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LESSONS FOR LIFE—PAST AND PRESENT MODES OF SEXUALITY EDUCATION IN TANZANIAN SOCIETY

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Abstract—The provision of sexuality education and contraceptive services to unmarried adolescents has became a key issue in the era of AIDS. International health organizations are promoting action worldwide. In Tanzania the Ministry of Health has started policy work, while the NGO sector is spearheading activities in the field. Yet there is a lot of public scepticism and resistance to launching such programmes, as many believe that these will promote promiscuity among the young. This article explores the efforts of the Family Planning Association of Tanzania (UMATI), collaborating with the Swedish Association of Sex Education (RFSU), to develop appropriate and sensitive programme activities, drawing on the experiences of other countries as well as on local customs tied to traditional initiation rites. Capacity building involving the provision of techniques for training, research, advocacy and outreach has been the focus of the exchange between the two NGOs. The aim has been to take a broad but integrated perspective on the issue, including an understanding of adolescent sexuality as well as that of reproduction. Most of the data presented here were generated during a follow-up study of the UMATI/RFSU collaboration. © 1997 Elsevier Science Ltd

Key words—sexuality education, initiation rituals, Tanzania, contraceptives

INTRODUCTION

During the 1990s, people in Tanzania have read articles in the local newspapers addressing the increasing problems of early pregnancy, induced abortion and the rapid spread of sexually transmitted disease (STD) and the Human Immune Deficiency Virus (HIV) among young people. Other articles, however, have simultaneously argued against the proposal to remedy this situation by introducing sexuality education in government schools. This, it is believed, will only enhance sexual promiscuity. Finally, at the back pages of some newspapers are announcements of the setting up of "*unyago*" clubs, where parents can bring their daughters to be initiated into adulthood in the "traditional" mode, which provides knowledge about matters of sexuality, body changes, responsible parenthood, and even contraception.

The information communicated in these various newspaper texts demonstrates vividly the complexity and contradictions embedded in the notion of educating young people on matters of sexuality and reproduction in contemporary Tanzanian society. Denial of the fact that young people are sexually active and need information about the risks they run and how they can protect themselves is widespread in Africa as well as in many countries in the West [1]. However, such an approach is judged by many as reprehensible and the call for abstinence as too simplistic.

Sexuality education and provision of contraceptive services to the young and unmarried was one of the most controversial issues at the Population Conference in Cairo in 1994, although it was established that such services should be the *right* of all those who are sexually active [9]. The issue continues to stir controversy and opposition in many countries where agencies are trying to initiate "youth friendly" programmes. As the status of policy and legislation to promote adolescent sexual and reproductive health (SRH) leaves much to be desired and since governments and health ministries have not felt ready to tackle the issue, it is largely the nongovernmental organization (NGO) sector that has made pioneering contributions in this field. Yet, after the Cairo Conference a new awareness of the SRH of young people is motivating research and action in many countries.

This article will explore the efforts of the Family Planning Association of Tanzania (UMATI) to spearhead advocacy and activity in this field and its collaboration with the Swedish Association of Sex Education (RFSU) in order to move both training, intervention and research forward from an interdisciplinary platform. The joint venture has been financed by the Swedish International Development Agency (SIDA).

Sweden is among the few countries in the world which have, through a positive investment in sexuality education in schools and the setting up of special "youth clinics", managed effectively to cut down teenage conception and infection rates during the past decades [3]. This has been made possible by a liberal legislation and government involve-

ment, enabling activities to be taken "to scale". Sweden and other Nordic countries have for some time actively supported the development of policy and action in the field of adolescent SRH via international organizations like the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF) or NGOs in Third World countries [3, 4].

The need to problematize the meaning and function of sexuality education, and the limits and possibilities in sharing models and experiences across socio-cultural barriers will be explored in the article. The exchange between the two family planning associations UMATI and RFSU, with very different points of departure for work, is pioneering. Medical personnel have worked in close conjunction with social workers and scientists. The collaboration has recently been the object of a follow-up study, taking a participatory, reflexive stance. This article reflects some aspects of that study, which was conducted by the author in collaboration with the Research and Evaluation Office at UMATI as well as other staff involved in youth programming.

Before we elaborate on the nature of the collaboration between the Swedish and the Tanzanian organizations, let us start off by delineating the sexual and reproductive health situation of young people in Tanzania today, including the status of policy and legislation to promote it.

THE CHANGING CONDITIONS OF ADOLESCENT SEXUALITY

In the last few decades major changes have taken place which have had an impact on the *expression of sexuality* and its consequences for adolescents and youth. On the whole, the experience of young people today is different in many ways from that of past generations. The world is rapidly urbanizing, especially in developing countries, with many more young people living in unstructured and impoverished conditions. The explosion of telecommunications across cultural boundaries and the increase in travel, tourism and migration also appear to be influencing the sexual behaviour of young people by providing models, pressures and opportunities for sexual encounters [5–9]. The family is in noticeable decline, the prevalence of the extended multigenerational family of traditional societies increasingly giving way from nuclear to single-parent and the no-parent families of street children. Furthermore, marriage has been delayed as demands on education have increased. This multitude of factors exerts greater pressures on young people to engage in sexual intercourse before marriage than in the past [6, 10].

In Tanzania, in urban as well as rural areas, the context of adolescent SRH has changed dramatically. Country specific data confirm that the SRH of young people is vulnerable. Figures show a *high degree of sexual involvement* among the young. Leshabari [11], for instance, shows that 61% of boys and 35% of girls aged 14 or younger in primary schools in Dar es Salaam are sexually active. Other data indicate that early pregnancy is a leading cause of dropping out of school for girls in primary and secondary school [12]. Some studies also indicate that the level of reproductive knowledge is low [11]. In a study by Kapiga *et al.* [13] teenagers comprised 54% of those who induced abortions (see also [14]). Data from blood donors indicate that there is rapid increase in HIV infection among adolescents. In the 15–19-year-old age group, for instance, prevalence rose from 0.0% in 1988 to 7.9% in 1989. Evidence shows considerable rates of transmission even before the age of 14 years [15, 16].

Other studies indicate that there is *disparity of age* of sexual partners between young men and women in Tanzanian society. Analysis of available census data by age and sex shows quite a wide variation between the proportion of married girls and boys [17]. In 1988, for example, only about 4% of boys aged 15–19 years were married compared to over 29% of the girls in the same age group. This variation suggests that courtship for marital purposes involves girls and older male partners. Consequently, variations by age and sex in extramarital or premarital sex may be reflecting this phenomena. Indeed, many sexually active girls report having older, working men as sexual partners, popularly called *Mshefas* or "sugar daddies" ("those who provide") [6, 7, 9, 12]. This is particularly true in urban areas. Obviously *economic gain* has to be acknowledged as having an impact on the courtship behaviour of adolescent girls. There is also evidence of a tendency to have multiple sexual partners among 13–19-year-old girls as well as boys [12].

Traditional mores and structures as well as *rituals of initiation* into adulthood which once functioned as systems of sexuality education have been widespread in East and Central Africa. However, today such rituals of initiation have disappeared in many societies, and in others they are only practised in fragments. They have lost their meaning and function as a mode of initiation in most socio-cultural contexts [6, 10, 18, 19]. The content of the original messages about responsible parenthood and what it entails to become a sexually active adult has been diluted and is no longer relevant to adolescent change in present-day society, as we shall explore later. However, these institutions have not been effectively replaced and today young people are being fed with conflicting values, no clear guidance on standards of behaviour and little information about matters of SRH. Peers, not parents, are the most important source of knowledge, but young people's perceptions are coloured by myths and misconceptions and are often mislead [6, 12].

Such changes have made the prevention of pregnancy in adolescence as well as STDs more urgent than ever before. The consequences of not taking adequate action to help the young include not only the *biomedical hazards* associated with too early or unwanted pregnancies and childbirth, induced abortion often in dangerous circumstances and STDs including HIV infection leading to AIDS, but also severe impact on the *psychological and socio-economic* development of individuals, their families and society as a whole.

It is in this context that the Tanzanian debate on the form and content of *sexuality education* should be understood. While the need for action has become more widely acknowledged in Tanzania as well as in many other countries, effective programmatic approaches to meet these needs are lacking. One reason is that such activities impinge upon some of the most sensitive issues of human experience, adolescent sexuality, the balance of power in decision-making between young people and adults, gender differences in sexual behaviour and relationships, and ideals of human development. These are part of deeply held value systems of every culture and have considerable influence over the provision of information and services to young people [20].

The *family planning services* in Tanzania have, until recently, not catered for the needs of youth. Those unmarried have not had the right of access to such services and young people have had to seek alternative solutions to their SRH needs, often clandestinely and through the informal, private sector. However, the Ministry of Health issued a new *National Family Planning Service Policy and Guideline* in 1992. Here it states that adolescents are eligible for contraceptive information and service when appropriately counselled. Although this is a step in the right direction, the policy has as of yet not been adequately disseminated to the relevant health workers—the adolescents themselves are not aware of it. Furthermore, the Ministry of Education is currently promoting a new Family Life Education curriculum. Presently it is being implemented on a pilot basis in a few schools, but the idea is that it will be launched nationwide. The reality of the sexual and reproductive behaviour of youth and the need for preventative measures is, then, increasingly being acknowledged by different authorities. But there is still a lot of fear of cultural and religious resistance among the majority of institutions working with adolescent development.

A major effort to make room for adolescent specific activities and services has all along been taken by UMATI. This NGO has for over a decade championed "responsible parenthood education" for youth in spite of opposition and lack of a conducive atmosphere. Since 1985, they have been running a centre for girls who have "dropped out" of school because of pregnancy, a centre which has generated a lot of attention and created debate about the need to change legislation. They have also conducted research on adolescent SRH issues [2, 15, 21, 22] and compiled a bibliography on adolescent SRH research in Tanzania [23]. This information work has served as a base for their intervention activities and influenced policy-makers in Tanzania in a positive direction.

SETTING UP A PARTNERSHIP OF EXCHANGE

The Family Planning Association of Tanzania has been in a leadership position of the family planning movement in Tanzania since its establishment in the 1950s. It has spearheaded work in sensitive and controversial fields. With the changing conditions of SRH in the country and the energy of a whole new generation of leaders in the secretariat, UMATI is ready once again to meet new challenges and pioneer new activity. In accordance with the Vision 2000, the strategic action plan of IPPF (International Planned Parenthood Federation), of which UMATI is a member, it has set up *youth and their access to SRH information, education and contraceptive services* as a new priority area.

Aware of the opposition to such a proposition, UMATI has consequently argued that there is no evidence that sexuality education should actually enhance promiscuity. Indeed, the WHO [24] recently analysed 35 studies of sexuality education programmes in schools around the world which support UMATI's argument. The analysis concluded that sexuality education does not lead to earlier or increased sexual activity. Of the 35 studies cited, 16 found that the onset of sexual activity among youth was delayed with sexuality education, and among those already sexually active there was either a decrease in the extent of sexual activity or an increased use of "safe sex" practices.

In order to get inspiration, advice and feedback about how to enhance work with youth issues, UMATI has intensified its collaboration with RFSU. The latter has played a key role in developing sexuality education and the access to services in Sweden since the organization started in the 1930s. It has also worked actively to promote the right to abortion.

The two organizations have set up a plan of collaboration involving exchange in experiences within training, project implementation, Information Education Communication (IEC) and evaluation/research. An intense dialogue about media and methods for reaching out to young people has now been ongoing for some years. Study visits have been arranged to the respective countries. Staff from UMATI have visited Swedish youth clinics, peer education projects and studied information campaigns to promote condom and "safe sex" practices. They have gained insight into how RFSU started out on a pioneering basis and over the years gained support from local and central government that

enabled sexuality education to become a compulsory subject in schools and youth clinics to be opened in every region of the country.

Swedish staff travelled to Tanzania to discuss and study the local conditions for dealing with sexuality and reproduction, as well as the "public" context for working with the provision of sexuality education and services to young people. What sort of Swedish experiences could best be shared with Tanzanian colleagues in a context where the form and content of sexuality education created so much heated debate and opposition?

As a point of departure, it was important for all parties involved to acknowledge that sexuality education is neither a new nor a foreign phenomenon to Tanzania since traditional societies have long been regulating sexuality among the youth.

REGULATING SEXUALITY IN TRADITIONAL SOCIETY

In the past many ethnic groups living in the East and Central African region had mechanisms tied to initiation ceremonies and circumcision, to regulate the strong sexual desires of adolescents in their societies and integrate youth into the local "moral order" [6, 10, 19].

Sexuality and sexual development carried special religious and mythic significance for different reasons, e.g. the communities saw sex as a source of supreme pleasure, as a source of life and the ability of individuals to reproduce themselves and the community to perpetuate itself. Indeed, symbols and metaphors for fertility, a reflection of the deep-seated desire to reproduce, permeate African cosmologies of life [25]. Furthermore, sexuality was regarded as a source of relations, of kinship and affinity, thereby as the basis of solidarity, reciprocity and cooperation. However, sexuality was also seen as a destructive force. Out of control it could endanger a whole society, cause emotional disturbance, spread physical infection, sow social discord, hate and envy. Recognizing the potential of sexuality for harm as well as good, traditional communities organized their patterns of behaviour to minimize risk and maximize pleasure [19] (p. 55). The communities then developed rules of behaviour and mechanisms for "control" which could balance the creative and destructive aspects of sexuality. Each group had its own elaborate code of when, where, and with whom one could have sex. Those who conformed were often rewarded and esteemed, while those who did not were regarded as dangers to themselves and society and even punished.

To impart appropriate codes of conduct on the young generation to prepare them for woman- and manhood, many communities had a clearly defined content or curriculum and a set form, a methodology, for going about this. During different stages of development these could include more informal "learning by doing", but at the onset of puberty and maturation the initiation ceremony was used containing elements of song, dance and seclusion. Rites of initiation marked the climax of training in gender roles. In Tanzania such rituals are generally referred to by the Swahili terms *Unyago* and *Jando*. *Unyago* is the initiation rites of women, and *Jando* that of men. Traditionally, they were performed separately, each accentuating the particularities of female and male roles, respectively.

The significance of the rituals was magnified by detailed ritual procedures, e.g. the use of pottery figurines, shaving hair, washing bodies and putting on new clothes to symbolize the initiant's new identity and new roles. The ultimate dramatization was/is demonstrated in many ethnic groups by physical operations or mutilations such as circumcision. Dominant cultural rules were transmitted including the meaning of sexual activities and the implication of marriage, gender specific roles, responsible parenthood, procreation, spacing, unwanted pregnancy and sexual skills.

Such initiation rites have taken on different forms depending on the socio-economic and cultural context and the organization of the group. Among matrilineal groups in particular, where women have some political and economic power, and the polarization between men and women is not so great, it has been a legitimate social objective to maximize pleasure. In initiation rites the use of amulets, perfumes, massages, fondling, wearing beads and belly/waist dancing was consequently taught to adolescent girls. However, marriage was expected soon after initiation and was the approved mode of mating. Premarital sexual experimentation was seldomly encouraged.

Among other groups, notably patrilineal societies, where the roles of men and women are very differentiated, taboos often defined women as polluted and polluting. The sexual relations in such society are often more strained and premarital relationships marked by prudishness and rigid prohibition. Female circumcision has often been undertaken, a practice which is associated with the curtailment of female pleasure, and a mechanism whereby men controlled women. Male circumcision, which has been practised among various groups, does not have the negative implication on pleasure as that of female circumcision.

Sexuality education through initiation did then entail fundamental lessons about sexual expression itself or the range of socio-economic skills, roles and responsibilities demanded. In other words, ethnic communities educated their children about sex in the holistic context of education about life, preparing them *for* life.

In the *Unyago* ritual, performed for young girls, the key figure is the female instructor, referred to as *somo* in Swahili, meaning ceremonial leader. This woman becomes her initiant's advisor from puberty throughout her married life, instructing her in all

the practical and magical details of the care of her husband, as well as other marital and fertility matters. She is also expected to help deliver her initiant's first child [6, 26, 27].

The *somo* is always a person with some distance to the girl initiated. She can never be a parent, as it is taboo for mothers to advice biological daughters on intimate matters of sexuality and reproduction. Indeed, the *somo* is usually recognized in the community as knowledgeable and has charismatic leadership qualities. She is often an older woman with child bearing experiences. During the initiation rite, which can be held for individual girls or for a collective, the *somo* will explain that the menstrual cycle is a sign of fertility and a blessing of God. She will teach the girl how to wash herself and how to use the menstrual cloth, and that all people have "private parts" which are gifts from God. These, she is told, must be respected and only used with his permission in marriage. The girl is made to understand that she is grown up and that sexual intercourse can result in a pregnancy. She is told that the main method to avoid pregnancy is abstinence. Other methods may also be explained. She is urged to control her sexual lust and advised to keep herself busy with work, and told that a good girl is expected to marry and only bear children after marriage [6, 27].

The *somo* instructor organizes and leads the ritual and everything is done after her directives. The girls are instructed on female duties through the medium of songs, dance, storytelling and different exercises. The songs often have hidden metaphorical meanings, but the act of sexual intercourse may be demonstrated dramatically in a hip dance [6]. Mockery and punishment are also used to rid the girl of bad manners and habits. The "wild" sources of sexuality and fertility are literally domesticated to functions in an ordered social world. The ritual usually entails a period where the girl is removed from everyday activities and isolated, after this period of "liminality", to be reincorporated into society in her new status as a mature, socially "adult" woman.

The initiation ritual is still a mechanism for defining womanhood in some contemporary societies in Tanzania. However, these are, as we mentioned earlier, rapidly loosing ground. Some elements are being abandoned, and the rituals generally fail to accommodate new social needs. As they are practised today, they often embody contradictory messages. On the one hand they provide instruction on sexuality, but on the other they insist on abstinence. Yet the marriage of young people is delayed in contemporary society because of their increasing engagement in schooling and income generation. As a result, the interval between puberty and marriage is growing larger and so is the period when young women are expected to abstain from having sexual relations.

Fuglesang [6], in her study from Lamu town on the East African coast, illustrates how abstinence has become an increasing problem as girls and boys interact more freely. Here young girls dance the erotic hip rolling dance (*chacatcha*), originating in *Unyago* initiation at wedding festivities for the young unmarried girls of the community. Through the dance they are constantly reminded of the erotic potential of their bodies, while at the same time they are told to deny it when mingling with men. That young women today have "sweethearts" before marriage and engage in sexual experimenting is an acknowledged fact in Lamu as it is in many other places.

Sometimes the practice of initiation rites may become distorted. In Lindi town in Tanzania, for instance, villagers have not been allowed to take young girls out of primary school for the customary three-month initiation ritual. School vacation is not sufficient time so the local response has been to initiate the girls before they start school, at the age of six and seven, i.e. before puberty [28]. What impact this may have is unclear, but it is obvious that the girls are too young to comprehend much of the meaning of the initiation, and it may prematurely encourage them to take an interest in sexual activity.

Where the rites of initiation have withered away, young girls do not receive any systematic instruction from reliable adults. The taboo for mothers to talk of sexuality with their daughters is still upheld, and aunts and grandmothers are not always accessible anymore. The fragmentary information they acquire comes from their peers and from the media. However, studies show that most parents are in favour of sexuality education for their children, but they want someone to conduct it for them, i.e. as in the past [29]. An interesting example of a conscious attempt to reintroduce the initiation ritual and make the traditional mode adaptable to the modern context is the following. A traditional female healer in Dar es Salaam set up contemporary *Unyago* clubs in the urban setting, placing advertisements in local newspapers to get customers. Ntukula [27] (p. 117) describes how the woman collected data from various ethnic groups on the need to improve initiation for girls. Parents with daughters who had had their menarche were encouraged to register their daughters at the club. Here a group of girls is instructed, each in accordance with her traditions and customs. The function of the club is, according to the healer, to teach girls at puberty, or brides-to-be, the function of the body and various problems related to reproductive health. Included is the meaning of puberty in relation to reproduction and various cultural taboos related to sexuality, as well as appropriate gender roles. Moreover, they are taught various means of fertility regulation, modern as well as traditional, and cautioned on their side effects. However, this instruction of contraception

depends on the wishes of the parents. AIDS and its effects are also incorporated in the teachings at the clubs.

INTEGRATED APPROACHES TO SRH IN THE PAST AND THE PRESENT

It is evident that launching systems of sexuality education and mechanisms for distribution of contraceptives in contemporary Tanzanian society has much to learn from the mode and content of such traditional systems. Much of what is proposed nowadays is very technical and biomedical. Regulation of SRH has been removed from its socio-cultural context and the realm of the community and family, to that of the state. This, for instance, is the case with much of the curriculum being developed for schools. This type of education, some argue, leaves gaps unfilled because social values, the personal and psychological, and a range of information about SRH are not covered.

Much can then be gained from the traditional approach, which is both more comprehensive and more community-based. It can be conducive to make contemporary efforts to educate young people more acceptable and meaningful. However, interest in the traditional modes, their contemporary form and their potential use in intervention is just emerging.

The Family Planning Association of Tanzania should be applauded for their early attempt to make use of past experiences. In 1960, the association published a book on sexuality education which they called *Unyago na Jando*, linking it to a past of tradition. However, at that time the book was banned by political and religious forces in the country as it was deemed inappropriate. Today, however, the atmosphere is much more conducive to such an approach. To recreate some of the mechanisms and insights which were so significant in initiation rites and so much more than just providing fragments of information has, then, become the challenge. Basically, one can say that the broad perspective, taking an integrated approach to reproductive health, including sexual health, identity development and addressing a range of vital related health and psychological needs, is very much in tune with the contemporary international debate on the need for an integrated approach to SRH. This has been proposed by SIDA, IPPF, WHO, and other international health agencies. Such an integrated perspective has been missing in the approach of many family planning associations, including that of UMATI. In Swedish sexuality education, this perspective has been the ideal of trainers as well as practitioners, although in practice it has not always been possible.

To problematize the need for a broad, integrated SRH approach and what this means in practice, UMATI and RFSU defined the need for *training* as a good starting point for their collaboration around issues of adolescent health. As UMATI was launching the community-based project "Youth Family Planning Services through Peers", in nine regions of the country the timing was appropriate.

Indeed, different categories of staff in UMATI expressed felt needs for counselling and interpersonal communication skills. The staff needed a more profound understanding of the specifics of not only the physiology but also the *psychology* of adolescent sexuality. They also needed a better *self-knowledge*, that is, insights into their own attitudes and values towards sexuality, the role of women and men, abortion, AIDS, etc. Finally, they need the ability to understand and get inside another person's situation, to learn to listen and talk about matters involving sexuality and living together. All of this would enable them to meet young people in a non-judgmental, positive way.

A series of training seminars was planned jointly by the two organizations. Professionals—a midwife, a nurse, a social worker and a psychologist—engaged in training in Sweden travelled to Tanzania twice for 14 days to hold these training seminars with local counterparts.

Techniques such as role play and group work which have been used extensively in training in Sweden with considerable success, and which were not so common in Tanzania, became key methods in the set-up. The mode of working was applauded by many of the participants who were not used to taking such an active part of training seminars or being encouraged to draw on their own personal experiences and feelings. Exercises like writing words for sex organs, whether formal, technical, slang or plain taboo on the board and explaining the way such phenomena are constructed in language were extremely useful. Making papier maché models of penises to be used as dummies for condom demonstration was also experienced as mind boggling, particularly by some of the women. The presentation and exploration of Swedish training techniques were, according to the follow-up study, experienced as very stimulating and thought provoking for many of the participants. One person said that a curtain was removed from over his eyes and he felt so relieved to talk of sexuality in such a natural, everyday way, as it is always there behind all the jargon of family planning.

However, not all the Swedish techniques were judged to be appropriate to use in the Tanzanian setting. It was stressed that it would be up to the UMATI staff to "translate" and make use of what they felt could work in their local field contexts.

CONDUCTING A FOLLOW-UP STUDY

Of the UMATI staff who participated in the training courses, nine were in charge of coordinating and training groups of peer counsellors in the

age group 17–21 in the project "Youth Family Planning Services through Peers". These, in their turn, councilled their peers (aged 13–19) on matters of SRH, distributed condoms and foam pills and referred STD clients to "youth friendly" services. At their disposal they had a series of information leaflets on various youth SRH issues to facilitate their work. The project is set up after the "CBD model", i.e. community-based distribution, in which UMATI has long-term experience.

There was a felt need by RFSU and UMATI to conduct a follow-up study after the project had been operating for about a year. This was to be participatory and involved the project coordinators, as well as the young people targeted. Feedback about how the project was running was needed, but also qualitative data on predominant value systems, meaning structures and nuances of the behaviour patterns of young people and the social relations which prevail in local "youth cultures". Such data could complement the knowledge, attitude and practice (KAP) studies which had been carried out before the project started, but which turned out to be of limited use for a more in-depth understanding of the situation of young people in the project sites. The qualitative follow-up study also served as a capacity building endeavour, as UMATI's Research and Evaluation Office did not have much experience or competence in carrying out such studies. Insights about the conditions of the youth were needed so as to enable UMATI and RFSU to improve intervention and deepen their understanding about what activities to plan for in the future. However, the study was not to be regarded as an "evaluation" of the project.

The follow-up study was carried out over a six-week period in November/December 1994 in four different project sites and regions in Tanzania [7, 30]. These were Temeke ward in suburban Dar es Salaam, Mwanjelwa ward in Mbeya in the southern highlands, Makujuni village outside Moshi near the Kenyan border, and Wete town in Pemba, Zanzibar, a stronghold of Islamic fundamentalists. We made field visits to the communities, participated in activities related to the project, e.g. public film shows and group counselling sessions, and we talked to various categories of people involved in youth activities. Participant observation, focused group discussions and individual interviews were the main research tools used. In the following section some of our most interesting findings will be elaborated. We will not, however, dwell on the details of how the peer education project is operating.

NEW INSIGHTS ABOUT ADOLESCENT SRH

Our discussions with young people as well as medical staff during the follow-up study revealed that adolescents in Tanzania, as in the developing world generally, tend to *stay away from health services*. There are many reasons for this: lack of knowledge among young people about what requires health care, lack of information about existing services, fear of the reactions of service providers and of others who might discover them using the services, and finally, lack of resources.

Young people expressed concern about STDs, but only had fragmentary knowledge of their signs, symptoms and effects, and how they are contracted. The information leaflet "Youth and STD" distributed by the "peer project" was found to be very popular among the young, particularly boys, and created a lot of discussion and further queries. Some boys and girls admitted to having had syphilis and gonorrhoea, which are the most common STDs in Tanzania and the developing world [3]. The youth clinic set up in Mbeya offered STD diagnosis and a "youth friendly service", set up for one day a week in Dar es Salaam, as was extremely popular. However, more boys than girls would seek out these services for information and diagnosis. This data confirm established knowledge that STDs are found predominantly among the young sexually active members of the population, with the highest rates among those aged 15–29 years [31]. Adolescent boys who acquire an STD will more often show signs and symptoms. Girls are less likely to have symptoms, and they may not realize that they should seek medical care, as our study confirmed. This often leads to further health problems, including infertility and/or abdominal pain.

However, generally, the youth we met indicated that they were hesitant about going to public clinics or hospitals and preferred to treat themselves with pharmaceuticals. Tetracycline and penicillin are available over the counter in quite a few local shops. Others seek out private dispensaries or local healers for help. A medical officer in Moshi, whom we interviewed, said that some manage to treat themselves, but others end up with chronic ill health. Knowledge about appropriate dosages of the drugs taken is scant and considerable experimentation goes on (see also [32]).

The importance of STD as a major threat to public health at a global level has increased dramatically since the early 1980s. The new position of prominence of STD within the public health arena has been the consequence of a number of factors, most significantly the advent of the HIV/AIDS pandemic, but also the changing epidemiology of this group of diseases as well as their serious medical and socio-economic consequences [32]. There is need for relevant data on the handling of such sexually transmitted diseases. In Tanzania STD surveillance systems suffer from grave underreporting and it is difficult to monitor the epidemic. Knowledge is overall scant about how people handle their STDs in East and Central Africa [33]. No detailed studies whatsoever have been made of adolescents in this respect.

We also found that the use of contraception by young people is limited, although the "peer project" has initiated condom and foam pill distribution which are reaching out to an increasingly larger group. The young people tend not to use contraception or they use ineffective methods, like young people in most parts of the developing world (see also [34]). The reason for this is the lack of knowledge about different methods and where to get them. Lack of information on how STDs are contracted and how pregnancy comes about also contributes. Furthermore, adolescent sexuality is often irregular and spontaneous and seldom planned. For young women, this situation may lead them into SRH problems, beyond that of STDs. Unfortunately, many end up with unplanned, unwanted pregnancies and resort to abortion, which is illegal in Tanzania. Often young women act in panic, fearing the reaction of those around them should the pregnancy be discovered. They may feel uncared for by a partner who wants nothing to do with the pregnancy. Some of the young women may turn to friends for advice; however, friends often give misleading and possibly dangerous advice on how to abort a pregnancy.

The follow-up study suggests that many young women in the communities studied misuse malaria profylaxis, e.g. chloroquine tablets, when attempting to *induce abortions*. Medical officers also confirmed that this practice is widely used, often repeatedly, sometimes with fatal consequences. In Dar es Salaam young women also take an excess dose of contraceptive pills to induce bleedings. They usually delay going to the hospital, and when they do they ask to have their uterus "cleaned" (scraped). Other substances and modes are also used to induce abortions, and some seem to seek the assistance of medical personnel directly in exchange for money [14]. Although the exact incidences of induced abortion as well as abortion-related mortality are difficult to establish, available data alone demonstrate that induced abortion is a serious and costly health problem in Tanzania [14].

Our follow-up study also showed that in the areas we visited it is common for a young girl to have an affair with an older man, a *Mshefa*, if he is able to offer her financial support. There is a clear connection between sex and economic survival for young women, ultimately rooted in conditions of poverty, disadvantage and lack of opportunity. Furthermore, with the AIDS pandemic, the fear of HIV infection leads men to seek out young girls in tender ages for sex. The men refer to the girls as "spring chickens" and "luxury cars", as they are regarded as new, "clean" and "pure", and therefore free of STD/HIV infection. Use of condoms is viewed negatively by many men, as it is said to reduce pleasure. Girls as young as 10 and 11 years, we were told, are lured into *sexual relations with older men* for "chips", Coca-Cola, transport to school, money for videos or just extra little things. These relations are often short-term, but many also extend over longer time periods. Whether we are dealing with a form of child prostitution here will have to be explored further. The consequences are of course devastating. As we have noted, many cases of early pregnancies and STD infection occur.

Men are seldom willing to take responsibility for the children they father in such relations. On the whole, evidence indicates that men in Tanzanian society are encouraged to be sexually irresponsible. Ideas of sexually active and potent men are fostered, as well as conceptions that responsibility for pregnancy is a woman's problem. Our study indicated that men regard it as vital for their self-identity to have sex frequently and with different partners, showing their capacity to "conquer". Young and old men told us that if they abstained from making approaches to girls they would be conceived of as impotent and unmanly.

Recent research on adolescents and young girls in East Africa has accumulated a deeper understanding and insight into their SRH and the changing conditions of their everyday life [6, 9, 12]. As has already been indicated, the pattern of young girls having sex with older men has been addressed in some of these studies. However, we still have little understanding and insight into the circumstances of the behaviour of the men in this concern. No study has yet taken men's rational as the point of departure. On the whole, the *SRH and behaviour of men* is a topic which has been gravely neglected, particularly in the Third World setting [35–38].

As patriarchal structures benefit males more than females, men have often been viewed as the "winners" and women as the "losers". During the past decades, feminist and women studies have therefore addressed the disadvantaged women and young girls. Their needs, statuses, roles and life conditions have been explored, problematized and made visible.

However, more recent discussions about power, dominance and gender asymmetry have brought about the realization that male–female relations are complex. We need a more *nuanced view of men*, their relation to sexuality and parenthood as well as interaction with women, if we want to attain a more dynamic and profound understanding of the life situation of both women and men in society as well as decision-making around fertility and sexual preferences. Problematizing men's SRH has seldom been done in the past, but as we noted earlier, a shift in perspective now uplifts men to the role of responsible partners in fertility regulation and protection against STDs and HIV. The need for studies on men, family planning and fertility in developing countries has been pronounced by several social scientists as well as family planning associations as a way of improving family planning efforts [36, 37].

CONCLUDING COMMENTS

The follow-up study generated, as we expected, interesting data about many aspects of the SRH situation of young people and underlines clearly the need for an integrated approach to the issue.

The fact that young people tend to stay away from the health services and misuse, for instance, pharmaceuticals to treat themselves poses a big challenge to those who work with adolescents. For UMATI and RFSU this topic is important to penetrate, to take up in training of service providers, and to integrate as a problem to be discussed in the sexuality education provided by peer counsellors to their peers. This has not been done in a systematic manner as of yet, as the awareness of the problem has not been spelled out.

How to deal with the issue of *Mshefas*, or older men who have sex with young girls in exchange for money, is a further dilemma which has to be tackled. Teaching young women to say *no* to such contacts is important but not easy, as many are in desperate need of the money they are offered. Yet the topic has to be taken up in both training of trainers and in sexuality education.

Both organizations agree that developing UMATI's capacity to conduct good, applicable studies is vital as a guarantee for the operation of relevant sustainable projects. As a result of the follow-up study, where the opinions and experiences of both the young people and the project staff involved were taken into account, the generated information is being fed back into project activities, ideas for new IEC material, and into the content of a series of new training seminars, and finally, a few more in-depth studies are in the process of being undertaken.

The UMATI/RFSU exchange, circling around the form and content of sexuality education, has thus greatly benefited from systematic studies of both past as well as present experiences of the phenomena in both Sweden and Tanzania.

REFERENCES

1. Editorial (1994) Sex education in schools: peers to rescue? *Lancet* **344,** 8927.
2. Family Care International (1994) *Action for the 21st Century. Reproductive Health and Rights for All.* Family Care International, New York.
3. Bygdeman, M. and Lindahl, K. (1994) *Sex Education and Reproductive Health in Sweden in the 20th Century.* Official Report No. 37, Swedish Government, Stockholm.
4. SIDA (1994) *SIDA's Action Plan for SRH.* SIDA, Stockholm.
5. Fuglesang, M. (1992) No longer ghosts: women's notions of development and modernity in Lamu town, Kenya. In *Kam-Ap and Take-Off: Local Notions of Development*, eds G. Dahl and A. Rabo, pp. 123–156. Stockholm Studies in Social Anthropology, Stockholm.
6. Fuglesang, M. (1994) *Veils and Videos. Female Youth Culture on the Kenyan Coast.* Stockholm Studies in Social Anthropology, Stockholm.
7. Fuglesang, M. (1995) *Red Card or Yellow—Are You Still in the Game? Being Young and Coping with Sexual and Reproductive Health in Tanzania.* RFSU, Stockholm.
8. World Health Organization (WHO) (1993) *The Health of Young People—A Challenge and a Promise.* WHO, Geneva.
9. Tumbo-Masabo, Z. and Liljeström, R. (1994) *Chelewa, Chelewa. The Dilemma of Teenage Girls.* Institute of African Studies, Uppsala.
10. Ahlberg, B. M. (1991) *Women, Sexuality and the Changing Social Order. The Impact of Government Policies on Reproductive Behaviour in Kenya.* Gordon and Breach, London.
11. Leshabari, M. T. (1988) Factors influencing school adolescents' fertility behaviour in Dar es Salaam, Tanzania. Ph.D. thesis, John Hopkins University.
12. Mwateba, R. (1993) *Effects of Intervention Strategies on Selected Aspects of Teenage Reproductive Health—A Case Study from Tanzania.* UMATI, Dar es Salaam.
13. Kapiga, S. H. *et al.* (1992) Abortion in hospital setting—hidden realities. Unpublished.
14. Mpangile, G. S. (1994) *Unsafe Abortion in Tanzania—Facts from Selected Health Care Facilities—A Study Report.* UMATI, Dar es Salaam.
15. UMATI (1994) *On Youth SRH.* KAP surveys, UMATI, Dar es Salaam.
16. Killewo, J. (1994) Epidemiology towards the control of HIV infection in Tanzania with special reference to Kagera Region. Ph.D. thesis, Department of Epidemiology and Public Health, Umeå University.
17. Leshabari, M. T. and Kaaya, S. F. (1995) *Youth in Jeopardy: Failure or Success in Tanzania.* Muhimbili University College of Health Science, Daressalaam.
18. Caplan, P. A. (1976) Boys' circumcision and girls' puberty rites among the Swahili of Mafia Island, Tanzania. *Africa* **46,** 21–33.
19. Mbunda, F. R. D. (1991) *Traditional Sex Education in Tanzania: A Study of Twelve Ethnic Groups.* WAZAZI (the Parents Association of Tanzania) and UNFPA, Daressalaam.
20. Friedman, H. C. (1993) *Adolescent Sexual and Reproductive Health: Research Needs and Approaches.* WHO, Geneva.
21. Mbunda, W. M. (1988) *Adolescent Fertility in Tanzania. Knowledge, Perception and Practices—A Survey Report.* UMATI, Dar es Salaam.
22. Mwamuya, S. J. (1990) *National Family Planning Service Policy and Guidelines for Tanzania.* Ministry of Health, Dar es Salaam.
23. Mpangile, G. S. and Mbunda, W. M. (1992) *An Annotated Bibliography of Information on Adolescent Sexuality in Dar es Salaam.* UMATI, Dar es Salaam.
24. World Health Organization (WHO)/Centre for Population Options (CPO) (1994) *Sex Education.* Population Reference Bureau and the Centre for Population Options International Centre on Adolescent Fertility, Geneva.
25. Jacobson-Widding, A. and van Beek, W. (1990) *The Creative Communion: African Folk Models of Fertility and the Regeneration of Life.* Uppsala Studies in Cultural Anthropology **15,** Almqvist and Wiksell, Stockholm.
26. Richards, A. (1982) *Chisungu: A Girls' Initiation Ceremony among the Bemba of Zambia.* Routhledge, London.
27. Ntukula, M. (1994) The initiation rite. In *Chelewa, Chelewa. The Dilemma of Teenage Girls*, eds Z. Tumbo-Masabo and R. Liljeström, pp. 96–119. Nordiska Afrikainsitutet, Uppsala.
28. Shuma, M. (1994) The case of the matrilineal Mwera of Lindi. In *Chelewa, Chelewa. The Dilemma of*

Teenage Girls, eds Z. Tumbo-Masabo and R. Liljeström, pp. 120–137. Nordiska Afrikainsitutet, Uppsala.
29. Makobwe, K. (1975) *Towards Family Life Education in Tanzanian Schools: Possibilities and Constraints.* University of Dar es Salaam, Dar es Salaam.
30. Fuglesang, M. and Simbamwaka, J. (1994) *Follow-up Study of the Project "Youth Family Planning Services through Peers"—A Summary of Preliminary Findings.* UMATI/RFSU, Dar es Salaam.
31. World Health Organization (WHO) (1993) *STDs among Adolescents in the Developing World—A Review of Published Data.* WHO, Geneva.
32. Tomson, G. and Sterky, G. (1986) Self-prescribing by way of pharmacies in three Asian developing countries. *Lancet* **2**, 620–622.
33. Faxelid, E. (1994) *Patients' Experience of STD Care in Sweden and Zambia.* Report No. 5, IHCAR, Stockholm.
34. Hawkins, K. and Meshesha, B. (1994) Reaching young people: ingredients of effective programs. In *Population Policies Reconsidered. Health, Empowerment and Rights*, eds G. Sen *et al.*, pp. 211–222. Harvard University Press, Boston.
35. Silberschmidt, M. (1991) *Rethinking Men and Gender Relations.* Centre for Development Research, Copenhagen.
36. Hawkins, K. (1992) *Male Participation in Family Planning—A Review of Programme Approaches in Africa.* IPPF, London.
37. Campbell, E. (1993) *Men's Attitudes towards Family Planning in Africa.* Report from a Conference on Reproductive and Family Health in Africa, Abijan, Cote d'Ivoire.
38. Ntozi, J. (1993) *The Role of Men in Determining Fertility among the Banyankore of Uganda.* Makarere University, Kampala.