Adolescent girls, illegal abortions and “sugar-daddies” in Dar es Salaam: vulnerable victims and active social agents

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Abstract

Adolescent girls’ early sexual activity, early pregnancy, induced abortions and the increase in HIV infections have become major concerns in Sub-Saharan Africa. Efforts, though, to understand their sexual behaviour and to prevent reproductive health problems are almost non-existent. Adolescent girls are normally seen as victims and easy preys of (often older and married) men’s sexual exploitation. This article, which is based on a qualitative study of 51 adolescent girls who had just had an illegal abortion in Dar es Salaam, Tanzania, reveals that these girls are not only victims but also willing preys and active social agents engaging in high-risk sexual behaviour. In order to get material benefits they expose themselves to serious health risks, including induced abortion — without realising their own vulnerability. In our study, one out of four girls had more than one partner at the time they became pregnant, and many counted on an illegally induced abortion if they got pregnant. Even if adolescents are now allowed free access to family planning information, education and services, our study shows that this remains in the realm of theory rather than practice. Moreover, most adolescent girls are not aware about their right to such services. The paper concludes that the vulnerability of adolescent girls increases without the recognition that sexuality education and contraceptive services do not constitute a licence to practice illicit sex — but rather a means to create more mature and responsible attitudes and to increase sexual and reproductive health. © 2001 Elsevier Science Ltd. All rights reserved.

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Introduction

Promoting adolescent sexual and reproductive health — in particular that of girls — in the developing world has become a major issue on the international agenda. Close to 17 million girls under the age of 20 give birth each year. Most of these pregnancies are unplanned, and it is estimated by the WHO that as many as 4.4 million abortions are sought by adolescent girls each year (WHO, 1998). In addition, more than 50% of all new HIV infections occur among the 15–24 years old, with young girls being at particular risk from contact with older men (Key actions for further implementation of the ICPD Programme of Action, 1999).

The issue of induced abortion in most sub-Saharan countries is highly controversial — as the heated discussions at the International Conference on Population and Development in Cairo in 1994 clearly reflected. The issue is even more controversial when it concerns adolescent girls, who are not expected to be sexually active, though it has been repeatedly documented that they are (Bledsoe & Cohen, 1993). Their early sexual activity is generally attributed to fundamental socio-economic change, the erosion of moral codes, familial control and abandoned rituals such as initiation.
cerebrations which served to prepare adolescents for their roles and responsibilities as adults. As such, early sexual activity is perceived as a moral problem.

Adolescent girls’ ‘illegitimate’ sexual activity, unintended pregnancies, induced abortions and deteriorating sexual and reproductive health are often linked to the fact that young girls are objects of (older) men’s choices. The ‘sugar daddy’ phenomenon which is particularly widespread in African cities is well described in the literature (see, for example Mpangile, Leshabari, Kayaa, & Kihwele, 1996; Haram, 1995; Komba-Malekela & Liljestrom, 1994; Bledsoe & Cohen, 1993). With increasing awareness of HIV/AIDS, these men are now increasingly blamed for luring younger, ‘safer’ girls who are hopefully too young to be infected by HIV into sexual relations by promising them some degree of financial security. The character, though, of these relationships, the role that these men play in the girls’ lives, the use of contraceptive measures and the degree of male involvement in the girls’ induced abortion are not well described.

In Tanzania, adolescent girls’ sexual activity is on the rise, and their unwanted pregnancies and illegal abortions constitute a major threat to their sexual and reproductive health (UMATI, 1994; Tanzania Demographic and Health Survey, 1993, 1997). In order to obtain a deeper insight into sensitive and less visible aspects of such adolescent girls, a qualitative study was undertaken in a hospital setting in Dar es Salaam. The aim was to understand illegal abortions in a broader socio-economic and cultural context — to acquire an in-depth knowledge of adolescent girls’ sexual activity, their relation with their partners, to find out whether the girls were ‘lured’ into unprotected sexual activity, or if they were active social actors themselves. Emphasis was also made to explore their access to contraceptives, and the factors that influenced them to have an illegal and expensive abortion. Although Tanzania’s Strategy for Reproductive Health and Child Survival 1997–2001 (1997) does give priority to adolescents’ reproductive health, there are no well co-ordinated programmes that address adolescents’ sexual and reproductive health needs and issues. Consequently, our aim was also to contribute knowledge for future reproductive health initiatives aimed at adolescent girls.

**Background**

Only very few African countries (e.g., Zambia, Burundi and recently South Africa) permit induced abortion for reasons other than those threatening life. Elsewhere, induced abortions being illegal, the number of safely induced abortions in sub-Saharan Africa is unknown. According to the WHO, 5,000,000 unsafe abortions are performed annually in Africa; these abortions constitute 13% of all maternal deaths (WHO, 1998). In Tanzania, illegal abortions are punishable by imprisonment of up to 14 years for the abortionist, seven years for the woman herself and three years for any person supplying drugs or instruments to induce such an abortion. Illegal abortions, however, are hidden realities. Although the law is very strict, prosecutions for abortion are rare (Tumbo-Masabo & Liljestrom, 1994). High morbidity is connected with illegal abortions as most are performed unsafely and by unskilled persons. This is reflected in the increasing number of women who have become infertile after an induced abortion (ibid). Thus, the risk of being prosecuted seems negligible compared with the health risks involved in induced abortions.

The rates of unplanned pregnancies and induced abortions in Tanzania are much higher than generally perceived by parents, teachers and policy makers (Mpangile & Mbunda, 1993). A study of four public hospitals in Dar es Salaam showed that about a third of the women admitted with complications from an illegal abortion were teenagers — 41.3% of whom aged 17 or under Mpangile, Leshabari, and Kihwele (1993). In the early 1990s, 22% of women who delivered at the Muhimbili Medical Centre in Dar es Salaam were teenagers. Among women hospitalised in Muhimbili gynaecological wards due to abortion-related complications, 54% were teenagers (Tumbo-Masabo & Liljestrom, 1994). A study carried out from 1991–1993 in Ilala District, Dar es Salaam showed that illegally induced abortions contributed to 15% of maternal deaths in that district. One-third of these abortions occurred among adolescent girls (Urassa, Massawe, Lindmark, & Nystrom, 1996). Studies from other sub-Saharan countries report similar findings (Kinoiti, Gaffikin, L, Benson, & Nicholson, 1997).

A recent hospital-based study from Dar es Salaam indicates that of the 362 women who had allegedly miscarried the majority had in fact had an illegal abortion. Half of the women were aged 20 years and under (Rasch, Silberschmidt, & Mehumvu (2000a); Rasch, Muhammad, Urić, & Bergström (2000b)). Similar findings are reported in hospital-based studies from other sub-Saharan countries (ibid). In general, though, the data on the extent of induced abortions in sub-Saharan Africa are unreliable. Accurate reporting is discouraged by the sensitive nature of the issue: community-based surveys tend to produce gross underestimates, and underreporting constitutes a major problem. As a result, many aspects of adolescent girls’ sexual behaviour, and why they are having an induced abortion, are still under-explored.

Until 1994, family planning in Tanzania would be used solely for child-spacing purposes. Hence family
planning advice was given primarily to married clients with at least one child. Adolescents’ access to education and information on sexual matters, including contraception had been seriously neglected, largely because of fear of encouraging any ‘immoral’ or unrestrained sexual behaviour. However, acknowledging the increasing problem of pregnancies among adolescents, the National Policy Guidelines and Standard for Family Planning were revised in, 1994 (Tanzania National Policy Guidelines and Standards for Family Planning Service Delivery and Training, 1994). It now states that “all males and females of reproductive age, including adolescents irrespective of their parity and marital status, shall have the right of access to family planning information, education and services” (1984, p. 83). However, as will be discussed below, a wide discrepancy exists between these guidelines and their practical application to adolescents’ access to services.

Methods

The present study was carried out in Dar es Salaam, the capital of Tanzania, which has about two million inhabitants and is divided into three districts. Each district has one district hospital, and the city has one referral hospital. The data collection took place at district hospital level in one of the districts.

From July to September 1997, a group of adolescents registered in the admission book with the diagnosis ‘incomplete abortion’ were approached consecutively. Fifty-one adolescents who admitted having had an induced abortion were included in the study. Thirty-eight had the abortion performed under safe conditions at the hospital where the interviews were carried out. The remaining thirteen were admitted with complications from an unsafe abortion performed by an unskilled person. All patients were informed that participation in the study was voluntary and would not affect their further treatment. Informed, oral consent was obtained, and confidentiality was assured.

The interviews took place in a private room in the gynaecological ward. One female nurse-midwife with extensive experience in interviewing women who had an abortion, conducted the interviews. In order to establish a comfortable interaction between the interviewer and the respondent, an open, sympathetic and trustworthy approach, free of moral judgements, was taken. Open-ended questions on sexual activity, access and use of contraception, the reason for having an induced abortion, and partner’s role and involvement, etc., were developed. The interviewer used guideline questions to focus the discussion, but was encouraged to probe respondents, follow leads and note as many quotations, details and case stories as possible. Special emphasis was placed on eliciting information on the relationship with partner, the circumstances under which they met, and the girls’ feelings and expectations toward their partner. Other questions addressed whether the interviewee was certain that a particular partner had made her pregnant, if she had other partners at the time she became pregnant, and if she would have continued the relationship had she not received material benefits.

The principal investigator collaborated very closely with the interviewer during the data collection, and each interview was discussed in detail and repeatedly. The insight gathered from the initial interviews was used to develop and add more in-depth guideline questions. Each interview lasted from two to two-and-a-half hours. No incentives were given, but the interviewee was offered a refreshment during the interview. Afterwards, our interviewer accompanied the girl to the family planning clinic at the hospital. Here she was provided with a choice of contraception and given a date to return.

All interviews were entered into a computer and grouped thematically and according to the following categories: age, religion, tribe, civil status, education, occupation and place of residence of the interviewees; age at first time of sexual contact; number of partners since first intercourse; number of partners when interviewee became pregnant; planned or unplanned pregnancy; contraceptive knowledge, attitude and practice; access to contraception; number of STD treatments; number of previously induced abortions. Each interviewee was also asked to identify what type of relationship she had with the partner responsible for the pregnancy and provide information on partner’s age, civil status, number of children and occupation of partner; length of relationship with partner; frequency of sexual meetings; material exchange between interviewee and partner; partner’s attitude to use of contraception; partner’s reaction when told about the pregnancy; partner’s (relatives’ or friends’) involvement in providing access to and paying for the abortion; whether the interviewee was still seeing the partner, and if she expected the relationship to continue after the abortion.

Because of the open-ended nature of the interview, the many different case stories and many quotations, each interview was scrutinised and analysed individually. This was done in order to capture all nuances, and to get a full picture of the interviewee, her situation, and how she interpreted it.

In order to contrast our data — obtained in a district hospital setting — with data collected in a non-hospital setting, one focus group discussion was carried out in the village of Bunjo, a rural area of Dar es Salaam with a group of nine young unmarried women (15–29 years). All of them had several self-induced abortions provoked by using locally grown herbs. They knew each other very well, and had agreed to participate after being informed.
beforehand about the theme of the discussion. The principal investigator and two of her research assistants led the discussion that lasted three and a half hours. The same type of themes/questions were asked as were in the hospital interviews.

**Analysis of Data from the hospital setting**

**Identification of respondents**

All 51 girls interviewed were unmarried. Their age varied from 15 to 19 (on average 17.5). They had different ethnic backgrounds. Eighteen of them were Christians and 33 were Muslims. Twenty-five of them (close to 50%) were still in school and resided with their parents or relatives. The other 26 girls (51%) who were employed as house girls, barmaids or engaged in petty trade, stayed in a room at their workplace or rented a room. Nineteen girls (27%) had finished primary school. Age at time of first sexual contact varied from 13 to 16. Several girls said they been forced by another adolescent, a houseboy or a schoolteacher to have sex, mainly the first time. Most of the girls’ current sexual partners were married men twice their age. Five of the girls (10.2%) had had an abortion before. One of them had three abortions before this one. One girl had a child.

**Patterns of sexual behaviour**

As described in the literature, gaining trustworthy answers, in general, and on sexual activity, in particular, has proven to be difficult due to the sensitive character of the issue (Rosenthal, Burklow, Biro, Pace, & DeVellis, 1996). When evaluating the first 35 interviews after the first month of interviewing, it was found that the majority of the girls claimed to have had two or three sexual partners (on average 2.7) since their sexual debut. The interviewer was then urged to elaborate (with sensitivity and a caring attitude free of any moral judgement) on this issue and to ascertain if this really corresponded to the reality: the average number of sexual partners rose from 2.7 to 5.6 with the number of sexual partners varying from one to eight in the remaining 16 interviews, and with many of girls reporting that they had several partners simultaneously. Twenty-five percent of the total sample admitted to having had more than one sexual partner at the time of conception. These girls could not say who was responsible for their pregnancy.

All the girls had regular intercourse, one to three times a week. None of the 25 girls staying with their parents (except one) had told them that they were sexually active, and that they had regular intercourse. Their sexual encounters were carried out in secrecy — often after school. Many would change from their school uniform to a dress, which they had brought along. The partner rented a room in a lodging. According to most girls, as both they and their partner were afraid of being discovered, the intercourse took place in a great hurry. In most cases, the sexual activity lasted from 15 to 30 min.

Condoms were hardly ever used. According to the interviewees, the reasons given by the men were that ‘they did not get the full pleasure out of the activity’ (a viewpoint that was shared by some of the girls); ‘condoms delayed the activity’; ‘they are against God’s will’; ‘they give discomforts and skin reactions’. The withdrawal method had not been practised. It was a ‘killer procedure’, some men argued. Besides, many girls had been told by their partner that sperm entering their vagina were good for them; ‘sperm should not be wasted’.

A few girls overlooked the possibility of becoming pregnant. Some thought they were too young to conceive. “Only girls over 18 can get pregnant”, one 16-year old girl said. A few others believed that when the sexual act was carried out in a hurry, or in a standing position, it was not possible to get pregnant. Another few argued that they had not become pregnant with their previous partners. Therefore, it did not occur to them that they would get pregnant with this one. Most of the girls, though, were aware that they could get pregnant through unprotected sex. However, it was not a major worry. Many thought of the possibility of having an abortion if they did get pregnant. They also relied on their partner’s support, as some of them had promised assistance to “solve the problem” in case of pregnancy. Quite a few kept their promise (see below).

Only five of our respondents became pregnant intentionally. They had expected their partner to marry them if they did get pregnant. When their partner failed to recognise paternity, they decided on an abortion. One 18-year old house girl had, in fact, used contraceptives which she purchased from a woman who worked at a family planning clinic. When she met her present partner, she stopped using them because her partner promised to marry her. She was convinced that if she got pregnant, ‘there was no way for him to leave her’. However, when she revealed that she was pregnant he denied responsibility: he was married, had two children, loved his wife and refused to see her anymore. She decided to have the pregnancy aborted.

Most of the girls were also aware of the possibility of contracting a sexually transmitted disease (STD) but they were not very concerned. Some of the girls had been told by their partner that there was no reason to fear HIV since they were the only one the partner had relations with. Others did not know if their partner had other relations. Seven of the girls reported having previously had a STD. These girls had all been treated,
and mentioned that if they were to contract a STD again they could always get treated for it.

**Contraceptive behaviour and access**

In a study of induced abortions in four public hospitals in Dar es Salaam (Mpangile et al., 1993), 88.5% of adolescent girls aged 17 and under did not know about any contraceptive method. In our study, all the girls except one illiterate girl knew of several types of contraceptive measures, in particular, oral contraceptives and injections (such as Depo-ProveraTM).

However, even if they were able to mention different contraceptive methods, their knowledge was very superficial. A common belief was that the pill should only be taken on the day of intercourse. Nine girls had tried oral contraceptives. Some had stopped using them because of side effects (e.g. irregular bleeding), and some because they wanted to become pregnant — hoping that pregnancy would result in marriage. Others had become pregnant while using contraception. Three girls complained of having become pregnant after having been injected with Depo-ProveraTM. This is a recurring phenomenon, often mentioned by other women interviewed (Silberschmidt, unpublished). It is assumed that these women did not get their follow-up injection at the correct time.

A vast majority of the girls had heard about different side-effects such as irregular bleeding and abdominal pain, both from oral contraception and injections. They had also heard rumours that oral contraception might lead to infertility if taken by a girl/woman who had not given birth, and had received this information from friends or relatives. One 18-year old student had been told by her 40 year-old partner that contraceptives were dangerous for her. In two cases, a mother had advised her daughter not to use contraception because it could cause uterine cancer.

However, the majority of the adolescent girls we interviewed had never used any contraception, nor did they know that they were entitled to receive free contraceptives from a family planning centre. To their knowledge, only women who had children were allowed at the family planning clinics. A few girls had purchased contraception from health personnel that they knew or had heard about and who were selling these on the side to supplement their salary. When checking at one of the government health centres if adolescents had access to family planning measures, we were immediately told about the new health policy (1994) that allowed adolescents access. However, we were also told that only two 16-year-old girls had received any family planning measure (in this instance, Depo-ProveraTM) during the past year at this centre. And they were prostitutes, according to the judgement of the FP-nurse in charge.

**Identity and role of male partner**

None of the girls in our sample lived with their sexual partner. As mentioned earlier, the vast majority was involved with a man who was twice as old. Forty-five percent of them were between 30 and 39 years and 27.5% 40 and over. Only seven girls (13.7%) reported that their partners aged 25 and under. In another study of abortion in Dar es Salaam almost a third of the adolescent girls had male partners aged 45 or above (Mpangile, Kihwele, Munos, & Indriso, 1997). Most of the men were businessmen, involved in petty business (e.g., selling oranges and coconuts, etc.). A few were shopkeepers. One was a banker who had a relationship with his house girl. According to the girls in our study, half of their partners were already married — or said they were. This is a much higher number than reported in other studies. However, as also noted in Mpangile’s study, the marital status of men who have affairs with teenage girls is difficult to establish from the teenagers’ accounts. They rarely inquire about the marital status of their sexual partners, and if they do, it is unlikely that the truth will be revealed. In our study, 15 girls knew of their partners having children. The remaining 36 girls did not know whether their partners had any children.

The length of the relationships varied, but they seemed fairly stable with ten of them having lasted one year or more. Twenty-nine had lasted from 5 to 12 months. The girls reported regular sexual contact with their partners (one to three times a week). Over 30 of the girls said that they were still seeing their partner at the time of the interview. Fifteen girls said that they were definitely not seeing the partner anymore: the partner had either disclaimed paternity or had disappeared as soon as the girl had revealed the pregnancy. The rest of the girls said that they were still seeing their partner. However, some of them admitted that they did not correspond now as much as before and some felt a bit ignored. A couple of the girls suspected that their partner had found another girlfriend. Apart from the five girls who had counted on marriage and therefore had intentionally become pregnant, the rest of the girls never intended to marry their partner, and their pregnancy was unintentional.

In a study of the role of male partners in induced abortions among teenagers in Dar es Salaam, three types of relationships are identified (Mpangile et al., 1996). The first is *rafiki* — a boyfriend with whom the girl has regular contact. The second is *mshikaji wa muda* — a temporary partner; regularity of contact varies. Such a relationship can range from short-term to a complex longer-term symbiotic relationship, often involving acquisition of property (varying from food and clothes to more expensive items). In the city of Dar es Salaam, relationships with men identified as *rafiki* receive more social acceptance and recognition than relationships
with a *mshikaji wa muda* (Mpangile et al., 1996). The third category comprises men with whom contact is infrequent or men that a girl has only had a single contact with.

In our sample, a fourth type of relationship was mentioned by a couple of girls: *mpenzi*—someone they considered having a love relationship with and even hoped to marry. However, the vast majority of girls referred to their partner as a *mshikaji wa muda* as a *buzi* (a goat to milk). A 17-year old student who had a relationship with a 22 year-old man — referred to him as a *mshikaji wa muda*. Most of the time, she received money from him in exchange for sex but not always. ‘Something is better than nothing’, she reasoned. She was now, however, looking for a man who could give her more money. She had also had sexual encounters with other partners at the time she became pregnant.

All the girls were provided with small ‘luxuries’ such as underwear, soap, cream and also pocket money and textbooks in exchange for their sexual services. ‘No money — no sex’ was a recurring remark. One girl mentioned that her 40-year-old, married partner had fallen in love with her. He gave her 5,000 Tanzanian shillings (Tsh) (roughly US$8) the first time they had intercourse. Other days he gave her 3,000 to 4,000 Tsh, but not always. In spite of the fact that, according to the girl, they were in love, she had no intention of continuing the relationship if she did not receive money from her partner. As she said: ‘there is no use of a partner who has no money’. Some girls also had a meal when they met with their partner. Others who were only treated with sodas and snacks were looking for a new *mshikaji wa muda*.

One 19 year-old girl, who worked as a hair-maker, found that ‘life is difficult without a *buzi*. Her *buzi* was also her landlord, and he let her stay in her rented room for free. He was 45 years-old, married and had six children. ‘He comes to me to escape frustrations from home’, ‘He takes me out for beer and snacks’. She took no sexual pleasure at all from the sexual activity and ‘wanted to get it over with as quickly as possible’, ‘but he is my major source of income, and I use him as my *buzi*. She was not concerned about getting a STD. If she got HIV now, it would be purely accidental — it would be *ajali kazini* (accident at work). This was her second abortion. As she had other partners she did not know who had made her pregnant this time. But she had ‘decided to give the burden to this *buzi* because he had money’. She had been convinced that she could make him pay for an abortion if she got pregnant. She was right. He facilitated her abortion at the hospital and paid Tsh. 35,000 (roughly US$85. The government minimum monthly wage for an unskilled worker is US $50).

An 18 year-old girl who worked in a bar complained about her partner: ‘I tried my best to make him give me some money, but he only gave me beer and food. When I told him I was pregnant, I never saw him again’. However, she was not sure if he was the one who had made her pregnant. She also had other partners because — as she said — her salary was small, and she needed money.

**Men’s role in advising/paying for the induced abortion**

As mentioned above, in the existing literature on induced abortions in Sub-Saharan Africa, there is hardly any information about the role that men play in the decision of a woman to terminate her pregnancy, beyond an indication that some men pay for induced abortion (Kinoti et al., 1997). In the early 1990s, when teenagers constituted 22% of women who delivered at the Muhimbili Medical Centre in Dar es Salaam, 40% of them did not have a partner willing to acknowledge paternity (Tumbo-Masabo & Liljestrom, 1994). In a study by Mpangile et al. (1993), men responsible for the pregnancies did not assist in looking for a solution to the problem (e.g. abortion services) to the same extent that other social support networks, such as mothers and other female relatives, did. Nevertheless, the men responsible tended to end up paying the bills. In a later study by Mpangile et al. (1996), one-third of the partners had advised the girls where to go for an abortion, and almost half of them had paid the fees required for the abortion. According to a study by Leshabari, Mpangile, Kaaya, and Kihwele (1994), only 60% of the girls had initially confided in the men with whom they had conceived. Nearly all these men had assisted in looking for an abortionist and paying for the abortion.

In our study, all the girls had informed their partner of their pregnancy. Twenty-one (41%) of the partners had advised the girls where to go for the abortion and had also paid for the procedure (i.e. about 30,000 Tsh) when the abortion had been carried out at a hospital. Seventeen of the girls had been advised by a girlfriend and had provided the money themselves. The majority of these girls had their abortion performed outside the hospital at the cost of about 10,000 Tsh. They were the ones in our sample who had been admitted to the hospital with complications. The remaining 14 girls had confided in their social support network and had received advice and financial assistance from mothers or other female relatives.

Summing up, even if most relationships in this study seemed relatively stable, none of the men (or the girls for that matter) intended to have a child with their partner (see below). And there was no disagreement between the girl and her partner in terms of the termination of the pregnancy. With men refusing to use condoms and with
many of them promising an induced abortion in case of pregnancy, it must be assumed that they were well aware that their young girlfriend might end up with a pregnancy. And while some refused to acknowledge paternity, twenty-one did take responsibility.

Discussion

According to Bledsoe and Cohen (1993), becoming pregnant deliberately is often a strategy for obtaining a husband and gaining in social status. Linked to this, most adolescent girls seem to believe that the need to find a suitable husband and begin a family far outweighs the costs to their education and career opportunities (ibid). However, none of the girls in our sample — but for five — had any intention of ‘trapping’ a husband. Also, even if their relationships seemed fairly stable, the fact that they referred to their ‘benefactors’ as mshikaji wa muda implies that most girls had no long-term goals for the relationship. Nor did they plan to get pregnant. On the contrary, they counted on an abortion in the event of pregnancy. The same attitude has also been reported in Studies from Kenya and Nigeria (Barker & Rich, 1992).

While most of the girls in our sample were aware that they could get pregnant if they had unprotected sex — except for those few who had used a contraceptive method — they accepted the fact that their partners refused to use condoms. They were not in a position of negotiation, because they either did not dare to propose condom use for fear of loosing their partner, or it did not occur to them that they could propose condom use. They did not expect to propose condom use. Not even a wife would dare to propose that her husband used a condom for fear of being accused of having had other sexual relations. Even if she suspected/knew that her husband had been unfaithful, she could not ask him to use a condom — this would imply a lack of respect on her part. Only prostitutes can ask their clients to use a condom.

As a result, abortion was used as a contraceptive method, because cultural and practical barriers — including access to contraception — present greater obstacles (shame) than the risk (fear) of having an abortion. Moreover, with 25% of girls having more than one sexual partner at a time, the non-use of condoms, the not-knowing who was responsible for the pregnancy, and 14% of girls having had a STD previously, all point to high-risk sexual behaviour on the part of the adolescent girls. Other Tanzanian studies of adolescent girls have stated a lower number of sexual partners (Kapiga, Hunter, & Nachtigal, 1992; Kapiga, Lwihula, Shao, & Hunter, 1995; Weinstein, Ngallaba, Cross, & Mburu, 1995; Mnyika, Kvale, & Ole, 1997), and also lower numbers of STD infections (Weinstein et al., 1995). We assume that the interaction between the interviewer and the respondents explains the much higher numbers of sexual partners admitted to by the girls.

‘I love him because he gives me money’

As noted by Bledsoe and Cohen (1993), documenting trends in adolescent fertility is a much easier task than explaining these trends. The same can be said about our attempt to explain adolescent girls’ sexual behaviour in Dar es Salaam. Contrary to boys, girls are easily dismissed by the community as promiscuous, if it is known that they are sexually active. Consequently, and although girls are today exposed to freer and more unrestrained behaviour regarding love and sex, their sexual experiences are still surrounded by secrecy. Peers, not parents, are the most important source of knowledge on sexual matters (Fuglesang, 1997). Many parents, though, are perfectly aware of their daughters’ escapades, and that they barter their sexuality for economic gains. But they choose to close their eyes because it relieves them of their financial responsibilities.

As to the girls in our sample, even if it may not be socially acceptable to have a mshikaji, they were proud of having a mshikaji wa muda or a buzi as their ‘financial resource’. They were also flattered by older men’s interest in them. As documented in other studies, a buzi gives prestige among peers since a girl’s status within this group is often dependent on having nice clothes and other material possessions. Such things are achieved most easily by entering a sexual relationship with a man who is willing to provide. Moreover, not many girls or women would enter into a premarital sexual relationship without the potential for material recompense. It is believed that sexual services are commodities that should be paid for. Only women with no self-respect would give such services for free (Silberschmidt, unpublished data). Men are aware of this conception, and they accept it as a fact. In exchange for financial compensation men gain sexual access and control over young women, a relationship which acts as a booster to their virility and self-esteem (Silberschmidt, 2001, 1999, 1992a, b).

While the girls in our study were involved in overtly transactional sex, this exchange was by no means comparable to or associated with prostitution. In fact, and as mentioned above, most women in a Tanzanian or an East African context — married or not — with any self-respect would be very reluctant to engage in a sexual relationship with a man without any material benefits. Men who are unable to provide such benefits are met with contempt (Silberschmidt, 1999, 2001). It was also apparent to the adolescent girls in our study that no man would give them money or other material benefits without receiving something in return. Sexual services
were all these girls could bargain with. And they were very willing to offer their services. Not as a means of survival — but rather as a means to gain access to small ‘luxuries’, textbooks, etc. not to mention prestige from peers. Even if the word ‘love’ was used by many during the interview, it was closely associated with money. ‘No money, no sex’ was a recurrent remark. A 16 year-old student said about her 30 year-old partner: ‘I love him and enjoy sex with him, because when I buy coconuts from him, I do not pay, and I can use the money as pocket money’. Or as one of them said, ‘I love him, because he gives me money’. Also girls who said they loved their partner would not continue the relationship without material benefits. Some of them were actually planning to find one more partner ‘in order to increase their financial resources’. The same observations are made in a study from northern Tanzania, where the transactional aspect of sexual relationships is crucial. Once gifts cease to flow the relationship will soon come to an end (Haram, 1995).

Contrary to boys, who often refer to their ‘lust’ and regard sex as the most pleasurable activity, (Silberschmidt, unpublished) the majority of the girls in this study did not consider sex as an activity by which their own sexual needs would be met. Sex was something that girls provided in return for a material benefit. As one of them said, ‘I only engage ‘minimum’ with this buzi. I enjoy sex more with other partners’. A buzi or a ‘sugar daddy’, however, is a good source of income that most girls do not want to lose.

While the young girls were overtly entrepreneurial and risk-taking in their approach to sex they were at the same time little aware of their own vulnerability having, for instance, no negotiating power in terms of contraception. Moreover, they did not appear motivated or concerned. On the economic front, the consensus was that had they tried to negotiate condoms, they might have lost their buzi. On the health front, some girls would note ‘he looks healthy so why bother’.

Higher HIV seroprevalence rates amongst girls are now being recorded in Tanzania, (Tanzania Demographic and Health Survey, 1997) as in other East African countries (Barnett & Blaikie, 1992 and many others). This increase is closely associated with the ‘sugar daddy’ phenomenon — such men are seen as responsible for bringing the AIDS virus to the teenage population (Liljestrom, Masanja, Rwebangira, & Urassa, 1998). If this is the case, there are serious implications for the teenage female population, which in turn increase the risk associated with abortions. Thus, the sexual irresponsibility of the men carries some serious repercussions on their young partners. From a gender point of view, the male partner exploits and takes advantage of the adolescent girl, who, without realising what she exposes herself to, ends up in a life-threatening situation. Therefore, it is the behaviour of these adult men that ought to be targeted in the first place in Tanzania (Mpangile et al., 1992, 1996). This is in line with the increasing international focus on the vulnerability of adolescent girls, the advocacy for gender equality and the promotion of male responsibility and partnership with women in sexual and reproductive health (The Hague International Forum, 1999; Overall review and appraisal of the implementation of the Programme of Action of the ICSD Report of the Ad Hoc Committee of the Whole of the 21 Special Session of the General Assembly, 1999; UNAIDS, 2000).

However, this being said, our data also indicate that the relationship between our interviewees and their ‘sugar-daddies’ was not a one-way exploitation. While young girls are often regarded as objects of other people’s choices — often those of ‘sugar daddies’ — these girls are also active social agents, entrepreneurs who deliberately exploit their partner(s). However, they are unaware of the potential consequences of their high-risk sexual behaviour, and the health hazards that they expose themselves to. Moreover, while the ‘sugar daddies’ trust that they are having ‘safe sex’ with their young girlfriends, they may, in fact, be jeopardising their own health, that of their wife and other partners. Consequently, both the behaviours of adult men and of the adolescent girls they engage with need to be addressed. If behavioural change is proposed as an intervention, it should target not only male irresponsible behaviour but also that of young girls. To the knowledge of the author of this article, no interventions in Tanzania have so far addressed the issue of adolescent girls’ irresponsible behaviour. However, the ‘sugar daddy’ phenomenon is well known, and young girls are advised to avoid such ‘daddies’.

**Urban versus rural girls and their access to safe abortion**

The girls in our study represent a privileged group of women who were either able to have their partner/relative pay or raise the money themselves for a safe abortion or have their complications treated professionally.. From this point of view, our sample is biased. It represents a group of privileged young girls. They can certainly not be compared with the young girls living in the streets of Dar es Salaam, who, in order to survive, engage in sexual contact with poor men who cannot afford ‘more sophisticated prostitutes’ and are often drawn into life-threatening relationships (Bamurange, 1998). Nor can they be compared to the nine adolescent girls/young women (15–29) from Bunjo, rural Dar es Salaam, who did not have a ‘sugar-daddy’ to pay for a safe abortion or were able to raise the money needed to have one performed safely.

In Bunjo, we learnt during a focus group discussion that many unmarried girls bleed to death or become infertile after six to eight induced abortions. All the girls
who participated in the discussion had several self-induced abortions using locally grown herbs. They were very knowledgeable about many different types of roots which could be used (muharobaini, mlonge, paw paw, mmavimawi, etc.) sometimes combined with chloroquine or cafanol tablets which are sold over the counter and require no prescription. One of the girls, though, admitted that she almost died once, when she combined one tea cup of boiled muharobaini roots with eight chloroquine tablets. The girls recommended ‘cassava leaf sticks’ (which contain cyanide) as the safest remedy. Even if they were aware of potential ‘misfortunes’ when inducing an abortion, they were not overtly concerned. Five of the young women, though, who were in their mid- to late 20s had no children. They were all sexually active but did not use any type of contraception. Why did they opt for induced abortion rather than trying to prevent getting pregnant? ‘It is very difficult to get these modern methods, because many of us are still young and unmarried’. ‘The modern devices are given to married women who have children. Therefore, most of us resort to traditional methods, which are cheap and easy to get: for instance, we make knots (mafundo) on a special string and tie it around the waist. One knot equals one year. So it depends on someone’s plans: the number of knots equals the number of years that one wants to wait before getting pregnant’. However, if these traditional methods did not work as a contraceptive method, the girls agreed that then ‘you can tell your friend who is somehow adult that she goes to the hospital and pretends that she needs family planning pills. And when she gets them she can give them to you’. This was the only way for young unmarried women to gain access to a modern contraceptive method.

All of the girls we spoke to in Bunjo knew of where and how to get an induced abortion from a ‘professional’ as well as its cost (Tsh 10,000 for a one-month pregnancy, Tsh 30,000 for a three-month pregnancy). However, ‘we have no money, and it is difficult to request money from parents or relatives to go and have a properly performed induced abortion. Therefore, we decide to perform it ourselves and get ready for any complication. Because we are sure that parents will be forced to take us to the hospital for more care. They cannot afford to see us dying. So it is easier to force them to take care of complications than requesting money for having an abortion’.

None of the girls relied on assistance from a partner. The age of their partners ranged from 22 to 35 and above. The younger ones ‘tended to insist on sex only’, whereas the older ones were ‘quite helpful’ with small luxuries. However, the latter had big families, many children, felt no responsibility and, according to the girls, would run away if they got pregnant. Therefore, the decision to induce the abortion was made by the girls themselves. Often because the girl was still in school and unable to care for a child, or when she was afraid of ‘missing’ a husband, because her pregnancy might have been caused by someone other than her fiancé. In that case, inducing an abortion can be a way of trying to ‘save face,’ and ‘it must be a personal secret’.

Concluding observations

Although this study was carried out in Tanzania, the issue of illegal induced abortions has wider implications. As do the issues of adolescent sexuality, family planning, abortion, communication with one’s partner, STD/HIV as well as male responsibility. In Sub-Saharan Africa — as elsewhere in the world — these issues are pertinent, and at the forefront of public health discussions. At the Cairo +5 conference meeting in the Hague (1999), adolescents’ sexual and reproductive health was regarded as one of the major challenges national governments and non-governmental agencies face worldwide. Governments are now being urged to promote women’s, and, in particular, adolescent girls’ sexual and reproductive health (Key Actions, 1999). However, in spite of the growing acceptance of the importance of addressing reproductive health care needs, such acceptance must be translated into adequate operational action at the country level.

As reported in an increasing number of studies from Tanzania (Leshabari, 1988; Kapiga et al., 1992; Leshabari, & Muhondwa, 1992; Leshabari, & Kaaya, 1996; Klepp, Biswalo & Talle, 1995; Rwebangira & Liljestro¨m, 1998) and underlined in our study, adolescent girls have an urgent need for sexual and reproductive health information as well as access to preventive measures. These girls are engaging in high-risk sexual behaviours, and clandestine, usually unsafe, abortions have become a common occurrence. While more privileged women can afford to pay for an abortion that will be performed safely in a hospital setting, most women though, have to resort to much less safe interventions. They are the ones admitted to the hospital with complications (Justesen, Kapiga, & van Asten, 1992; Mpangile et al., 1997) unless they bleed to death before getting there. However, the 51 girls in our study from urban Dar es Salaam were also putting their health and lives at risk. The way in which they negotiate their own sexuality leaves them extremely vulnerable, and their economic gains seem negligible compared with the health risks they unknowingly take.

The Tanzanian Government is aware that teenagers are sexually active and, in 1994, launched a policy to encourage the provision of family planning information and measures to people in need, including teenagers. Information and services to adolescents also figure prominently in Tanzania’s Strategy for Reproductive Health and Child Survival 1997–2001 (1997). However, there is still a vast discrepancy between policy guidelines
and their practical application. Adolescent girls face serious cultural barriers, not the least from the health services where health workers have strong moral objections to offer them the services that they are entitled to according to the revised National Policy Guidelines (1994).

However, even if adolescents do have access to information and services, evidence from around the world shows that abortions cannot be completely eradicated (Kulczycki, Potts, & Rosenfield, 1996). Therefore, as abortions continue to happen, the controversial issue and ethical challenge of how to make clandestine abortions safe is now receiving increasing international as well as national attention. According to recommendations from The Centre for Reproductive Law and Policy (1999), there is a need to address the practice of unsafe abortions, particularly its high incidence among adolescents. Linked to this, governments should consider enacting laws that permit abortion on broad grounds. In addition, law enforcement officials should refrain from prosecuting women who have undergone abortion procedures and the providers who have performed abortions (ibid). This is in line with observations already made among others by Kinoti et al. (1997), Sai (1996), and Rogo (1996), who argue that abortion laws not only in Tanzania but in Africa, in general, need to take into account adolescent girls’ vulnerability and consider how clandestine abortions can be made safe. Even if abortion is legalised, unsafe abortions will continue to be performed because of health budget constraints in developing countries. However, legalisation means transforming abortion from a ‘guilty secret’ into a socially accepted method (Kissling, 1993).

Evidence from around the world also shows that information and services do not encourage irresponsible lifestyles. On the contrary, providing information and building skills on human sexuality and human relationships helps to avert health problems, and creates more mature and responsible attitudes (Brundtland, 1999). This calls for a reconsideration of priorities and strategies by all national governments, including the Tanzanian government. As pointed out in the report from The Hague International Forum (1999), there is a particular need for innovative strategies that provide adolescents with sexual and reproductive health information through both formal and informal education — including peer counselling — and national plans should be developed and implemented with the full involvement of adolescents (ibid). It is particularly important to assure that the attitudes of health care providers do not restrict the access of young people to the services and information that they need.

The concept of positive role models was introduced at the Hague Forum: fathers have a responsibility to be positive role models and mentors for their adolescent children, particularly their daughters in order to enable them to take responsibility for their own lives (ibid). How this is to be carried out in practice and under harsh socio-economic decline is yet to be seen (Silberschmidt, 1999, 2000). The concept of ‘male involvement’ which was emphasised both at the ICPD in Cairo (1994), and again at the Hague Forum reflects the recent emphasis on encouraging men to be supportive and involved partners. It recognises that the health and socio-economic problems of women cannot be solved without involving men. However, there is so far no generally accepted understanding of what male involvement actually means. In the meantime, adolescent girls as those in this study cannot wait for their sugar-daddies to become responsible partners. They need to be assisted both in the development of more mature and responsible attitudes as well as in gaining access to information and services, so that they can begin to take better care of their own health.

A few health and family planning initiatives specifically aimed at addressing adolescents’ needs are now operated by NGOs in Tanzania. These initiatives are the ‘Youth Friendly Services’ and ‘Youth Family Planning Services through Peers’, which provide education, information and services to adolescents. However, as virtually no operational research has been carried out on how information and services can best be designed to meet the needs of adolescent girls (Kinoti et al., 1997), there is still an urgent need for such research. There is a particular need for research on how such services can be made sustainable. More research is also needed on men’s perspectives on their own role, responsibility and the implications of their relationships with adolescent girls.

References


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