

Bridging the information gap: sexual maturity and reproductive health problems among youth in Tanzania



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Abstract

The paper presents a brief review of the available literature on exposure to premarital sexual intercourse in the youth population, then discusses youth's current and preferred sources of reproductive health information, as well as the contexts of both acquisition of such information and exposure to coital experiences; what is known regarding consequences of unprotected premarital sexual intercourse among young people; and barriers to reproductive health information and services as well as potential approaches to solutions.

Many Tanzanian young people have unprotected premarital coital experiences, and suffer from subsequent ill-effects on their health. Current reproductive health information sources for this population in Tanzania are largely informal, and young people have difficulty in access to information from responsible adults in communities; they are more exposed to information on sexual intercourse than on more basic issues related to biological maturity and its significance. The circumstances of sexual intercourse experiences appear to include cultural gender differences in the ability to negotiate relationships with the opposite sex, economic factors, and changes in the socialization roles of parents which decrease parental supervision of youth activities. Many of these factors reflect changes in society in general, presenting a challenge to current socialization structures such as families, communities, the education and health systems and religious bodies to find ways of working together to provide consistent messages to youth. There is also an urgent need to address the needs of youth in contemporary Tanzanian societies, for appropriate and healthy psychosexual development.

Background

The youth (age range 10-24 years), who constitute about a third of the population in Tanzania, face several reproductive health problems. These include exposure to unprotected sex, low levels of reproductive health knowledge, poor awareness of the potential consequences of unprotected sex and lack of counselling services on reproductive health issues. Although there are no national data on the extent of coital experience among youth, available information suggests that only about 20 per cent experience coitus through marriage (Leshabari and Kaaya 1994).

Table 1

Census data on the percentage of married youth by age and sex, 1967, 1978 and 1988

Age group	Census year	Proportion married (%)
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		Males	Females	Total
10-14	1988	0.5	1.1	0.8
	1978	0.2	0.8	0.5
	1967	0.4	3.2	1.8
15-19	1988	4.1	29.3	17.0
	1978	3.5	36.8	20.5
	1967	6.9	51.9	30.6
20-24	1988	30.9	73.8	55.0
	1978	34.3	83.7	61.9
	1967	43.1	90.5	71.1
10-24	1988	8.7	30.2	19.9
	1978	9.3	35.9	23.0
	1967	13.0	47.2	31.0

Source: Computed from 1967 *Population Census*, Vol. 3, Table 202; 1978 *Population Census: Basic Demographic and Socio Economic Characteristics*, Table 2; 1988 *Population Census: Basic Demographic and Socio-Economic Characteristics*, Table 4.

Census data, summarized in Table 1, indicate that the proportion of married youth has decreased from 31 per cent in 1967 to about 20 per cent in 1988 (Bureau of Statistics 1971, 1982, 1992). Part of this decrease is probably due to an increase in school enrolment, which was increased by implementation of the Universal Primary Education Policy from 2.2 million children in 1977, to 3.9 million in 1988 (BEST 1996). This implies that many girls who, according to tradition, would have been married soon after menarche now get married several years after completing at least their primary school education.

However, despite a decrease in the proportion of married youth over the past few generations, there is a persistent variation by sex of married youth in all age groups of the census data years, with a larger proportion of married females than males in younger age-group categories. For example in 1988, only four per cent of boys aged 15 to 19 years were married, compared to 30 per cent of girls in the same age group, suggesting that young females do not draw partners from their age category but are married to men older than themselves. This wide difference between the ages of married male and female youth is one possible explanation for the higher cumulative AIDS cases observed amongst young females, who are likely to be exposed to older and more sexually experienced partners, increasing their chances of acquiring HIV (NACP 1994).

'Sugar daddies' have often been blamed for observed coital relationships between single girls and older men, where financial or material gain for the girls is implied (Lema and Kabeberi-Macharia 1992; Lwihula, Nyamuryekung'e and Hamelmann 1996). However, the 'sugar daddy' phenomenon may be too simplistic an explanation for the dynamics of sexual relations in Africa, particularly with respect to the youth population. In a study conducted in Dar es Salaam for example, a large proportion of 200 teenagers with abortion complications, the majority of whom were single, reported their partners to be men above the age of 45 years (Mpangile, Leshabari and Kihwele 1993). Almost 40 per cent of these partners lived in the same poor neighbourhoods as the girls and were not perceived to be better-off financially. Thus financial and material benefit for the girls may not have been the only reason for their relationships with the older men. Often when the 'sugar daddy' phenomenon is discussed, a shift from established cultural rules which governed sexual morality and sexual partnership in the African context is implied.

Although the choice of sexual and marital partner is influenced by a host of socio-cultural constructions of relationships with the opposite sex and contexts governing sexual intimacy in many African cultures, Setel (1997) noted that the notion that there ever were clear-cut

universally obeyed rules and rigid social institutions governing sexual behaviour is no truer for Africa than for Europe. Cultural systems and structures in Africa have been influenced by external factors such as Christianity, Islam, colonization, capitalism and modernity. Norms governing sexual partnership and intimacy being largely cultural constructs are bound to acquire a dynamic in keeping with cultural changes. Leshabari, Kaaya et al. (1996) noted, from in-depth interviews amongst elders in Southern Tanzania, a deep resentment of what was viewed as the amoral sexual behaviour of young people, which deviated from a more puritanical morality reported to have existed about two to three decades before the study, as is illustrated by the following account:

Nowadays the secrecy governing the whole process of sexual advances between men and women has disappeared. Even taboos are no longer adhered to. What you see today is a bunch of young men and women going after each other in broad daylight, ridiculing each other in public (by doing so),Some young women use their bodies as income generating machines, sleeping with whoever is ready to pay them (Leshabari, Kaaya et al. 1996:22).

However, this account from a female elder invites the question whether the concerns expressed relate to observation of increased occurrence of premarital sexual activity *per se*, or to a change in the context of premarital sexual experiences such that they are more explicit and the cultural secrecy which surrounds sex and sexual relations in many African cultures is removed. This interpretation is supported by ethnographic studies conducted in northern Tanzania by Haram (1995) who noted the links between maintaining dignity and succumbing to sexual desire:

Whether one indulges in premarital or extramarital sex is not the real question. What seems to be crucial is how it is done..... if you want to 'steal' sex (a term referring to illicit relationships) it must be done with dignity and respect (Haram 1995:37).

Setel (1995), in a review of sexual morality and cultural convention in the late nineteenth and the twentieth century in Northern Tanzania, noted that in the 1890s, 'premarital intercourse [was allowed] and virginity was not specially valued' and that 'avoiding premarital pregnancy rather than premarital sexual activity was the main priority'. The dynamic nature of cultural sexual morality is noted in Setel's account of the twin influences of missionary activity and land pressures in the early twentieth century which resulted in increased rigidity of the more accommodating attitudes towards premarital sexual activity, with a higher premium being placed on virginity.

Traditionally, men in many African societies married relatively young brides in monogamous or polygamous relationships, and there were socially accepted procedures and various roles and obligations which had to be observed. These social controls may to a certain extent have ensured that sexual partnerships culminated in marriage. It is possible that the cultural norms governing the acceptable age gap between sexual partners have persisted in recent times, in the absence of the social controls which ensured such partnerships led to marriage. There have been several reports of the loss of cultural institutions and structures which governed sexual morality in many Tanzanian societies. These include rites of passage which have been noted to lack relevance in matriarchal societies which continue the practice, or which have declined completely in patriarchal societies of Tanzania; teachings related to sexuality and community living which were part of the initiation ceremonies have not been replaced (Ntukula 1994; Shuma 1994). Current social structures are unable to sustain early age at marriage which used to serve as a control on premarital pregnancy amongst young females, and Bledsoe and Cohen (1993) note a similar trend of later age at marriage in many

sub-Saharan African countries. There also appears to be a decrease in the authority of elders over the behaviour of male and female youth (Leshabari, Kaaya et al. 1996:74). Such weakening or lack of relevance of traditional controls which governed relationships with the opposite sex may facilitate the use of sex for recreational and material benefits among both men and women.

Socio-economic factors from a different perspective have also maintained sexual relationships between girls and older men. In many sub-Saharan countries, including Tanzania, declining material and financial resources have created a situation where few men can afford to marry when young. Although bridewealth, strictly defined, has to a large extent been abandoned, other demands have sustained the high costs of marrying in a socially acceptable manner for young men. The traditional expectation for younger people to be dependable rather than independent, and cultural norms regarding the responsibilities of a son-in-law in many groups, create a situation where as well as setting up a new home, a son-in-law is expected to contribute towards food costs, medical treatment and school fees for younger members of a wife's family. Vallenga (1986), in Ghana, noted that where child betrothal exists, an intended husband may be expected to meet the costs for educating his future bride. Older men are better established financially than younger men, and hence more attractive as potential husbands. It has been noted that in communities where bridewealth and polygamous marriages continue to exist, young girls tend to compete for husbands from a small pool of older men whose numbers are declining through mortality. The gender differences in age at marriage, noted from the above census reports in Tanzania, are therefore not surprising. However, there are health implications for young girls particularly with respect to HIV transmission, as older men are more likely than young men to have extensive experience with multiple sexual partners, increasing their risks of having contracted the infection.

There is little documented evidence to support the assumption that the age gap between young females and their husbands is also reflected in premarital sexual partners of this population subgroup. However, this age gap in premarital sexual relations can be inferred from HIV/AIDS sero-surveillance data, which demonstrated a higher cumulative AIDS case rate of 281 per 100,000 amongst females aged 20-24 years, than that of 140 per 100,000 amongst males of similar age (NACP 1994). The HIV prevalence rates among teenage male blood donors (15-19) increased from 0 per cent in 1987 to 3.3 per cent in 1990 while that among teenage girls increased from 0 to nearly 7.5 per cent in the same period. This phenomenon has already been observed in other countries in Sub-Saharan Africa where women are infected at an earlier age than men (Fleming 1994). The lower peak age of females with AIDS, compared to males, suggests that amongst other factors, sexual partners of young females may be drawn from an older and more sexually experienced population than those of young males.

Although nationwide figures are not available, data from small-scale surveys in both rural and urban Tanzania suggest that a significant proportion of teenage boys and girls engage in unprotected premarital sexual intercourse. There is however, less information on the circumstances surrounding such behaviour. Small-scale surveys involving school teenagers show that a substantial number of them are sexually active. An urban-based study conducted in Dar es Salaam covering a random selection of 657 school students revealed that 62 per cent of primary-school boys and 35 per cent of primary-school girls had coital experience by the age of 14 years (Leshabari 1988). A more recent survey in Dar es Salaam (Lwihula et al. 1996) indicates that coital experience in the youth population continues to be high despite the AIDS pandemic, as shown in Table 2.

In the sample of primary-school students, with a mean age of 14 years, by the age of 15 years 29 per cent reported having had sex at least once. Available data from other small-scale

surveys in different parts of Tanzania also suggest that many young people are sexually active (Fundikira 1985; Mbunda 1988; Kapiga, Hunter and Nachtigal 1992; Klepp et al. 1994).

Table 2
Percentage of urban primary-school students who have had coital experience, by age and sex

Age (years)	Percentage with coital exposure		
	Boys	Girls	Total
11 - 13	23.0 78	6.0 94	14.0 172
14 - 15	43.0 164	16.0 186	29.0 350
16 - 19	49.0 112	17.0 46	40.0 158
All age groups (11-19)	40.0 354	14.0 326	27.4 680

The numbers below each proportion indicate the denominators on which the percentages are based.

Source: Lwihula et al. 1996, Table 24.

A recent survey using qualitative methods in a rural district in Southern Tanzania revealed that multi-partnered sexual behaviour among youth was common (Leshabari et al. 1994). Parents in this setting appeared to be either indifferent, or unable to exert any control over young people's sexual behaviour, which they reported as associated with the settings in which petty trade activities occurred such as the *magulio* (flea markets), where the young were amongst traders who travelled from one *gulio* to another across communities in the district.

These trade environments were reported to involve alcohol use, late-night discothèques and indiscriminate sexual intercourse; activities in which young people also took part. The links between sexual behaviour and trade environments has been reported by other authors, such as O'Connor, Leshabari and Lwihula (1992), in their ethnographic account of behaviours at truck-stops, and Setel (1995) in his accounts of the links between work, desire and the social person in contemporary Chagga society. Trade environments may provide greater opportunity and increase the vulnerability of youth to unprotected sex and its consequences, and the lifestyles associated with petty trade activities amongst young people may not be conducive to maintaining the cultural integrity of many communities (Setel 1995:57) and hence become the routes of bad *tabia* (behaviour), unrestrained desire and consequent HIV infection.

It seems that significant social changes have taken place within the last generation or two affecting the socialization processes of children and young people in many communities in Tanzania. Qualitative studies conducted in the Mbeya, Arusha and Kilimanjaro regions suggest a combination of declining social-economic conditions with other social changes which have influenced the factors which defined masculinity and femininity, as well as roles and obligations of fathers and mothers in the individual household. These changes are bound to influence the socialization patterns of the young at home, and accounts from both the Mbeya and Kilimanjaro regions imply that there have been adverse effects on the growth and psychosexual development of children and youth. Many of these are related to the growth of a new cultural sexual morality which links the concepts of desire, behaviour, migration and economic productivity amongst youth (Setel 1995:50-57; Leshabari, Nyamyekung'e and Hamelmann 1996). Such changes have probably influenced the current health-risk behaviour of youth in these societies.

Sources of young people's reproductive health information

Although large numbers of youth are sexually active, there is evidence that the reported sexual behaviour is taking place in an atmosphere of ignorance and misconceptions on basic reproductive health issues. Information which revealed poor reproductive health awareness among youth dates back more than a decade. Fundikira (1985) reported that many teenage school girls believed abortion could be induced by swallowing large doses of chloroquine (used for the treatment of acute malaria). Douching with rice water or tea without milk are among methods of attempting abortion reported during a survey of 658 school students in a rural setting in Tanzania (Leshabari, Kaaya and Kawau 1996). Use of cassava leaves and sharp instruments has also been reported in certain parts of the country (Mpangile et al. 1993). Lwihula and his colleagues (1996) note from a survey of school youth in Dar es Salaam that about ten per cent of secondary-school students identified as contraceptive methods swallowing chloroquine tablets, and not wearing shoes during sexual intercourse. Many of the methods used for inducing abortions have serious consequences. Causes of mortality include chloroquine overdoses, or the complications of illegal abortion attempts.

Table 3
Primary sources of information on menstruation, wet dreams and sexual intercourse among school youth in Rombo District (Rural) and Dar es Salaam (Urban) (%)

Source of Information	Reported sources of information on...					
	Menstruation		Wet dreams		Sexual intercourse	
	Rural	Urban	Rural	Urban	Rural	Urban
Peers	29.2	21.0	28.8	44.0	24.1	21.0
Teacher	26.2	19.0	14.1	6.0	11.1	7.0
Other relative	12.0	6.0	17.1	19.0	9.8	7.0
Print media	5.2	11.0	11.8	16.0	21.8	31.0
Radio/film	3.4	2.0	10.0	1.0	17.1	17.0
Father	19.7	4.0	9.4	2.0	4.8	2.0
Mother	1.3	19.0	1.2	1.0	0.8	2.0
Health worker	0.4	10.0	4.7	5.0	6.7	8.0
Religious leaders	0.9	5.0	1.8	4.0	3.6	3.0
Missing responses	1.7	1.0	1.2	5.0	0.0	2.0
Total respondents (N)	233	271	170	200	357	459

Sources: Leshabari, Kaaya and Kawau 1996; Lwihula et al. 1996.

Although prevention of pregnancy could minimize many of the above problems, many young people appear to be ignorant about fertility control. Demographic and health surveys which have been conducted in Tanzania recently revealed that teenagers as a group were less informed about methods of preventing pregnancy than older youth and adults (TDHS 1995). Data from the study conducted amongst school youth in the rural setting of Rombo district cited above (Leshabari, Kaaya and Kawau 1996) indicated that when knowledge on biological maturity and fertility control was tested using a 22-item test, 48 per cent of males and 62 per cent of females scored below 25 per cent.

Lack of formal sources of reproductive health information and services contributes towards some of the health difficulties of young people. There is some evidence that peers and the mass media are their major sources of reproductive health information, probably because parents often communicate reproductive health information in the form of a list of prohibitions or reprimands, and are rarely able to discuss at length the sex-related concerns of their teenage children. Two surveys using similar instruments covering 657 rural school

students with a mean age of about 14.9 years (Leshabari, Kaaya and Kawau 1996), and 681 urban school youth with a mean age of 14 years (Lwihula et al. 1996), revealed an interesting pattern in the reported primary sources of information on menstruation, wet dreams and sexual intercourse, among youth who had ever heard of these reproductive health related items (Table 3).

Peers were the main primary sources of information mentioned by both rural and urban school youth. However, given the reported low levels of reproductive health knowledge among youth, it appears these young people are forced into a situation where 'the blind lead the blind'. Although parents in general were not a major primary source of such information for both urban and rural school youth, a somewhat higher proportion of rural youth reported fathers to be primary sources of information on menstruation, while mothers were more likely than fathers to be reported as a source of such information by urban youth. When the proportions were desegregated by gender, it was noted that 87 per cent of those reporting fathers as sources of information were females. Though the context within which such information was provided to girls by fathers was not explored, the findings suggested a possible change in cultural norms where the silence between fathers and their daughters on issues related to reproductive health is being broken. Of concern, however, is the continued silence of mothers as evidenced by the students' responses. The low level of reproductive health knowledge found amongst school youth in Rombo district suggests that even written literature, which featured prominently as a primary source of reproductive health information, is unlikely to be a relevant teaching guide for what youth need to know about reproductive health.

Table 4
School students' preferred sources of information on menstruation, wet dreams and sexual intercourse in Rombo District (%)

	Preferred source of information on...		
	Menstruation	Wet dreams	Sexual Intercourse
Health worker	35.2	36.6	41.4
Teachers	35.7	38.8	33.1
Parents	22.2	16.6	15.9
Mass media	1.7	2.5	3.1
Religious leaders	2.0	2.9	3.6
Peers	1.7	1.3	1.0
Others	1.4	1.3	2.1
Total respondents (N)	347	314	384

Source: Leshabari, Kaaya and Kawau 1996

When the rural school students reported above were asked about their preferred sources of information on menstruation, wet dreams and sexual intercourse, other sources featured highly in the pattern of responses which emerged. Given a choice, it appears students would prefer to be taught about various reproductive health issues by a combination of people.

The survey based in Rombo District which targeted rural school youth (Leshabari, Mwanri et al. 1996) indicated that health workers, teachers and parents were the most preferred sources of information on menstruation, menarche and sexual intercourse. Peers and the mass media were ranked very low as preferred sources of information even though in practice they were the main sources (Table 4).

Because the current sources of reproductive health information are informal, it appears that for both rural and urban areas, exposure to information on sexual intercourse is greater than exposure to more basic information related to human growth and development such as

the onset of menstruation and wet dreams, and their implications on reproductive health, as summarized in Table 5. While about half of rural and urban school students had ever heard of sexual intercourse, only about 40 per cent or less reported having heard of menstruation and an even lower proportion had information on wet dreams. There was also a considerable variation by sex in exposure to information on menstruation and wet dreams. More girls than boys had information about menstruation, more boys knew about wet dreams.

Table 5
Proportion of urban and rural youth who had been exposed to information on menstruation, wet dreams, and sexual intercourse (%)

Rural/Urban	Proportion who had ever heard of...								
	Menstruation			Wet dreams			Sexual intercourse		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Rural Youth ^a	21.0	47.2	35.3	31.8	13.9	22.0	57.3	48.5	48.5
N	286	345	631	286	345	631	279	340	619
Urban Youth ^b	30.0	51.0	40.0	42.0	15.0	29.0	75.0	60.0	67.0
N	350	325	681	357	324	681	352	325	681

Numbers below each proportion represent the denominators on which the proportions are based. Sources ^aLeshabari, Mwanri et al. 1996, Table 2; ^bLwihula et al. 1996, Tables 13,16 and 19.

Rounding percentages to the nearest unit in the source data probably accounts for the discrepancy in total scores for each reproductive health information item.

This implies that despite the reported high rates of coital experience in the school student population, exposure to information on the biological processes of the transition to adulthood is poor. Evidence from the *Ngao*¹ intervention study conducted in Northern Tanzania indicated that a community-participatory approach in the introduction of a reproductive health and AIDS education program in schools, where didactic sessions and practical skills development approaches were used, was effective in increasing restrictive subjective norms towards sexual intercourse among both boys and girls, as well as decreasing intention to engage in sexual intercourse over the next three months amongst boys (Ndeki et al. 1995). However, such pilot projects have not been replicated or translated to nationwide programs. The absence of comprehensive reproductive health education within the school system, or in the community, means that young people will physically become adults with little, and sometimes distorted, understanding of the biological processes surrounding childbirth and fertility control.

Schools could be good focal points for reproductive health education, as they serve a large proportion of youth, in a teaching and learning setting. However, the dropout rates in the final stages of primary school, as well as a recent observation that only half the children eligible for school are enrolled in schools (Leshabari, Mwanri et al. 1996), mean that policy makers must find ways of targeting out-of-school youth when thinking of reproductive health information and services for this population subgroup. It also appears that menstruating girls miss several classes each month since, amongst other problems, most schools lack an adequate water supply and the necessary privacy for girls who are menstruating during school

¹*Ngao* in Kiswahili means 'shield'.

time. Although teachers claimed this only applied to girls during their first menstrual experience, many primary schools were observed to lack conditions which would be favourable for menstruating girls to attend classes comfortably. These problems can easily be handled within schools by mobilizing communities to construct latrines and other facilities needed by menstruating girls while in school. Provision of such services will minimize problems of poor school attendance amongst girls.

Since schools and health care units are present in most Tanzanian communities, the reported preferred sources of reproductive health information present a challenge to workers in these settings to work with communities in socializing youth on reproductive health issues. As evidenced from the *Ngao* project, for schools to be an effective focal point for reproductive health information, thought needs to go into the planning of the curriculum, and how to involve the community, so that messages provided by the school system can complement those provided by parents, health workers, teachers and even religious leaders. The *Ngao* project experience also indicates a need to consider training of teachers on the most appropriate methods to use in communicating reproductive health information to young people. Such a comprehensive approach will allow young people to learn about reproductive health issues from a holistic perspective. Indeed, there are various aspects of reproductive health which can be communicated by parents, teachers, health care workers and religious leaders, each contributing towards what young people should know.

Circumstances surrounding acquisition of reproductive health information

There is very little retrievable information on the current circumstances surrounding the acquisition of reproductive health information in the youth population of Tanzania. In the Rombo rural school youth study reported above, contexts within which reproductive health information was acquired were explored in five each of 'female only' and 'male only' focus-group discussions and eight which had both male and female participants. Generally it appeared from the data that acquisition of such information varies with the age and sex of the students. Younger males (14 years and below) acquired such information by listening to conversations of older males. Many reported that in most cases older youths felt uncomfortable talking about such issues in the presence of younger ones who were asked to leave if caught listening. Girls revealed that they got some information on issues related to reproductive health through discussions with other girls about their relationships with the opposite sex. The young girls pointed out that sometimes mothers and older siblings might be consulted about these issues but this had to be done with caution, as a verbal or physical reprimand was a real risk, particularly from mothers.

Traditional sources of information for young people such as extended family members, especially aunts and grandmothers, appeared to play a rather small role, even though the upbringing of most young people in this study was predominantly rural. While participants in the younger male focus-group discussions agreed that seeking information from a father on issues related to sex would sometimes result in being ignored because the parent felt the boy was too young for such information, the focus groups with older boys agreed that when sexual issues were not well understood, clarification could be sought from an older brother or a friend. However, this involved a lot of embarrassment and shyness on the part of the youth seeking information (Leshabari, Kaaya and Kawau 1996).

The disappearance of traditional sources of reproductive health information in the Rombo study area may partly be due to the influence of Christianity. In many parts of Sub-Saharan Africa, the role of initiation rites in defining femininity and masculinity as well as strengthening cultural identity posed a threat to the spread of Christianity, and the rites of passage were discouraged by the church (Wellbourne 1961; Strayer 1978). However, such discouragement deprived young people of a source of reproductive health information,

without making adequate provision for other sources which would take into consideration cultural norms; a situation which has persisted to date in many 'Christianized' parts of Tanzania.

Contexts of school students' sexual experience

There is very little information available on the contexts within which sexual experience occurs within the school population. A qualitative rural community-based study, in which data were collected using in-depth interviews and focus groups, revealed that involvement of school students in petty trade activities, use of alcohol and lack of parental supervision during leisure were factors which exposed them to the risk of promiscuous behaviour (Leshabari, Kaaya and Kawau 1996).

In two studies there is information on the circumstances of sexual experience of urban and rural school students (Lwihula et al. 1996; Leshabari, Kaaya and Kawau 1996). Coital experiences among school youth in both these studies fell broadly into two categories, sex between male and female students and sex between female students and out-of-school youths. In the category of sex between male and female students, circumstances in which such relationships occurred amongst urban and rural youth differed. Amongst the urban youth, coital experience was associated with the need of girls to do well at school, which was exploited by boys who offered academically weak girls help with school work in return for sexual favours; gifts or money from boys in return for sex; peer pressure; and to a lesser extent cultural gender-related factors which govern power relationships with the opposite sex.

Focus-group discussion data from the rural based study revealed more cultural gender power difference factors which govern sexual relationships, though the gifts or money from boys in return for sex theme also persisted as an important factor which increased the vulnerability of youth to coital experiences. In the rural focus-group data, male students were noted to be unable to deal constructively with rejection of their sexual advances, when such rejection resulted in public embarrassment. To a certain extent, girls would sometimes give in to pressure to have sex, for fear of possible rape. In the second category mentioned of girls who had sex with out-of-school youths or adult men, it appeared from both rural and urban based focus-group data that the economic gain factors predominated in increasing girls' vulnerability to coital experiences. However, the extent of the material or financial gain achieved in return for sex was variable. In the rural sample it was reported that the payments to female students could range from a soft drink from a boy-friend, to gifts such as fashionable clothes and shoes or more expensive gifts including large sums of money. In the urban sample in addition to material and financial gain, in some cases a female student would live with an adult male partner, with the knowledge of her parents, who would not oppose such a move as long as the partner paid for her basic needs, including expenses required by the school (Haram 1995:36; Lwihula et al. 1996).

The findings suggest a difficulty in separating financial and material gain to the female students in both study samples from the symbolic nature of gift exchange. It appears, particularly from the rural focus groups, that exchange of gifts had a symbolic significance in the social construction of the negotiation of coital sexual relationships in both the rural and urban youth subculture. In the male, female and mixed rural focus-group data there was consensus that accepting a gift from an interested male committed a girl to agreeing to whatever her boyfriend requested including a coital relationship. Culturally in many parts of sub-Saharan Africa, it is the male's prerogative to determine the nature and direction of a sexual relationship, while females are expected to be compliant. However, it was noted that females do have a role in initiating a liaison, particularly when this occurred between schoolboys and girls. The initiating roles of a female were implicit rather than explicit, and interpreted as such by youths when a girl was perceived to be flirting with the boy in class.

However, the implicit nature of such overtures from girls appeared to be open to misinterpretation by boys, as evidenced by the girls' accounts of fear of rape.

Consequences of unprotected sex for young people

Unprotected sex among young people has three major undesirable outcomes. First is the psychological effect of participating in behaviour of which parents, neighbours, and the community disapprove. Unfortunately, so far, little is known about the extent of this type of problem in the youth population in Tanzania. Virtually nothing is known about the psychological problems surrounding the processes preceding the stage when young people are sexually active. Secondly, there is the problem of unwanted pregnancy and its related psychological, economic, social and health consequences. Anecdotal accounts indicate that the number of unwanted premarital pregnancies among young people in Tanzanian societies has increased, though no prevalence data are available.

Data from the Ministry of Education and Culture show that in 1992 alone, 13 per cent of 21,594 primary girls who dropped out of school gave unwanted pregnancy as a reason (BEST 1994). The true proportion is probably much higher than this as the illegal nature of school pregnancies influences the reason reported for leaving school at both the school and the Ministry of Education level. Surprisingly, some of the pregnant girls were in the second year of their primary school education (BEST 1994); an observation which raises questions about the stage at which reproductive health information and services should be introduced in the school system.

The plight of young people who are not at school largely remains unknown even though there are indications that there is more tolerance for premarital pregnancies in the current generation of parents, than was the case only a generation ago (Leshabari et al. 1994). Increasing economic hardships have forced many young people, especially girls, to resort to promiscuous behaviour to make a living. The fear of AIDS, let alone other STDs, is of less concern than the more immediate lack of basic needs such as food, clothes and shelter (O'Connor et al. 1992).

Thirdly, any sexually active young person risks infection with sexually transmitted disease. Given the large number of this population subgroup which practises unprotected sex, STDs, including HIV infection, appear to be one of their major problems. The prevalence of STDs among youth in Tanzania is generally unknown even though some small-scale studies indicate that it may be a serious problem. Data from the Arusha Region, for example, revealed that nearly 13 per cent of females aged 15 to 24 years in Arusha Urban District are infected with the AIDS virus (Klepp et al. 1994). A survey carried out in Moshi Rural District found high rates of STDs including HIV among rural youth (Kessy 1996). The summary in Table 6 shows that four per cent of youths and over six per cent of girls had gonorrhoea; nine per cent of males and 15 per cent of females in the study sample had a history of syphilis. Given that these data were collected from a random selection of youth (mainly not in school), who were recruited while going about their day-to-day activities, HIV and STD infection rates among them are a matter of serious concern. The higher rates of HIV infection in females reflect trends also noted from sero-surveillance data compiled by the National AIDS Control Programme (1994). It appears that quite a large number of young people die from AIDS and this in the long run will have serious implications for the national economy.

Table 6
Variation of STD infection (including HIV) by age and sex among youth in Moshi Rural District (%)

Type of STD	Males/age in years	Females/age in years	Total
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	15-19	20-24	Total	15-19	20-25	Total	
Gonorrhoea	2.2 (322)	7.1 (183)	4.0 (505)	3.0 (268)	9.6 (272)	6.3 (540)	7.5 (1045)
Trichomoniasis	3.7 (322)	18.6 (183)	9.1 (505)	9.7 (267)	28.3 (272)	19.1 (539)	14.3 (1044)
Genital ulcer disease	0.6 (322)	1.1 (183)	0.8 (505)	1.1 (267)	2.6 (272)	1.9 (539)	1.3 (1044)
Syphilis	5.8 (308)	13.7 (168)	8.6 (476)	13.5 (259)	14.9 (268)	14.2 (527)	14.2 (1003)
HIV	3.6 (308)	7.7 (168)	5.0 (476)	6.2 (259)	13.1 (268)	9.7 (527)	7.5 (1003)

Figures in brackets are denominators on which the proportions are based; Source: Kessy (1996)

The findings of high prevalence rates of STDs and HIV are not surprising given the information from different areas of the country of high-risk sexual activity in the youth population (O'Connor et al. 1992; Leshabari et al. 1994; Haram 1995). Anecdotal qualitative survey reports show promiscuity among the youth to be fairly high, much of it precipitated and maintained by economic hardship, and socio-cultural changes which have affected their lives.

Barriers to reproductive health information and services, and potential opportunities

Many parents, health care providers, policy makers and religious leaders may not be aware of the lack of basic reproductive health knowledge amongst the young, and the implications of such ignorance for reproductive health behaviour. Part of the difficulty arises from the assumption that providing reproductive health information and services for this population will encourage promiscuity. This argument ignores the fact that many, if not most, young people are already sexually active and their promiscuous behaviour is not related to exposure to reproductive health information. As pointed out earlier, most young people learn about reproductive health from peers and the mass media, and what they learn is not only incorrect but also dangerous as they are unable to make informed decisions regarding their sexual behaviour. It is unfortunate that available literature is sometimes misquoted in order to justify moral perceptions of reproductive health issues. For example, there have been reports from religious leaders in Tanzania that only three per cent of condoms work. This approach towards such a critical issue is counterproductive.

There is a need to identify how potential resources such as the education and health sectors, parents, and religious leaders can best be exploited to provide reproductive health information, which takes into consideration the current socio-cultural and economic realities in many Tanzanian societies. There has been a basic assumption that inclusion of reproductive health issues in the curricula of primary and secondary schools will be sufficient. But this needs to be combined with concerted efforts to address issues such as the terminology to be used in explaining reproductive health to children and young people; the special skills that

teachers need to impart such information with ease to this population; and the needs for psychological support for sexually active youth.

Apart from teachers, various responsible adults in the society have a role to play in reproductive health education for children and youth. Parents, health workers and religious leaders all have some contribution to make. Every group of responsible adults brings to the issue of reproductive health education its own perspective: religious leaders contribute a spiritual and moral perspective, parents and teachers a social perspective, health workers a more health-related perspective. However, for young people, a holistic approach is necessary, which incorporates the perspectives of all responsible adults who have the potential to contribute to their knowledge base. It is also important to take into consideration the views of young people themselves on their preferred source of information.

There is also a problem in defining the most appropriate stage at which reproductive health information should be introduced into the life of a young person. In the Tanzanian context, this raises serious challenges for two major reasons. While schools are good places for imparting this information, school enrolment has declined and drop-outs have increased to the extent that only half of school-aged children are in the education system (Leshabari, Mwanri et al. 1996). Consequently there is a need to find means of reaching youth who are not at school. Within schools there are wide variations in the composition of classes by age. Age at enrolment varies from as young as five to as old as thirteen years (BEST 1994): in any one class, there may be students at a stage where they can assimilate and comprehend information on menarche, as well as those perhaps too young to benefit from such information. There is a need to realistically confront the reproductive health problems of youth to deal appropriately with pertinent issues such as older teenagers who are sexually active or already pregnant, teenagers who already have an STD, or those who are worried about menarche or wet dreams.

An important aspect of reproductive health services which is lacking in Tanzania for both school and out-of-school youth is counselling and social skills development. Given the pressure to conform to peer norms, coupled with psychological and physical changes brought about by puberty, there is a need for services which will deal with the conflicts that the young experience with regard to their developing sexuality. There are no formal counselling services for young people, and the informal traditional support services within which sexuality was dealt with do not appear to be operational or relevant for the current life styles of many Tanzanian communities. Focus-group discussions in Rombo District, Tanzania indicated that wet dreams were interpreted as an illness arising from lack of a coital relationship (Leshabari, Kaaya and Kawau 1996). However, there is no documented information on other apprehensions young people may have regarding their sexual development. Data indicate difficulties for both boys and girls in negotiating a healthy relationship with the opposite sex (Leshabari, Kaaya and Kawau 1996). In the Rombo survey there appeared to be a very fine demarcation between verbal acknowledgment of sexual attraction and sexual intercourse; ways are needed to develop the social skills of young people to allow for healthy interactions between the sexes. There is a need for appropriate reproductive health counselling services, as well as identification and development of the necessary social skills to ensure healthy sexual behaviour.

Existing policies now allow reproductive health information and services for any sexually active person (MOH 1994). However, implementation of such policies is not possible when there has been no change in the attitudes of service providers towards provision of such services to youth, especially adolescents. Similarly, the communication skills of providers should be modified to meet the needs of youth; and the infrastructure for providing services to youth needs to be considered. It would be unrealistic to expect that a single 15-year-old girl

will approach a clinic providing contraceptive services during adult consultation times, considering that her adult relatives may be attending the clinic.

Pregnant girls are now allowed to continue school after delivery, but given the poor state of repair of most schools, this will be difficult. For school girls with babies to continue with classes, schools need childcare facilities. Given that existing schools do not have even basic facilities to cater for learning and teaching, let alone hygiene needs, it is difficult to see how girls with their babies can be accommodated.

The current move towards introducing reproductive health information as part of family life education in schools in Tanzania is encouraging. However, these measures have primarily involved the Ministry of Education. There is a strong need for a multidisciplinary approach in the planning and implementation of measures concerning young people's reproductive health. It is important for all those involved in the socialization of children and youth to realize the importance of the roles and responsibilities of each participant rather than isolation and blame of others.

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