	Mean household size	6.9	5.6	6.5
Age (years)	18 - 25	2 (1.9)	2 (4.3)	4 (2.7)
	26 - 35	20 (19.4)	11 (23.4)	31 (20.7)
	36 - 44	23 (22.3)	13 (27.7)	36 (24.0)
	45 - 60	43 (41.7)	16 (34.0)	59 (39.3)
	Above 60	15 (14.6)	5 (10.6)	20 (13.3)
	Mean age	46.8	43.7	45.9
Education level	No formal education	4 (3.9)	5 (10.6)	9 (6.0)
	Primary education	97 (94.2)	40 (85.1)	137 (91.3)
	Secondary education	2 (1.9)	1 (2.1)	3 (2.0)
	Post-secondary education	0 (0.0)	1 (2.1)	1 (0.7)
	Business	3 (2.9)	4 (8.5)	7 (4.7)
Tribe	Nyaturu	100 (97.1)	47 (100.0)	147 (98.0)
	Rangi	1 (1.0)	0 (0.0)	1 (0.7)
	Nyiramba	1 (1.0)	0 (0.0)	1 (0.7)
	Pogoro	1 (1.0)	0 (0.0)	1 (0.7)

Figures in brackets are percents.

should undergo FGM or not. They revealed that more of those who believed in religious support for FGM would undergo the procedure than those who did not [20].

3.2. Community Awareness on FGM

In this study, community awareness on FGM was assessed by asking household respondents and school girls whether had heard about FGM, whether it was practiced in their community, by who, how and why. Almost all household respondents (98%) reported that had ever heard about FGM, with no significant variation between males and females ($p = 0.675$). Similarly, 85% of the school girls had heard about FGM, suggesting that FGM is not a new practice in the study area. For household respondents, the major sources of information on FGM were radio (54%), as reported by 62% and 47% of the male and female respondents, respectively. Over one third of respondents had heard about FGM through churches/mosques (39%) and relatives and friends (36%). A significantly ($p < 0.029$) larger proportion of female (47%) than male (29%) respondents had heard about FGM at churches and mosques, indicating that women

were more likely to be involved in religious activities than men. More female (41%) than male (31%) respondents got information about FGM from relatives and friends, reflecting the fact women have closer ties with relatives and friends within the domestic sphere, thus, serving as sources of information for different issues including FGM (Table 3). Overall, the findings show that most community members, men and women alike, had access to information on FGM through various channels, which could have greatly contributed to increasing their awareness about the practice.

About half of the school girls (49%) accessed FGM information at school, 44% through religious interventions and 39% through radio. This was confirmed by a group of pupils in one of the primary schools visited who sang and performed a drama showing the sources of FGM (ignorance), the person who made the decision for the girl to be mutilated (a mother), the person who conducted the practice of mutilation (*ngariba*), how the anti-FGM champion reported the case to the police, and how the law was enforced in court. This shows that FGM education has been integrated in both primary and secondary school extra curricula activities, thus, has contributed to enhancing pupils and students' awareness on FGM.

Further, over half of the household respondents agreed that FGM was practiced in their area (53%), with a significantly ($p < 0.000$) larger percent of female (72%) than male (32%) respondents. This could mean that either most men in the area were not aware of the FGM practices going on in their areas or were afraid of saying the truth about the practice partly because of the secrecy and sensitivity associated with it [6]. It could also justify the fact that, since women are mostly involved in the care and maintenance of their households within the domestic sphere, they could undertake FGM on their daughters without notifying their husbands. These findings corroborate what was reported by Tearfund

Table 3. Respondents' awareness of FGM and source of information by sex (n = 150).

Variable	Response	Male	Female	All
Ever heard of FGM	Yes	68 (98.6)	79 (97.5)	147 (98.0)
	No	1 (1.4)	2 (2.5)	3 (2.0)
Source of information about FGM	Radio	42 (61.8)	38 (46.9)	80 (53.7)
	Television	5 (7.4)	12 (14.8)	17 (11.4)
	Newspapers	16 (23.5)	18 (22.2)	34 (22.8)
	At school	22 (32.4)	20 (24.7)	42 (28.2)
	At home	26 (38.8)	12 (14.8)	38 (25.7)
	Relatives and friends	21 (30.9)	33 (40.7)	54 (36.2)
	Church/mosque	20 (29.4)	38 (46.9)	58 (38.9)
	Community meetings	18 (26.5)	13 (16.0)	31 (20.8)
Flyers and banners	11 (16.2)	12 (14.8)	23 (15.4)	

Figures in brackets are percents. Percents exceed 100 because of multiple responses.

and the Christian Council of Tanzania in their study in Manyoni district, which found that 54% of the respondents indicated that FGM was practiced in their areas [21].

It was found that FGM is commonly known as “*ihongu*”, “*ukurya*” “*ngo*” and “*kibawi*” and “*irongho*” among the Nyanturu meaning a thing closely related to the gods, the ancestors, who are called “*arongo*”. Most of the respondents (88%) stated that FGM was mainly conducted by traditional circumcisers or “*ngaribas*” (who were normally elderly women). The semi-structured interviews revealed that the position of “*ngaribas*” is often inherited from mother or grandmother to daughter through the generations within a clan, and that they are thought to possess supernatural powers. Viewed from the behavioural-change perspective, it is indicative from the findings that the people who practice FGM share a similar “mental map” that is inherited from one generation to another within the society and that FGM in this community is attached to spiritual and religious reasons [1]. Traditional birth attendants were reported by 11% of the respondents (4% males and 14% females). Also, most respondents opined that FGM is usually carried out at “*ngaribas*” houses (63%) and at home (47%). These findings corroborate the observation by those elderly women in the community and traditional birth attendants are designated to perform this task. Unlike in other countries such as Sudan (67%), Egypt (38%), Guinea (15%) and Nigeria (15%) where medical professionals also perform FGM [22], in Ikungi district, medical professionals were not involved in the practice since it is a cultural practice which is normally undertaken in secrecy. In the study district, FGM was reportedly to be undertaken mainly using razor blades (77%) and special knives (24%). Also, medicinal plants and locally made tools were used though at a lower rate (Table 4). It was also found that, human urine (specifically from a mutilated patient or virgin girls) and medicinal plants (“*ndulele*”) were used as antibacterial cure.

Table 5 shows the reasons for FGM practices in the surveyed area as stated by the heads of households. The major reason for FGM was to fulfill sexual demands as reported by 97% and 89% of the male and female respondents, respectively. Other reasons were to reduce promiscuity among girls (38%) and increase girls’ beauty (30%). Other respondents indicated fulfilling spouse demand (12%), initiating girls into womanhood (11%), and satisfying peer influence. These reasons fall into two of three main categories articulated by WHO in the behavioural-change perspective: sociological and hygienic reasons [1] [4] [6]. Consequently, they seem to indoctrinate society into the practice without explicitly addressing women’s sexuality [1].

3.3. FGM Prevalence in the Study District

The prevalence of FGM was based on self-reporting by asking female respondents whether had been mutilated, who took the decision and who performed it. Additionally, prevalence was measured by soliciting respondents’ perceptions on

Table 4. FGM practice in the area by sex (n = 150).

Variable	Response	Male	Female	All
Who performs FGM	Traditional circumcisers	21 (84.0)	53 (89.8)	74 (88.1)
	Traditional birth attendants	1 (4.0)	8 (13.6)	9 (10.7)
	Doctors	0 (0.0)	1 (1.7)	1 (1.2)
	Nurses and midwives	1 (4.0)	0 (0.0)	1 (1.2)
	Don't know	2 (8.0)	1 (1.7)	3 (3.6)
Where is FGM usually performed	At home	40 (62.5)	26 (34.2)	66 (47.1)
	At health facility	0 (0.0)	1 (1.3)	1 (0.7)
	In bushes	4 (6.3)	8 (10.5)	12 (8.6)
Equipments commonly used for FGM	At <i>ngaribas'</i> houses	46 (71.9)	42 (55.3)	88 (62.9)
	Special knives	18 (28.1)	16 (20.8)	34 (24.1)
	Scalpels	2 (3.1)	1 (1.3)	3 (2.1)
	Razor blades	41 (64.1)	67 (87.0)	108 (76.6)
	Locally made tools	16 (25.4)	3 (3.9)	19 (13.6)
	Medicinal plants	16 (25.0)	7 (9.1)	23 (16.3)

Figures in brackets are percents. Percents exceed 100 because of multiple responses.

Table 5. Reasons for FGM in the study villages (n = 139).

Reasons	Male	Female	All
Reduce promiscuity among girls	25 (38.5)	28 (37.8)	53 (38.1)
Fulfill cultural demands	63 (96.9)	66 (89.2)	129 (92.8)
Satisfy peers influence	7 (10.8)	6 (8.1)	13 (9.4)
Initiate girls into womanhood	9 (13.8)	6 (8.2)	15 (10.9)
Fulfill spouse demand	5 (7.7)	12 (16.2)	17 (12.2)
To be able to deliver a baby	5 (7.7)	9 (12.2)	14 (10.1)
To prevent death of a baby	1 (1.5)	10 (13.5)	11 (7.9)
To satisfy sexual demands	2 (3.1)	9 (12.2)	11 (7.9)
Increase a girl's beauty	20 (30.8)	22 (29.7)	42 (30.2)

Figures in brackets are percents.

the proportion of women and girls mutilated in their community. It was established that 83% of the older women reported that had been mutilated. The prevalence of mutilated women in the study area is significantly higher than that reported by Msuya *et al.* in Kilimanjaro Region of Tanzania, which was 16.6% [12], although the latter study used clinical examinations. In this study, older women were significantly ($p = 0.049$) more likely to have been mutilated than younger ones, reflecting the same finding by Msuya *et al.* that women who had undergone FGM were slightly older than those who had not [12]. For most of these respondents, it was the mother who took the decision of their daughters to

be mutilated (82%), followed by the father (45%), although grandmothers (23%) also played an important role in such decisions. This implies that FGM was a parental decision. In Nigeria, WHO shows that parents are the most important decision makers regarding excision for the girls of the household [4]. In Sudan, the mother was said to be the decision maker in most cases of FGM whereas the father was more involved when there was a decision not to perform FGM [20]. Traditional circumcisers (80%) were the mostly performers of the practice (Table 6), also confirming our findings discussed earlier in this paper.

When asked about their perceptions about proportion of women (25 years and older) in their community who were mutilated, about 62% indicated that most women were mutilated, another 30% said many were mutilated and only about 9% said few women were mutilated. The mean score for this three-point Likert scale question was 2.5 (which was closer to 3.0), thus, interpreted as ‘most women’ were mutilated. There was no significant variation ($p = 0.117$) on the mean scores between male and female respondents, suggesting that both men and women held similar views on this issue. Regarding girls younger than 25 years, 70% of men and 61% of women reported that few of them were mutilated, 17% said many were mutilated and 18% said most girls. A significantly ($p = 0.053$) larger proportion of females (25%) than their male counterparts (9%) reported that many girls were mutilated. The mean score was 1.5, which could be interpreted as “many girls” were mutilated (Table 7).

The findings in Table 7 further show that most household heads (85%) reported that over the past five years few girls were being mutilated, with a significantly ($p = 0.002$) higher proportion of male (95%) than female (77%) respondents. Over one fifth of respondents (22%) noted that more girls were being mutilated than in the past, although few male respondents had this view (5%). The FGD participants narrated that this significant decrease was due to the anti-FGM campaigns conducted mainly by faith based organisations, which led some

Table 6. Prevalence of FGM (n = 100).

Variable	Response	Frequency	Percent (%)
Are you mutilated	Yes	83	83.0
	No	17	17.0
Who took the decision to be mutilated	Father	37	44.6
	Mother	68	81.9
	Grandmother	19	22.9
	Husband	1	1.2
	I don't know	9	10.8
Who performed the circumcision exercise	Traditional circumcisers	62	79.5
	Traditional birth attendants	6	7.7
	Don't know	10	12.8

Figures in brackets are percents.

Table 7. Perceptions on the proportion of women and girls mutilated (n = 150).

Variable	Response	Male	Female	All
Proportion of women (25 years or older) mutilated	Few women	1 (1.5)	12 (15.0)	13 (8.9)
	Many women	23 (34.8)	20 (25.0)	43 (29.5)
	Most women	42 (63.6)	48 (60.0)	90 (61.6)
	Mean score	2.6	2.5	2.5
Proportion of girls (younger than 25 years) mutilated	Few girls	47 (70.1)	49 (61.2)	96 (65.3)
	Many girls	14 (20.9)	11 (13.8)	25 (17.0)
	Most girls	6 (9.0)	20 (25.0)	26 (17.7)
	Mean score	1.4	1.6	1.5
Extent to which number of girls mutilated has increased or declined over the past five years	More girls are now being mutilated than in the past	3 (4.6)	17 (22.1)	20 (14.1)
	No any changes	0 (0.0)	1 (1.3)	1 (0.7)
	Fewer girls are now being mutilated than in the past	62 (95.4)	59 (76.6)	121 (85.2)
	Mean score	1.1	1.5	1.3

Figures in brackets are percents.

“*ngaribas*” to stop the practice and were reported to be assisting in monitoring for FGM issues in their respective areas.

It was further revealed that 12% of the surveyed young girls aged 9 - 21 years had been mutilated. Also, 85% of the adolescent girls confirmed not being mutilated, while 14% were not aware of their status since many girls were mutilated at their tender ages, hence, was not easy for them to recognize their true biological make-up. This reflects the findings by WHO in Nigeria where although adolescence was often the preferred time, in reality, girls could be excised at any age from a few days old to 20 years or more. In Egypt, most women were excised between the ages of 9 and 13 years, usually during national or religious holidays [4]. The relatively lower rate of mutilated adolescent girls could also be associated with the fact that some of them felt embarrassed about their FGM status, therefore, did not possibly tell the truth (after realizing the effects of FGM). This was revealed during the focus group discussion with male respondents who told us that “*it is difficult to find un-mutilated girl teenage in the study area*”. Similarly, FGM practices are now prohibited by law, which might have caused respondents not to say the truth about it. Another possible explanation could be that interventions by different actors to raise community awareness among young girls have had an impact. A study conducted by AFNET *et al.* in Manyoni district reported that 84% of girls aged 0 - 2 years had been mutilated [23]. UNICEF reported a prevalence rate of between 10% - 25% in Tanzania [13].

Information obtained from health facilities and police posts revealed that two FGM cases had been recorded in the surveyed area concerning the mutilated girls at ages lower than five years, within one year before the survey. The key in-

formants indicated that lack of information in relation to mutilation among girls at tender ages was possibly because mutilation was undertaken within families in secrecy. This mirrors what was reported in the national demographic and health survey that, currently, girls undergo FGM at a younger age—with those cut before reaching the age of one year and that FGM was done often in secrecy among some ethnic groups such as the Nyaturu, Gogo and Maasai [7].

4. Conclusion and Recommendations

This study has examined community awareness and prevalence of FGM in Ikungi district. The study findings have revealed that community awareness on FGM, including how it is practiced, is generally high both among adults and school girls. Most community members in the study villages obtain information about FGM through radio, schools, churches and mosques. There is evidence that FGM is still being practiced in the area although most men do not subscribe to this view, partly because of the secrecy and sensitivity associated with the practice. FGM prevalence rate in the area is estimated at 12% although can be higher among young girls and in more remote rural villages where the practice appears to be more prevalent than in small towns and peri-urban areas. In order to strengthen the on-going anti-FGM interventions in Ikungi District and Tanzania at large, it is recommended that the government and other actors should use the available community radio stations and other local media to disseminate information aiming to change current cultural notions and practices favoring FGM in the district. Further, Ikungi District Council should work closely with non-state actors in the fight against FGM, including empowering and working closely with the para legal officers so that they can take a good lead in their current duties. Religious leaders should strengthen peer group discussions at church and mosque levels because FGM is not a religious requirement, but their voice is important in addressing the problem. This study was limited to few villages in one district and used survey methods only. Thus, further research covering more rural districts, and combining clinical and survey approaches should be conducted to clearly understand the phenomenon and draw conclusions and policy recommendations which can be generalizable across the country.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

- [1] World Health Organisation (1999) Female Genital Mutilation Programmes to Date: What Works and What Doesn't: A Review. Department of Women's Health, Health Systems and Community Health, WHO, Geneva.
- [2] Lightfoot-Klein, H. (1983) Pharaonic Circumcision of Females in the Sudan. *Medicine and Law*, **2**, 353-360.
- [3] Slack, A.T. (1987) Female Circumcision: A Critical Appraisal. *Human Rights Quar-*

- terly, **10**, 439-486.
- [4] World Health Organisation (2000) Female Genital Mutilation: A handbook for Frontline Workers. WHO, Department for Women's Health Family and Community Health, Geneva.
- [5] World Health Organisation (2008) Eliminating Female Genital Mutilation. An Interagency Statement by OCHR, UNAIDS, UNDP, UNE-CA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM and WHO, Referring to the DHS and MICS Statistics. WHO, Geneva.
- [6] World Health Organisation (2011) An Update on WHO's Work on Female Genital Mutilation (FGM): Progress Report. WHO, Geneva.
- [7] United Republic of Tanzania (2010) Tanzania Demographic and Health Survey 2010. National Bureau of Statistics, Dar es Salaam.
- [8] TearFund (2013) Country Profile: FGM in Tanzania. [https://www.28toomany.org/static/media/uploads/Country%20Research%20and%20Resources/Tanzania/tanzania_country_profile_v1_\(december_2013\).pdf](https://www.28toomany.org/static/media/uploads/Country%20Research%20and%20Resources/Tanzania/tanzania_country_profile_v1_(december_2013).pdf)
- [9] Yusuf, C. and Fessha, Y. (2013) Female Genital Mutilation as a Human Rights Issue: Examining the Effectiveness of the Law against Female Genital Mutilation in Tanzania. *African Human Rights Law Journal*, **13**, 356-382.
- [10] World Health Organisation (2014) Female Genital Mutilation. Fact Sheet.
- [11] United Nations Children's Fund (2005) Changing a Harmful Social Convention: Female Genital Mutilation. <https://www.unicef-irc.org>
- [12] Msuya, S.E., Mbizvo, E., Hussain, A., Sundby, J., Sam, N.E. and Stray-Pedersen, B. (2002) Female Genital Cutting in Kilimanjaro, Tanzania: Changing Attitudes? *Tropical Medicine and International Health*, **7**, 159-165. <https://doi.org/10.1046/j.1365-3156.2002.00838.x>
- [13] United Nations Children's Fund (2013) Female Genital Cutting/Mutilation: A Statistical Overview and Exploration of the Dynamics of Change. UNICEF, New York.
- [14] United Republic of Tanzania (2013) National Census Statistical Book—2012. National Bureau of Statistics, Dar es Salaam.
- [15] UN Women (2012) Escaping the Scourge of Female Genital Mutilation in Tanzania: a Maasai Girls' School Provides Scholarships for Those at Risk. <http://www.unwomen.org/en/news/stories/2012/11/escaping-the-scourge-of-female-genital-mutilation-in-tanzania-a-masai-girls-school-provides-scholarships>
- [16] UN Women (2014) World Survey on the Role of Women in Development 2014: Gender Equality and Sustainable Development. <http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2014/world-survey-on-the-role-of-women-in-development-2014-en.pdf?la=en&vs=3045>
- [17] Boyle, E.H., Songora, F. and Foss, G. (2001) International Discourse and Local Politics: Anti-Female-Genital-Cutting Laws in Egypt, Tanzania, and the United States. *Social Problems*, **48**, 524-544. <https://doi.org/10.1525/sp.2001.48.4.524>
- [18] Kothari, C.R. (2009) Research Methodology: Methods and Techniques. Second Revised Edition, New Age International Publishers, New Delhi.
- [19] United Republic of Tanzania (2014) Basic Demographic and Socio-Economic Profile Statistical Tables: Tanzania Mainland. National Bureau of Statistics, Dar es Salaam.
- [20] Almroth, L., Almroth-Berggren, V., Hassanein, O.M., El Hadi, N., Al-Said, S.S.E.,

Hasan, S.S.A., Lithell, U.B. and Bergstrom, S. (2001) A Community-Based Study on the Change of Practice of Female Genital Mutilation in a Sudanese Village. *International Journal of Gynecology & Obstetrics*, **74**, 179-185.

[https://doi.org/10.1016/S0020-7292\(01\)00392-7](https://doi.org/10.1016/S0020-7292(01)00392-7)

- [21] TearFund and Christian Council of Tanzania (2008) Singida Female Genital Mutilation Status Report. CCT, Dodoma.
- [22] United Nations Population Fund (2010) A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting, New York.
- [23] AFNET, Christian Council of Tanzania and Africa Inland Church of Tanzania (2010) Working to End Female Genital Mutilation and Cutting in Tanzania: The Role and Response of the Church.
https://www.28toomany.org/media/uploads/blog/tanzania_fgm_report-final_version_low_res.pdf