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Sexually Transmitted Diseases among the Women of Northern Tanzania and the Government Initiatives to Control the Diseases in Colonial and Post-Colonial Tanzania From The 1890s to 2000s

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Abstract

This paper explores the trends in prevalence of Sexually Transmitted Disease among the Women of Northern Tanzania and the Government Initiatives to control the diseases in Colonial and Post colonial Tanzania from the 1890s to 2000s. Specifically, the paper focuses on the forces that shaped the spread of STDs, the discourses on their socio-economic impact; and the government initiatives to control the diseases. Rather than focusing on STDs on the general population as it has been the case with many other studies, this paper examines the history of STDs among the women in northern Tanzania. It is argued that the spread, impacts and responses to the disease were determined by global context, government and culture. On understanding the cultural and biological aspects of STDs the paper draws the combination of political economy and social constructionism theories. The paper has established that the prevalence of STDs can be traced specifically during the early contact of African community with the external world, the sailors and the merchants, that its spread was driven by different factors; and that the diseases enlisted varied initiatives from both government and society at large. To support the aforementioned findings, this paper used secondary sources namely historical and medical books, journal articles, theses and electronic materials. This study is significant as it adds to a body of historical knowledge on how STDs affected women and the initiatives the community, colonial and post-colonial Tanzania governments took to control such diseases.

Key Words: *diseases, sexually, transmitted, colonial, post -colonial*

Introduction

The history of Sexually Transmitted Diseases (STDs) is as old as history of mankind. Epidemics are mentioned in both old Chinese writing as early as 2637 BC and in the Old Testament (Exodus, 20:14). In these ancient times STDs were coincided to individual misconduct or misbehavior towards God or other human beings. Thus, the disease was seen as punishment as a result of misconduct in the society. Moreover, European in the late 14th and early 15th centuries witnessed diseases which its name was not known but it was widely spread and were transmitted by European soldiers through sexual intercourse during the wars. Scholars associated this with the modern venereal diseases.

Venereal diseases incorporated number of diseases transmitted through sexual contacts includes; Syphilis, Gonorrhea, Chlamydia and the currently wide spread, Human Immunodeficiency Virus (HIV/AIDS). Such diseases can be transmitted during vaginal or other types of sexual intercourse including oral and anal sex (Kollar, 2005). Syphilis and Gonorrhea were the most common STDs known and widely spread all over the world, and it is said that women are more vulnerable to gonorrhea than men (Sadock 2005).

Africans were also the victim of such diseases. Giblin (1996) documented the presence of STDs in the interior of East Africa, which its spread was associated with the Portuguese Voyages. In Giblin's statement the transmission of the diseases came from the Indian Ocean Ports, and the argument is that STDs were transmitted through intermingling of



the different society in one centre of production. Thus by 1903 STDs were reported as being widely spread in the interior of Tanzania.

In the late 19th and early 20th centuries Tanzania like any other country in Africa witnessed an increased number of infectious diseases. It was noted that on the onset of long-distance trade the community around the coast and along the trading routes experienced the infliction of STDs (Ferguson, 1980 & Zeleza, 1993). The establishment of coastal trade routes increased the spread of STDs (Sadock, 2005). As noted by Chirwa (1993) in the context of Malawi STDs were foreign diseases, they were spread by foreigners. Moreover, in the early 20th century, the influence of colonialism especially the establishment of new economic activities in Tanzania changed the nature of diseases. Colonial activities brought about social disorganizations, which consequently led to favorable environment for the spread of STDs. In these relations, African population which had been stable during the pre-colonial time became more mobile and disintegrated as a result of changes in socio-political and economic organizations.

As for the northern Tanzania, the paper attempted to cover the Northern part of Tanzania stretches from Tanga, Kilimanjaro and the then Arusha. These areas has been settled for centuries by the Chagga, Pare, Maasai, Shambaa, Digo, Wambugwe, Iraqw and the Meru people to mention just a few. The area was termed by the British as Northern Provinces, (Stahl 1965). It was in these areas were both German and British colonial government and private sectors established plantation agriculture and different European schemes. The prominent plantations, in this regard, were the sisal plantation estate in Tanga, coffee plantation in Hai Moshi and at Oldean in Mbulu. These European plantations in the era of colonialism determine the nature and pattern of diseases in these regions. However, it is important to note that nature of diseases and their control measures changes over time as noted by Feirman (1992). The implication is that the prevalence of STDs during the post colonial northern Tanzania increased with the emergency of new pandemic disease HIV/AIDS from 1980s. With the onset of HIV/AIDS, women in one hand were the most vulnerable, infected with the disease and on the other hand affected with poverty. With this and the aforesaid reasons, Tanzania government like any other African government started to orient different initiatives to control STDs, as it has been explained in the next section of the paper.

Many studies dealt with Sexually transmitted diseases revealed that, STDs are deadly diseases caused by germs that live on the skin or in body fluids such as semen, blood or vaginal fluid (Satel, 1999, Hunter, 2003, Collar, 2005 and Shmaefsky, 2010). In Africa, STDs were not created in a vacuum but based on local and external development brought by foreigners. Scholars also noted that STDs by nature infected individuals who engaged in sexual networks. The study conducted by Lwihula et al, for example, indicates that the spread of STDs depends on the transmission sites such as plantation area, mining sectors, trade routes, ports and market places. This was also the case in the context of Tanzania. However, little has been done on the aspect of STDs among women in Northern Tanzania and the government initiatives to control STDs. This paper, therefore, covers that gap by focusing on the prevalence of STDs among women during the colonial and post colonial time. The paper examines the trends in the development and prevalence of STDs; the impacts of STDs, the perception of both community and that of colonial and post colonial government on STDs. The paper also analyzes different initiatives taken by colonial and post colonial government to control STDs in the Northern Tanzania.

The paper strived to:

- i. Examine trends in the development and prevalence of sexually transmitted diseases in northern Tanzania from the 1900s to 2000s.
- ii. Investigate on the perception of both local communities and that of colonial and post colonial government on STDs among women in northern Tanzania.
- iii. Analyze the extent to which colonial and post colonial governments took initiatives to control the prevalence of STDs among the women in northern Tanzania.
- iv. Document the impacts of STDs encountered by women and the community in the northern Tanzania.

In exploring sexually transmitted diseases among women in northern Tanzania, this paper combined two theories: political economy and social constructionisms. Political economists link health to the patterns of political, economic transformations and the social relations arising out of production process (Singer, 1998 & Kaijage, 1993), in the sense that uneven distribution of resources including medical attention, poverty, labour migration and environment in which



labourers were made to live exacerbated health problems among Africans (Packed, 1992). In this context, the political economic perspective is applicable because it links health to wider political and economic transformations and its arising social relations. By applying this perspective in northern regions and Tanzania in general, diseases such as STDs were the result of political and economic factors such as poverty, migration, social class, urbanization and money economy. Ehiri (2009) argues that human health is influenced by politics and economic power at global, national and local levels. The statement made by Ehiri fits well in explaining the case of STDs among the women population in northern Tanzania since new form of politics led to economic changes and consequently the indigenous economy collapsed, resulting into indirect effects of displacement and vulnerability to infectious diseases.

Despite its usefulness, the political economy approach has been criticized for neglecting social and cultural aspects. As John R. Hjelm (2010), documented, health and diseases as the “cultural concept”, that is to say, different cultures have different explanation on the meaning and causes of ill-health. Social scientists link the causes of STDs to tradition and customary laws which often discriminated, oppressed and exploited women and consequently jeopardize their health. Among the Chagga for example, women were deprived of their rights to means of production such as land (Sally & Puritt, 1977). Therefore, some scholars have embraced this perspective since the theory cuts across socio-economic and cultural aspects of the community. A good example in this category is the work of Turshen (1991). Turshen’s central analysis is that the cultural subordination of women and limited opportunities African women had or have through productive work is the root of the problem of women involvement into multi-partner sexual relation and thus contracting STDs. Building on the Turshen’s observation, this paper has explored how aspects of culture in northern Tanzania have had bearing on the spread of STDs among the women of northern Tanzania. Although it is difficult to accept these explanations in natural science, this paper has established the socially acceptable explanation of diseases in the next section of the paper in relation to STDs.

Methodology

This qualitative study employed multiple sources. We therefore, collected information from books, journal articles, and documents such as archival records. Additionally, literature review of relevant disciplines such medicine, anthropology, ethnography and sociology was done exhaustively. In establishing this paper, we started with the library search in the library of Mwenge Catholic University in Moshi and the University of Dar es Salaam. In the library, secondary data were obtained mainly from books, study reports and journal articles. These secondary sources provided information on STDs prominent in Africa and Tanzania.

Despite their usefulness, secondary sources had some limitation: they lacked information on the prevalence of STDs at local level and among the local women of Kilimanjaro, Arusha and Tanga. This problem was overcome by consulting archival sources. The archival sources were from Tanzania National Archives in Dar es Salaam (TNT). From the archival sources we consulted district books, colonial medical reports and government report on STDs. These archival documents contain bulk of information on the prevalence of STDs in Tanga and all colonial centres of production in Tanzania, factors for the spread of STDs and its impact to women.

However, archival sources lacked some necessary information about social setting, culture and interaction among the community. This problem however, was solved by consulting anthropological and ethnographic work. All this work not only provided us with information on STDs, but also offered information on the social setting of African ethnic groups and on the sexual culture of the Chagga, Meru, Iraqw, Pare and others. Specifically, the paper showed how the ethnic groups interacted with each other and with external intruders. This knowledge on the ethnic interaction was useful for the analysis of how STDs were influenced by such cultural interactions in the communities and their neighbours. Therefore, it is through the combination of library findings, and archival sources that enabled the contextualization and reconstruction of the history on STDs prevalence among the women in northern Tanzania.

Emergence and Prevalence of STDs in Northern Tanzania

It is not clear on how or when STDs were introduced into Tanzania. Since pre-colonial times, gonorrhea, syphilis, and Chlamydia have continued to inflict people. Its appearance in Africa and Tanzania, however, is coincided with the interaction of local community with foreigners from either Middle East or Europe. This is acknowledged because syphilis appeared prominently in Europe since the 14th century and by 1500 the disease had spread everywhere in the continent facilitated by Napoleonic war (Marius 1954 & Tanganyika Medical Department 1936). Although its name



was not known, European in the 16th and 18th centuries experienced an epidemic of new disease called the “French disease” in absence of laboratory test; however, it was difficult to know whether the disease was the modern venereal syphilis or gonorrhoea. What is important to note is that the disease was primarily spread through sexual intercourse. To show its prevalence, in England for example, the British feminist Christabel Pankhurst used male exposure to venereal diseases to champion the rights of women. In one of her statement made in the 1880s, she argued that “Never again must young women enter into a marriage blindfolded...they must be warned that marriage is dangerous, until such time as men’s moral standards are completely changed and become clean living as women” (Mbogoni 2013:p 15). The statement made by Christabel and other scholars’ shows that STDs existed in Europe since time immemorial. Europeans had already developed and relied on biological mode of treatment of sulphur drugs and antibiotics, which were found in 1879 for gonorrhoea and 1905 for syphilis.

As for its existence in Africa it was believed that the disease was supposedly carried by Vasco da Gamas’s crew and reached the continent by the 1490s. As noted by Turshen (1984), these two phenomena played a greater role in the spread of diseases and in this case STDs. On the same line Feirman (1982) points out that diseases including STDs do not happened in a vacuum, but are link to the social context. To Feirman argument, the spread of STDs from Europe to Africa was facilitated by commerce, dominated by Portuguese. This is reasonably true because syphilis followed the Portuguese mercantile roots around the continent and it was said that the crew of Portuguese ships brought the diseases to the present day coast of Tanzania which also includes the present Tanga in the late 1520s, and were known by Swahili names *Kaswende* for syphilis and *Kisonono* for gonorrhoea. Although Portuguese spearheaded the spread of STDs, it is also important to note that Arabs also had the hand for the spread of STDs to the present day Tanzania.

Historically we know that Sultan Seyyid Said shifted his capital from Muscat to Zanzibar in the 1840s. The establishment of his capital in Zanzibar was associated with the development of slave trade and thus, the prevalence of STDs in Zanzibar and to the Coastal areas more particularly the present Tanga. As noted by Mbogoni (2013), slavery facilitated sexual exploitation of African women. Slavery provided Arab men the opportunity to abuse both female and male African slaves, known by Swahili names, *Vijakazi*. As articulated by Mbogoni, an inter-racial sexual liaison, more particularly between Arabs and African women was a norm. African women were either abusively or in their own accord, used for sexual pleasure. This was obvious from the statement made by one Yusuf, a Sailor who said “Sailors from Arabs eagerly looked forward to their arrival in Zanzibar, where they could carouse, with best local women” (TNA 456, DSM No.3). That is to say African women were available in a casual basis. Therefore, besides being looked at as moral pollutants, the coastal women posed medical danger as alleged source of sexually transmitted diseases in the coastal areas and to the northern part of present Tanzania.

Moreover, STDs affected women of what scholars called “productive and reproductive age” (Berger & White, 1995,p: 40). It is said that in one hand women of age between twenty to forty years old were mostly succumbed by STDs since they were in risk sex. Although in pre-colonial African culture, women were confined around houses, as noted by Lawi (1999), the community held the belief that women of child bearing age were vulnerable to malevolent attacks of *neetlaag’w*(evil spirit). Despite this restriction, women flock to production area or along the trading routes since they had little or no opportunity that male had over resources. In addition, women movements were also connected to the African culture of male dominance over female, thus, women were either escaping from their husbands violence or control of their fathers or brothers. Consequently this had bearing effect on women vulnerability to STDs.

Colonialism and Trends in Prevalence of STDs in Colonial Northern Tanzania Since the 1900s to 1950s

This section highlights the penetration of colonialism and its relationship to disease environment in northern Tanzania from the 1900s to 1950s. The argument of this section is that the colonial activities facilitated spread of STDs and undermined indigenous systems in handling diseases. Although it is true that colonial governments established social services in Tanzania, it is arguably the fact that the facilities did not check the outbreak of alien diseases which had severe impacts not only on women but to the whole community. Feirman and Janzen (1992) said that each pattern of production is associated with a particular distribution of health problems as they are shaped by the changes in natural environment. In Tanganyika, colonialism started with the German rule from 1885 to 1918, followed by British from 1919 to 1960 (Kaniki 1985, p. 383). This shows changes in the society in terms of socio-economic and political structure. These changes as claimed by Feirman had bearing effect on the prevalence of diseases and their healing processes.



However, the paper did not find specific statistics on the prevalence of STDs among the women in northern Tanzania during the German period, because of two reasons. The first being, the availability of documents since German destroyed their available documents when they were escaping from British. The second thing was on the socio-economic basis, in the sense that women as well as the general African population in the early period of colonialism were reluctant to work on colonial centre of production for two reasons. The first being the cultural basis that confined women around their homes and the second being on economic basis (Grier, 1994, Chirwa 1993, Cooper 1994 & Swai 1977).

Thus in the early decades of the 20th century, white farmers were preoccupied with labour problems. Therefore, creation and regular supply of labour became necessary not only in Tanzania but also in every colonial sector in Africa. Scholars argue that several steps were taken by the state and private capital to increase the supply of adult labourers. These included forced labour, taxation and recruitment of labourers from the neighbouring colonies (Arrighi 1973). This was also the case in northern Tanzania where taxes were a great burden. Under such conditions, colonial centre of production such as farms were potential areas where money for tax could be earned if a person could not earn it from his field or cattle. Moreover, as pointed out by Illife (1979) and Turshen (1984), taxation served the purpose of monetizing the economy and forcing Africans to sell their labour power. Although the will to work in these farms was discouraged by elders, it can be argued that there was no other means a youth could have paid tax. Generally, the colonial centre of production were seen as the place where African male and female could secure better income, have access to better social services, be able to pay tax and to provide for the family.

From the 1920s, therefore, the high prevalence of STDs was attributed to increased mobility, especially of migrant workers, porters and men in the colonial administration (military, police, penal camps, schools and administration) and the breaking up of the social structure. It was said that the invaders brought venereal diseases; spread by porters, workers, road and railway constructors and the people living adjacent to roads. According to the information obtained from the TNA, road workers in Mbulu area for example, were distributed in gangs and housed in camps. Between 1926 and 1927, the total number of workers in camps reached up to 13, 410 and were coming from different ethnic groups in and beyond the district. It was noticed that the infection of venereal diseases was high in the camps and areas along the road (Greening TNA). In 1929, the medical officer of the Northern Province checked on the record of venereal diseases among the road workers. The record showed that between 60% and 75% of workers who attended various dispensaries as patients down the escarpment were suffering from venereal diseases. The highest 75% were found at Madukani (Magugu) camp (TNA: 305). The reason for venereal diseases among the workers was that, the workers were away from their families for several days and thus interacted with women selling food and living around the camps. Therefore, it is possible that workers might have engaged themselves in sexual relations with the women and consequently contracted venereal diseases.

This was a sharp contrast to the pre-colonial period, a period marked by fewer venereal diseases. Illustrating this, Fosbrooke (1957, P. 46) noted that when Europeans arrived in present day Mbulu, they appreciated the fact that the district above the rift valley was clean from venereal diseases. The reason given for this was that the “uncouthness and penury” of the Iraqw seldom attracted the alien women; hence, many people were spared from STDs. However, it is significant to look beyond the explanation given by Fosbrooke (1957). The primary reason was the role of *meta* and *metida*, literary known as seclusion, held by both the Iraqw and Barbaig. The institution spared the community from sexual contact with alien people; it was a taboo an Iraqw woman or man to have sexual relation with a woman or a man from an alien ethnic group, particularly from beyond the region. These indigenous culture that spared community from interaction, however, was destructed by socio-economic and political changes brought by colonialism.

On the working place, also women had little bargaining power in refusing sex, that is to say the African culture contribute to put women at the increased risk of contracting STDs. Fredrick Kaijage (1993), revealed that during the 1940s and 1950s, a story was told about the movement of women from Haya areas of western Tanzania to colonial centre of production and big cities, many of whom engaged in commercial sex as means of earning living. Work on the colonial centre of production exposed women to the hostile environment conducive for spread of STDs. The transmission, therefore, expand along emerging network of geographical mobility and urbanization. Women prostitutes frequently travelled between one working centre to another.



The analysis made by Kaijage (1993) among the Haya is the same as what the Iraqw elders observed. Oldeani was the source where alien diseases had entered the Iraqw country. It is argued that many youths who flock to the plantations had returned ruined in health and others never came back at all. On the extreme end, the returning labourers to the villages transferred venereal diseases to the rural areas (Tango 2017). Prostitutions had been a regular custom not only in Oldeani but also in all colonial sectors in Africa. Sociologists Culwick in the 1930s and Hans Cory in the 1950s, single out prostitutions and sexual promiscuity as the most crucial factors in the spread of syphilis and gonorrhoea in colonial Tanga. The infection as noted came from the full range of the racial spectrum, namely European, Asian and Africans. The medical Research Institute, revealed that for 1936, the specimens of 10 European tested positive, compared to 3 and 2 positive results for Asian and African respectively. Additionally, a clinical lab at Sewa Haji hospital in Dar es Salaam, tested 143 specimens and out of them 69 had gonococci bacteria. A newly laboratory, opened in Tanga tested 233, and 52% were found positive (Tanganyika Medical Department 1936). Mbulu was not an exception; anthropologists tell us that in 1954, the report of the district Medical Assistant, Dr. P. S. Mgaga, showed that for the workers who attended Oldeani hospital as patients, 231 males out of 567 and 187 females out of 419 were suffering from venereal diseases (TNA 305). This was almost 50% of all patients treated in the hospital for a particular period. These results were the same as what Sadock (2005) has discovered in Rungwe. However, it should be reckoned that the figures may be higher than these because other cases of STDs were either treated locally through herbal medicines or were not reported in hospitals.

Furthermore, the growing colonial centre of productions became magnetic places for young women. It is believed that from 1930s to 1940s, there was massive influx of Europeans, African soldiers, workers and administrators that made young girls and boys flock in these production areas for prostitution and domestic services. Ufom Ekpe-Otu (2009) made analysis in Nigeria and noted that, many girls were fetched from rural areas to Lagos by their relatives and family friends as part of employment, but in turn they were used in prostitution or as domestic servants. Similarly, in Tanga, Mbulu and Moshi, young girls were either taken from home literally by their friends, boyfriends, or trafficked by relatives and they ended up in prostitution. This behaviour of women engaging in prostitutions and girls trafficking, amounts, in effect, to a kind of sexual census akin to the socio-economic changes of the 19th and 20th centuries.

Furthermore, the migration to colonial centre of production had economic, social and cultural effects on the women left behind by men or to the female labourers in the working areas. To the women left behind, the married men cut off themselves from the home economy which was left in the hands of women and children. In this regard, the farms and cattle left under the women's care deteriorated and agricultural production declined drastically, thus poverty. As noted in Kilimanjaro and Tanga, married women sometimes turn to prostitutions or enter into sexual relation with alien men so as to supplement their households' income (Clarke & Olsen, 1999). This had impact on the further prevalence of STDs in rural areas. Additional, Married women became childless that cost both their happiness and marriage. Although the relationship between infertility and STDs is complex, Simon Szveter (2019) in 1953 noted that among the Haya there was growing breakup of married couples at the early stage of their marriage life on the ground of childlessness. In 1959 among the Haya 22% of ever married women in their twenties were divorced or separated and another 24% were in their second or third marriage. This was also the case in northern eastern Tanzania. The generalization was because infertility in many African cultures legitimized divorce. The family of the husband would argue that it was justifiable for their son to divorce because the wife had no children; she was like a prostitute to him. Due to this prevalence rate of STDs colonial government took different measures, as explained in the next section of this paper.

Colonial Government Initiatives to Control STDs and Community Perception

As noted earlier, STDs were wide spread in all social groups including the Europeans. In that regard the colonial authorities' instituted number of medical services throughout the country in the late 19th and early 20th centuries (Mihanjo 2003). The services' main focus was on the control of infectious and transmitted diseases like STDs, as well as tropical diseases such as malaria. For example, in 1895, the German built Bombo, the current Regional hospital and Amani Biomedical Laboratory in Tanga (Beck, 1977). They also built Mawenzi the current regional hospital in Moshi in 1920 as German soldier's dispensary and later became hospital in 1956. Moreover, in 1922, the British colonial government under the leadership of Dr. Frank Apted, established a medical service Unit in Tabora. This was followed by the establishment of East African Malaria Unit (EAMU) at Muheza by Captain Dr. Bagster in 1949 which was later moved to Amani at Usamabara in 1951 and it was renamed as East African Malaria Institute (EAMI). As noted



by Turshen (1984), the colonialist attempted to deal with diseases such as STDs, partly to serve European settlers, administrators and soldiers from infections. Thus, many hospitals, dispensaries and dressing stations were established in northern Tanzania. For example, by the 1930s, Arusha, Tanga and Kilimanjaro had number of dispensaries and dressing stations.

Both the German and British government at different time also developed various medical policy. The German for example, in the 1910s developed a policy of licensing a compulsory medical examination of sex workers in every colonial centre. The British also in 1925 developed medical examination policy among the soldiers and the police force in Dar es Salaam and Tanga. This went hand in hand with the introduction of compulsory medical examination for sex workers and controlling the sexuality of a specific social group perceived as transmitters of diseases to the public. These include female sex workers, mobile unmarried women and movement of migrant labourers. As noted by Sadock colonial authority believed that migrants and female prostitutes were the transmitters of STDs. Thus in 1925, 56 female sex workers were detained in Dar es Salaam and were forced to undergo medical examination for VD. Unfortunately, 35 were found suffering from gonorrhoea and 3 from syphilis (Sadock 2005). The results show how dangerous the situation was on the ground of STDs, and it was the case, not only in northern Tanzania but throughout colonial Tanzania. Furthermore, VD prevention campaigns were also put in place. In Tanganyika, for example, colonial authority agreed on the need for education to fight the diseases. The local community were not left out in the campaign of preventing STDs. Chagga in Kilimanjaro for example, proposed the formation of their own Medical Executive Committee, which was to take the duty of advising government health officials on the control of STDs (Satel 1999).

Yet, the established services could not cope with increasing epidemics resulting from changes brought by colonialism. The changes as Turshen aptly put it, made people more vulnerable to diseases (Turshen 1991). Generally, this means that the colonial invasion altered socio-political and economic environment leading to the rise of epidemics among the indigenous. Despite all the government efforts African women were reluctant to attend health facilities for two reasons. In one hand they tend to use alternative means of treatment by traditional healers and on the other hand, the stigma and shame associated with VD led to those who had contracted them to conceal their condition (Sadock 2005). In this context one Meru woman said “I do not take hospital medicines for any disease...Until I prove that the traditional medicines have failed completely”(Sally & Puritt 1977). The argument is that understanding of disease played a greater role in the decision to use traditional medicine. Similarly, the community believed that foreigners entering the country introduced strange forms of impurity which provoked the ‘earth spirit’, thus making massive attack on the health of inhabitants. Thus the community sacrifices could prevent epidemic diseases or bring them to an end.

Moreover, the lacks of inadequate medical facilities together with medical personnel were the obstacles to African women. In 1945 for example Venereologist Dr. W. A. Young was appointed to coordinate VD control in the colony but he was affected by a lack of junior medical staff, women in particular (Kaijage 1993). The lack of women medical staff had effect on African women health because this caused them to shy away from attending medical facilities for VD treatment as male doctors’ access to their genitalia was culturally unacceptable. Additional, the income level of African women was a problem. They could not afford medical service due to women’s lack of control of resources. As noted by Sally and Puritt (1977) among the Chagga and Meru women in northern Tanzania, there were a lot of accounts of women inability to pay for drugs. In her account, one woman as quoted by Puritt, has this to say. “I have small garden that I grow beans....my husband is the one who decide how money should be spent...I cannot refuse, he will take the money by force.” This finding was the same as what Sadock (2005) has observed. He noted that in the 1940s the League of Nations Health Organization at the time stipulated a minimum of thirty two injections of ‘bismuth’ for the treatment of syphilis. The injection together with the penicillin drug was too expensive to the extent that women with VD had not been able to go to hospital instead they go to traditional healer or wait at home to die. This together with the aforesaid reasons, were the obstacles to colonial initiatives and control measures of STDs during the colonial period. The situation was even worse in post-colonial Tanzania, with the economic crises and vulnerability of newly emerged pandemic HIV/AIDs in the 1980s.



The Impacts of HIV/AIDS and STDs Among Women and Government Initiatives to Control STDs in Post-Colonial Period

Tanzania like most of other countries in the 1960s experienced different changes in its socio-economic and political systems. As noted earlier, the changes in these institutions have had bearing effects on the spread and impact of different diseases and in this case VD. As Feirman and Janzen (1992) aptly puts, changing pattern of diseases depends on the integral changes in social and economic aspect of a given society. Taking from Fierman ideas, Tanzania for example, after independence started to restructure her economy. The late President Mwalimu Julius Kambarage Nyerere at the time focused on the development of his people after observing that his people were suffering from three “enemies” ignorance, poverty and diseases. Thus the first five years development plan aimed among other things to increase the life span of the people by improving the health services. In this regard, the plan of the government also focused on training their human resources in order to have fully-qualified citizen to fill all skilled professionals and managerial jobs. However, it is important to note that the public health and medical system in most African countries in the immediate post colonial period were the continuations of the colonial system and were the opposite of what was needed. In this relation, Tanzania and other developing countries spent over 80% of its national health budget. Thus, the first wave of health reforms initiatives, in the country in the 1960s, efforts were directed towards orienting the health sectors away from curative to preventive and promotive health services. This was partly the implementation of the first five year development plan from 1964-1969.

The period from 1970s saw the expansion on the role of state. Under Ujumaa, the government provided free social services financed primarily by foreign aid. For example the establishment of Muhimbili hospital, Tanga the sub-constructive hospital, KCMC and Bugando hospitals under the Lutheran and Roman Catholic Churches respectively, were funded by Good Samaritan Foundation in collaboration with Luther Hjalpen from Sweden, Central Agency and Bread for the World of German and Roman Catholic Church (Beck 1997). This shows that the government achieved milestone in implementing its primary health care strategies, by providing her citizen free medical treatment and drugs at government hospitals and dispensaries. Thus between 1970s and 1980s, it was observed that prevalence of gonorrhoea among women range from 24% in the 1970s and 16% in the 1980s and syphilis range from 15% in 1970s and 8% in 1980s (Mayaud& Mabey, 2004). The decrease of STDs cases was due to increase of awareness and control measures. The government of Tanzania and non-governmental organizations dedicated their efforts to improve primary health care.

However, in the 1980s, during the economic downturn and the emergence of new pandemic disease, HIV/AIDS, foreign aid declined and the economy became dependent, that also includes health services. As noted by Turshen (1991) there was decline in overall government revenue, despite extensive networks of hospitals, health centers and dispensaries across the country, the quality of health services started to deteriorate. There were no funds for staffs, drugs and facilities among other things. Therefore, the medical institutions started to experience shortage of drugs and inadequate services. Consequently a country entered into cost sharing. This forced the countries to adopt Structural Adjustment Program (SAP) which came with conditions. The impact of SAP was seen in women health. In this context, Caren and Elisa as quoted by Sally and Puritt (1977), revealed that women were dying prematurely because they could not afford to purchase treatment of STDs. On this, one woman has this to say, “The diseases does not inform you as to when will it come...so that you start serving...in fact there is no need to hide, once I fall sick I go to traditional healer or wait at home to die...”The 1980s, besides being the time of economic crises, the pandemic HIV/AIDS inflicted the country as noted earlier. The diseases which its origin is still unknown, and the common response as noted by Illife, are blaming others (Illife, 2006). European believes that Africa continent was the source while African believes that the disease might have originated from the whites. As revealed by Satel, Tanzania in general and Kilimanjaro in particular, experienced the prevalence of the pandemic HIV/AIDS (Daniel et-al, 2018). The first case of HIV/AIDS in northern Tanzania (Kilimanjaro) was diagnosed at the Kilimanjaro Christian Medical Centre (KCMC) in 1984; the year after the disease was identified in Kagera. By 1988 scientific and popular explanations of the presence of diseases in the region began to emerge. It was said that the disease was brought to Kilimanjaro by traders and travelers. The attitude of blaming others as argued by Illife, continued in the sense that the villagers blamed townsmen while the townsmen blamed the villagers, the elders blamed young men, men and women blamed each other. This was also the case in Tanga, whereby, women were accused of adultery and prostitution, implicating that they have brought diseases to the region. In the context of Kilimanjaro, the Chagga engaged in business nearly the whole region, both young people and adults travelled in and outside Kilimanjaro (Satel, 1999).This



situation was said to have increased the vulnerability of the diseases among the women and the whole population in Kilimanjaro and other parts of the region.

Apart from trade the vulnerability of IHV/AIDS and other STDs were attributed to economic crisis and cultural subordination of African women. It is noted that economic crisis affects more severely women and their children. This was the case in northern Tanzania. The Chagga, Pare, Iraqw and Meru women, for example, became available illegal enterprise (Mikell 1997). This argument was supported by Dr. Waithera (2011), in the context of Kenya. She revealed that women in Africa were vulnerable to HIV infections because they lack power and economic independence over their sexual lives. To Waithera, cultural norms and a combination of sexual vulnerabilities place women and girls at higher risk of HIV/AIDS. Among the northern Tanzanian societies gender relation was characterized by unequal power distribution. The subordination of women by men in division of labour and limited control over resources forced women to move from rural to urban areas in searching of job in bars, market places, industrial sectors, and domestic works to mention just a few. Thus in 1994 for example, WHO estimated that 1.75 million people in Sub-Saharan Africa were HIV infected and 20% cases were the pregnant women in the capital and cities between 1985 and 1993 (Way & Staneck 1994). The prevalence was attributed to sexual practices before and outside marriage and in aforementioned places. This conclusion was made because the infection concentrated in the ages of peak sexual activities from the late teens to about age of 30s to 45 age range. It was also noted that one in three children born to HIV infected mothers in developing countries were themselves HIV positive.

Thus up until 2004, in total enrollment of 125,139 patients, more than half were women (Bohle 2013). Most of them could not afford ARV drugs. This is so because in African context women dependent on men, despite this being the major factor in influencing HIV vulnerability, without an income woman are desperate and are forced to stay in disastrous relationship that creates opportunities for HIV vulnerability. Thus according to Nombo (2007), in 2006, it was estimated women are having higher prevalence rates of 8% than men 6% while the national prevalence rates was 7%. This shows that despite the continuation decline on the prevalence rates since 2002, some rural areas are still having infection rates of more than 20%.

The above information might be subjected to underestimation because according to NACP many people in the rural areas were unwilling to go for HIV test. Most of them were reluctant to reveal their medical condition because of the stigma. Stigma according to Farmer (1999) refers to prejudice, discrediting and discrimination directed to people perceived to have HIV/AIDS by individuals or communities with which they are associated. Stigma creates fear and secrecy that distance a person from normal life. Thus women living in poverty, having lower education level and being located in rural area have highly stigmatized attitudes. As noted by Nombo, in Tanga, some individual have taken HIV as death sentence and local community in these areas perceived it as sorcery or spiritual bedevilment, the situation that increase stigma and vulnerability. Hence it was noted that up to 2010 many people in Tanzania more particularly women are affected in younger age than men as surveyed by the UNDP. The results shows women in polygamous union rate high, 10% of infection than monogamous married women rates 7% infections. Despite a wide spread knowledge on HIV transmission and efforts to reduce stigma, women living with HIV are regarded as shameful and irresponsible. That is to say stigma is responsible in preventing women in seeking counseling and HIV testing. Moreover, as noted by Nombo (2007), ARVs treatment of AIDS related infection is limited to some localities and small proportion to those in need. Knowledge of condoms is also limited to urban areas. For example in Tanga, despite the fact that condoms are available in every "kiosk" women do not have courage to ask publicly. They are afraid of being offensive gossips; finger pointing and being face with accusation of adultery or prostitutions.

In developing countries like Tanzania HIV have profound impacts. It increased the level of poverty and in some cases of serious food insecurity. Evidence from Tanga, Moshi, Karatu and in Makete, Ulunga and Kilombero districts in Tanzania indicate that poverty among infected women increased. Affected households in these districts are poorer than non affected ones. It is important to reckon that members of the families that affected with diseases experienced a significant reduction in income and increases in health expenditures. Knowing women as primary care givers to the families and to the sick, the burden on them increased on the grounds of HIV/AIDS.

Globally, millions of women risk their lives because of HIV and other STDs which has long term impacts on reproductive systems. As it was said, STDs encompasses diseases and disabilities that were and still associated with



reproductive systems. It should be noted that, HIV/AIDS like syphilis is associated with adverse pregnancy outcomes (stillbirth, abortion, pre mature rupture of membrane, pneumonia and low birth weight) among the inflected women (Mayaud et-al 1995). As a matter of fact, HIV/AIDS projected to reduce life expectancy of the entire population up to 15%. Although, the death rate on the ground of HIV is decreasing in Tanzania, 1.3 million children by 2010 had already been orphaned.

The existence of HIV/AIDS and other STDs in Tanzania made the government to increase their budget for health sector in order to control diseases. The government together with different NGOs also created different programme such as National AIDS Control Programme (NACP) in 1985, Voluntary Counseling and Testing (VTC) in 1997, focusing on prevention and provision of health services to people suffering from HIV. Moreover, in 1999, the president of Tanzania Benjamin William Mkapa, declared HIV epidemic a national disaster and called the epidemic an extraordinary crisis that requires extraordinary measures to deal with. Thus, in 2002 Prevention of Mother to Child Transmission (PMTCT) programs were launched by the Tanzania government, with support from UNICEF. This was followed by distribution of ARVs in 2004. These centers were working under AMREF and the affiliated Angaza Project. This being the case different NGOs were established to support women and children in dealing with HIV/AIDS. NGOs established mechanisms for ensuring the security and protection of women and children at risk of abuse and women exploitation. Furthermore, the NGOs provided psychological and legal services for vulnerable women. However, poverty, stigma and social cultural practices (taboos and beliefs) as we have seen earlier, creates a culture of silence among women hence hindered the efforts of controlling HIV and other STDs.

Conclusion

The paper indicates that the weakening of socio-political, economic and cultural status of the local communities by the Europeans increased the vulnerability to STDs in the area. The argument here is that socio-cultural practices and stigmatization hinder women to attend to hospitals and to reveal their medical conditions. On the aspect of culture for example women were and are still vulnerable because sexual relationship between men and women in African culture take place in a context in which roles are determined by patriarchal culture, where women have little say in sexual matters. That is to say HIV affects women who are least able to protect themselves, the vulnerable and insecure. The diseases are not strictly natural occurrences; rather, they are social events that are linked with the relation of production.

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