POLICY BRIEF

PHYSICAL AUTONOMY FOR WOMEN AND GIRLS IN TANZANIA

Introduction

This brief relies on data and findings from the Social Institutions and Gender Index (SIGI) Report 2022, complemented by online literature.[1] Physical autonomy for women and girls refers to their freedom and self-governance over their bodies and reproductive processes. Violence and other harmful behaviors violate women's and girls' physical autonomy both internationally and in Tanzania, with serious consequences for their chances, empowerment, and general well-being. This brief will examine issues of violence against women and girls, including female genital mutilation/cutting (FGM/C), as well as women's reproductive autonomy in Tanzania, using data gathered within the scope of SIGI Tanzania. The brief examines Tanzania's promises and efforts to stop these destructive activities, assesses how common they are across the country, and reveals the crucial role that societal norms and other underlying causes play.

Violence against women and girls in Tanzania

The impact of violence against women and girls on these groups, as well as on society at large, is profound. Gender-based violence against women and girls, which is fueled by power disparities between men and women, includes a wide range of destructive behaviors, such as FGM/C and intimate relationships, non-partner, and family violence, which includes physical, sexual, psychological, and financial abuse. Gender-based violence against women and girls not only endangers their health, well-being, and opportunities, but it also has a substantial negative economic impact.[2] The government of Tanzania has recognized the need to stop violence against women and girls on a global and regional scale, and it has made this goal a top priority in its most recent national action plans.[3]

According to García-Moreno,[4] discriminatory social norms and power inequalities are the root causes of violence against women and girls, a widespread problem with substantial societal and economic implications. The necessity for immediate action is highlighted by its effects on women's health and well-being and its wider societal ramifications.[5] This problem, which is frequently disregarded and tolerated, calls for an all-encompassing strategy that tackles its underlying causes and incorporates response and preventative techniques into several industries. The fact that this problem is an avoidable epidemic only highlights how urgent it is.[6] The necessity for a coordinated effort to put an end to this pervasive type of gender-based violence is highlighted by the high incidence of violence against women and girls, its serious health repercussions, and the infrequency of prosecution and conviction of perpetrators.[7]

Action plans have been developed in Zanzibar and on Tanzania's mainland to end violence against women and girls. The National Plan of Action to End Violence against Women and Children 2017/18–2021/22 on the Continent of Tanzania provides a framework for targeted initia-

tives, such as campaigns to lower the prevalence of FGM/C and enhance the well-being of women and girls. With distinct operational aims for each strategy, the plan, which consists of eight strategies, addresses various topics, including norms and values, safe schools and life skills, response and support services, coordination, monitoring, evaluation, and more.[8] The National Action Plan to End Violence against Women and Children 2017–2022, which is being implemented in Zanzibar, is to establish a thorough framework for the prevention and treatment of violence against women and children. Three objectives are outlined in the plan, all of which were to be completed by 2022: the development of a comprehensive and integrated national response system; the strengthening of prevention programs and services; and the creation of an environment in Zanzibar that is supportive of the protection and empowerment of women and children.[9] Tanzania funds programs and services that support victims and survivors of violence against women and girls to carry out these aims.

A substantial portion of women and girls in Tanzania encounter various types of violence that often overlap

In Tanzania, violence against women and girls is a serious and enduring issue. Women in Tanzania are more likely than males to endure any type of violence, with over half of them having experienced at least one form of it in their lifetime (55 per cent), including both non-partner violence and intimate partner violence (IPV).[10] Both intimate partner and non-partner violence, including physical, sexual, economic, and psychological abuse, affect a sizable portion of Tanzanian women. Furthermore, a lot of women experience abuse in many ways throughout their lives, often from multiple attackers. Women's dread of violence in public settings where they reside is a reflection of the pervasiveness of violence against women. The persistence of these crimes may be attributed to gaps in the legislation on violence against women. For instance, there is currently no legislation that expressly targets gender-based violence against women, and the use of violence against children is permitted.

A significant share of women in Tanzania are subjected to intimate partner violence (IPV)

In Tanzania, violence against women by intimate partners is widespread. Although the number of reported cases of violence is probably underestimated, 23 per cent of Tanzanian women who have ever been in a relationship said they had experienced IPV in the previous year, and 48 per cent of women said they had experienced it at least once in their lives. Comparatively, according to data from the worldwide SIGI, 36 per cent of women in East Africa reported having experienced IPV at least once in their lives in 2019, and 24 per cent reported having done so within 12 months.[11]

In Zanzibar, IPV rates against women are far lower than in mainland Tanzania, even though both urban and rural areas experience comparable levels of this crime. Just 7 per cent of women in Zanzibar reported having experienced IPV in the previous years, compared to 24 per cent of women in mainland Tanzania. Similarly, Zanzibar has a 20 per cent lifetime IPV rate, while Tanzania's mainland has a 49 per cent rate. The incidence of intimate partner violence (IPV) against women differs throughout Tanzania. In 2021, the prevalence of violence has varied from 4 per cent in Mjini Magharibi and Kaskazini Unguja to 7 per cent in Zanzibar, 40 per cent in Mbeya, and 46 per cent in Arusha. The majority of people in the rural Mbulu District of Manyara, where the rate of violence against women over the past 12 months is 37 per cent, believe that high rates of intimate partner violence (IPV) are caused by socioeconomic stress, which includes things like a lack of food and other resources, a decline in household income, and misusing money or property, among other things.[12]

There are many different forms of intimate partner violence (IPV), but the most common ones are physical and psychological abuse. In the United States,

15% of women who have ever been in a relationship claim that their current or past spouse has physically abused them recently

38% have experienced this kind of violence at least once in their lifetime. Regarding psychological IPV

35% of women report having experienced such conduct at least once in their lifetime,

16% of women report having experienced humiliation, threats, insults, or fear from a current or previous partner in the last year.

9% of women report non-consensual sexual activity by their present or previous partner in the last year

16% report having experienced this at least once in their lifetime.

Even though intimate partner sexual assault appears to be less common, it is nevertheless noteworthy.

Younger women are more likely to have experienced intimate partner violence (IPV), especially those between the ages of 20 and 39 and those who have children. The prevalence of intimate partner violence (IPV) among women who have had partners over the past year varies by age group.[13] The greatest recorded incidence of IPV among women aged

30-39 is 30%

which is higher than the incidences among other age groups. Closely behind,

27% of women in the 20–29 age range report having survived IPV in the previous year

On the other hand, the 12-month prevalence rates of IPV are lowest for women in the older age groups (50-59, 60-69, and 70+ years), with rates of 17 per cent, 13 per cent, and 11 per cent, respectively. Compared to women without children, women who have children are also more likely to experience IPV at least once throughout their lifetime. Furthermore, compared to women without children, women who have two or three children are more likely to report incidences of IPV that happened in the previous year.

Factors associated with experiencing intimate partner violence

Women are more likely to experience IPV if they are exposed to other forms of violence, are married at a younger age, or are in a different kind of marriage. IPV is more common in child marriage, and women who marry before turning 18 are more likely to have been victims of IPV in the last years as well as throughout their lifetime.[14]

At least

24% of these women had encountered IPV in the previous 12 months in 2021

and

53% had experienced it at least once in their lifetime.[15]

Prevalence rates were lower among women who married after turning 18, with 35 per cent reporting having experienced IPV at least once in their lifetime and 17 per cent reporting having experienced it in the previous 12 months. Women who are married before the age of eighteen years of age are more vulnerable to intimate partner violence (IPV) due to the age gaps between spouses that are a common feature of child marriages, particularly in sub-Saharan Africa.[16]

Furthermore, women who do not marry before the age of 18 typically have greater levels of education, which could help to explain why married women experience lower rates of

violence, as higher levels of education give them more negotiating power in the home. Additionally, it increases their likelihood of experiencing IPV in the last 12 months compared to women in non-polygamous marriages. According to Vyas and Jansen[17], women in polygamous relationships tend to be more vulnerable since they have less authority and are more reliant on their spouses. There is potential that this finding reflects this phenomenon. Additionally, there is a higher likelihood of IPV among women who experience non-partner violence. Stated differently, women who have survived violence perpetrated by someone other than an intimate partner may be more vulnerable to abuse from an intimate relationship.

A large number of women who report surviving intimate partner violence have been subjected to various types of abuse. About one-third of Tanzanian women who have ever been in a relationship and who have survived IPV throughout their lives, 48 per cent of all women, have only ever been victims of one form of IPV. Stated differently, two-thirds of Tanzanian women who have experienced IPV over their lifetime have experienced two distinct types of violence. More specifically, 32 per cent of survivors have endured two different types of IPV, 22 per cent have endured three forms, and 13 per cent have experienced all four forms of IPV: psychological, sexual, economic, and physical.[18] According to these statistics, a large number of women who are IPV victims or survivors encounter several, possibly overlapping, types of violence throughout their lives.

Many women have experienced multiple forms of abuse

Despite the presence of systems for reporting violence, evidence suggests that violence against women, particularly intimate partner violence (IPV), is still severely underreported in Tanzania. 60 per cent of victims of physical IPV never sought assistance, according to data from a 2005 study conducted in Dar es Salaam and Mbeya[19]. This hesitation stems from the perception that violence against women is commonplace, as well as the guilt and stigma associated with it.[20] 56 per cent and 48 per cent, respectively, of the women in Dar es Salaam and Mbeya who never sought assistance said that they did not do so because they believed that violence was either typical or not serious enough.[21] Though gender-based violence reporting channels are well known, focus group talks indicate that gender-based violence is underreported. This is probably partly because of societal norms that see gender-based violence as normal, even acceptable.[22] The low number of cases of this type of assault in the legal system may be a reflection of underreporting. Only 1091 cases of violence against women and children were prosecuted between 2017 and 2018.[23]

Non-partner violence is also pervasive for both men and women

Non-partner violence, or violence by someone other than the survivors' current or previous intimate partner, is a common occurrence in Tanzania. Numerous men and women have been victims of non-partner sexual and physical abuse.[24] In their lives, 26 per cent of women and 29 per cent of males' report having experienced physical abuse from someone other than their spouse or partner, such as beatings, slaps, kicks, or other physical assaults using various objects. In Tanzania, more men (7 per cent) than women (5 per cent) report having been the victim of non-partner sexual assault[25] at least once in their lives, and roughly 2 per cent of both sexes have been the victims of non-partner rape.[26] Compared to rural areas, a higher percentage of people live in metropolitan areas and have experienced physical and/or sexual abuse by someone other than a partner. For example, compared to rural settings, the rate of non-partner sexual assault in urban regions is substantially higher (9 per cent) at 5 per cent. This could suggest that living in an urban location increases the likelihood of encountering non-partner violence.

Significantly, 26 per cent of Tanzanian women say they have, at some point in their lives, experienced physical abuse from someone other than a boyfriend. The rates of non-partner physical violence vary significantly between Tanzania's regions. For instance, compared to 77 per cent of women in Kaskazini Pemba, only 2 per cent of women in Lindi report having ever been the victim of non-partner physical abuse.

Parents and teachers were the primary offenders of non-partner physical abuse for both men and women, indicating that the incident most frequently occurred during

childhood or adolescence. According to a study conducted in Zanzibar, over 60 per cent of participants thought that instructors at Koranic madrassas and schools used violence against kids.[27] The perception that violence is usual and, therefore, socially acceptable or, at the least, tacitly sanctioned is influenced by violence, especially when it is committed against young people.[28] In fact, according to statistics from Zanzibar, 42 per cent of respondents think that "physical punishment of a child by parents is necessary to raise him or her well."[29] A cycle of violence wherein women experience abuse from an intimate partner may potentially be exacerbated by parental violence.[30] According to the statistics, women were more likely than non-survivors to encounter intimate partner violence (IPV) at least once in their lives if they had witnessed violence from a parental figure. 57 per cent of women who had suffered parental abuse also experienced intimate partner violence (IPV), compared to 47 per cent of women who had not.

A major contributing element to men's propensity for aggression can be their early exposure to violence. Of the 29 per cent of men who reported having been physically abused by someone other than their partner at least once in their lives, the majority (52 per cent) said that their father was the one who did it. A stronger acceptance of violence and a conviction in its legitimacy is probably caused by having witnessed violence done by one's father, who serves as a role model for many children. According to research conducted in Tanzania, men who watched or experienced violence against their mothers as children had a higher likelihood of using violence against other people as adults.[31] Additionally, data reveal that a sizable portion of men in this category reported having been violently attacked by their mothers (43 per cent) and teachers (41 per cent), suggesting that these incidents most likely occurred in childhood or adolescence.

In Tanzania, many women especially experience insecurity in public areas. 38 per cent of people nationwide claim they do not feel safe going for nighttime walks by themselves where they reside. More women than men consistently report feeling unsafe in every region. Women experience this sense of uneasiness at far higher rates than males. Compared to 25 per cent of males, nearly half of Tanzanian women (49 per cent) say they do not feel comfortable going alone at night where they live. Insecurity is not felt the same way throughout Tanzania. While the percentage of men and women who feel frightened varies slightly between rural and urban areas, it is noticeably lower in Zanzibar than in Tanzania's mainland. Regional variations are significant as well. For instance, 6 per cent of women in Morogoro, compared to 75 per cent of women in Singida, 76 per cent in Dodoma, and 78 per cent in Kagera, said they do not feel comfortable going alone at night.

Half of Tanzanian women feel unsafe

There is a noticeable gender difference in the fear of going for a nighttime stroll by yourself, more women than males express concern about potential violence. The possibility of physical attack, robbery, kidnapping, rape, sexual harassment, and verbal abuse are the leading causes of women's dread, with 45 per cent of them identifying violence as their top concern. Only 22 per cent of males, on the other hand, have similar anxieties. Women are particularly afraid of rape (25 per cent) and physical assault (28 per cent), as well as robbery (33 per cent). Regional differences show that some places—like Kagera, where 52 per cent of women feel insecure because they dread being physically attacked—have higher levels of fear than others.[32] Furthermore, in three regions, more than half of the women say that they feel unsafe precisely because they are afraid of being raped.

Tanzanian women primarily fear physical violence

Persistent violence against women and girls is rooted in social norms justifying violence

In certain situations, violence against women is seen to be more socially acceptable and justified. This is frequently associated with women who defy conventional gender norms. Across the country, 59 per cent of people think that a man has the right to use violence against his wife if she cheats on him; 37 per cent feel the same way if they dispute; and 29 per cent concur if she ignores the kids or goes for a new career or line of work without getting his approval.[33] When women defy the expectations of their gender, including those of obedience, such violence may be seen as a kind of retribution. The belief that "real" men should always have the last word

and adhere to restrictive ideals of masculinity are factors that support violence and its social acceptance.

There is little difference in the acceptance of intimate partner violence (IPV) between age groups; older generations tend to accept IPV at lower rates. But even among those 70 years of age and older, 43 per cent still think that there are situations in which a husband has the right to strike his wife. With 52 per cent approval, the 20–29 age bracket presents the biggest obstacle to efforts to alter societal norms surrounding IPV. In general, women are more inclined than males to defend IPV, and having personally experienced IPV is linked to higher levels of acceptance among women. In contrast to those who have not encountered violence (51 per cent), women who have experienced violence are more likely to rationalize IPV (59 per cent) as a sign that violence is becoming more commonplace and may have an effect on reporting and help-seeking behaviors. Understanding and addressing these attitudes across generations is crucial for effective intervention and societal change.[34]

Determinants of attitudes justifying intimate-partner violence against women

Higher education levels are correlated with lower acceptability rates of violence against women, according to the study. Just 23 per cent of those with postsecondary education believed that husband-wife violence was acceptable in some situations. In comparison, 44 per cent of those with secondary education and 51 per cent of those with primary school agreed. At 53 per cent, those without any schooling were the most accepted. Attitudes towards violence are also related to other variables such as wealth, marital status, and the size of the household. The acceptance of intimate partner violence (IPV) declines as household size and wealth rise. Those who are single are more inclined than married people to defend IPV.[35] The survey also reveals sentiments toward women's sexual autonomy, with 42 per cent of respondents disagreeing with a woman's choice of when to engage in sexual activity. As demonstrated by societal norms around forced sexual relations in marriages, this fosters an atmosphere in which sexual violence is not only accepted but also allowed.[36]

Restrictive masculinities promote a cycle of violence against women in Tanzania

Restrictive masculinities that support men's power over women are linked to the high prevalence of intimate partner violence in Tanzania.[37] Traditional assumptions that men should be protectors and breadwinners define these masculinities. In Tanzania, wives are expected to ask their husbands for permission before engaging in any activity; according to 71–84 per cent of Tanzanians, this includes going to the market or engaging in leisure activities.[38] If a woman goes out without alerting a male, 29 per cent of respondents feel that beating her is acceptable. Therefore, not following through could legitimize using violence. 92 per cent of people think that males are the "real" breadwinners, and women who contribute financially contradict these stereotypes. The use of violence to uphold gender norms may be the cause of the marginally higher IPV rates among women in the workforce. This links gender norms, economic empowerment, and IPV prevalence in Tanzania.[39]

Female genital mutilation/cutting (FGM/C)

FGM/C is concentrated in specific regions of Tanzania

In Tanzania, more than 2 million women—or 12 per cent of the country's total female population—have spoken out against female genital mutilation and/or cutting (FGM/C). On the other hand, according to SIGI data worldwide,

38% of women and girls in East Africa experienced FGM/C in 2019.[40]

Tanzania's national average conceals significant regional differences, with FGM/C mostly concentrated in particular areas. While FGM/C is almost nonexistent in Zanzibar, it is most common in northern Tanzania. FGM/C is not practiced in twelve regions of the nation, while it is more common than 30 per cent in six, including Manyara (63 per cent) and Arusha (58 per cent). Moreover, the impact of excision is

noticeably greater on rural women (15 per cent) than on urban women (7 per cent).[41]

Tanzanian women who have experienced female genital mutilation/cutting (FGM/C) show a declining tendency in the practice, with the prevalence declining across successive generations, according to a review of their age profiles. While

20% of women in the country between the ages of 60 and 69 report having had FGM or C, among women between the ages of 15 and 29

this number falls dramatically to 5-6 per cent, suggesting a considerable decline in the destructive tradition. Types 1 and 2 are the most prevalent and are linked to serious health issues. Traditional cutters typically perform FGM/C on young teenagers, frequently at the behest of the affected lady, who seldom makes the decision herself. While the characteristics of the six locations are similar, there are differences in the average age of excision and the principal decision maker. Overall, the results point to a change in favor of giving up FGM/C, highlighting the necessity for ongoing efforts to end this harmful practice.[42]

Discriminatory norms perpetuate the practice of FGM/C and are particularly acute in regions where FGM/C is more common

In Tanzania, 91 per cent of people, on average, including comparable numbers of men and women, agree that female genital mutilation/cutting, often known as FGM/C, should be outlawed as a harmful practice. Regional differences exist, though, with lower percentages of people favoring abandonment in Morogoro and Kaskazini Pemba. FGM/C is nevertheless common in some groups, despite widespread rejection and is associated with ideas about acceptable sexual behavior and marital customs. According to certain communities, FGM/C ensures marital faithfulness, protects virginity, and discourages promiscuity.

94 per cent of Tanzanians surveyed said they would not want their daughters to have FGM or C, a slightly higher rate in Zanzibar than on the country's mainland. The study reports that 79 per cent of people consider the practice a component of traditional customs, demonstrating the practice's rootedness in tradition.[43] However, only 6 per cent of respondents believe that it is required by religion. Discriminatory attitudes in some areas lead to increased rates of FGM/C among women, and prevalence rates are also influenced by willingness to have daughters undergo the procedure. Even though the majority is against FGM/C, views and practices are nevertheless influenced by regional differences and cultural beliefs.[44]

Reproductive autonomy

The freedom of women to control their fertility is emphasized as a fundamental human right, and women's sexual and reproductive health and rights are generally acknowledged in the international community. Women's autonomy in reproductive concerns includes their right to choose how and when to use contraception, give birth, and become pregnant. These skills are essential for women's empowerment, impacting their general well-being and opportunities in work, education, and entrepreneurship. Tanzanian women's reproductive health restrictions are seen as an economic expense since they impede the growth of women's human capital. This section first describes Tanzania's commitment to these rights before going over a number of family planning-related topics, including the use of contraceptives, unmet family planning needs, teenage pregnancy, access to sexual and reproductive healthcare and education, and the availability of abortion services. Evidence supporting the idea that discriminatory social institutions in Tanzania limit women's reproductive autonomy is provided throughout this section.

Tanzania is currently implementing several programs to address issues related to sexual and reproductive health. As with its predecessors, Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) is given priority in the Health Sector Strategic Plan for July 2021–June 2026 (HSSP V).[45] HSSP V's main goal is to improve women's, newborns', kids', and teenagers' health by making health and nutrition services more widely available and easily accessible. Due to the dedication to this objective, the number of health facilities providing these services increased from 3,369 to 7,268 between 2007 and 2019.[46]

HSSP V aims to reduce adolescent pregnancies by improving young people's access to sexual and reproductive health services. In addition, the National Family Planning Cost Implementation Plan 2019–2023 aims to improve Tanzania's family planning information and service availability, demand, and quality.[47] Notably, this plan's strategic targets aim to address social norms that impede the use of contraception and to give young people between the ages of 10 and 24 age-appropriate information and access to contraceptives.[48]

Finally, the Ministry of Health, Social Welfare, Elderly, Gender, and Children. In 2019, Zanzibar listed several strategic objectives in the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategic Plan for 2019–2023 to enhance the quality and delivery of services and advance reproductive health. These all-inclusive programs show a determined attempt to address Tanzania's problems with sexual and reproductive health.[49]

Access to and uptake of family planning among women and men in Tanzania is uneven across geography, age group and other sociodemographic factors

The ability to control the number of children born and the spacing between them is one of the most important aspects of family planning, enabling individuals and families to make well-informed decisions about the size of their ideal family. Women's health, general well-being, and sense of empowerment can all be greatly impacted by their capacity to restrict and control when they give birth. The importance of protecting women's sexual and reproductive health is emphasized in the Maputo Protocol, which is an extension of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

The Maputo Protocol calls on states to protect women's reproductive rights, including the ability to manage their fertility, decide when and how many children to have, and select an appropriate form of birth control. The protocol also highlights the importance of making family planning education accessible (Article 14). In addition, it requests that States parties recognize and defend women's reproductive rights by permitting medical abortion in instances of rape, sexual assault, incest, or circumstances in which the mother's physical or mental health, or the life of the fetus, is in danger due to the pregnancy (Article 14, Section 2). This emphasizes how crucial it is to respect and protect women's autonomy and welfare when it comes to reproductive health issues.

Laws and social norms related to abortion in Tanzania

Abortion is illegal under Tanzania's law

Tanzania's Penal Code forbids abortion, which includes medical personnel as well as women seeking an abortion. According to the Code, a person who intentionally causes a woman to miscarry faces a fourteen-year prison sentence. A pregnant woman who tries to have an abortion on her own may also face criminal charges and a seven-year prison sentence. It is observed that Tanzania has not modified its domestic legislation to comply with Article 14, Section 2 of the Maputo Protocol, so the legal system is not compliant with the Maputo Protocol.[50]

Views on abortion depend on the circumstances

The majority of people in the surveyed area, 96 per cent of men and women, are against abortion being available without restrictions. But when particular scenarios are taken into account, opinions toward abortion become more complex. A sizable majority, 76 per cent in favor of abortion to preserve a woman's life and 79 per cent in favor of it when the fetus is not viable, supports the procedure when either the mother's life or the foetus' viability is in jeopardy. However, support for legalizing abortion in other situations is lower, such as when it comes to protecting a woman's bodily or mental health (25 per cent and 28 per cent, respectively) or when it comes to rape, statutory rape, or incest (26 per cent).

In Tanzania, there is wide variation in the use, methods and sources of contraceptives

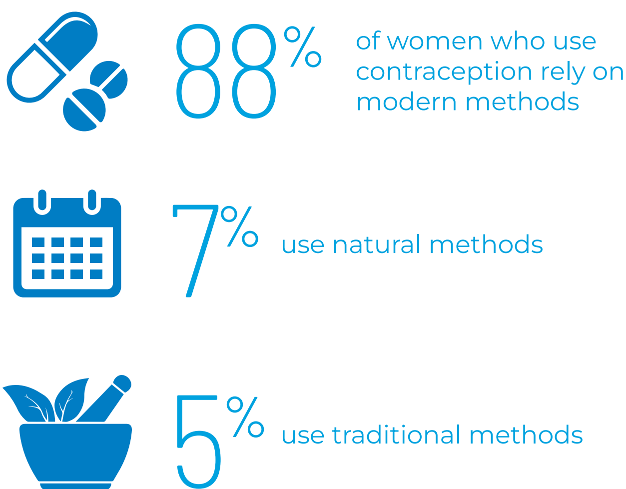
There are some health advantages to using contraceptive techniques. These include minimizing the risks of unfavorable maternal, perinatal, and newborn mortality; preventing

unintended pregnancies; and establishing an ideal child spacing.[51] 31 per cent of adults in the general population say they, along with their spouse, use a contraceptive technique to delay or prevent getting pregnant.[52] The percentage of the population reporting contraceptives in Zanzibar (17 per cent) is significantly lower than the corresponding percentage in mainland Tanzania (32 per cent). However, there have been no changes in this number across urban and rural areas.

Women primarily use modern contraceptive methods

In Tanzania, the majority of women use contemporary methods of contraception, but there is also a large dependence on natural and traditional methods, which are less effective when used regularly. Sterilization, intrauterine devices, injectables, implants, pills, condoms, and emergency contraception are examples of modern approaches.[53] The calendar rhythm method, the lactational amenorrhea method, withdrawal, and other natural approaches are examples of methods. Conventional healers offer conventional approaches. Regionally, places like Kilimanjaro, Tanga, and Singida are more likely to use natural ways.

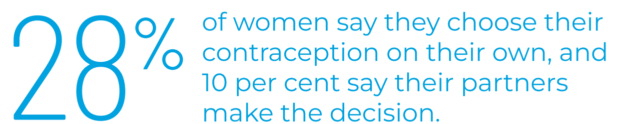
According to research,



Modern contraception is provided mainly by the public sector, particularly hospitals and public dispensaries; 38 per cent of women get their contraception from public centres and 16 per cent from public dispensaries. Young women, especially those in the 15–19 and 20–24 age groups, frequently purchase contraceptives from pharmacies out of concern for social shame and inadequate privacy at health clinics.[54]

In Tanzania,

But males tend to take the lead when it comes to making decisions.[55]



Many women use contraceptives surreptitiously because they feel their spouses are against them and because they have unequal decision-making authority.[56] Around 11 per cent of women who use contraception say their partners do not know about it; among women in their 20s and 30s, this number jumps to almost 15 per cent. The use of covert contraceptives is more common in Zanzibar and urban regions; in Mara and Njombe, it is 31 per cent, whereas in Kilimanjaro and Rukwa, it is less than 3 per cent.

A large share of Tanzanian women, especially adolescent women, have unmet needs for family planning

In Tanzania, 38 per cent of women of reproductive age do not use contraception despite not wishing to have more children or wanting to delay having a child.[57] This represents women's unmet demand for family planning. Sub-national disparities indicate that Zanzibar has a greater prevalence (56 per cent) than Tanzania's mainland (37 per cent) and that rates in rural areas (39 per cent) are marginally higher than those in urban areas (35 per cent).[58] 11 regions have more than a 50 per cent unmet demand, with regional differences ranging from 8 per cent in Mtwara to 74 per cent in Mwanza. Not having a current partner or spouse is the main reason given by 48 per cent of women with unmet requirements for not utilizing contraception. Religious beliefs (3 per cent),

occasional sexual engagement (4 per cent), and worries about adverse effects (12 per cent) are some more justifications. The greatest unmet need is seen in women aged 15–19 and 40–49, reaching 60 per cent in women aged 45–49. The lowest percentage of unmet needs is found in women aged 30-34, at 22 per cent.

More than one-third of Tanzania women have unmet needs for family planning

Three-quarters of Tanzanian women became pregnant for the first time before turning twenty. Adolescent pregnancy was more common in rural regions (35 per cent) than in urban areas (29 per cent), with mainland Tanzania reporting a higher prevalence (33 per cent) than Zanzibar (27 per cent). There were apparent regional differences: nine regions reported that more than 40 per cent of women became pregnant for the first time before turning twenty, while just three areas, Kilimanjaro, Mjini Magharibi, and Tanga, had rates lower than 20 per cent.[59] The proportion of women having their first pregnancy before the age of 20 has increased across all age cohorts, which suggests a rise in teenage pregnancies. In Tanzania, the percentage of women who became pregnant as teenagers increased from 33 per cent among those aged 30-34 to 35 per cent among those aged 25-29 and a whopping 45 per cent among those aged 20-24.

Rates of adolescent pregnancy in Tanzania are high and worsening

Tanzania has made addressing adolescent pregnancy a top priority because of the grave consequences it has for women's and girls' empowerment, health, and education.[60] Adolescent pregnancy has detrimental effects on both the individual and the larger community, as difficulties connected to pregnancy and childbirth are among the world's leading causes of death for teenage girls. Unfit girls run the risk of experiencing difficulties during childbirth, hemorrhaging after giving birth and developing an obstetric fistula.[61] Malnutrition and death rates are also greater in children born to teenage moms. Teenage moms may be shunned and socially isolated, which affects Tanzanian society by undervaluing human capital. Teenage pregnancy interferes with education and skill development, which has a detrimental impact on Tanzania's overall human capital levels and economic empowerment. Compared to women who have their first child after the age of 20, teenage pregnant women had lower educational attainment greater incidence of child marriage, and intimate partner violence (IPV). Perhaps as a result of social guilt, early pregnancy is linked to early marriage and lower educational attainment. Women who become pregnant as adolescents have a higher lifetime IPV prevalence rate (65 per cent) than do women who become pregnant after the age of twenty-one (51 per cent).

Discriminatory social norms and gendered power imbalances restrict women's and girls' physical autonomy

Diverse perspectives on women's reproductive autonomy result from Tanzania's restricted masculinities, which hold that "real" men should control sexual and reproductive decisions. There should be no autonomy for women to choose how to use contraception, according to 37 per cent of respondents; nevertheless, there are notable regional variations, with larger percentages in Zanzibar and other areas.[62] Men are important decision-makers when it comes to reproduction, and 34 per cent of Tanzanian men don't think women should have the freedom to choose how they want to use contraception.[63] Religious convictions have a significant impact on views; for example, some males oppose the use of contraceptives out of fear of marital infidelity and for other religious reasons. Reproductive decisions are also influenced by traditional decision-making procedures, marked by power disparities favoring males. Forty per cent of men disagree that a woman should have the final say over the size of her family.

Adolescent pregnancies are impacted by sexual assault against girls, which is a result of gender inequality and power inequalities. In rural Tanzania, 43 per cent of women started having sex at the age of 14, and 17 per cent of women said that forced sexual relations was their first sexual experience.[64] A little over 39 per cent of respondents—with larger percentages in rural areas—think a girl might become a mother before 18. There were regional differences in the average age at which girls were thought to become pregnant, ranging from 15.0 years in Kigoma to 19.6 years in Morogoro. Just

21 per cent of respondents suggested that a boy should become a father before the age of 18, with a higher average age of 20.2 years for boys to become fathers.

Sexual education can have an important bearing on sexual and reproductive health outcomes

In Tanzania, lowering adolescent pregnancies and addressing unmet family planning needs are made possible through sexual and reproductive education. The percentage of people who have received sexual education is about 55 per cent; women have a greater percentage (66 per cent) than men (45 per cent). There are regional differences: in Manyara, 84 per cent of the population receives sexual education, whereas in four other regions, the percentage is 40 per cent or below. Sexual education impacts family planning knowledge, crucial in determining its utilization. Sexual education is vital for all sexes, yet social standards still view it as exclusively a "women's issue." Sexual education is supported by most people for both boys and girls, but more people (97 per cent) support it for females than for boys (90 per cent). The results of sexual and reproductive health are not ideal because of this notion. The adoption of family planning is severely hampered by misinformation about contraception, especially among males.[65] Health facilities serve as the main resource for sexual education for people of all genders. Women benefit greatly from prenatal and postnatal care, and media and educational institutions also advance public awareness of sex and reproduction. In Tanzania, improving sexual and reproductive health outcomes and enabling informed decision-making requires addressing misinformation and advancing comprehensive sexual education.[66]

Programmatic and Policy Recommendations

Violence against women and girls

- Laws Targeting Gender-Based Violence: Pass laws that expressly address violence against women and girls based on their gender. Make sure that all aspects of domestic violence are covered, including economic, psychological, sexual, and physical assault.
- Extension of the Statute of Limitations for Sexual Harassment: Give victims and survivors more realistic time to file complaints and pursue justice by extending the statute of limitations in sexual harassment cases beyond 60 days.
- Protection from Marital Rape: Make sure that there is clear protection against marital rape in the legal definition of rape.
- Support programs that actively involve men and boys as allies in the group effort to prevent violence against women and girls. This includes initiatives run by civil society organizations.
- Data Collection on Masculine Norms: To assist in creating policies and initiatives that alter popular conceptions of masculinity, frequent data collection on masculine norms is necessary.
- Advocacy Campaigns for Reporting Violence: Create and carry out advocacy campaigns concentrating on gender-based violence to promote the reporting of violent crimes.
- Establish educational initiatives and campaigns against corporal punishment by parents and guardians on their children to change societal norms.
- Ban on Corporal Punishment in Schools: To end the practice of corporal punishment in schools, implement a thorough ban and work with educators and administrators to make this change.
- Encourage programs that take a gender-transformative stance and actively involve men and women in recognizing and questioning gender norms, particularly those that are connected to violence.
- Study on Public Safety Concerns: Conduct qualitative and quantitative research on public safety issues that affect women and girls. Examine and distribute this information to help guide policy conversations on enforcement and infrastructure (e.g., sanitary facilities and public transportation).
- One Stop Center Expansion: Provide additional funding and support to One Stop Centers in every region of Tanzania so they may grow their networks, provide better follow-up services, and improve access.

FGM/C

- Sustained Sensitization Efforts: Persist in and intensify your efforts to educate the public about the harmful effects of FGM/C on women's and girls' health and well-being, as well as the broader societal ramifications of this practice.

- Programs for Raising Awareness in Specific locations: Maintain and Grow Awareness-Building Initiatives in the following areas: Arusha, Dodoma, Kilimanjaro, Manyara, Mara, and Singida. These are the locations where FGM/C is most common.
- Interaction with Traditional Structures: Work together with traditional structures to gradually remove the practice of female genital mutilation/ cutting from customary ceremonies of passage into adulthood. Recognize the important part traditional cutters and midwives play in these practices and include them in the conversation to guarantee a thorough approach.
- Legal Revision for Age Restriction: Taking into account a legal revision that forbids FGM/C for women who are eighteen years of age or older, this revision acknowledges the necessity of legal safeguards to shield adult women from this damaging procedure.

Reproductive autonomy

- Maintain initiatives to raise awareness of sexual and reproductive health issues among the general public, with a focus on adolescents, and to enhance demand for and accessibility to safe, contemporary contraception.
- Reforms to the Abortion Law: Take into consideration updating the abortion laws to conform to global norms, particularly the Maputo Protocol. This includes decriminalizing abortion in situations involving rape, incest, sexual assault, and situations in which the mother's life or mental health is in jeopardy due to the pregnancy.
- The advocacy of family planning services: bolster and broaden family planning programs nationwide, particularly in areas with limited access. This could entail expanding the number of medical facilities offering these services and improving the accessibility and availability of nutrition and health services.
- Resolving Regional Inequalities: Focus on areas like Zanzibar, where unmet family planning needs are more common. Put into practice region-specific measures to address the particular difficulties that women in these communities' experience.
- Programs for Education and Awareness: Establish thorough programs for sexual and reproductive education in communities and schools to guarantee that girls and boys alike are given accurate information. To debunk myths, emphasize the significance of family planning, contraception, and reproductive rights.
- Participation in the Community: Work with religious and community leaders to create a more accepting culture of sexual and reproductive health. Clear any misunderstandings and seek to lessen the stigma attached to using contraceptives.
- Specialized Initiatives for Youths: Create and implement focused initiatives to reduce the high incidence of adolescent pregnancies. This could entail community engagement to alter social norms, comprehensive sex education, and enhanced access to sexual and reproductive health care.
- Taking Gender Inequality Seriously: Put policies into place to combat discriminatory societal norms and advance gender parity. This entails correcting power disparities, empowering women to make decisions, and bringing men into conversations about reproductive health and family planning.
- Improving Access to Current Forms of Birth Control: Provide equal access to a range of contemporary contraceptive techniques, highlighting their superior efficacy over conventional and natural alternatives. Educate people on the advantages of contraception and address regional differences in its use.
- Improving Privacy and Reducing Stigma: Take steps to dispel the stigma attached to using contraceptives, particularly among youth. Enhance patient privacy and confidentiality in medical settings, especially for young people seeking reproductive health care.
- Investigation and Gathering of Data: Invest in research to continuously evaluate the effects on women's sexual and reproductive health of current policies and actions. Gather and evaluate data regularly to support evidence-based decision-making.

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