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CONTINUUM *Complete*

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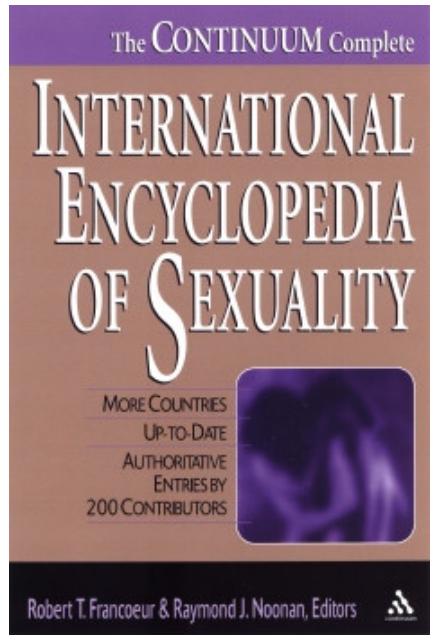

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CU59

Tanzania

(The United Republic of Tanzania)

Philip Setel, Eleuther Mwageni,
Namsifu Mndeme, and Yusuf Hemed*
*Additional comments by Beldina Opiyo-Omolo, B.Sc.***

Contents

Demographics and a Brief Historical Perspective

PHILIP SETEL

A. Demographics

The United Republic of Tanzania is situated on the mainland of the East Coast of Africa and includes the Islands of Zanzibar and Pemba, separated from the mainland by a 25-mile-wide (40-km) channel. The country is one of the largest in Eastern Africa, with an area of about 364,900 square miles (945,000 square kilometers), about twice the size of the state of California in the United States. Tanzania shares borders with Kenya and Uganda to the north, Rwanda and Burundi to the northwest, Zaire to the west, Zambia to the southwest, and Malawi and Mozambique to the south.

(CIA 2002)

Tanzania has a diverse topography. The narrow coastline lies less than 200 meters (655 ft.) above sea level. Most of the country is a plateau with an altitude of more than 1,000 meters (3,280 ft.) above sea level. The landscape rises towards the south to reach about 3,000 meters (9,840 ft.) above sea level in the Southern Highlands. Further north, the altitude reaches over 5,000 meters (16,400 ft.) in the Northern Highlands of Tanzania. Mount Kilimanjaro, the highest point in Africa, is 5,895 meters (19,340 ft.) above sea level. Tanzania contains three of Africa's best-known lakes: Victoria in the north, Tanganyika in the west, and Nyasa in the south. The highlands of Tanzania are the most fertile areas in the country, and have a denser population than other parts of the country. Tanzania's climate is reflected in the variations in altitude. The coastal area has high temperatures of about 30° C (86° F) and receives long rains between February and May and short rains during the October to December period. The plateau is subject to high temperatures during the day and is relatively cool at night. This area has a low rainfall and experiences long dry spells between May and October. The highlands as well as the western part of the country have high rainfall, especially between February and April.

In July 2002, Tanzania had an estimated population of just over 37 million. The estimates presented below explicitly take into account the effects of excess mortality because of AIDS. This can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected. (All data are from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: *0-14 years*: 44.6% with 1.01 male(s) per female (sex ratio); *15-64 years*: 52.5% with 0.98 male(s) per female; *65 years and over*: 2.9% with 0.83 male(s) per female; *Total population sex ratio*: 0.99 male(s) to 1 female

Life Expectancy at Birth: *Total Population*: 51.98 years; *male*: 51.04 years; *female*: 52.95 years

Urban/Rural Distribution: 25% to 75%. In 2001, Dar es Saalam, the capital, had an estimated population of about 1.4 million and Mwanza about 225,000.

Ethnic Distribution: Mainland: native African 99% (of which 95% are Bantu consisting of more than 130 tribes);

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***Editors' Note*: We would call the reader's attention to a simple but crucial sentence in the Brief Historical Perspective, where the authors note that "Tanzania is one of the poorest countries in the world, with a per capita gross domestic product (GDP) of US$220." (Five years earlier, in 1997, the GDP was $700.) Since 1990, Tanzania's economic condition has steadily worsened, stressed by a near 3% annual population growth. Between 1993 and 1996, close to a half million Rwandan Hutu fled into Tanzania to escape ethnic strife with the Tutsi. In the 1990s, the nation's infrastructure and access to medical services and commodities, well-established in the 1970s, collapsed. In the midst of the deteriorating situation, Philip Setel, Project Director, Adult Morbidity and Mortality Project in the Ministry of Health, recognized the importance of this *International Encyclopedia* and organized a team to research and write this chapter on their country. Unfortunately, deteriorating meager resources and more-urgent health priorities, including over 800,000 AIDS orphans, made it impossible for them to provide information on all the topics in our standard outline. We thank them for their sincere effort and the insights they provide that are not available elsewhere.

other 1% (consisting of Asian, European, and Arab). Zanzibar: Arab, native African, and mixed Arab.

Religious Distribution: Mainland: Christian: 45%; Muslim: 35%; indigenous beliefs: 30%. Zanzibar: more than 99% Muslim. Tanzanians often affiliate with both indigenous and Western religious beliefs.

Birth Rate: 39.12 births per 1,000 population

Death Rate: 13.02 per 1,000 population

Infant Mortality Rate: 77.85 deaths per 1,000 live births

Net Migration Rate: –0.08 migrant(s) per 1,000 population

Total Fertility Rate: 1.33 children born per woman

Population Growth Rate: 2.6%

HIV/AIDS (1999 est.): *Adult prevalence*: 8.09%; *Persons living with HIV/AIDS*: 1.3 million; *Deaths*: 140,000. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (*defined as those age 15 and over who can read and write*): 67.8% (*male*: 79.4%, *female*: 56.8%). Education is free and compulsory between ages 7 and 14. Swahili and English are the official languages of Tanzania, though the majority of people continue to use the language of their ethnic group.

Per Capita Gross Domestic Product (*purchasing power parity*): $610 (2001 est.); *Inflation*: 5%; *Unemployment*: NA; *Living below the poverty line*: 51.1% (1991 est.)

Some basic demographic indicators for the country are presented in Table 1. Population growth in Tanzania, as in most African countries, is largely influenced by fertility and mortality rates, particularly deaths because of HIV/AIDS. As shown in Table 1, the total fertility rate is high, but showed a significant decline in the 1990s.

B. A Brief Historical Perspective and Cultural Setting

The original inhabitants of Tanzania were probably hunter/gatherers of the Khoisan-speaking peoples. The remnants of these are the Sandawe and Hadzapi minorities found in central Tanzania. During the first millennium, Bantu-speaking people occupied and settled most of what is now Tanzania. The Nilotic people migrating from the Sudan and the Semi-Cushitic who settled in the northern plains of the country followed later.

Tanzanian contacts with people from outside the African continent began around 700 C.E., when Arab traders visited the East African coast. Portuguese explorers reached the coastal area around 1500 and dominated trade up to the 17th century, when the Arabs from Oman displaced them. The fluorescence of coastal trade and society gave rise to the Swahili language about 1,200 years ago. Swahili has become a *lingua franca* from south Somalia, to Kenya, Uganda, the Democratic Republic of Congo, the Comoros, and North Mozambique. Following the partition of Africa by the colonialists, Tanganyika became a colony of Germany, together with Rwanda and Burundi. After World War I, Tanganyika was taken over by British colonialists as a protectorate. Tanganyika attained its independence in 1961 after about 77 years of colonial rule. Zanzibar was under the dominance of the Oman Arabs until 1890, when it came under the British colonial rule. In 1964, Zanzibar became independent. In the same year, Tanganyika and Zanzibar united to form a United Republic of Tanzania.

Tanzania is one of the poorest countries in the world, with a per capita gross domestic product (GDP) of US$220 (Population Reference Bureau 2000). The country has a mixed economy, with agriculture, mining, and tourism contributing the largest shares. Economic performance and trends in Tanzania have not been favorable since attaining independence in 1961. During the 1960s, the GDP was estimated to be growing at an annual rate of 6%. There was a growth decline of GDP to about 4% during the 1970s, and a further decline to less than 2% growth during the 1980s (The Planning Commission 1992).

Several internal and external factors have contributed to the dismal economic situation, especially during the late 1970s and mid 1980s. Internally, the economy was mismanaged and there were many policy failures. An annual population growth rate of about 3% during this period was another contributing factor (The Planning Commission 1992). Population growth put additional pressure on economic and social conditions, especially in terms of provision of social services and access to basic commodities. The existence and the quality of a good health infrastructure, for example, which was established in the early 1970s, deteriorated, and services collapsed because of lack of drugs and medical supplies.

Externally, the Tanzanian economy was affected by the deterioration of the country's major exports (sisal, coffee, and tea) on the world market and the oil crisis of the 1970s. Between 1978 and 1979, the country also considerably depleted its economic resources in the war against Uganda, which toppled President Idi Amin. Finally, there was a tremendous decline in external assistance as the country's external debt burden increased because of some of the factors just mentioned. The combined effects of these factors were devastating to the living standards of the population.

The economic growth rate has started to show some signs of recovery as a result of economic reforms. GDP grew 3% in 1994 and 3.9% in 1995 (Bureau of Statistics and Macro International 1997). This growth rate was still lower than the targeted 5% envisaged by the 1995-1998 Economic Recovery Programmes.

1. Basic Sexological Premises, and 2. Religious, Ethnic, and Gender Factors Affecting Sexuality

A. Character of Gender Roles

Gender roles are shaped within the social structure. There is, however, a diversity of tribal societies often with distinct gender roles in Tanzania. In most of Tanzania, gender roles reflect the dominance of men over women. Customs tend to discriminate against women and men have an upper hand in the ownership and control of resources of pro-

Table 1

Selected Demographic Indicators, Tanzania 1967-1997

Indicator	1967	1978	1988	2000	2002
Population (millions)	12.3	17.5	23.2	35.3	37
Density (pop. per km^2)	14.0	20.0	26.0	37.4	—
Percent urban	6.4	13.8	18.3	20.0	25
Crude birthrate	47.0	49.0	46.0	42.0	39
Crude death rate	24.4	19.0	15.0	13.0	13
Total fertility rate	6.6	6.9	6.5	5.6	1.33
Infant mortality rate (per 1,000 live births)	155.0	137.0	115.0	99.0	78
Under-5 mortality rate per 1,000	—	—	—	143.0	—
Life expectancy at birth	41.0	44.0	48.0	53.0	52
Household size	4.4	4.9	5.2	—	—

Source: Bureau of Statistics 1989; Ngallaba et al. 1993; Population Reference Bureau 2000

duction and distribution (such as land, livestock, tools, and children) as well as in decision making. There is a strong sexual division of labor, especially in the domestic sphere, which is associated with women.

B. Sociolegal Status of Males and Females

The social and family structures of Tanzania's many ethnic groups influence the ideological, cultural values and norms including sexuality. Traditionally, the social structure has been based on two kinship patterns, the patrilineal and matrilineal systems. In patrilineal systems, inheritance and power is vested with the husband's clan, based on the father-son relationship. In matrilineal societies, the status of children is established through their mother's clan. A woman's brother, though, has power and authority over the children of his sister and they normally inherit through him. In other words, contrary to the patrilineal system, in the matrilineal system, ties are not established between mother and daughters but between the mother's brother and her children. An estimated 80% of the Tanzania's ethnic groups are patrilineal (TGNP & SARDC-WIDSAA 1997). Matrilineal societies, historically more prevalent in coastal areas, declined in the 19th and 20th centuries.

C. General Concepts of Sexuality and Love

Sexuality is rooted in social reproduction (Setel 1999) and is part of the social structure as stated earlier. Traditionally, in many societies, the issue of sexuality was considered secretive and the domain of adults. Sexual knowledge and education was part and parcel of initiation into adulthood for both males and females. Sexual life in Tanzania is widely considered to have three major roles: reproduction, expansion of kinship, and physical pleasure (Mbunda 1991). Sexual pleasure required expertise and the appropriate social context. Different ethnic groups had different ways of achieving sexual excitement. These included use of amulets, massage, caresses, fondling, wearing beads, waist, and belly dancing. However, sexual pleasure had to occur in a socially accepted context like marriage. Other kinds of sexual activity, such as adultery, homosexuality, child abuse, incest, and rape, were unacceptable, as they violated the social order.

Sexuality is also associated with physical and social development within the communities' social-control framework. There was a clear code of "dos and don'ts" at different stages of physical development. Members of the community are expected to observe certain norms before puberty, at puberty, and at marriage (see norms in Sections 5A, Interpersonal Heterosexual Behaviors, Children, 5B, Adolescents, and 5C, Adults). Those who conform are rewarded and those who do not are punished. For example, among the Zaramo, brides who were not virgins on their wedding day were ridiculed and were regarded as a disgrace to their family members; the marriage could be dissolved on such occasions (Mbunda 1991). Likewise, among the traditional Meru and other groups that follow the age-set system (Maasai, for example), it was considered to be incest for a man to have a sexual affair or to marry any woman other than a woman of his own age set (Haram 1999). This is because these daughters were considered as their categorical daughters. Most of these norms were not only monitored by the family, but also by the community, including neighbors, elders, and clan members.

These norms were imparted from one generation to another through socialization, a process whereby the youngest members of the community were prepared to live in the world of adults, reflecting the norms and values of the specific society. This socialization process took a variety of forms from one society to another, although at the lowest level, it involved the family as an institution and the community at the highest level. On both levels, socialization was done separately for girls and boys. At the family level, boys were socialized at the father's fireplace school and girls by mothers in the kitchen school (Mbunda 1991). While boys were trained to be "men" (outside looking, open minded, and making decisions), girls were trained for their role of housewife and mother.

At the community level, socialization was achieved through initiation ceremonies. These were meant to transmit knowledge and values concerning procreation, mores, sexual skills, and good manners. Initiation ceremonies were offered once boys and girls had attained puberty. As stated earlier, boys and girls were separated for these rites. Boys' initiation is called (in Kiswahili) *jando* and that for girls *unyago* (Ntukula 1994). Among the Zaramo, for example, the *jando* curriculum for boys included good manners, bravery, the secrets of life, marriage, death, the responsibilities a man has to carry, and the customs and taboos to be observed. Girls were taught about male physiology, sexual intercourse, pregnancy, childbirth, and responsibilities of a good wife and mother in their *unyago* 'schools.' (Mbunda 1991). In some societies, circumcision (of both males and females) culminated the initiation ceremony.

3. Knowledge and Education about Sexuality

BELDINA OPIYO-OMOLO

A. Formal Sources of Sexual Knowledge

See the preceding paragraph.

[*Comment 2003*: In Tanzania, puberty is a culturally marked period of the lifecycle in which young men and women learn about their social responsibilities, including knowledge about sexual behavior and reproduction as adults in their communities through initiation rites, or passage to adulthood.

[B. Informal Sources of Sexual Knowledge

[Although sex education was an important component of puberty rituals for Tanzanian adolescents, in the past, such rituals were not common to all Tanzanian settings. The Shinyanga Region of west central Tanzania is a case in point. Knowledge about sexuality was not necessarily acquired through structured rituals of initiation. Young girls learned about their bodies and about the reproductive cycle in an informal, non-uniform way. For example, mothers would give some instruction on sexual techniques to daughters who were about to get married on how to satisfy their husbands, thus preventing them from wandering off elsewhere to find pleasure. Other informal networks of information available to young girls included discussion with each other, and practical experience gained through interactions with young men who visited the huts where the girls slept late at night. The girls slept in what was called *Maji*, outer rooms for grandparents where girls slept on their own. (*End of comment by B. Opiyo-Omolo*)]

4. Autoerotic Behaviors and Patterns

For attitudes toward masturbation and its practice by children, adolescents, and adult men and women, see Sections 5A, Children, and 5B, Adolescents, below.

5. Interpersonal Heterosexual Behaviors

A. Children

The following list indicates specific sexual behaviors that are acceptable as normal before puberty by different tribal cultures. This is not a comprehensive list because atti-

tudinal information is only available for a few behaviors in the many tribal traditions in Tanzania.

- Playing with one's own genitals: Chagga
- Singing & dancing love songs: Chagga, Fipa, Nyakusa, Sukuma, Zaramo
- Touching or fondling and sucking mother's breasts: Chagga, Gogo, Makonde, Makonde Malaba, Maasai, Nyakyusa, Nyaturu Sukuma, Zaramo
- Playing father/mother games: Chagga, Fipa, Makonde, Makonde Malaba, Maasai, Nyakyusa, Nyaturu Sukuma, Zaramo
- Fondling and kissing: Chagga, Makonde, Makonde Malaba
- Masturbation: Fipa
- Interest in sexually exciting stories and games: Fipa, Nyaturu
- Interest in one's own genitals or buttocks: looking or touching: Gogo, Maasai, Nyaturu, Zaramo
- Enjoying genitals being touched during washing: Gogo, Zaramo
- Causing penis or clitoris to become erect: Gogo, Makonde, Makonde Malaba, Sukuma
- Interest in opposite sex: Maasai
- Lovemaking and sexual intercourse: age 7 to 14: Maasai (*Source*: Mbunda 1991)

Sexual behaviors that are unacceptable for children before they enter puberty; again this is not a comprehensive list.

- Sexual intercourse: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Maasai, Nyaturu, Sukuma, Zaramo
- Overindulgence in private masturbation: Fipa, Makonde, Makonde Malaba
- Interest in watching animals mate: Gogo, Makonde, Makonde Malaba, Nyakyusa, Nyaturu
- Watching people mating: Zaramo
- Public masturbation: Makonde, Sukuma
- Prostitution: Makonde
- Sodomy: Maasai
- Bestiality: Maasai
- Rape: Maasai
- Incest: Maasai
- Preoccupation with one's own genitals: Nyakyusa, Nyaturu, Zaramo
- Association with the other sex: Nyakyusa
- Touching anothers' genitals: Zaramo (*Source*: Mbunda 1991)

B. Adolescents

The onset of puberty brings major changes in what behaviors the various cultures of Tanzania consider acceptable for adolescents. Acceptable behaviors include:

- Interest in the other sex: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Maasai, Nyakyusa, Nyaturtu, Zaramo
- Private masturbation: Chagga, Fipa, Gogo, Nyakyusa, Nyaturtu, Sukuma, Zaramo
- Interest in sex-related stories, songs, and dancing: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa, Sukuma, Zaramo
- Female or male circumcision: Chagga, Gogo, Maasai, Nyaturu, Zaramo
- Interest in sex ornaments, e.g., beads: Chagga, Zaramo
- Interest in sexual development: Fipa, Gogo, Nyakyusa, Nyaturu, Zaramo
- Interest in learning lovemaking techniques: Fipa, Zaramo
- Playing father and mother: Gogo
- Sexual intercourse with several partners: Maasai
- Sexual fantasies: Gogo, Nyakyusa
- Enlargement of clitoris: Nyakyusa
- Interest in male activities: Nyaturu
- Playing *chagulaga* ("Choose the one you love"), a premarital sex-for-fun game often played after evening dances, where a boy runs after a girl, usually one with whom some kind of understanding has been established: Sukuma (*Source*: Mbunda 1991)

Sexual practices unacceptable for adolescents after the onset of puberty include:

- Public masturbation: Chagga, Makonde, Makonde Malaba, Nyakyusa, Nyaturu, Zaramo
- Interest in watching animals mate: Chagga, Fipa, Gogo, Nyakyusa, Sukuma
- Sexual intercourse: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Courtship: Makonde, Makonde Malaba, Nyakyusa
- Sodomy: Makonde, Makonde Malaba, Maasai, Nyakyusa
- Bestiality: Makonde, Makonde Malaba, Maasai
- Rape: Makonde, Maasai
- Incest: Makonde, Maasai
- Child abuse: Makonde, Makonde Malaba
- Lesbianism: Maasai, Nyakyusa
- Close association with the other sex: Nyakyusa, Nyaturu (*Source*: Mbunda 1991)

Male Circumcision. See Section 5B above.

Female Circumcision. The government of Tanzania has made female circumcision (genital mutilation) illegal and a punishable offense. Although it has been illegal for some time, female circumcision was traditionally and still is practiced secretly in several regions of Tanzania as an initiation ritual of preparing youth for womanhood. The justifications for female circumcision are varied. It is argued that female circumcision trained a woman to overcome the pains, and thus prepared her to bear the pains of child labor and birth (Haram 1999). It is also reported that female circumcision in some ethnic groups of Tanzania was practiced as a measure to control the sexuality of women (Mbunda 1994; Haram 1999). It is assumed that circumcision reduces the woman's sexual urge and thus makes her faithful to her partner (Mbunda 1991; Haram 1999).

Data on the levels and patterns of female circumcision in Tanzania have been documented by the 1996 DHS (Bureau of Statistics & Macro International 1997). Nationwide, about 18% of Tanzanian women have undergone circumcision, mainly in eight out of 25 regions in the country. The regions with the highest incidence are: Arusha 81.4%; Dodoma 67.4%; Mara 43.7%; Kilimanjaro 36.9%; Iringa 27%; Singida 25.4%; Tanga 25.1%; and Morogoro 20.2%.

Clitoridectomy and excision are the major types of circumcision in the country. The majority of women are circumcised between ages 6 to 20 years. Circumcision is more likely to be practiced by those living in the rural areas than their urban counterparts. As in many other parts of sub-Saharan Africa, traditional practitioners perform circumcision. These are normally elderly women who have experience in the practice.

The unhygienic condition through which female circumcision is conducted is creating serious health risks among women. Political leaders, religious organizations, and other nongovernmental agencies (NGOs) have campaigned against the practice, but without success. This is because, as stated previously, the practice is done secretly. Sometimes the victims and the practitioners are either hidden or shielded. Perhaps sensitization of the adults, the main promoters, and examination of the cultural factors underlying the practice can help.

C. Adults

Patterns of sexual values and relations in Tanzania have changed following the influence of colonialism and imperialism since the beginning of the 19th century. However, local or "customary" norms and patterns are still practiced in many rural areas. The coming of colonialism led to the introduction of a cash economy based especially on plantation agriculture. This led to labor migration from labor-exporting areas to the plantations and mines. The process had an impact in both areas. The male labor migration led to a deficit of men in labor-exporting areas and a surplus of men in the cash-economy areas. Rural migration, urbanization, and formal education are other factors that have led to social change in traditions. As a result, family composition, structure, and functions have also changed, as they have in similar ways in much of the rest of sub-Saharan Africa. Extended family and kinship structures are changing to a more nuclear model. Parental authority is weakening, intermarriages among Tanzanian ethic groups are on the increase, and an increasing number of people remain unmarried or are attached to temporary relationships. For example, in the past, conjugal relations were formalized with negotiations between parents and relatives of the couples (taking care of the parents' of the couples interests). Nowadays, it is not uncommon to find that such negotiations involve the partners concerned.

The Ideal Spouse

The characteristics of the ideal husband and wife vary with different cultures within Tanzania. Some examples of ideal characteristics for husbands follow with no indication of ranking:

- Sexually virile and attractive: Chagga, Fipa, Gogo, Makonde, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Graduate of puberty initiation: Chagga, Gogo, Makonde, Makonde Malaba, Zaramo
- Circumcised: Chagga, Gogo, Maasai, Nyaturu
- Uncircumcised: Nyakyusa
- Hard working and productive: Chagga, Fipa, Makonde, Maasai, Zaramo
- Able to support the family financially: Chagga, Fipa, Gogo, Nyakyusa, Nyaturu, Sukuma
- Healthy and strong: Chagga, Makonde, Makonde Malaba
- Loyal to family, clan, and in-laws: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Masai, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Affectionate to wife and children: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Sexually stimulating and appealing: Fipa, Makonde, Makonde Malaba, Maasai, Nyakyusa, Sukuma, Nyaturu, Zaramo
- Rich in cows or cattle: Gogo, Maasai
- Courageous in war: Nyakyusa
- Cooperative and helpful to in-laws: Nyaturu (*Source*: Mbunda 1991)

The characteristics valued in a wife are as follows (not ranked):

- Sexually energetic and attractive: Chagga, Gogo, Makonde, Makonde Malaba, Maasai, Sukuma Nyakyusa, Nyaturu, Zaramo
- Enlarged clitoris: Nyakyusa
- Able to bear many children: Chagga, Fipa, Gogo, Makonde, Maasai, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Able to care for family: Chagga, Fipa, Gogo, Makonde, Maasai, Nyakyusa, Nyaturu, Sukuma, Makonde Malaba
- Loyal and affectionate to husband and children: Chagga, Fipa, Gogo, Makonde, Maasai, Nyakyusa, Nyaturu, Sukuma, Zaramo, Makonde Malaba
- Affectionate to clan and in-laws: Chagga, Fipa, Makonde, Makonde Malaba, Maasai, Nyaturu, Nyakyusa, Sukuma, Zaramo
- Expert at lovemaking and sexual intercourse: Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa
- Good housewife and cook: Gogo, Makonde, Nyakyusa
- Able to get along with husband's other wives: Gogo
- Hard working: Makonde, Makonde Malaba, Nyaturu, Sukuma, Zaramo
- Well-educated sexually: Maasai
- Circumcised: Nyaturu
- Graduate of puberty initiation: Zaramo (*Source*: Mbunda 1991)

Marital Norms and Values

Just as puberty marks the transition from childhood to adolescence and a new set of behavioral values, both acceptable and unacceptable, so marriage is marked by a new set of behavioral values. Among the norms acceptable for married persons are:

- Courtship: Chagga, Fipa, Gogo, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Wedding: Chagga, Fipa, Gogo, Nyaturu, Sukuma, Zaramo
- Sexual intercourse: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa, Nyaturu, Zaramo
- Masturbation: Chagga, Makonde, Makonde Malaba
- Polygamy: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa, Nyaturu, Zaramo
- Secret liaisons for barren couples: Gogo
- Fondling: Makonde, Makonde Malaba
- Sex-related stories and dances: Makonde, Makonde Malaba
- Sexual intercourse with spouse only: Masai
- Pregnancy and childbirth: Chagga, Fipa, Gogo, Makonde, Makonde-Malaba, Masai, Sukuma, Nyakyusa, Nyaturu, Zaramo
- Playing *chagulaga*: Sukuma (*Source*: Mbunda 1991)

Unacceptable sexual behaviors for married persons include:

- Adultery: Chagga, Fipa, Makonde, Makonde Malaba, Maasai, Nyakyusa, Nyaturu, Sukuma, Zaramo. As noted later in Section 9, Contraception, Abortion, and Population Planning, available data indicate that between 14% and 26% of Tanzanian men are involved in extramarital relationships (Weinstein et al 1995; Mwageni 1996).
- Sodomy: Chagga, Fipa, Makonde, Makonde Malaba, Maasai, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Child abuse: Chagga, Maasai, Nyakyusa, Sukuma
- Rape: Chagga, Gogo, Makonde, Makonde Malaba, Maasai, Nyaturu, Sukuma, Zaramo
- Prostitution: Chagga, Fipa, Makonde, Nyaturu, Sukuma, Zaramo
- Abortion: Chagga, Fipa, Gogo, Makonde, Makonde Malaba, Nyakyusa, Zaramo
- Incest: Chagga, Fipa, Makonde, Makonde Malaba, Maasai, Nyaturu, Sukuma, Zaramo
- Bestiality: Fipa, Maasai, Nyakyusa, Nyaturu, Sukuma, Zaramo
- Masturbation: Fipa
- Lesbianism: Makonde, Makonde Malaba, Maasai, Nyakyusa
- Polyandry: Nyakyusa (*Source*: Mbunda 1991)

[*"Dry Sex" or "Wet Sex"*

[*Comment 2001*: As noted earlier in the Nigeria and Kenya chapters, sexual relations in subequatorial Africa are male-dominated, with the male initiating coitus and dictating its style and pace. Female response and satisfaction are not considered important. Coitus usually takes place with no foreplay. The male-above position is standard, and marital coitus is for procreation, not for pleasure. Women in many African cultures do not even know what female orgasm is, and may have never experienced it. In describing mating customs in the chapter on Ghana, Augustine Ankoma reports that penile-vaginal penetrative sex with little foreplay is the normal sexual style. Although among the well-educated youth, some forms of foreplay are gaining a foothold, fellatio and cunnilingus are abhorrent. Genital manipulation is hardly accepted and traditionally women feel shy to touch the penis, and most men are not interested in having their genitals manipulated.

[These male-oriented cultural values underlie what is appropriately termed "dry sex," a common practice throughout sub-Saharan Africa. The "dry sex" mating behavior fits comfortably with the male distaste for vaginal secretions, foreplay, and disinterest in female sexual arousal and orgasm. In this setting, males quickly reach orgasm and their satisfaction. Women experience painful intercourse, with no arousal and no orgasm.

[In many African cultures, women prepare themselves to pleasure their husbands with a dry vagina by mixing the powdered stem and leaf of the *Mugugudhu* tree with water, wrapped in a bit of nylon stocking and inserted into the vagina 10 to 15 minutes before intercourse. Other women use *Mutendo wegudo*, soil mixed with baboon urine, which they obtain from traditional healers, Still others use detergents, salt, cotton, or shredded newspaper. These swell the vaginal tissue, make it hot, and dry it out. The women admit that sexual intercourse is "very painful, but our African husbands enjoy sex with a dry vagina" (Schoofs 2000).

[The inevitable results of "dry sex" include increased friction, vaginal lacerations, suppression of the vagina's natural bacteria, and torn condoms (when these are used). All these consequences increase a woman's risk of STD and HIV infections. Fortunately, the tradition of "dry sex" is waning among the educated urban young, but any change in this traditional mating behavior is also resisted because of rejection of Western gender roles (Stellwaggon 2001).

["Dry sex" is a well-established and more or less wide spread practice in various subequatorial African cultures. It is common in Southern Africa, particularly in Zimbabwe, Zambia, Malawi, some parts of Nigeria, some parts of Uganda, in Southern Sudan, and even in Kenya and Botswana. The only difference is in what these women use for drying up their vaginas.

[In the northwest part of Tanzania and neighboring regions, "wet sex" is widely known and practiced. "Wet sex" consists of foreplay where there is intense stimulation by the male partner on the woman's labia and clitoral regions. This stimulation results in copious production of secretions (thought to come from Bartholin's glands). People talk about it openly, sometimes mixed with a sense of humor and intertribe jokes. Some researchers have blamed this practice for the high incidence and prevalence of HIV and STDs. The implications of this kind of information for action plans (resource inputs and sociocultural issues) are enormous. Now that these behaviors have been brought into public attention, a well thought-out survey that is representative of different segments of the populations becomes essential for an effective public health policy (Tanzania, personal communication 2003).

[In March 2003, when the editor of *CCIES* inquired whether "dry sex" was observed in Botswana, Dr. Ian Taylor replied; "'Dry sex' is common in Botswana as well and leads to vaginal tears and lesions which help spread HIV/AIDS, it is true." (*End of comment by B. Opiyo-Omolo*)]

6. Homoerotic, Homosexual, and Bisexual Behaviors

[*Comment 2003*: In Tanzania, male homosexuality is illegal under the penal code inherited from the British. The law in Tanzania criminalizes gays. Male homosexual acts are punishable by up to 14 years, even though in practice, the law is rarely enforced, because it is difficult to obtain any proof that someone is a homosexual. In Swahili, there is traditionally no word for *male homosexual*. However, recently a word has been coined: *Msenge*, a Swahili word for "passive" or "femme" gay man. There is also a term for *lesbian*: *Msagaji*, literally, "one who grinds." The verb for lesbian lovemaking, *Sagana* means "grind together." In Tanzania, lesbians are even less visible than gay men. (*End of comment by B. Opiyo-Omolo*)]

7. Gender Diversity and Transgender Issues

Not reported.

8. Significant Unconventional Sexual Behaviors

As noted earlier, the purpose of sexual relations was traditionally viewed as having three functions: reproduction, expansion of kinship, and pleasure. It was also reported that some unconventional sexual relations that were harshly dealt with were sanctioned within a specific social context. However, sexual life, like political, religious, cultural, and social life, continues to change, and new forms of sexual behavior, some of which could be called "unconventional," are emerging, as described in detail in the following sections.

A. Coercive Sexual Behaviors

The penal code recognizes various sexual offenses. These offenses include forced marriage, sexual assault, and procurement of women or girls for the purpose of prostitution (The Centre for Reproductive Law and Policy 1997. In Tanzania, child sexual abuse and rape are punishable by imprisonment for life.

Child Sexual Abuse, Rape, and Sexual Harassment

Reported sexual abuse of young girls is on the increase in Tanzania. In 1995, about 756 child sexual abuse cases were reported (TAMWA undated). In 1997, of the 129 reported incidences of sexual abuse, 63% were in Dar es Salaam and 8% were in Mbeya (LHRC 1997). The victims of sexual abuse are as young as nine months old while the assailants are adults mainly in their 20s or 30s, but a few are as old as 50 years (LHRC 1997). The majority of the cases, however, are not reported because of social stigma, fear, ignorance, and cumbersome legal procedures. The increase in reported sexual abuse cases could easily be because of a rise in the consciousness of women's rights and an increased willingness to use official judicial channels to deal with such matters.

In the case of child sexual abuse, the assailant usually seduces the victim with sweets or other gifts and later abuses the child. In other incidences, the assailants are individuals trusted by mothers to take temporary care of their children while they perform other duties nearby or are a distance away doing some errand. Others are simply ambushed on their way home or to school. Sexual abuse is not limited

only to girls, but also involves boys. While sexual abuse for boys involves anal penetration, for girls it is both anal and vaginal penetration. The assailants are sometimes known to the victims and in others cases they are not.

The reasons for the increase of sexual abuse to children are not exactly known. It is argued that some adults are seeking to have sexual relations with young people thought to be free of HIV (Rajani & Kudreti 1995). Certain groups of people appear to be more vulnerable to sexual abuse than others. For example, girls, street children, the disabled, and children that are not biologically related to the family are more likely to be abused than others. Sexual abuse in such situations is made in exchange of protection offered by the assailants. Abuse to children is also caused by inability of the assailant to approach mature women. Sometimes abuse is associated with superstition; success in business is believed to be associated with having sexual relations with certain special groups of people. Usually, a traditional fortuneteller gives such advice. For example, LHRC (1997) reported that in November 1996, one assailant, assisted by his wife, abused a 9-year-old girl in one of the gold-mining areas of Tanzania dominated by small-scale miners. In other incidences, assailants claim to have irresistible sexual drive (LHRC 1997).

Reported incidences of rape increased from 81 in 1990 to 365 in 1993. It is noted that rape cases increased from 497 in 1991 to 736 in 1992, while sexual assaults increased from 8 in 1992 to 37 in 1993 (TGNP & SARDC-WIDSAA 1997).

Between 1990 and 1992, no cases of sexual harassment were recorded in Tanzania. This does not mean they were no such incidences, but, as argued earlier, people did not report such incidents. However, by 1995, 74 cases were reported (TAMWA undated). These included touches on the buttocks or breasts. Protection against sexual harassment in the working place is found in the Security of Employment Act, although the definition of harassment is not provided. Although police are responsible for arresting the accused once any offense is reported, most cases go unreported and no one is arrested.

B. Prostitution

Prostitution is translated in Kiswahili as *umalaya* and the prostitute as *Malaya*. *Umalaya* is used to refer to the sex life of an individual considered to be promiscuous or loose in sexual relations. Prostitution is mainly urban-based and usually refers to women; in the traditional African culture, promiscuous or "loose" men are not considered as prostitutes. Traditionally, men were free to take as many sexual partners as they liked or could afford. In the l970s and 1980s, women practicing *umalaya* were known to be from certain ethnic groups. However, currently this is not the case, as it involves many Tanzanian ethnic groups. There are no real brothels, pimps, or touts in Tanzania. Most of the *Malaya* women are working for themselves.

There are several forms of prostitution. The "classical" *Malaya* women operate indoors. They stay inside their rooms and wait for men to visit them. These women have sex with any number of men who visit them for an agreed charge. Apart from providing her customers with sexual services, such a woman can offer other services to a regular partner, like food, bath water, and breakfast, in case a man spends a night in the house. In most cases, it is the customer who pays for most of these expenses. Although this form of prostitution ensures security from police arrests, it does not allow women to control who should come to them.

Another form of prostitution involves barmaids, guesthouse workers, and promiscuous married women. These types of women have their own residences like the classical *Malaya*; however, they may or may not invite their clientele to their places. Promiscuous married women mainly prefer guesthouses or the residence of the customer, while for the other categories of women, in addition to these two places, a customer may rent a separate room. In these types of sexual relationships, a woman has several boyfriends who may provide shelter or money for food and clothing in exchange for sexual pleasure (Setel 1999).

A new form of *umalaya* has emerged in Tanzania in the late 1990s, nicknamed *Uchangu Doa* (the person is nicknamed *Changu Doa* or *CD*. The name comes from a species of fish from the Indian Ocean. These fish are small in size, abundant, easy to fish, and cheaper compared to other species. The species is also known as *janja* (literally meaning clever in a cunning way, deceitful, or crafty). These features of the fish describe why the name *Changu Doa* was adopted to label this type of sexual behavior. *CD*s are young women in their teens and 20s, who usually earn their living by having multiple sexual partners. This type of sexual behavior is normally urban-based. *CD*s use different tactics to attract their customers. The tactics include positioning themselves in very strategic locations like street junctions or near famous pubs, tourist hotels, casinos, nightclubs, and other dark spots. They dress scantly in order attract the attention of their customers. The *CD*s "uniforms" include tights, see-through materials, miniskirts, and colorful materials. *CD*s are often assertive with their customers by calling, signaling, or revealing their most "valuable" body parts if need be. Many *CD*s acquire their training and tactics from peer groups, as well as from reading and watching pornographic magazines or films.

The *CD*s practice their operations during nights. Their "day" begins at around 9 p.m. Quitting time is largely influenced by their success in being picked by a customer, but is seldom later than 3 to 4 a.m. The main customers of the *CD*s are normally people who are seemingly rich, such as government officials and foreigners, especially the whites, tourists, and businessmen. Most of these people have money, yet do not have time to look around for women in order to satisfy their sexual desires.

Payment for services is negotiable and depends on the duration of the service, the economic and social status of the customer, status of the urban area, the location where the *CD* was encountered, time of the night, and education level of the *CD*. The longer the duration of services, the higher the price. *CD*s operate in large or well-known urban areas like Dar es Salaam, Arusha, or Dodoma. Those encountered near tourist hotels, city centers, and nightclubs or casinos are likely to be more expensive than elsewhere. Foreigners and wealthy customers are likely to be charged more than others. At times, a foreigner may even be required to pay in foreign currency. Likewise, *CD*s picked in the early hours of their operation may charge more than those picked in the late hours of the "day." Educated *CD*s have a better bargaining power and thus may be more expensive than those less educated.

Though *CD*s are mainly operating in urban areas, there are elements of this type of sexual behavior in rural areas, especially in small towns. In the rural areas, while *CD*s linger near bars and guesthouses, they are, however, not as aggressive as those found in large urban areas.

Rural women who have migrated to the city, and poor urban women, dominate the prostitution sector. Increased economic hardships, unemployment, and commercialization of goods as well as services, have contributed to the increase in prostitution. It can be argued that women engage in different forms of prostitution for economic motives as a means to secure resources that are owned and monopolized by men. Through such sexual relations, women use men as patrons to secure employment, cover for illicit business, advance their economic aspirations, purchase land, meet their

material needs, and obtain cash to make their ends meet (White 1990). In a way, such relations provide social and economic security among the women concerned. To some women, though, different forms of prostitution are practiced so as to maximize their sexual desires. The male partners, however, are after sexual pleasure, and having many sexual partners may be a symbol of virility as well as economic status. There is a feeling that a man who has several female partners has resources to do so and is thus wealthy.

Prostitution is illegal in Tanzania. Thus, such individuals are from time to time rounded up by police and the locations known to house prostitutes are raided. However, the victims of these raids are always females, as the male partners and patrons are left untouched.

C. Pornography and Erotica

[*Comment 2003*: Pornography is illegal in Tanzania. However, with greater access to technology and increasing Internet usage, Tanzania's antipornography laws are becoming more difficult to enforce. In June 2001, Tanzanian President Benjamin Mkapa announced that his government would be cracking down on pornography, particularly on the Internet.

[At a 2002 meeting of the UN committee on the Rights of the Child in Geneva, Switzerland, the committee raised concerns about the large and reportedly increasing number of child victims of commercial sex exploitation and sex tourism in Tanzania, including pornography. Under Tanzania Sexual Offenses Act of 1998, people found guilty of sexual exploitation of children, including child pornography, can face long jail terms.

[Despite all these, Tanzania still lacks the resources to put its antipornography policies into practice. The body charged with policing the Internet, the Tanzania Communication Commission (TCC), will have to find a way of stretching resources if it is to control the problem. (*End of comment by B. Opiyo-Omolo*)]

D. Other Unconventional Sexual Behaviors

There are occasional reported cases of males having carnal knowledge with animals (donkeys, goats, and birds, mostly ducks). This behavior is associated with superstition. The few cases reported involved men working in mining areas. It is thought by some individuals that having sexual relations with animals may increase their luck.

9. Contraception, Abortion, and Population Planning

A. Contraception

Contraceptive Knowledge

Large-scale reliable data on contraception in Tanzania has been available since 1993 following the introduction of the Demographic and Health Surveys (DHS) and the Tanzania Reproductive and Child Health Survey (TRCHS). According to TRCHS, as many as 93% of Tanzanians are aware of contraception (National Bureau of Statistics & Macro International 2000). Knowledge of modern methods is higher than it is of the traditional contraceptives, with 92% of the people aware of modern methods compared with 62% aware of traditional contraceptives. The most popular modern methods are the pill, IUD, male condom, injectables, and female sterilization, while withdrawal and periodic abstinence are the best known among the traditional ones. Men are more likely than women to be aware of the methods (92.8% vs. 90.9%). Among the currently married, men and women are more knowledgeable than sexually active unmarried men and women: 97.1% and 95.3% versus 96.1% and 91.6%, respectively.

Knowledge of modern contraceptive methods is higher among Tanzanian men and women who are: aged 20 to 34; living in urban areas; those with primary education or higher; monogamous men; those with one to three children; those who have not experienced child death; and skilled workers (Mwageni 1996; Bureau of Statistics & Macro International 1997). There are also regional variations in terms of awareness of the methods, with higher levels in Dar es Salaam, the coast, and the Lindi, Tabora, and Mbeya regions than in the rest of the country. (Compare with contraceptive use described below.)

Contraceptive Use

Rates of contraceptive use are inconsistent with awareness of the methods. Overall, 29.3% of men are more likely to use the methods than women (22.3%). Modern methods are more used than the traditional ones. The most popular methods are condoms, the calendar or rhythm method, pill, and injection. The discrepancy between knowledge and use calls for more promotion of family planning activities in Tanzania (National Bureau of Statistics & Macro International 2000).

The difference in use of methods between men and women needs more attention. It seems there is underreporting or exaggeration of some methods by men and women, respectively. Examination of variations in reporting usage of two methods, namely condom and withdrawal, may shed more light on this aspect (see Table 2). These two methods have been chosen because both partners have to be aware of their use. Under normal circumstances, if reporting is correct, very little difference would be expected between men and women. According to Table 2, concordance in reporting is more likely to occur with withdrawal than with the condom.

More unmarried women than married women use contraceptives, 33% compared with 25.4% (National Bureau of Statistics & Macro International 2000). However, among men, the opposite is the case (37% of husbands compared with 31% of single men). Several plausible reasons can be offered for this pattern. Firstly, it appears that the unmarried women are concerned about premarital childbearing. Secondly, a reasonable proportion of married men may have extramarital sexual relations with these single women, and use methods such as condoms both for family planning and for protection against STDs. Available data indicate that be-

Table 2

Male-Female Variation in the Use of Condoms and Withdrawal in Tanzania (in Percentages)

	Condom			Withdrawal		
Category	**Men**	**Women**	**Difference**	**Men**	**Women**	**Difference**
Tanzania (Total)	7.3	1.3	6.0	2.4	1.9	0.5
Mainland Tanzania	7.5	1.3	6.2	2.4	1.9	0.5
Total urban	15.2	3.5	11.7	1.3	1.1	0.2
Dar es Salaam	16.9	4.4	12.5	1.1	1.5	–0.4
Other urban	14.4	3.1	11.3	1.3	0.9	0.4
Total rural	5.2	0.7	4.5	2.8	2.2	0.6
Currently married	16.1	6.5	9.6	19.2	11.5	7.7
Sexually active single	35.2	18.4	16.8	11.5	8.1	3.4

Source: Compiled from Tanzania DHS 1996

tween 14% and 26% of men are involved in extramarital relationships in Tanzania (Weinstein et al. 1995; Mwageni 1996. Thirdly, it is possible that unmarried women are concerned with the costs of taking care of the children. Fourthly, this group of women may consist of students, who by law are not allowed to marry or bear children.

Data also reveal regional variation in the use of methods, with Kilimanjaro 38%), Dar es Salaam (30%), and the Coast regions (27%) leading in contraceptive use among women, while Rukwa (53%), Mbeya (39%), Singida (37%), Kigoma (33%), Dar es Salaam (32%) and Coastal regions (31%) are prominent for men using contraceptives (Bureau of Statistics & Macro International 1997). Furthermore, contraceptive use is higher for Tanzanian men and women who are: between age 30 to 40 years, living in urban areas, with secondary education or higher, with three to five living children, those with no experience of dead children, and highly skilled workers (Muvandi & Simbamwaka 1996; Mwageni 1996; Bureau of Statistics & Macro International 1997).

Trends in Contraceptive Knowledge and Use

Nationwide trends in Tanzania reveal an increase over time in awareness and use of both modern and traditional contraceptive methods. In 1991, for example, knowledge of modern and traditional contraceptive methods was 72% and 44%, respectively. By 1999, these levels had increased to 91% and 58% (National Bureau of Statistics & Macro International 2000). Use of modern contraceptive methods among women in 1991 was 10%; by 1999, this level had increased to 22% (National Bureau of Statistics & Macro International 2000).

Attitudes Towards Family Planning

Attitudes towards family planning are an important aspect in effective use of contraceptive methods. Several methods can be used to ascertain attitudes towards family planning, including surveys of approval, intention to use methods in the future, and acceptability of media messages on family planning.

Available data reveal that among the married, about 48% approve of family planning methods (Bureau of Statistics & Macro International 1997). Surprisingly, women (78%) are more likely than men (51%) to approve of family planning, although the level of knowledge and use is higher for men than for women. Otherwise, approval is likely to be higher among the educated and urban residents compared to other categories. In terms of differences between couples, approval is higher when the wife is older in age, where couples have age differences of less than four years, and where both the husband and wife are educated than the other way around. Further findings reveal that individuals with no religion and the unmarried are unlikely to approve of family planning (Muvandi & Simbamwaka 1996).

The intention to use family planning in the future is considerably high among both males and females than current actual use, although it is higher for the men than for the women. The majority of men and women accept the dissemination of family planning messages and information through media channels, especially radio and television (Bureau of Statistics & Macro International 1997).

B. Teenage (Unmarried) Pregnancies

Teenage pregnancy is not an uncommon phenomenon in Tanzania. According to available data, the youngest age at which girls become sexually active in the country is 11 years (Mpangile, Leshabari & Kihwele 1993). About 26% of women in the country begin childbearing during their teen years, between 15 and 19 years of age (Bureau of Statistics & Macro International 1997). As reported earlier, there are cases where girls had their first pregnancy at age 13 (Rugumyamheto et al. 1994; Tumbo-Masabo 1994; Mwageni 1998). Teenage pregnancy is more common among girls with no education (40%), as well as rural residents (27%), than among educated or urban residents (Bureau of Statistics & Macro International 1997).

Studies conducted in Tanzania reveal that the men responsible for adolescent pregnancies are heterogeneous. It is noted that the partner's age ranged between 16 to 52, the majority of them being over age 45 (Mpangile, Leshabari & Kihwele 1993). In another study, the partners of teenage mothers were noted to be of different social status, including the jobless, fellow students, mechanics, drivers, teachers, and managers (Mwageni 1998).

Teenage pregnancy is influenced by several factors. As noted, premarital sex was rare in the past because of earlier mean age of marriage, more parental control, as well as strong social sanctions. These conditions are no longer effective nowadays. Lack of communication between parents and children is another plausible factor. Ignorance among teenagers of the woman's physiological changes also contributes to teenage pregnancy. In a study of 40 teenage mothers in Dar es Salaam and Kigoma, Tumbo-Masabo (1994) noted that many of them learned about the relationship between menarche and conception after they had conceived. Such girls had also little knowledge of the process of labor and childbirth. One can argue that many teenage pregnancies happen because of ignorance of the consequences of sexual behavior.

Legal measures to control teenage pregnancy in Tanzania are complicated by contradictions within the existing laws. According to the Marriage Act, a man can marry upon attaining 18 years of age, and a woman at age 15. However, the Penal Code also states that "any person may marry or permit the marriage of a girl under the age of 12 years in accordance with the custom of the tribe or religion." At the same time, the law states that "any person who carnally knows any girl under age of 14 years is guilty of a felony and is liable to imprisonment for life, with or without corporal punishment."

C. Abortion

Induced abortion is illegal in Tanzania except when performed to save the mother's life. However, there is widespread practice of illegal induced abortion. [*Comment 2003*: In Tanzania, young girls who find themselves pregnant are expelled from school, a stark reality that is seen as instrumental to a young girl's decision to abort. (*End of comment by B. Opiyo-Omolo*)] Using a sample of 300 respondents among women who were admitted to a hospital in Dar es Salaam, a study found that 34% of them had practiced illegal abortion (Justeen, Kapiga & Asten 1992). In another study again done in Dar es Salaam, about 35% of the respondents interviewed had admitted intentionally terminating their pregnancies (Mpangile, Leshabari & Kihwele 1993). These estimates of abortion could be on the low side, because many abortions are conducted secretly and never reported. Either the male partner or a relative—mother, sister, or aunt, or the victim herself—facilitates the connection to the abortionist, including payment. The abortionists consist mainly of health workers or sometimes quacks. Places where abortions are conducted are numerous, including health facilities, hospitals, health centers, dispensaries, ordinary bedrooms, and occasionally in a simple room.

Induced abortion is more a problem of the young, unmarried, those with primary education, those who have lived in the city for six years or more, and those who know little about modern or traditional methods of family plan-

ning. The main reasons leading to abortion decisions include: inability to take care of an additional child, accidental pregnancy, inadequate birth spacing, and because the woman concerned was a student and feared expulsion (Mpangile, Leshabari & Kihwele 1993). Stambach (1996), in a study conducted in Machame, contends that there is a feeling among the residents that abortion rates are higher among secondary school students than other categories. This is because students want to avoid having their educational aspirations terminated. Stambach (1996) also asserts that some, especially older persons, associate higher rates of abortion among schoolgirls to the abandoning of traditional norms like female circumcision.

D. Population Planning

The population policy of Tanzania provides the framework within which population planning is undertaken. Tanzania, like many other African countries, moved gradually from a position of implicit population policies in the 1970s to a position where active steps were taken towards the formulation of explicit policies in the mid-1980s. Early implicit population policies in Tanzania followed the country's policy of socialism and rural development introduced in 1967. As a result, several measures related to population policy were taken. These included: a spatial population distribution policy, which relocated, dislocated, and scattered rural families and the urban unemployed into planned settlements. Another policy was the growth pole policy, which was designed to promote an industrial dispersion away from the capital city (Dar es Salaam to ten other regional towns), and the Human Resource Deployment Act, which aimed at discouraging rural-to-urban migration.

Tanzania officially formulated a National Population Policy in 1992. The major objective of Tanzania's population policy is to "reinforce national development through developing available resources in order to improve the quality of life of the people" (Planning Commission 1992). The emphasis of this population policy is "on regulating population growth rate, enhancing population quality and improving the health and welfare of women and children" (Planning Commission 1992). Other concerns set forth in the policy include establishing information education and communication (IEC) systems that disseminate knowledge and information about use of services related to family planning, and making family planning means or services easily accessible. The policy also focuses on preparing young unmarried people to become responsible parents after their marriage through provision of family life education. The policy underscores the importance of educating the public on the benefits of women marrying after age 18 years. Taken together, the policy is really concerned with regulating population growth in Tanzania.

In 1959, long before the launching of the national population policy, the Family Planning Association of Tanzania (UMATI) began efforts to regulate reproductive behavior in Tanzania. During the early years, UMATI's services were urban-based (Ministry of Health 1989). As UMATI expanded, services were further extended to several other regions in the country. UMATI now has branches in all the regions, and several districts, as well as some villages of Tanzania.

The efforts of UMATI to introduce family planning (FP) in the early post-independence period were not well received by many people. The attitudes of many, including some party, government, and religious leaders, were negative. As in most parts of Africa, FP services in Tanzania were seen by many as designed by outsiders to control Tanzania's population. During the early post-independence period, the majority of African countries, including Tanzania, did not consider population growth as a problem. This was partly because of the feeling that there were few people, while resources were plenty. In addition, the economies of many countries by then could cope well with the small population size.

However, as population growth slowly began to put pressure on resources, changes began to be implemented in many African countries. In the case of Tanzania, in 1974, FP services began to be provided officially in all government health facilities (Ministry of Health 1989). UMATI was officially recognized and given the responsibility of procuring and distributing contraceptives in all maternal and child health (MCH) clinics established in almost all health institutions. Following these developments, the Ministry of Health began to involve itself in expanding and improving the quality of FP services in the country. In 1989, the Ministry of Health developed and launched the National Family Planning Programme for the years 1989 to 1993.

The program set out national goals, targets, and strategies for achieving FP services in Tanzania. The broad objective of the program was to raise the contraceptive acceptance rate in the country from 7% to 25% by 1993. In 1999, however, only 16% of women used modern contraceptives (National Bureau of Statistics & Macro International 2000). Other specific objectives were: improvement of the quality and accessibility of FP services; improvement in the general health of mothers and children; and raising awareness and demand of FP services in the country (Ministry of Health 1989).

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

STDs other than HIV/AIDS are common and have been identified as important factors in HIV transmission. It is estimated that an average of 2,372 cases of STDs were reported per month in 1995 and, in total, there were about 28,463 STD cases in 1995 (Bureau of Statistics & Macro International 1997). More females than males are infected with STDs, 58% and 42%, respectively. These findings however, do not tell the true picture among men, since women are more frequent users of health facilities than men. Among the most common STDs in Tanzania, apart from HIV/AIDS, are discharge from the penis, gonorrhea, penile sores/ulcers, and syphilis (Bureau Statistics & Macro International 1997). According to the Department of Health Services, sexually active persons aged 20 to 39, formerly married, urban residents, those without education, and those with complete primary education are more likely to be infected with an STD than other groups (Bureau Statistics & Macro International 1997). Policies that affect prevention of STDs are similar to those of HIV/AIDS as stated in Section 10B, below.

B. HIV/AIDS

[*Update 2002*: UNAIDS Epidemiological Assessment: Tanzania is made up of mainland Tanzania and the island of Zanzibar. HIV information among antenatal clinic attendees has been available from mainland Tanzania since the mid-1980s. Mbeya district produced more consistently better quality of data on HIV prevalence among antenatal clinic attendees than any other district. The prevalence in Mbeya shows a fluctuation of HIV-infection rates ranging from 23% to 24% in 1998, to 29.5% in 1999, and 21.6% in 2000. In Moshi district, another district outside the major urban area, HIV prevalence was 20% in 1998 and 16.6% in 2000. No antenatal clinic surveillance survey was conducted in 2001. Implementation of a 2002 antenatal clinic sentinel surveillance survey has begun and results will be available later in 2003.

[Serial population-based surveys conducted in the Kagera region of mainland Tanzania showed a decline in HIV-1 prevalence from 24.2% in 1987 to 18.3% in 1993 in Bukoba town. HIV prevalence among women aged 15-24 years in Bukoba town declined from 27.6% in 1987 to 11.2% in 1993. For rural Bukoba, there was a decline in HIV prevalence from 10% in 1987 to 6.8% in 1996. A marked decline in HIV prevalence was also recorded among young women aged 15-24 years, from 9.7% in 1987 to 3.1% in 1996.

[In Zanzibar, fluctuating HIV-prevalence rates have been observed among antenatal clinic attendees, with rates lower than those observed in mainland Tanzania. HIV prevalence increased from 0.3% in 1987 to 3.8% in 1995, and then to 0.6% in 1996, 11.4% in 1997, and 0.7% in both 1999 and 2000. A population-based HIV serosurvey was to be conducted in 2002 to validate the magnitude of HIV infection in Zanzibar.

[Information on HIV prevalence among sex workers in Dar es Salaam has been available since the mid-1980s. HIV prevalence among sex workers tested increased from 29% in 1986 to 50% in 1993. Outside of Dar es Salaam, HIV information on sex workers is available from Kilimanjaro, Arusha, Moshi, Tanga, Dodoma, and Singida in 1988. In Zanzibar, HIV prevalence among STD clinic patients tested increased from 5% in 1992 to 28% in 1993.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	1,300,000	(rate: 7.8%)
Women ages 15-49:	750,000	
Children ages 0-15:	170,000	

[An estimated 140,000 adults and children died of AIDS during 2001.

[At the end of 2001, an estimated 810,000 Tanzanian children under age 15 were living without one or both parents who had died of AIDS. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

[*Comment 2003*: The most obvious sexual disorder is sterility. A barren woman is always in despair. The desire for children makes impotence in men even more disgraceful and pitiful. A childless couple is scorned and despised. The source of childlessness is usually attributed to the wife rather than the husband. Although family planning centers and general hospitals may provide some advice and counseling, professional therapy is almost nonexistent. (*End of comment by B. Opiyo-Omolo*)]

12. Sex Research and Advanced Professional Education

Not reported.

A Brief Conclusion

Although this is, as explained in the Editor's opening Note, a partial report with no information on some important aspects of sexual attitudes and behavior in Tanzania, the authors and Editor hope that enough information is provided for the reader to form a clear picture of sexuality in Tanzania.

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