Graduate School of Development Studies

Framing and Claiming Reproductive Rights: A Case Study of Civil Society Actors in Tanzania

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List of Acronyms

ANC – Antenatal Care
AU – African Union
BPA – Beijing Platform for Action
CEDAW – Convention on the Elimination of all forms of Discrimination Against Women
CRC – Convention on the Rights of the Child
CSA – Centre for Social Accountability
CSO – Civil Society Organization
CSSC – Christian Social Services Commission
DMO – District Medical Officer
DSM - Dar es Salaam
EmOC – Emergency Obstetric Care
FP – Family Planning
FGM – Female Genital Mutilation
HIV/AIDS – Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSSP – Health Sector Strategic Plan
ICCPR – International Covenant on Civil and Political Rights
ICESCR – International Covenant on Economic, Social and Cultural Rights
ICPD – International Conference on Population and Development
IRRRAG – International Reproductive Rights Research Action Group
MCH – Maternal Child Health
MDG – Millennium Development Goal
MEWATA – Medical Women's Association of Tanzania
MOH – Ministry of Health
NGO – Non-Governmental Organization
PMNCH – Partnership for Maternal Newborn and Child Health
PMOLRG – Prime Ministers Office of Local and Regional Governance
PRINMAT – Private Nurses and Midwives Association of Tanzania
RAS – Regional Administrative Secretary
RBA – Rights Based Approach
RMO – Regional Medical Officer
SOSPA – Sexual Offences and Special Provision Act
TBA – Traditional Birth Attendants
TDHS – Tanzania Demographic and Household Survey
TGNP – Tanzania Gender Networking Partnership
TYC – Tanzania Youth Coalition
UN – United Nations
UNFPA – United Nations Population Fund
UNICEF – United Nations Children's Fund
USAID – United States Agency for International Development
USD – United States Dollar
VEO – Village Executive Officer
WD – Women's Dignity Project
WHO – World Health Organization
WRATZ – White Ribbon Alliance for Safe Motherhood in Tanzania
YAV – Youth Action Volunteers

Abstract

This research paper focuses on the issue of maternal mortality in Tanzania from a human rights perspective examining the role of civil society actors in framing and claiming rights related to women's reproductive health. The research process included qualitative interviews with organizations working in Dar es Salaam on issues related to reproductive health, focus group discussions with rural women in Dodoma and a review of secondary data including documents produced at the international level. A key aspect of the research involved examining how reproductive rights are translated into the local context and in turn how they are used by civil society actors.

The findings and analysis of this study include a critical examination of the way in which culture and tradition are framed within current safe motherhood discourses with a key example of such being the naming of "traditional" birth attendants. The framing of the issue of maternal mortality by civil society actors was also found to inform the way in which rights claims are made. A delineation was found in the research between those organizations that take what Merry calls a "social-service approach" to rights promotion and those that take a "human rights advocacy approach" (Merry 2006a:138). Although both approaches converge in important ways there are fundamental differences in the way in which their work is carried out. In addition, the study found that while many organizations are involved in mobilization, building a widespread political movement was not a priority for the organizations interviewed. The investigation of "translators" also found more evidence of *translations,* programs or projects that have been adopted from other contexts. Finally, the relationship between CSO's and the state on the issue of maternal mortality was found to be influenced by the chosen approach to human rights promotion.

The aim of this research is to contribute to the existing knowledge of civil society organizations and donors working in Tanzania, although the dual inquiry approach to exploring how organizations frame and claim rights could be applied to other contexts and issues.

Relevance to Development Studies

The maternal mortality ratio is a strong indicator of development. For safe delivery women require access to health services including trained health staff, a ready supply of drugs, power and water and a means of transport to deliver women to the appropriate health facility when complications arise. A human rights perspective provides a lens to see the current inequalities of the health system in Tanzania and the failings on the part of duty bearer (the state) to provide the enabling conditions for women to deliver safely. MDG 5 acknowledges the importance of reducing maternal mortality globally as a key development goal.

Key Words

Human Rights, Reproductive Health, Tanzania, Maternal Mortality, Translators, Civil Society

Chapter 1: Introduction

> A strategy built on ideas drawn from human rights transforms the health system from a static agglomeration of buildings, equipment, drugs and staff, into a dynamic entity through which citizens interact with their government and the wider civil society (Freedman 2003:105).

In this paper I will explore how human rights are being *used* by Civil Society actors using the issue of maternal mortality in the context of Tanzania as a lens to focus my research. While much has been written about the theoretical debates of the origin, value and ethnocentrism of human rights generally, my research aimed to go beyond this debate. My interest was driven both by a deep concern for the issue of maternal mortality in Tanzania, a country that I have lived and worked in as well as a curiosity in how organizations working at a local level, in a context far removed from Geneva or New York were engaging with, understanding and using human rights. While I have used a particular setting and issue to focus my research, my dual inquiry of exploring how organizations frame and claim their own priority issues with respect to rights claims could be applied to other contexts and issues. In addition, some of the issues I raise in this paper may be relevant to other organizations choosing to engage with human rights elsewhere.

I stumbled across the issue of high maternal mortality in Tanzania almost accidentally after being sent to a conference to represent the organization I was working for at the time. While my work then was focused on reducing child mortality, the conference was aimed at integrating infant, child and maternal health interventions. A short film was shown in which women and health workers spoke about their own experiences with respect to the issue of safe motherhood which had a powerful affect on me. Hearing women's stories of their long, painful and uncertain journeys into motherhood forced my own confrontation with the layered and complex inequities women face in Tanzania.

A year later, as a student of human rights I was increasingly aware of the theoretical link between rights and the issue of maternal mortality but how to take on this approach at the local level was murkier for me. Thus I decided to pursue this research interest and marry my concern for maternal mortality as a serious and neglected social justice issue with my curiosity in how rights are framed and claimed at the local level.

My research was initially borne out of many questions, for example, how is the issue of maternal mortality framed as a human rights issue? What treaties and rights are most closely linked to protecting women? I was also curious in the current development context where many civil society actors have adopted a "Rights Based Approach" (RBA), how rights are being *used* by civil society actors in Tanzania and how this came to be. A number of international initiatives and organizations have become increasingly concerned about maternal mortality in Tanzania which provided an opportunity to trace how human rights norms are (or are not) used locally and the disjuncture between their articulations at the international level and how they are understood, experienced and translated into the Tanzania context. While my research interest focused on civil society actors, I was also curious to hear about women's lived experiences of access to reproductive health services beyond the city limits of Dar es Salaam where most of the civil society actors in Tanzania are based.

Moving from understanding how rights related to reproductive health are framed in Tanzania I also wanted to understand in what ways they are claimed. This method of dual inquiry of exploring "framing" and "claiming" allowed me to examine first how the issue of maternal

mortality is articulated and what is included and excluded in this articulation as well as the action that may follow. For example, does claiming involve lobbying and advocacy efforts only? Is using rights simply an issue of semantics or does this approach fundamentally change the activities and relationships of the organizations involved? Is mobilization a key area for rights claiming in Tanzania? Key to exploring the process of "claiming" involved inquiring into how rights are being used as tools at the local level.

To achieve my research objective of exploring the current dynamics of framing and claiming reproductive rights by civil society organizations (CSO's) my field work included speaking with actors in Dar es Salaam (the economic capital of Tanzania) and tracing their relationships with both external and internal actors. In addition, my research took me to a rural community in Dodoma in Central Tanzania to contextualize my conversations with CSO's by speaking with women they generally claim to serve. In the course of doing field research during July and August of 2008 I asked myself, "How do these actors frame reproductive rights and make claims based on these rights?

This paper begins with an explanation of my theoretical framework (chapter two) which provides the foundation for my research. I explain concepts related to maternal mortality, reproductive health rights and civil society and sketch out my theoretical approach. I also discuss my methodology which involved qualitative interviews with civil society actors and focus group discussions with rural women. The chapter ends with a discussion of the limitations and challenges to my methodology.

After grounding my research to theories and concepts I locate it within the research setting of Tanzania in chapter three. This includes a brief background on the health system in Tanzania, the current indicators on maternal health and a description of the current actors working on safe motherhood initiatives. The chapter concludes with a brief overview of the political and legal context of Tanzania with respect to reproductive health.

Chapter four highlights my findings and analysis. The chapter is a response to and reflection on my sub-research questions (listed in section 2.4) and begins with a discussion on the lived realities of reproductive rights drawn from my focus group discussions with rural women (4.1). I then examine how these experiences relate (or not) with civil society actors framing (4.2) and claiming (4.3) of reproductive rights.

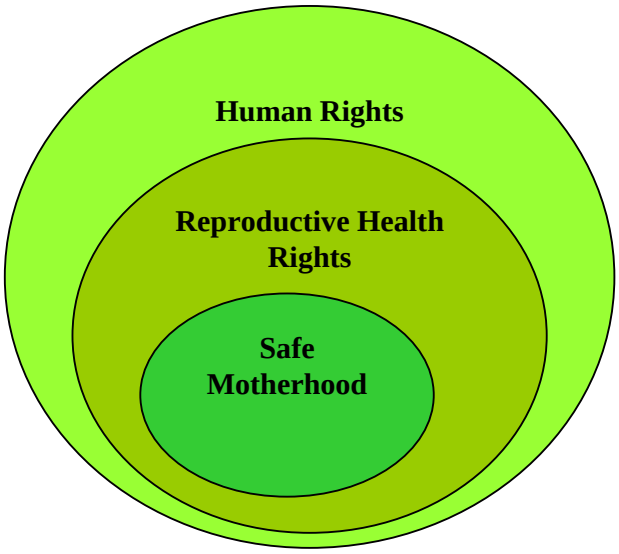
The paper concludes with chapter five in which I reflect on the questions raised that inspired this research. The aim of this paper is to contribute to the existing knowledge of civil society organizations and donors working in Tanzania on how they may engage with women and the state on reproductive health issues through future advocacy efforts or programs. It is my hope that this research may be useful to organizations working to support and strengthen health systems and access to safe motherhood for women in Tanzania as well as provide a useful model for exploring rights engagement on other social justice issues beyond Tanzania's borders.

Chapter 2: Concepts & Theoretical Framework

In this chapter I define what I mean by "maternal mortality" and "reproductive health and rights" and then go on to explain my theoretical framework which draws on socio-legal theory and aspects of the International Reproductive Rights Research Action Group (IRRAG) framework. This chapter also includes a description of the research methodology with an acknowledgement of the particular limitations and challenges to the methods chosen.

At the heart of my framework is the link between human rights and safe motherhood. As illustrated below, safe motherhood is one aspect of reproductive health rights which are located within broader human rights principles.

Figure 1: Locating Safe Motherhood



2.1 Concepts and Definitions

Maternal Mortality

'Maternal Mortality' is defined by the World Health Organization (WHO) in the International Classification of Diseases and Related Health Problems, Tenth Revision, 1992 as:

> The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO 2007:4).

This definition includes deaths resulting from both direct causes, such as obstetric complications of the pregnancy as well as indirect causes such as pre-existing diseases and those developed during and aggravated by pregnancy (WHO 2007:4).

Measuring maternal morality is generally calculated in one of three ways, the maternal mortality ratio, rate or adult risk. The maternal mortality *ratio* is the method referenced in this paper and is

calculated by the number of maternal deaths during a given period (normally one year) per 100,000 live births during the same period (WHO 2007:5).

A number of challenges exist in measuring maternal mortality. The WHO, UNICEF, UNFPA and the World Bank have identified that in many countries in which maternal mortality is reportedly high, civil registration systems may not exist or may not consistently collect information about causes of death. Their 2007 joint report indicates that Tanzania lacks a complete registration of deaths and that the direct sisterhood method[1] (adjusted for bias and HIV/AIDS) is the best available source of measuring maternal mortality (WHO 2007:10). The report lists the 2005 maternal mortality ratio for Tanzania at 950 per 100,000 live births which is much higher than the reported ratio of 578 per 100,000 by the Tanzania Demographic and Health Survey (TDHS) of 2004/2005. I will provide more detail on specific statistics related to reproductive health and maternal mortality in Tanzania in the following chapter.

Reproductive Health & Rights

The concept of reproductive health has been fully articulated by the Programme of Action developed and agreed upon at the International Conference on Population and Development (ICPD) in Cairo (1994). I have used the following definition of "reproductive health" in my research:

> Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that will enable women to go safely through pregnancy and childbirth. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations. (UN 1994: Chapter 7:A).

The Platform for Action developed in Beijing (BPA) at the Fourth World Conference on Women (1995) builds on the Cairo definition of reproductive health and defines reproductive rights below. I have used this broad definition of "reproductive rights" in my research:

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences (UN 1995: para. 96).

[1] Sisterhood methods obtain information by interviewing a representative sample of respondents about the survival of all their adult sisters (to determine the number of ever-married sisters, how many are alive, how many are dead, and how many died during pregnancy, delivery, or within six weeks of pregnancy) (WHO 2007: 6).

While these definitions are fairly broad and inclusive, like other rights articulations they are the result of extensive negotiations between a wide range of groups representing different interests. Some may argue, especially with respect to access to safe abortion that these articulations do not go far enough to protect women or to challenge patriarchal notions of female sexuality.

2.2 Theoretical Approach

Broadly the theoretical framework for my research is grounded in a Human Rights Approach which allows for exploration of the issue of high maternal mortality in Tanzania as inextricably linked with a number of human rights violations. As Cook and Dickens argue,

> A human rights approach shows that women's maternal mortality and morbidity result not simply from their disadvantages but frequently from cumulative denials of their human rights; that is, failure to address their preventable death and sickness is a result of injustices that women experience. A human rights approach to safe motherhood identifies forums to acknowledge the wrongs women suffer through the neglect of their basic health care needs as denials of their human rights, and seeks means by which these denials can be remedied (Cook & Dickens 2001:5).

Underlying my investigation into how reproductive rights are framed and claimed in Tanzania is the assertion that all Tanzanian women are rights holders and the state is primarily a duty bearer in providing the enabling conditions that serve women's reproductive health needs. A number of human rights can be linked to the issue of maternal mortality which are found in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on Human and People's Rights on the Rights of Women. All four agreements have been signed and ratified by Tanzania.

A "rights-based approach" (RBA) to development work is part of operationalizing a human rights approach. During my field research a range of definitions were uncovered with respect to how a RBA is defined and implemented – which I discuss in Chapter four. However general characteristics of a "RBA" Molyneux and Lazar argue can be described as:

> Encouraging people to assume their rights on a personal, subjective level, strengthening popular organizations so that people can make their own demands, working directly with agents of the state to create and/or strengthen legal mechanisms, applying political pressure through lobbying and campaigning (Molyneux and Lazar 2003:50).

Related to the description above, understanding how to support the assumption of rights and demands by Tanzanians and to apply political pressure to hold the state accountable raised the concept of "mobilization" in my research as one way in which rights claims may be made. According to the Oxford English Reference Dictionary, the term mobilization originated as a military term of assembling and preparing troops for war (Pearsall and Trumble 1996:927), however I have used the term loosely as connected to social movements describing groups of people involved in protests or collective political action. In my interviews I have tried to allow space for key respondents to define their

own interpretations of mobilization as a means of rights claiming. I discuss this more in chapter 4.

An additional piece of my human rights approach includes socio-legal theory as a framework for exploring the relationship between international human rights norms and how these are understood, experienced and practiced in the Tanzania context. Particularly useful to my research has been Sally E. Merry's conceptualization of "translators", whom she describes as civil society actors who travel between transnational forums, such as those involved in articulating internationally agreed upon global human rights norms and their local context to translate these norms into the vernacular (Merry 2006a). The term "vernacularization" was initially developed to describe the process in which national languages separated in the 19th century moving away from the use of Latin. Merry argues that a similar process occurs in human rights language when adapted from international to national and local contexts (Merry 2006b:39).

While recognizing that in contexts such as Tanzania there is a large gap between ratified human rights at the national level and the reality on the ground in realizing these rights, socio-legal theory helped me to explore how rights and the law can be used as tools for those challenging and contesting the status quo and lobbying the State for change. Organizations with international links may play a role in transforming internationally articulated reproductive health rights into the Tanzania context as well as lobbying the State to implement at a policy level. Socio-legal theory therefore helped me to explore these processes in my research.

While exploring the role of actors moving between the international and national/local contexts, I was also interested in how women at the local level perceived reproductive health and rights generally in their community. I felt it was important to explore the lived realities of women and how these experiences linked with the work of civil society actors in Tanzania. To do this I borrowed from the work of the International Reproductive Rights Research Action Group (IRRRAG) framework. The IRRAG conducted a four year, multi-country study on reproductive rights and their framework was helpful in inquiring about perceptions and power relations and the concept of "entitlements" in developing my focus group questions.

> Thus our inquiry travels back and forth between two levels of social reality. One is that of *perceptions* – how women articulate their entitlements and aspirations in light of both community norms and their own (and their children's) most urgent material and emotional needs. The other is that of *power relations and enabling conditions* – how they negotiate relations with parents, husbands and other sexual partners, clinicians, religious and public authorities, as well as scarce resources and services, in order to translate such needs into deliberate claims of right or justice. A shared observation of all the country studies, based on the research findings, is that women engage in such negotiations as active agents rather than passive victims, even though circumstances and those with more power may defeat efforts (Petchesky and Judd 1998:8).

While a sense of entitlement, especially in relation to reproductive health rights is shaped by one's social context and "perception of need" (Chatterjee 1988), this approach aimed to provide an opportunity for women to frame rights claims through a vision of what they think ought to be. By using the entitlements approach the main emphasis of the focus group discussion was not on formal laws but social norms and justifications moving away from international definitions and allowing for contextual analysis and definition (van Eerdewijk 2001:432). This approach was also helpful in exploring

women's agency in both the private and public sphere in accessing reproductive health services.

2.3 Current Framing in the Literature

As part of my field research preparation I reviewed a number of documents produced at the international level. I found that the current framing of maternal mortality increasingly links human rights and safe motherhood at a conceptual level and links maternal health with wider development goals. In addition, the literature points to cost-effective and proven health interventions to achieve safe motherhood.

While Millennium Development Goal (MDG) 5[2] is the latest international initiative to prioritize maternal health, it follows agreements signed at the ICPD in Cairo (1994), the Fourth World Conference on Women (1995) in Beijing and the Safe Motherhood Initiative launched in 1987. The key focus areas for health interventions have not changed greatly over the last decade. The WHO, the Lancet Neonatal Survival Series and the Commission for Macroeconomics and Health have all come up with costed intervention packages for achieving MDG 5 (Gill, Pande and Malhotra 2007:39) that incorporate most of the key actions identified at the ICPD five year review almost 10 years ago.

There appears to be clear international consensus that programmes to reduce maternal mortality should be based on the principle that every pregnant women is at risk of life-threatening complications (Freedman 2003:102). Three key health interventions including a skilled attendant at birth, access to emergency obstetric care (EmOC) and a referral system to ensure that women who experience complications reach EmOC in time have been established as effective in reducing maternal mortality (Freedman 2003:102).

In addition to a clear understanding of what health interventions work, a number of studies indicate that they are cost-effective. Gill et al reference a recent study that found primary care interventions for mothers and preventative community-level interventions for newborns highly cost-effective in both Sub-Saharan Africa and South East Asia. A World Bank study also found that antenatal and delivery care and family planning were two of the six most cost-effective interventions for clinical services in low and middle income countries (Gill et al. 2007:37). The proposed intervention packages designed by the Lancet, WHO and the Commission for Macroeconomics and Health ranged from 22 cents to 58 cents USD per capita (Gill et al. 2007:39).

While the link between human rights and safe motherhood may provide tools to open space for additional advocacy work to hold governments accountable as duty bearers – studies documenting how to successfully operationalize these links are less readily available. In addition, linking human rights and health system strengthening may go beyond building political will and opening up the coffers to fund the interventions previously mentioned. As Freedman argues, rebuilding and strengthening a health system based on fundamental principles of human rights provides an opportunity to promote "constructive accountability" which gives people a space to effect change and interact

[2] Millennium Development Goal 5 is aimed at improving maternal health by reducing by three quarters the maternal mortality ratio and achieving universal access to reproductive health by 2015(UN).

with their government and wider civil society at the community level (Freedman 2003:105).

While the health interventions and the money required to implement these interventions have been clearly articulated within the literature, operationalizing advocacy efforts using human rights and the effectiveness of this approach are still unclear.

2.4 Methodology

My research involved inquiring into Civil Society Organization's (CSO's) relationships with the state, international links and the women they aimed to serve. My research was specifically aimed at answering the question, "How do civil society actors in Tanzania frame reproductive rights and make claims based on these rights?"

To answer this question I articulated nine sub-research questions:

1. How do some poor and rural women frame the issue of maternal mortality?
2. How do civil society organizations frame the issue of maternal mortality?
3. What is the role of "translators"?
4. Are poor and rural women asked about the issue of maternal mortality by organizations working to lobby on their behalf? If so, how are their experiences used?
5. What reproductive rights claims are civil society actors making?
6. How do civil society organizations see mobilization? Is it a priority of their work? What are the structural opportunities and barriers to mobilizing?
7. Are civil society organizations mobilizing women? In what ways?
8. Who are the "State" actors that civil society actors interact with? How?
9. Do civil society actors work with health sector actors on the issue of maternal mortality? How?
10. Are poor and rural women asked about the issue of maternal mortality by organizations working to lobby on their behalf? If so, how are their experiences used?

My research involved both the collection of primary data in the form of qualitative interviews and focus group discussions as well as reviewing secondary data sources including journal articles, materials produced by multilateral and international organizations and grey materials produced by organizations working in Tanzania.

I traveled to Tanzania on July 14th 2008 and remained in the country until the 17th of August 2008. The goal of my in-country research was twofold; to conduct qualitative interviews with civil society organizations currently working on reducing maternal mortality or more broadly promoting reproductive health, and to conduct focus group discussions with women in a rural area of Tanzania to investigate rural women's perspectives on access to reproductive health services and the concept of rights.

I used a broad definition borrowed from the Centre for Civil Society at the London School of Economics to identify CSO's:

> Civil societies are often populated by organisations such as registered charities, development non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trades unions,

> self-help groups, social movements, business associations, coalitions and advocacy group (CCS 2004).

This definition was used to identify key civil society organizations working in Tanzania who included in their mission work on "reproductive health", "rights" or "safe motherhood". Key informants also helped to identify other "key" organizations. I particularly looked for organizations that had international links so that I could investigate the process of translation previously described. Although I have included multilateral organizations such as UNFPA and the WHO in my research, I define them as separate from civil society organizations. I have included these two multilateral organizations as well a respondent from the Ministry of Health because of my interest in their relationship with civil society actors and because of the important role they play in Tanzania with respect to maternal mortality reduction.

In total I conducted 10 interviews with representatives from the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), CARE Tanzania (who also spoke about the work of the Health Equity Group), Youth Action Volunteers (YAV), Women's Dignity Project, the White Ribbon Alliance for Safe Motherhood in Tanzania (WRATZ), The Christian Social Services Commission (CSSC), The Private Nurses and Midwives Association of Tanzania (PRINMAT), The Medical Women's Association of Tanzania (MEWATA) and the Ministry of Health, Reproductive and Child Health Section.

The questions asked of the respondents were prepared beforehand and although all followed the same flow and themes, slight adjustments were made depending on the organization's mission and mandate (see Appendix I for questions and interview notes). For example, during the interview process, the theme of government decentralization emerged as key issue for how organizations currently organize their work and advocacy efforts. Therefore, a question about decentralization was added to the list of questions asked of each organization. The questions prepared were open-ended and as different themes emerged from the interviews I allowed for further probing and elaboration. All of the qualitative in-depth interviews were conducted in English. An analysis of the interview findings can be found in chapter 4.

The second focus of my field research was conducting focus group discussions in two rural communities. The discussions were facilitated by Neema Wilson, a Tanzanian woman who I had worked with previously. Neema facilitated, transcribed and translated the focus group discussions (see Appendix III). The focus groups were held in two villages in the district of Chamwino in Dodoma region on July 23rd and 24th, 2008. The objective of the discussions was to hear from rural women on their experiences of accessing reproductive health services and how women themselves conceptualized both opportunities and challenges to reproductive health and rights in their communities.

Dodoma region was chosen to conduct the focus group discussions because of the higher rate of home births with unskilled attendants present as the maternal mortality ratio for the region was unavailable. According to the 2004/2005 TDHS, 32.2% of women in Dodoma delivered in a health facility compared to the national average of 47% for that year. In addition, its proximity to Dar es Salaam made it possible to travel in one day to the region.

The Regional Administrative Secretary as well as the Regional Medical Officer for Dodoma assisted us to identify Chamwino district because of fairly good access by road as well as proximity to Dodoma town where we were based for the week. The District Medical Officer (DMO) identified two villages where we could conduct the focus groups and arranged for mothers attending "watoto clinics" (health screening clinics for children under 5) to be asked to

participate. The DMO provided the use of his car and driver in return for us paying for fuel and a small stipend.

The district of Chamwino is located on the central Plateau of Tanzania and according to the 2008 District Profile Report (provided by the DMO) is among the least developed districts and the poorest in terms of estimated income per Capita. The district economy is almost entirely dependent on agriculture and livestock farming and agriculture is characterised by low productivity resulting from low and erratic rainfall as well as low moisture holding surface soils. In addition, the District Profile Report revealed that on average, residents are required to walk approximately 2 to 10 kilometres in order to access health services. During the rainy season 40% of road networks are impassable. The District Profile Report also indicates that Chamwino is extremely short-staffed. For a population of 289,343 projected for 2008, the district has 206 staff out of the 416 indicated as required. Of the 206 health workers currently employed by the district, 70 are unskilled and do not have the required training for their positions. The District Profile Report identifies maternal mortality as a priority health issue in Chamwino.

We chose to visit one village with a dispensary and one village without. The first focus group was held on July 23rd in Buigiri Village in the local dispensary. Eleven mothers participated in the discussion after attending a health screening clinic for their children. The second discussion was held on July 24th in Chinangali I at the village executive office. A mobile health screening clinic for children under 5 was held that morning so women attending the clinic were asked to participate in our discussion. Thirteen women participated. The closest dispensary for village residents in Chinangali I is 10 kilometers away.

The focus group discussions were facilitated in Kiswahili as well as the local dialect for Dodoma region. Fixed questions prepared ahead of time (see Appendix II) were asked of the group. The questions were open-ended which allowed for additional exploration of issues raised during the discussion which was recorded. An analysis of the focus group discussions can be found in Chapter 4.

In addition to my literature review, I reviewed secondary data which included documents produced at the international level promoting maternal mortality reduction strategies and reproductive rights as well as the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015, otherwise referred to as the "Road Map". I have also collected and reviewed grey materials produced by organizations interviewed in Tanzania. Through an analysis of these documents I have tried to supplement my understanding of the role and relationships of "translators" and looked for the inclusion or exclusion of poor and rural women's voices in advocacy efforts at various levels. As the issue of culture and tradition emerged from my research as a theme I actively looked for the mention of this in my review of these materials. Other sources of secondary data used in my research include previous research in Tanzania on the success of maternal mortality reduction strategies and the status of women (i.e. CEDAW reports) as well as a review of civic mobilization in Tanzania.

Limitations & Challenges of Methodology

There are a number of challenges and limitations to my research that should be noted. In terms of the qualitative interviews, not all organizations I identified as key actors were able or willing to speak with me. TGNP (the fourth member of the Health Equity Group), TAMWA and FemAct are feminist organizations that I was unable to secure interviews with. For those organizations I did speak with, an interview of a few hours only provided a limited view on the structure and

work of the organization. Thus the organizations included in my research have a breadth and depth to their work that could not possibly be reflected in this paper.

It should also be noted that the quotes presented in this paper from my interviews and the focus group discussions are not verbatim and instead come from my interview notes and the transcribed and translated focus group report.

In terms of the focus group discussions the process of gaining access to a rural community initially proved to be a challenge. After arriving in Tanzania I was informed that I required a research permit in order to speak with rural women. The process of obtaining a permit was both extremely costly and prohibitively lengthy (3 to 4 month waiting period). Alternately, I was able to connect with an NGO called Tanzania Youth Coalition (TYC) that was interested in collecting information on access to reproductive health as one of their key strategic areas of focus (Youth, Health and Gender). TYC reviewed my list of questions and added some additional related questions such as a section on female genital mutilation and additional questions on family planning. I was therefore charged with doing a community assessment for TYC on a volunteer basis allowing me to collect the information I needed for my research and providing TYC with information (in the form of a report) that may be useful to them for future planning and program development.

Other challenges with the focus groups included the use of a recorder. This was helpful in writing up the notes post-discussion but because of background noise (mostly babies crying) and a few technical difficulties (the recorder was stopped by the facilitator accidentally towards the end of the first discussion) a third team member who could have hand written notes would have been helpful. Luckily at the point that the recorder was stopped the discussion was being captured on flip chart so the discussion notes remained complete.

In addition, participation was a challenge for the facilitator who at times had to ask questions in various ways to solicit responses. This may have caused some "leading" as she tried to evoke answers from participants. The facilitator noted that there was a much lower level of understanding of the concepts discussed in Chinangali I then in Buigiri and that the women we spoke with were unaccustomed to being engaged in this way (i.e. asking women to put themselves in the position of the DMO was a difficult exercise). The presence of health staff in the dispensary in Buigiri and the village executive officer (a female) in Chinangali I may have also influenced the discussions. There appeared to be an "influencer" in the focus group in Chinangali I who seemed (to the facilitator) to influence some of the answers of the younger participants who agreed with the answers the older woman gave. Being unfamiliar with the community before arriving, it was impossible for us to identify or predict the dynamics of the groups. It was agreed that conducting the focus group discussions was a learning process for both of us.

The results of the focus group discussions are in no way representative of the issues faced by all rural women across Tanzania. Because we spoke to women in only two villages in one district the issues raised are simply a snapshot of some of the issues existing in Tanzania. Where possible I have tried to supplement the focus group findings with other studies conducted in Tanzania.

Finally, being a white Canadian woman most likely influenced how people chose to interact with me and the information they provided. This was most evident at my meeting at MEWATA where they explicitly asked if I could help them with securing funding. While being an outsider has its disadvantages, having lived in Tanzania for a year before conducting my research helped with navigating my way through the process of accessing both the rural community I visited for the focus group discussions as well as securing interviews. In addition, my perspective as an

outsider is both an opportunity and a disadvantage. While there are inevitably things I missed picking up on, my perspective from the outside is a unique one that may have provided an opportunity for observing things which may be taken for granted by someone doing research in their home context.

Chapter 3: The Research Setting: Maternal Mortality, Reproductive Rights and Mobilization in Tanzania

To provide contextual information on the research setting where I chose to explore opportunities for organizations framing and claiming rights, I briefly present some background information on the health sector in Tanzania, current indicators of maternal mortality and related actors and programs. The last section in this chapter describes the current political and legal context in relation to claiming reproductive rights with respect to safe motherhood.

3.1 Background – Health Sector in Tanzania

Tanzania's first President post-independence, Julius Nyerere took on the issue of access to primary health services through the "Arusha Declaration" in 1967. The Declaration outlined a new program for the provision of free medical care for all Tanzanians and banned private, for-profit health services. By 1978 the program had resulted in a health clinic within 10 kilometers of 90 percent of the population (Benson 2001).

Unfortunately, Tanzania faced an economic crisis beginning in the mid 1970's. This included an acute shortage of foreign exchange, balance of payment problems and large budget deficits (Lugalla 1995). By the mid 1980's improving the health of the population was compromised by world commodity prices as well as the introduction of structural adjustment programs and debt-servicing. As a result, under-funding of the health system led to shortages in drugs and supplies, the deterioration of health facilities, low staff morale and poor quality of care (Mamdani and Bangser 2004). From 1977 to 1990 the share of the national budget spent on health decreased from 7.23% to 4.62% (Lugalla 1995:44). Decreasing funds meant that the Government was not able to establish more health facilities and hire additional health personnel as the population rapidly increased.

In an effort to respond to the declining health system, the Tanzanian government introduced a Health Sector Reform program in 1995/96 to decentralize authority and resources to the district level. 'The reforms centre on key issues that affect health service delivery: equity, efficiency, cost-effectiveness and quality of care' (Mamdani and Bangser 2004:139). As part of the reform process, financial sustainability via user-fees was introduced in four stages, at referral, regional and district hospitals in 1993 and by 1994 at the district level. Fees were also been introduced at dispensaries and health centers. A Community Health Fund was launched in 1995 to support the rural population and informal workers with a primary health care insurance scheme at the district level. In addition, a National Health Insurance Scheme was introduced primarily for civil servants and their dependants (Mamdani and Bangser 2004:139).

While exemption policies were introduced to provide public health services for vulnerable social groups (including maternal and child health (MCH) services and those with specific diseases and long term mental disorders), a 2004 literature review examining poor people's experiences of health services in Tanzania suggests that even in the case of exemptions, the poor are faced with financial barriers to access health care. 'User fees are not the only charges the poor have to pay; other costs include travel time, transport costs, other "unofficial" costs including bribes, and for drugs and supplies' (Mamdani and Bangser 2004:151). In addition, the authors conclude that, 'the poorest of households end up excluded from using health facilities when they most need them' (Mamdani and Bangser 2004:139).

In addition to problems related to access and the weak infrastructure of the health system (including the disrepair of facilities and lack of equipment and drugs), Tanzania is facing a human resources crisis – especially at lower-level health facilities such as dispensaries and health centers which, according to the Ministry of Health (MOH), have a 65.6% and 71.6% shortage of staff respectively (MOH 2008:12). Some of the challenges in recruiting health workers to improve maternal, newborn and child heath as noted by the Ministry include a poor skills mix, non-attractive incentive and salary packages, poor motivation, inadequate performance assessment and rewarding systems and difficulty in retaining staff in remote and hard to reach areas (MOH 2008:12).

3.2 Current Indicators of Maternal Health

The indicators related to maternal health reflect the barriers poor women face in accessing health services. While 94% of pregnant women make at least one antenatal care (ANC) visit according to the MOH, the quality of these visits is inadequate. The Tanzania Demographic and Household Survey (TDHS) 2004/2005 found that 47% of women attending clinics are informed of the danger signs in pregnancy (MOH 2008:3) and only 14% of pregnant women access these clinics in their first trimester. While malaria is widespread in Tanzania and causes up to 15% of maternal anemia, only 22% of pregnant women received preventative treatment during their pregnancy (TDHS 2004/05).

Pregnant women are particularly vulnerable to anemia and require additional folic acid and iron in their diet. However the TDHS for 2004/05 found that 58% of pregnant women and 48% of breast-feeding mothers were found to be anemic. This is especially concerning as anemia contributes to postpartum hemorrhage, the leading cause of maternal deaths in Tanzania (MOH 2008:5).

While obstetric complications such as hemorrhaging can be dealt with by skilled birth attendants working in a health facility with the proper equipment, supplies and drugs available, only 47% of women in Tanzania deliver in a health facility and only 46% with a skilled birth attendant. Of the 53% of births that take place at home, 31% are assisted by relatives, 19% by traditional birth attendants (TBA's) and 3% of women deliver without assistance (TDHS 2004/05).

While the TDHS for 2004/05 estimated the maternal mortality ratio at 578 per 100,000 live births, the WHO in conjunction with other UN agencies estimated for 2005 that the maternal mortality ratio was in fact much higher at 950 per 100,000 live births (WHO 2007:27). The report classified Tanzania as a country lacking a complete registration of deaths and therefore used a "direct sisterhood method" to collect data on maternal mortality. These figures were then adjusted upwards as previous studies have shown that this method systematically underestimates true levels of mortality (WHO 2007:10).

According to the TDHS 2004/05 the major barrier perceived by women in accessing facility-based delivery services included lack of money (40%), long distance (38%) and lack of transport (37%). In addition, socio-economic differences in health care utilization exist in Tanzania with women in urban areas more than twice as likely to deliver in a health facility as their rural counterparts and 3.6 times more likely to deliver by cesarean section. In addition, women with at least some secondary education are 2.6 times more likely to deliver at a health facility. 'Education and economic empowerment (cash-based income) are necessary pre-requisites for women's access to quality reproductive health care services in Tanzania' (Musa and Ndomo 2007:36).

While family planning resulting in spaced intervals between pregnancies can significantly avert maternal deaths (Singh et al 2004:29) only 26% of married women in Tanzania use any method of contraception (TDHS 2004/05). The unmet need for family planning in Tanzania was calculated at 26%, although it should be noted that how "unmet need" is measured is problematic. The assumption that all women using contraception have their needs met and the exclusion of women who are not in consensual or marital unions does not provide an accurate measure of "unmet need" (Dixon-Mueller and Germain, 2000:79).

In addition, abortion is illegal in Tanzania unless required to save a woman's life. Under section 151 of the Tanzania Penal Code, a convicted woman can be imprisoned for a maximum of 14 years. Extensive evidence suggests that unsafe abortion is one of the major direct causes of maternal mortality and morbidity. The WHO estimates that unsafe abortion accounts for 13% of maternal deaths worldwide (Gill et al. 2007:28). A study in Sub-Saharan Africa found that one third of all maternal deaths in the region were caused by unsafe abortion (Thonneau et al 2002). While the exact magnitude of unsafe abortion is unknown in Tanzania, it was found to be a contributing factor in 15% of maternal deaths in Dar es Salaam, the largest urban centre in Tanzania (Rasch and Lyaru 2005). Other studies in Tanzania reported nearly one third of all maternal deaths were related to unsafe abortion (Mswia et al. 2003) and my key-informant from the Ministry of Health indicated unsafe abortion is one of the five leading causes of maternal mortality in Tanzania. While post-abortion care is referenced in the Tanzania "Road Map", only 5% of health facilities in Tanzania provide this service.

3.3 Current Actors and Programs

Initiatives in Tanzania to improve maternal health to date include the adoption of the Safe Motherhood Initiative in 1989 (after the global initiative was launched in Kenya in 1987), the establishment of a reproductive and child health section within the Ministry of Health and the development of a reproductive and child health strategy in response to the ICPD 1994 Plan of Action. Tanzania has also signed the 2001 Abuja Declaration on health care financing that commits the Government to allocating 15% of the national budget to healthcare. However, to date the Government has yet to meet that commitment.

Health policy attempts to address maternal, newborn and child health include the National Health Policy (revised in 2003), health sector reforms as well as the Health Sector Strategic Plan (HSSP) 2003 – 2007. The Reproductive and Child Health Strategy 2005 – 2010 and the National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Mortality 2006 – 2010 as well the latest "Road Map" that aims to merge the last two strategic plans, have all tried to address the issue of reducing maternal mortality.

In addition to the documents described above, improving MNCH is also highlighted as priority issues in the National Strategy for Growth and Poverty Reduction "MKUKTUTA" 2005 – 2010. Two new programs, the Health Sector Support Programme III 2008 -2012 and the Primary Health Service Development Programme 2007 – 2017 also incorporate and address MNCH issues. Finally, the Tanzania Partnership for Maternal, Newborn and Child Health (PMNCH) was officially launched in April 2007

through the WHO global secretariat. The PMNCH is coordinated by the Ministry of Health.

While health sector policies and plans can play a critical role in moving safe motherhood strategies forward, it should be noted that CSO's interviewed as well as a key informant at the Ministry of Health expressed frustration with the lack of financial resources attached to the most recent "Road Map" which one key informant pointed out, is missing from the health budget. In addition, the health allocation in the budget for 2007/08 was 10.3% well below the 15% pledge at Ajuba in 2001 (HEG 2008).

3.4 Legal and Political Context

Looking beyond the health sector, opportunities and challenges exist in Tanzania in relation to achieving reproductive health rights from a legal and political perspective. As part of the ratification of the ICPD Platform of Action, Tanzania introduced the Sexual Offenses Special Provision Act (SOSPA) in 1998. This act resulted in an increased age of consent to sexual intimacy to 18, protects women against marital rape (though only in the case of separation), recognizes sexual harassment as a punishable offence as well as provides for protection of children by their guardians. This last aspect of SOSPA allowed for CSO's to initiate anti-female genital mutilation (FGM) campaigns as well as opened space politically to discuss sexual and reproductive health rights (Musa and Ndomo 2007:38).

Tanzania's law system reflects the culturally and religiously diverse population and allows customary law to exist alongside statutory secular law. However this binary system has disadvantages for women whose rights are sometimes left unprotected under customary law. For example, customary law allows girls to marry at the age of 15. The Committee on the Rights of the Child (CRC) along with the Committee on the Elimination on all forms of Discrimination Against Women (CEDAW) expressed concern that the legal age of marriage for girls remains at 15 under customary law while for boys it is age 18. In addition the CEDAW Committee's proposed amendments to Inheritance Laws, the Marriage Act of 1971 and the Law on Custodian of Children have not yet been implemented. Of specific concern to the Committee is that Tanzania does not recognize marital rape as a crime, nor does the Marriage act have provisions for enforcing penalties for domestic violence between spouses (UN 2007:3).

There is no uniform law for inheritance of property in Tanzania and instead three systems of law may be applied – statutory, Islamic and customary law. Both customary and Islamic laws have stipulations that disadvantage women in the distribution of property (Legal and Human Rights Centre 2007:59-60).

The Tanzanian constitution has also not been reformed to correspond to the 1984 Universal Declaration on Human Rights and does not include the right to health. The education act (1992) allows for pregnant girls to be expelled from school and the penal code (16) severely restricts women's access to abortion. In Zanzibar the Spinsters and Female Divorce Protection Act provides for two years imprisonment for a woman found guilty of becoming pregnant out of wedlock (Musa and Ndomo 2007:59).

Contradictions between customary and statutory law are barriers to Tanzania living up to its international obligations. Access to the legal system is another barrier faced by women

in Tanzania. Women have limited access to information on their rights and services even within the context of legal reforms. In addition, crimes such as rape, sexual harassment, incest and FGM are crimes that police do not take seriously (Musa and Ndomo 2007:40). Pursuing legal avenues as part of advocacy and lobbying activities arose in the interviews and is described in more detail in chapter four (section 4.3).

Political space has opened considerably in Tanzania since a multi-party system was introduced. The easing of restrictions in 1985 for organizing and registering CSO's as part of democratic reforms has allowed for greater opportunities for organizations to mobilize politically (Brown 2001:78). Some authors argue that the fight for associational autonomy by civil society actors have contributed more to strengthening democracy in Tanzania than the introduction of a multi-party system because of weak and fractured opposition parties. 'Taken together, these struggles have had a greater impact on the quality of democratic life than any electoral outcome, because the opposition parties in Tanzania that might have pressed for change have been so internally divided and weak that they have had little impact on legislative processes since being elected to seats in Parliament' (Tripp 2000:197).

While key informants reinforced that there exists more open political space (YAV, WRATZ, Women's Dignity) the struggle for autonomy continues and was demonstrated by the temporary government ban of all media entities from publishing advertisements or announcements by Haki Elimu in 2005 (Legal and Human Rights Centre 2007:28). Haki Elimu, a rights-based education advocacy organization had been using the media as a key tool in their work. In addition, key informants suggested that certain CSO's had more access to Ministries than others. This theme is explored in more detail in the next chapter.

Chapter 4: Findings & Analysis

> Health care systems that do not offer care – that take a narrow or an abusive view of their duties – thereby contribute profoundly to people's experience of what it is to be poor. To face abuse or to have fear cumulated when at one's most vulnerable – to be denied care – is an element of what poverty is as it is experienced (Mackintosh 2001:184).

The following analysis involved transcribing the qualitative interviews conducted, applying my theoretical framework and grouping the information collected by recurring themes. I then returned to the sub-research questions and looked at how these had been answered. These answers were grouped together and slotted under the relevant sub-research question/s. The same process was followed with the information collected at the focus group discussions. Some of my sub-research questions flowed directly from my theoretical framework.

In the review of grey materials collected at the organizations as well as the literature review of international safe motherhood strategies I actively read looking for the particular theme of culture and tradition after it emerged as an interesting theme in my qualitative research. I also actively looked for how the voices and experiences of local community members were used in the grey materials collected at the organizations I visited.

Once my findings were grouped by theme I returned to my theoretical framework and looked at how these theories could be further applied to provide a deeper and richer analysis of the data collected. For example, during the process of my field research I observed a division between organizations in how they were engaged with promoting reproductive health rights. A similar division was found in Merry's research on organizations working to end violence against women and so I was able to apply her framework to my own data, as a way of analyzing and presenting my findings.

This chapter begins with my inquiry into the lived realities of reproductive rights and presents my findings and analysis drawn from the focus group discussions (4.1). I then present my findings on how rights are framed by civil society actors (4.2). This includes an analysis on the discourse around tradition and culture and political will, my investigation of "translators" and my finding of a plurality of rights based approaches to framing maternal mortality. I then turn to how rights are claimed (4.3) by Civil Society Organizations' (CSO's). This includes how CSO's interpret and act on the right to health which I argue also influences their relationship with the state. I also present my findings on tools for rights claiming such as mobilization and the law and legislation.

4.1 Realities of Reproductive Rights

> 'We don't care whether the nurse is too young or old, as long as at the end of the day we have our babies with us.' –Focus Group Participant, Chinangali I

As I prepared to do this research, my expectation was that poor and rural women were unlikely to articulate the current barriers they faced to reproductive health services as "rights violations,"

however, I felt it was important to contextualize my research with some discussion of women's lived experiences of reproductive health services, the barriers they face and the solutions they see with respect to access to safe motherhood. I also felt it was important to look for women's agency in their community and locate the issue of reproductive health within a larger framework of women's needs, entitlements and kinship arrangements.

Drawing on the focus group discussions held in Dodoma, how women framed issues related to reproductive health was not surprisingly, shaped by their level of access to reproductive health services. As Petchesky and Judd suggest, women's *perceptions* are shaped both by community norms as well as to what extent they and their children's needs [which I would argue includes health] are being met (1998:8).

While nine women in Buigiri (where a dispensary and nurse midwife were present) had delivered all their babies at a health facility, only 3 women in Chinangali I (where no access to a nearby health facility exists) had delivered only at health facilities. The women in Chinangali I indicated that distance was the key barrier in accessing delivery services.

Women in Buigiri also noted that a functioning referral system existed at the dispensary. In addition, a local school for the blind had a vehicle that was available to transport women with complications during delivery to the regional hospital. The women in Buigiri appeared quite satisfied with the level of access for delivery services. Camaraderie and appreciation for the health workers at the dispensary was observed before and after the focus group discussion. Those who had experienced complications, talked about accessing additional health services in time.

In Chinangali I, some women talked of the difficulties they faced with their pregnancies and accessing healthcare. One woman described being taken in a cart in the night to a dispensary after a long and difficult labour. On the way to the dispensary she fell out of the cart at which time her baby was born. Another participant described being left to labour in pain for two days before being taken to a dispensary where she delivered a stillborn. A similar experience was described by a participant who made it to the dispensary but upon arrival there were no health staff and she was forced to deliver alone. Many of the women, especially those that had experienced complications stressed that their preference was to deliver in a health facility rather than with a traditional birth attendant (TBA). As one participant commented, 'I do deliver at home but I would sincerely like to go to hospital for child birth. Distance is the main hindrance but for me really, hospital would be the best of my choice if distance was not a matter.' Some of the women commented on the lack of skills and knowledge of the TBA's in their community, another participant in describing her last delivery stated, 'I had problems that the TBA couldn't manage' and another participant, 'If you have complications while delivering at home this can be dangerous. TBAs may fail to come up with solutions and I advise that because I had a bad experience and I lost my first baby!' In Chinangali I it was also suggested that health facilities provided more privacy than delivering with a TBA, 'it is better in the hospital because privacy is observed. With birth attendants in the village there is no privacy. A lot of women just come and watch you, they may even shout at you!'

In terms of accessing maternal delivery services a clear sense of "entitlement" and desire on the part of most participants was identified for skilled assistance in delivery. I am using the term "entitlement" both in the sense that there exists an aspiration to change one's own situation (Petchesky and Judd 1998) as well as what the authors describe as "situated entitlement" which locates a desire for entitlement as shaped by 'relational or situational conditions rather than a clear notion of bodily integrity' (1998:14). This approach situates claims of entitlement within

women's social, cultural economic and family relationships and 'as a form of rights discourse is more complex and multi-layered than conventional Western notions of "privacy" and "individualism"' (Petchesky and Judd 1998:15). Women's role of mother and caregiver therefore shapes her responsibility for the well-being of her babies. While the key barrier described to facility-based delivery services was distance and transport, where there existed access to delivery services, such as the case in Buigiri, women accessed these services. This finding challenges other studies that have highlighted cultural barriers as major determinants for the first delay in seeking care by women and their families. Even in Chinangali I where these barriers exist, the women's testimonies above suggest that they often still attempted to access facility-based health services. These findings are supported by a recent study published in 2007 that surveyed 21,600 households in southern Tanzania. 'Most women, from nearly all villages, reported that they give birth at home because of lack of money to pay for delivery kits, fare and food' (Mrisho et al. 2007:865).

Access to family planning has been identified as a key component to maternal mortality reduction, according to the 2004/2005 Tanzania Demographic and Household Survey (TDHS) there exists a 22% unmet need for contraception. It has been argued that by spacing pregnancies, women are 2.5 times more likely to survive child birth (Setty-Venugopal and Upadhyay 2002). While all women in Buigiri had heard of family planning, only three women had ever accessed family planning services at the dispensary – though all women were aware of the service being offered by the health staff. In Chinangali I, similarly, only two women had accessed family planning methods. All but one woman suggested that family planning was something they did not discuss with their partners and it was one way in which they could exercise agency in controlling how many children they had. While all women agreed men did not like to use condoms, accessing other forms of contraception such as injections and pills allowed them to control how many children they had independent of their partners' wishes. As one participant in Buigiri commented, 'husbands do not like the family planning methods, they want us to go on and on getting children' and another participant in Chinangali I stated, 'there are few people who do that [practice family planning] but most men don't like it. In those cases a woman should be brave and plan for herself.'

The discussions around family planning highlight how women located themselves between what Petchesky and Judd call in their research the "accommodation-resistance nexus" defined as 'a continuum model in which accommodation and resistant acts are linked by a large grey area in between, reflecting the specific cultural and material circumstances in which our respondents find themselves' (1998:17).

In Buigiri the women said they were fairly satisfied with their access to health services, though one participant suggested that the district hospital was too far and cost too much money to follow the "guideline" of delivering your first child in a hospital. The women in Buigiri also indicated that the age of childbearing was too young for some members of their community. They gave examples of girls at age 12 and 14 having children. They also felt that families in their community were having too many children. The cause of these problems was indicated as an inability to meet basic needs and for women to provide for themselves. The women spoke about other women in their community putting themselves at risk (of sexual violence) to support their families by spending time at a place to sell goods where men often drank heavily. The women would have to stay after dark and the environment was identified as unsafe for women and young girls. Participants noted that 'mothers should not go there and be better role models' however one of the solutions indicated to the challenge of too many children was 'to engage in income generating activities to better their situation'. This demonstrates conflicting notions linking women's identity as a mother and provider through economic activities but also as a bad

role model when putting herself at risk to do so. This highlights the sometimes very small space between accommodation and resistance in which poor women must make constrained choices.

Although participants in both groups found it difficult to envision themselves as decision-makers for their community, when asked how they would allocate resources for women if they were in the District Medical Officer's position, a clear entitlement for a dispensary with skilled health workers and access to transport for referrals was indicated in Chinangali I.

When asked about participants knowledge of "rights" the women in Buigiri identified their rights as including the right to marriage (and being able to say no to marrying someone), the right to own property, the right to self-sufficiency, the right to vote and the right to participate in leadership as well as give ideas and express themselves in their community.

The participants in Chinangali I identified their rights as the right to employment, the right to inherit property in the family and the right to run for leadership positions in the government (it should be noted that the Village Executive Officer in Chinangali I is a woman). One participant suggested that anything (in terms of material goods) one can get is her right, such as a farm, building or house. The participants identified the radio as the key medium for learning about rights.

It is interesting to note that in the IRRRAG studies it was found that

> The active assertion of rights or entitlement is very often linked to economic activities, which in turn are seen as part of the burdens and responsibilities of motherhood; in almost all the research sites, personal growth and leisure, as well as claims on behalf of a woman's sexual determination and pleasure, come last. This may be attributed to the fact that in low-income households, economic survival is the woman's most urgent need. But it would also seem that in many cases resistance in the name of economic necessity or survival is more socially acceptable, since the woman is generally perceived as resisting not for herself but for her family (Petchesky and Judd 1998:19).

My findings from the focus group discussions support this assertion – participants primarily articulated rights in relation to property, employment and inheritance. Interestingly, civil and political rights were also highlighted.

Women's knowledge of their rights, while not linked to accessing health services may be a valuable basis for building demand for improved access to reproductive health services. Radio appeared to be an effective means for reaching a rural community such as Chinangali I and could be an effective strategy in increasing demand at the local level for increased services. According to key informants from CARE and Women's Dignity, projects in which the community is mobilized to organize funds and transport for emergency obstetric care have proven to be effective in isolated communities in Tanzania. In addition, women's sense of entitlement to facility-based delivery services may also be a key starting point for engaging with women on wider issues related to reproductive health. Petchesky and Judd note,

> 'Many of our respondents, whether organized or not, seemed to find it easier to articulate a sense of injustice toward public institutions than towards partners and kin, those with whom they have to live. Perhaps negotiating public conflicts over reproductive and sexual rights will make it more possible for women to negotiate the private conflicts at home' (Petchesky and Judd 1998:316).

The women I spoke with had very limited direct contact with CSO's. While the question of representation was not asked directly, assistance by CSO's was not raised in any of the discussions with grassroots women. This may be in part because the focus of the CSO's I spoke with was on working with district level health officials and therefore their interaction was mediated with respect to reproductive rights promotion.

4.2 Framing Reproductive Rights

When CSO's were asked about root causes of maternal mortality almost all key informants (including one multilateral organization) identified weak health infrastructure as intimately linked with high maternal mortality in Tanzania. Lack of money in the national budget for both maternal health and health generally was highlighted by seven respondents including one representative from a multilateral organization and a key informant from the Ministry of Health (MOH). Five respondents (including one informant from the MOH and one from a multilateral organization) articulated the root causes of maternal mortality distinguished between direct and indirect causes or as health system and non-health system related contributing factors.

Direct causes were identified as obstetric complications during delivery while indirect causes were described as weak health infrastructure, lack of access to health services, lack of skilled health workers as well as issues related to gender disparities. The respondents from CSO's that articulated maternal mortality in this way were also focused on delivering services or advocating for increased services to fill in the gaps related to access to services for women (MEWATA, PRINMAT, WRATZ) as well as the MOH.

Role of "Tradition" & "Culture"

Five respondents identified cultural or traditional factors as indirect causes of maternal mortality such as 'negative socio-cultural beliefs and practices (MEWATA), or 'women not having a say in the matter [in where they delivered]' (PRINMAT). Another respondent indicated that the 'attitude in Tanzania is that pregnancy is not a disease, a "*god-willing*" belief and attitude that pregnant women still have hands to work with' (UNFPA). Interestingly, when the respondent from YAV was asked about the role of tradition or culture in relation to maternal mortality he suggested, 'community members are fully aware that pregnant women need care in the situations they are in…health systems key and first problem – culture not the first issue. Access would prevent decisions over money and transport being an issue for women.'

The discourse around tradition and culture is interesting because of the way it is presented by some of the key informants and print materials reviewed. Instead of seeing culture as 'a fluid and changing set of values and practices' (Merry 2006a:14) culture or "socio-cultural beliefs and practices" are often presented as barriers to safe motherhood strategies. For example, in the "Road Map" produced by the Tanzanian Government "social cultural beliefs and practices" are sighted as a critical challenge in reducing maternal mortality (2008:1). Merry argues that culture is often used as a synonym for tradition, 'labeling a culture as traditional evokes an evolutionary vision of change from a primitive form to something like civilization' (Merry 2006a:12). This perspective often does not allow for uncovering opportunities to use cultural practices to promote human rights. This I would argue, is evident in the labeling of "traditional" birth attendants (TBA's), women who live and work in communities in Tanzania assisting women in delivery. The assumption attached to the label is that of "unskilled" and juxtaposed against "modern" medicine. Although the role of TBA's is a highly contested subject within the Safe Motherhood movement, I raise the issue only as an example of how culture and tradition are

conceptualized within this paradigm. If we are to think about cultural practices as shaped by their context, access (or lack thereof) to reproductive and maternal health services may reinforce such barriers as well as women's lower status. As Merry argues,

> Insofar as human rights relies on an essentialized model of culture, it does not take advantage of the potential of local cultural practices for change. Practices labeled harmful and traditional are rarely viewed as part of wider systems of kinship and community, yet they are deeply embedded in patterns of family and religion (Merry 2006a:11).

Political Will

Five respondents highlighted corruption or lack of political will as part of the framing of maternal mortality in Tanzania. Of the five, three worked for organizations that are also members of the Health Equity Group. The respondent from YAV suggested that the root causes included lack of political will on many levels, 'health is highly politicized – there are many plans and commitments however, nothing changes on the ground'. Indeed the focus of the Health Equity Group's efforts include key policy demands such as the revision of the marriage act and issues related to early marriage and challenging issues related to transactional sex and family planning. The respondent from CARE and an active member of the Health Equity Group explained, 'Health Equity group is explicitly challenging power dynamics vis a vis health inequality and vis a vis reproductive health and maternal health'. This work is focused on monitoring and analyzing the health budget and working with Members of Parliament to educate them on the issue of maternal health. The respondent from Women's Dignity also indicated that the organizations' focus has shifted to budget advocacy and analysis with respect to maternal health (whereas the previous focus was on increasing access to treatment for women suffering from obstetric fistula[3]). This included a recent costing exercise that determined the Tanzania Government has the financial capacity to provide free delivery kits to all women in Tanzania (in line with the existing policy adopted in 1994). One of the UNFPA respondents also mentioned lack of political will as a key barrier to their work on safe motherhood and PRINMAT's respondent suggested that their funding structure which flows directly to their facilities is an advantage because it does not have to go through the Government.

What emerged out of how respondents framed the issue of maternal mortality was a division between those organizations working to compliment Government services by "gap-filling" and advocating for increased funding for health services in a non-confrontational manner and those that were working to challenge current health system structures and promote Government accountability. A member of the health equity group suggested that those advocacy organizations that also provide service delivery have more opportunity and space to interact with the Government (at various levels) while 'to do advocacy-only work is very difficult'. The way in which maternal mortality was framed also informed how rights were engaged with which will be discussed in section 4.3.

Translation

According to Merry, "translators" are civil society actors traveling between transnational forums, such as those involved in articulating internationally agreed upon global human rights norms and

[3] Obstetric Fistula is caused by tissue damage most often due to a prolonged labour. An opening or "fistula" between the vagina and the bladder or rectum can result in chronic incontinence for the woman leading to additional medical complications as well as social isolation and stigma (Jones 2007:6).

their local context to translate these norms into the vernacular (Merry 2006a). In my research I found more evidence of *translation* then translators, or what Merry describes as programs and strategies that are transplanted from one social context to another (Merry 2006a). This may not necessarily be an indication of the non-existence of translators in Tanzania but rather that I was not able to speak with organizations in which "translators" work. It should be noted that I was unable to secure an interview with either of the key transformative feminist organizations or with the legal and human rights centre in Tanzania.

Evidence of translations included the Centre for Social Accountability (CSA) model based out of South Africa being used by YAV. According to the key informant YAV uses the CSA model in their work in Tanzania by promoting social accountability through existing volunteer networks at the district level. This is an example of how a program has been transplanted to the Tanzania context yet adapted (via the use of volunteers) in the implementation.

YAV, CARE and Women's Dignity are also working with the International Budgeting Project (IBP) based in Washington, DC. The Project aims to support organizations focusing on the impact of budgets within their countries on poor and marginalized groups.

CARE and Women's Dignity have adapted a "scorecard" created by CARE Malawi to use at the community level to engage citizens in monitoring and holding accountable district health systems and leaders and Women's Dignity has introduced a popular tribunal and uses a film created in Chad "Dead Mum's Don't Cry" as part of their education and outreach work.

The existence of the White Ribbon Alliance in Tanzania could also be conceptualized as a "translation". The Alliance was formed by a group of international nongovernmental organizations, United Nations agencies, and the U.S. Agency for International Development (USAID) in 1999. The WRATZ was established in Tanzania in 2004 after the coordinator and key respondent attended a conference sponsored by the Global Alliance in India. Similarly, "White Ribbon Day" has been transplanted to Tanzania through the global Alliance.

The definition of reproductive health used by MEWATA, 'the rights of couples and individuals to decide freely and responsibly spacing of the their children, to have the information, education and means to do so, attain the highest standards of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion and violence' (MEWATA) draws on the language of the Beijing Platform of Action which I also argue is evidence of translation.

Multilateral organizations such as the UNFPA and WHO played more of a role of "translator" of global agendas then the CSO's that were interviewed. According to the key informant at the WHO the 'global agenda is translated into the national context' (WHO). For example, their office was requested to establish the Partnership for Maternal, Newborn and Child Health (PMNCH) in Tanzania by the global secretariat in Geneva. The PMNCH is now housed with the Ministry of Health - however its establishment is the translation of an international initiative. In addition, the "Road Map" is the result of a WHO Reproductive Health Task Force for Africa meeting in which the WHO and UNFPA were tasked with developing a framework for countries to achieve MDG's 4 & 5. Although the Ministry of Health contributed to the plan along with other partners, its existence is a translation of international initiatives to reduce maternal mortality (such as the Millennium Development Goals).

The CSO's that were interviewed however, could very much be considered "translators" working between the national and local context. For example, the respondent from MEWATA described the role of CSO's as to 'complement government efforts in the provision of quality MNCH'

(Maternal, Newborn, Child Health) to 'disseminate the MNCH strategic plan' and 'mobilize and allocate resources for implementation of the MNCH strategy' (MEWATA). In addition, the Health Equity Group has worked to translate up to the national level the voice and experience of citizens at the community level, through the popular tribunal, as well as by advocating for space for CSO's in the health sector review process. The group is currently planning a parallel meeting for the next review process to provide citizens and community leaders a space to be heard (CARE).

The respondents from the WHO and UNFPA also commented on the challenges of translating policy from the national to the local level, 'national level plays the role of developing and adopting good policies, these are to flow down but then capacity building of the districts is also required for districts to implement. Money does not address the main issues' (WHO). Similarly the UNFPA respondent commented, 'one of the challenges of the health sector is that national strategies and plans have to be implemented into actions at the district level. There are some allocation criteria in light of decentralization however, how is this translated? The challenge is that the district officials are on the ground and should be able to prioritize and often they do, but challenge is on HOW the money is spent with respect to maternal mortality reduction?' (UNFPA). The key informant from UNFPA also suggested that they relied on CSO's to translate up to them the issues at the community level.

While all the organizations interviewed had some international links, aside from the multilateral organizations opportunities to engage with like-minded organizations within the region or attend regional or international conferences were limited because of lack of funding. The respondent from CARE identified project-based funding as a key barrier to being able to attend such forums and PRINMAT's respondent identified liaising with similar associations in East Africa as part of their strategic plan but because of lack of funding this has not yet been possible. The key informant from WRATZ identified the most experience attending such forums because of her link with a global alliance. She identified these experiences as valuable and described how her perspective on TBA's changed when it was framed as a human rights issue at the Women Deliver conference. She also spoke of the conceptualization of development being equated with safe motherhood for all women, because of the complexity of the issue with relation to infrastructure, education, poverty and women's rights. This for her was a powerful new way of looking at the issue of maternal mortality and helped her to come up with new tools and strategies for her advocacy work.

Rights Based Approach(es)

In terms of working from a rights based approach, UNFPA and WRATZ were the only respondents to identify themselves as explicitly working from this perspective. The UNFPA respondent highlighted the challenge of working with partners with different understandings of how this was operationalized (even though training was provided by UNFPA). Although the key informant at UNFPA suggested that the organization plays a neutral role with the Government this may undermine taking a rights based approach which often involves political engagement on behalf of those most marginalized. A plurality of rights based approaches I would argue, provides further evidence of how rights are appropriated and adapted into a local context.

4.3 Claiming Reproductive Rights

In exploring how CSO's claim reproductive rights related to safe motherhood, four inter-related themes emerged. These include how organizations make claims related to the right to health and

in turn how how these claims influence their relationship with the state. The role of mobilization by CSO's was also explored as well as how CSO's engage with Tanzanian law and legislation with respect to their rights claims.

Right to Health

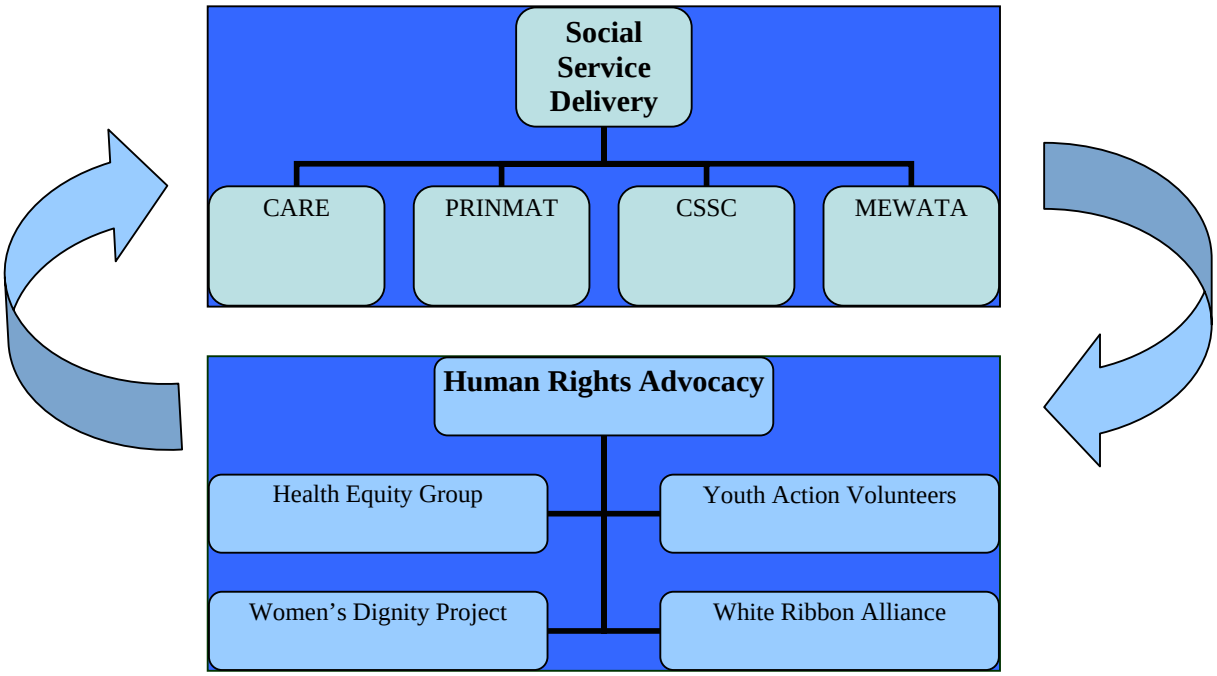
Seven respondents identified their work in relation to the first theme – the right to health. For example, the respondent from YAV suggested that their work involved increasing health service providers and rights holders' understanding of rights, 'If people became aware of their rights it [decentralization of the health system] would not be a problem, but if people are not aware of their rights it is difficult to hold service providers accountable. As well, service providers know nothing about health sector reform…some service providers do not like reform, and do not inform about rights and provide access to information' (YAV). MEWATA's respondents also identified working in the community to inform and educate about women's right to health services as part of their breast cancer screening program. The key informants described using megaphones and radio PSA's to promote their screening activities at the community level and women's right to health services. The PRINMAT respondent identified the right to safe delivery (with a midwife or via access to a health facility where there is risk of complications) as the key focus of their work, with PRINMAT midwives acting as key advocates for promoting these rights. The WHO respondent although admittedly focused at the national level and not a "CSO", suggested there is a need to increase both supply and demand with regards to the right to health, which she identified as a key area for her work. Similarly, the WRATZ respondent identified the right to skilled health personnel during delivery (not a TBA) as the key right promoted in their work. Rights related to family planning were also identified by MEWATA and Health Equity Group. More broadly, the respondent from the Health Equity Group suggested that health inequities were highlighted by using reproductive rights as a lens, while MEWATA has adopted part of the ICPD/Beijing definition of reproductive rights in their work.

Advocating for citizen's participation in health budgeting and planning and government accountability was the second theme that emerged within the discussion about claims related to the right to health. The YAV respondent suggested that this is a key area of their work in promoting citizen's assertion of their rights and trying to hold duty bearers accountable through their network of volunteers. As he explained, 'volunteers also work with administrative structures to disseminate information from YAV and to follow-up on health service delivery plans and supply issues' (YAV). CARE has also worked at the district level to promote community action. The Health Equity Group has worked hard to open space for CSO's to participate in the health sector reviews and Women's Dignity organized a popular tribunal on reproductive health issues. They are also involved in budget analysis as well as working with communities to use a scorecard to evaluate and monitor health service in their communities.

Merry suggests two approaches to translating human rights that came out of her research that I have applied to the Tanzania context. Those organizations that take a "social-service approach" and those that take a "human rights advocacy approach" (Merry 2006a:138). In her study on violence against women, she found that organizations either focused on transplanting social service programs or worked to change national laws and institutions (Merry 2006a:138). While many of the respondents suggested that they were involved in both areas, the organizations I interviewed appeared to focus on one approach over another. For example the Health Equity Group was most clearly engaged in and planning to work from what I classify as a human rights advocacy approach. Those respondents primarily involved in service delivery did not necessarily formulate their work in terms of transforming structures and systems, which I would argue is

part of taking a rights based approach. Figure two illustrates how I have grouped the organizations I spoke with.

Figure 2: **Social Service Delivery & Human Rights Advocacy Approaches in Tanzania**



As Merry argues, both approaches (illustrated above) are valuable and mutually reinforcing.

> Despite the disparate origins and fundamental differences between the two movements, there is a growing convergence between them. National interest in participating in the human rights system creates spaces for rights-based social service programs at the grassroots. As local social service programs encourage clients to frame their grievances in terms of human rights, they develop a rights-conscious local constituency that pushes governments to abide by the standards of the international system. Thus, human rights institutions benefit from the rights consciousness promoted by local social service programs and local social service programs benefit from adopting a nationally and internationally recognized framework (Merry 2006a:138).

Relationships with the State

All of the CSO's interviewed worked with the Government in some capacity with regard to reducing maternal mortality and all identified the Ministry of Health as a key actor in their work. The nature of that relationship however, differed by CSO and the type of work that they were engaged with. For example, respondents who previously identified as taking a "social service approach" such as CARE, MEWATA and CSSC described their relationship with the state (either at the Ministry or district level) quite positively, 'the opportunities we see as an association are that we have a committed government that aims at reducing maternal and child mortality' (MEWATA) and the CSSC respondent described the government as their biggest stakeholder,

'the relationship is mutual – the government says that they can't manage without CSSC.' Another informant at CSSC commented, 'CSSC has a very close relationship with the government, in a way we work for the government' (CSSC). The respondent from CARE suggested that their work at the district level provided opportunities that other CSO's did not have, 'working with the government at the local level is not difficult because there is a history and relationship and CARE has implemented projects in the communities we work in. To do advocacy-only work is very difficult' (CARE). Interestingly, although WRATZ is not a social service delivery organization, its close ties with the government since its inception have most likely influenced its positive description of the organization's relationship with the government. 'WRATZ works with the government but not as part of it but as an advocacy organization… [We] work together with core committee members and the departments of maternal and child health and reproductive health services were involved in the launch' (WRATZ).

Other CSO's previously defined as taking a human rights advocacy approach described a more antagonistic relationship with the government. When describing YAV's work at the district level the key informant stated, 'to be honest this has not been a friendly engagement. Those in power have not wanted to be followed up on, to be questioned' (YAV). Similarly, the informant from Women's Dignity described some of the challenges working with the government with relation to their budget analysis work, 'for example, we received the last [draft] budget too late to conduct an analysis so there was no space for contribution by CSO's. This makes it difficult to engage…there needs to be a more transparent process where CSO's could provide input' (Women's Dignity). Although identified as taking a social service approach, PRINMAT's respondent also saw the relationship between CSO's and the government as strained, 'CSO's are doing good work – however there is a need for the Government to recognize and support this work. Even simple acknowledgement and appreciation would go a long way in improving the work of CSO's' (PRINMAT). A report on sexual and reproductive health rights in Tanzania echoed similar sentiments while noting that openness depended on the Ministry. 'Some departments like the Ministry of Community Development, Gender and Children now view CSO's as partners in development. Nevertheless such collaboration is tricky for CSO's since it could compromise their outspoken advocacy. Others like the Ministry of Health in particular, remain closed; any sector dialogue is primarily lip service and is limited to Ministry-friendly CSO's' (Musa and Ndomo 2007:38-39).

The key informant from the Ministry of Health showed some distrust of CSO's because of his experience working at district-level hospitals and his encounters with CSO's, 'implementation is lacking and money is not used well' but also expressed some good experiences as well. Interestingly, he suggested that there was not in fact space for CSO's in the PMNCH coordinated by his office (which contradicted the WHO respondent who indicated there was space for CSO's to participate). The same respondent indicated appreciation for advocacy organizations such as Health Equity Group when shown their flier for advocating for more funding for maternal health, 'the Ministry needs all the help it can get to secure more money' (MOH).

Mobilization

Six of the seven CSO's identified mobilization as part of their work, though how mobilization was conceptualized varied by respondent. A few of the interviewees asked for clarification on what I meant by "mobilization" which then required me to specify "political mobilization". This deviated from my original intention of having CSO's use their own definitions of mobilization and describe how they do or do not operationalize in their work.

Generally respondents talked about either mobilizing community members or political leaders. At the community level MEWATA's respondent talked about their breast screening campaigns, the WRATZ respondent described their annual "White Ribbon Day", a rally and commemoration of women who have died in childbirth and the PRINMAT respondent described working with community leaders to set-up women-to-women education sessions on safe motherhood. CARE and Women's Dignity's respondents talked about their efforts to mobilize community action.

MEWATA and WRATZ informants described their campaigns as also garnering political will. The respondent from Women's Dignity suggested that they would like to link politicians with their community mobilization efforts (for example involving politicians at the popular tribunal for this coming year and creating more space for citizens to be heard in political forums, such as the health sector review process). Only MEWATA's respondent suggested explicitly that mobilization was a "priority" of their work.

In terms of opportunities and challenges to mobilization both MEWATA and WRATZ's respondents highlighted decentralization of the health system in Tanzania. MEWATA's informant suggested that decentralization provided an opportunity for implementation of action plans but that competing priorities and limited funds were a barrier at the district level. The WRATZ respondent suggested that because they were an alliance made up of members from across Tanzania this was an opportunity for mobilization, however the challenge was working with the Prime Minister's Office for Local and Regional Governance (PMOLRG) to prioritize maternal health budgeting at the district level, as well as providing support on *how* to prioritize. The respondent from Women's Dignity commented, 'Decentralization has created more opportunities for organizations as well as the involvement of local community members…for example, a chairman of a village came up with the idea of creating a local emergency fund to transport women to the hospital.'

Building citizenship engagement required for mobilization was highlighted as both a challenge and opportunity. Both WRATZ and YAV respondents suggested that more needs to be done to build community-level demand and UNFPA's informant suggested that not much activism exists in Tanzania outside of organizations such as TGNP, TAMWA and the coalition FemAct who are explicitly activist and feminist groups. When asked about the existence of a women's movement in Tanzania, WRATZ, Women's Dignity and CARE respondents all highlighted TGNP and FemAct as explicitly feminist organizations however a "women's movement" was more difficult to pinpoint. The informant from the Health Equity Group said the focus of their work is 'to build a popular health movement' through various media and initiatives at the community level (CARE).

While decentralization of the health system in Tanzania is designed to encourage greater participation in setting and planning for health priorities at the local level, involving women regularly in consultations is not currently happening in the communities we visited. Opportunities for further involving women in local health planning could provide district officials with valuable information for planning as well as challenge women's lower status in the community.

The respondent from YAV also suggested that the push to mobilize in Tanzania currently comes from CSO's and not from citizens, '[we] need to work harder in Tanzania to increase political mobilization on all issues. This is in part because of historical reasons – a single party system which discouraged citizen participation and was characterized by a closed political environment.'

UNFPA also agreed that political space has opened up, 'there are opportunities for this [political mobilization] especially now that people can speak their mind with regard to political freedom.'

Other opportunities highlighted included key political leaders as ambassadors for safe motherhood efforts and women's rights. Women's Dignity and CARE informants both mentioned Dr. Gertrude Mongella, a long-time Member of Parliament and current President of the Pan-African Parliament as an important figure in advocating for reproductive rights of women.

From the interviews conducted in Tanzania, it appears that mobilization is often connected to programs or strategies, some of which are transplanted from other parts of the world. Widespread mobilization or movements calling for change that are common in parts of Latin America are not currently happening in Tanzania. Instead it appears that mobilization often occurs in isolated ways and mass mobilization is not the focus or priority of the organizations I spoke with.

Law & Legislation

The last theme that emerged was law and legislation. The Health Equity Group was the only organization whose respondent identified linking rights and the law as part of their future work, although they suggested they were unsure of the best way to engage with the law. One of the key focus areas for the group is the revision of the marriage act. It should be noted that when the Legal and Human Rights Centre of Tanzania was contacted for an interview they informed me that they did not currently work on issues related to reproductive rights or maternal health.

The various framing of rights around the issue of maternal mortality suggested to me that translation and appropriation of human rights with respect to reproductive health were predominantly unconnected with formal laws. Respondents for the most part seemed to be comfortable using the rhetoric of rights language, but did not appear to link their claims with national laws or international treaties that support these claims. For example, while most of the respondents linked rights with the right or access to health, none of the respondents suggested that their work involved lobbying for constitutional reform to include the right to health.

In this paper I have argued that civil society actors have taken two different approaches to promoting safe motherhood in Tanzania within a human rights framework. While a social service approach delivers much needed services and builds what Merry calls a "rights consciousness" within a local constituency, I would argue that more could be done from a human rights advocacy approach in order to further the safe motherhood agenda in Tanzania. The current President has recognized the issue of maternal mortality and committed his government in numerous speeches to reducing the number of women dying in childbirth yet no tangible effort has been made to allocate funding to do so. As one key informant noted, 'If there was a real commitment he [the president] would have set up a commission like he did with AIDS' (CARE). It is interesting to note that the Mozambican President recently launched his Presidential Initiative for the Health of Mothers and Children to speed up the reduction of maternal and infant mortality and promote family health care. Mozambique has a lower maternal mortality ratio (480 per 100,000 live births) then Tanzania (PMNCH 2008). In addition, I would argue that most of the work by the government to date has been in response to bilateral and multilateral pressure such as the implementation of the Partnership for Maternal, Newborn and Child Health but without international funding to accompany these initiatives, the government has thus far not demonstrated any commitment in terms of increasing financial resources to implement such plans.

Chapter 5: Conclusion & Reflections

My research has focused on how Civil Society Organizations (CSO's) are framing and claiming rights related to reproductive health in the Tanzania context. I started this paper by raising a number of questions I was interested in exploring. I now return to these questions to reflect on what I have found through my research, what new questions have been raised and how this method of dual inquiry could be applied to other contexts.

The point of entry for my field research began with exploring the lived realities of reproductive health and rights in Tanzania. How the issue of safe motherhood was framed in rural Dodoma and negotiated by grassroots women I felt was important in contextualizing my conversations with CSO's. These discussions provided rich material in which women talked about their access (or lack thereof) to reproductive health services and their desire and sense of entitlement for safe deliveries with skilled attendants *as well as* broader access to health services in their community. In addition, participants clearly articulated their limited opportunities for increased economic empowerment and self-sufficiency - an important reminder that reproductive health rights are located within the larger context of women's lives.

The women I spoke with were also familiar with the language of rights, though not linked with access to health services but primarily related to property, marriage, employment and inheritance. It was interesting to note that in the IRRAG study women also articulated rights in this way suggesting that resistance in the case of economic necessity or survival is more socially acceptable than rights related to a women's bodily integrity (Petchesky and Judd 1998:19). Focus group participants also had very limited direct contact with CSO's on these issues. This may be in part because the focus of the CSO's I spoke with was on working with district level health officials and therefore their interaction was mediated by health officials with respect to reproductive rights promotion.

Returning to the focus of my research – CSO's, I then explored how organizations based in Dar es Salaam framed the issue of maternal mortality, reproductive health and rights. My research findings highlight the way in which culture and tradition are framed within current safe motherhood discourses – often as a barrier to women's access to safe delivery. This monolithic and static presentation of culture I have argued makes it difficult to see women's agency as well local opportunities for rights promotion. Theorizing culture and tradition as an open and flexible system provides a lens to see the capacity of social arrangements as both an opportunity as well as potential barrier.

Corruption and lack of political will was also highlighted as a barrier to achieving reproductive rights in Tanzania. What emerged from my research was a division between those organizations working to compliment Government services by "gap-filling" and those that were working to challenge current health system structures and promote Government accountability. Regardless of how organizations chose to interact with the State - their relationship played a key role in their work.

Tracing how CSO's came to frame their work in terms of rights involved my investigation of "translators" defined in chapter two. While my investigation found more evidence of *translations* than *translators*, the value and desire for further opportunities on the part of civil society organizations to attend international forums raises an important issue in terms of the potential

exclusion and elitism of transnational organizing around international human rights norms. Who gains access to such forums and the issue of funding are beyond the realm of my paper but could be further areas of interest to explore. In addition, funding agencies may further investigate the value of providing financial support for partner organizations to access these forums. From the interviews, organizations that had the opportunity to participate at this level felt that the sharing process was useful for their work.

Finally, a challenge and opportunity related to the framing of rights that emerged out of my research was differing definitions of what working from a "rights based approach" actually meant. While some common themes are identified in my theoretical framework in section 2.3, differing conceptualizations make it difficult to talk about a singular "rights based approach". A plurality of approaches to implementing rights into social justice work is a common thread throughout my research and I would argue, reflects how rights are "translated" and appropriated in a multitude of ways. This was an important lesson for me, as I initially approached my research with a very specific definition of what taking an "RBA" meant – which was challenged during the course of this research.

Moving from framing to claiming rights, I argue that the way in which the issue of maternal mortality is framed by organizations informs the way in which rights claims are made. Delineation was found in my research between those organizations that take what Merry calls a "social-service approach" and those that take a "human rights advocacy approach" (Merry 2006a:138). Although both approaches converge in important ways there are fundamental differences in the way in which their work is carried out which influences how the state and civil society actors perceived their relationship with each other.

I also asked organizations about the issue of mobilization as a tool for claiming rights, the role it plays in their work and the opportunities and challenges to political mobilization with respect to reproductive rights. While many organizations are involved in mobilization in various ways, building a widespread political movement was not a priority for the organizations I spoke with. However, promoting rights consciousness among local constituents was found to be a key intervention necessary to reinforce and support the realization of rights at both the local and national level (Merry 2000a). The focus group discussions suggested that there may be a certain foundation of rights consciousness that can be built on by CSO's in linking reproductive health and rights in the minds of citizens.

The last theme that emerged was law and legislation. The Health Equity Group was the only organization whose respondent identified linking rights and the law as part of their future work, although they suggested they were unsure of the best way to engage in this area. Respondents for the most part seemed to be comfortable using the rhetoric of rights language, but did not appear to link their claims with national laws or international treaties that support these claims. This may be an area of focus for future advocacy efforts of CSO's.

This method of dual inquiry has been useful in exploring both how rights are framed as well as claimed with respect to a particular social justice issue – in this case safe motherhood. This research also demonstrates the permeation of rights both as an articulation and as a tool in a context far removed from Geneva or New York. While I am hopeful that this research will be useful to CSO's in Tanzania, this model of inquiry could also be adapted to other contexts and social justice issues. An action-oriented research project of inquiring into the framing and claiming of rights could be coupled with building rights consciousness among rights holders and duty bearers moving the reproductive rights agenda closer to ***realizing*** rights.

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APPENDICES

Appendix I – Interview Questions and Notes

Name	Organization	Date
Dorcas Robinson	CARE Tanzania	28/07/08

Interview Questions:

1. Can you describe briefly the work or programs that your organization is involved in related to reproductive health and reducing maternal mortality?

2. Why did your organization decide to focus on these issues?

3. What do you see as the root causes of maternal mortality?

4. Do you use the language of "rights" in your work? If so, how and with whom?

5. Do you facilitate or support political mobilization of women in your work around issues related to reproductive health? If so, how?

6. Is political mobilization a priority for your work?

7. What do you see are the opportunities and challenges to political mobilization in Tanzania?

8. Do you see a women's movement in Tanzania? If so, how would you describe it?

9. How are priority issues for CARE in Tanzania decided upon?

10. How often do you travel outside of Tanzania for your work? For example, to attend conferences such as the Women Deliver conference or meetings of coalitions/networks or what some may call "transnational women's organizations". How do you integrate information collected at these meetings into your work in Tanzania? Do you also share information about the issues you work on in Tanzania? How?

11. Do you work with the Government? At what levels and how? How do you see your relationship with regard to your work on gender equity issues/reproductive health?

12. Do you engage with rural women on reproductive health issues? How?

Interview Notes

CARE has been in Tanzania since the mid 1990s originally working in the area of refugee rights and then shifted to development work.

Community Based Reproductive Health project was started in Mwanza, funded by USAID with tech assistance provided by CDC.

Project combined improving basic health services, training local health staff, as well as lots of work around community action. The project trained 200 health workers (at the village level) to provide home-based support who reported to both health facilities and village leaders. This project ended in 2001 (running from 1996) and also established a community based surveillance and transport system. Part of the project evaluation was to identify gaps in comprehensive care and CARE worked with two hospitals at the end of 2001 to implement quality EOC. This was an AMDD project.

CARE has also worked to set up VCT clinics which then expanded to PMTCT which is another component of safe motherhood. Project ended in 2005 in part because of other initiatives around maternal health.

In early 2004 the PRS for Tanzania highlighted MM, Women's Dignity also highlighted the need for more collective action on the issue of MM and it became a strategic focus for Dorcas. She sees MM as a lens for looking at the health system generally and highlighting the inequalities.

(Dorcas did her PhD on the role of NGO's in Health Sector Reform viewed as part of a neoliberal agenda).

Dorcas began working with Maggie Bangser at Women's Dignity as individuals (not representing orgs), with other concerned citizens for MH as well as UNFPA staff, members of Government – but very much a group of individuals. The group identified a need for a high level consultation process across all sectors to identify medium-term set of actions for 3-5 years. The idea was to cost out this set of "quick win" actions.

However in 2005 World Health Day focused on MH, and it became a political issue, UNFPA also had a separate mandate on supporting Govt's in the development of Roadmaps and the PMNCH was also being set-up. The small working group became seen as a separate parallel consultation process and became too political, so instead the actions identified were fed into the Roadmap.

CARE is also a member of WRA at the global level (began in early 2005) and is part of the steering committee and has been very involved in setting up white ribbon day, staff have worked on campaign and coordinator was hosted in CARE office for the first year.

Maggie and Dorcas have also worked hard to provide input to health sector reviews by CSO's and organize consultation groups and lobby for a voice and space to contribute to review process.

At this point there was decision to shift from political work back to grassroots activist work at the local level. The Health Equity Group was created around the time of PRSP II. Includes 5 organizations: YAV, SAVE, WDP, CARE and TGNP. There is currently no secretariat and the group works very informally. They are formulating key policy demands related to MH:

1. Revision of the marriage act
2. Issues related to early marriage
3. Challenging issues related to transactional sex
4. Family planning

They also work to monitor and analyze the health budget and work with members of parliament and educate them on the issue of MH.

WDP also held a popular tribunal. TGNP also holds a gender festival every two years with the last day focused on "bodily integrity".

The group is working to build a popular health movement using maternal health as lens.
In terms of collective actions:

CARE is working with Kivulini in Mwanza
WDP is partnering with HAPA in Singida
TGNP has their gender networks
YAV has their volunteer networks

Multiple strategies are being used to build movement such as media, radio, TV spots, general public engagement, events such as gender festival, working with communities to develop local score cards for health services. This involves working with at the village level with communities to monitor and score access to reproductive health. Also provides an opportunity to link with media and as an advocacy tool.

Also working to link people into national events and provide space for voices of community members – such as health sector review which often has representation of donors – for example only 4 spaces were made available for CSO's. Next year they are planning to organize a parallel event to provide space for community members.

For CARE working with the Gov't at the local level is not difficult because there is a history and relationship and CARE has implemented projects in the communities they work in. To do advocacy-only work is very difficult.

WRA is not out there to challenge power relations in Tanzania – it is using relationships with Govt but not challenging power.

Health Equity Group is explicitly challenging power dynamics vis a vis health inequality and vis a vis RH & MH. TGNP is a feminist organization and therefore challenging male power in Tanzania explicitly.

It is difficult to measure impact of Health Equity Group. The fact that the President is talking about MH is not necessarily a result of the work of the group. In fact is it an "impact" if he is talking but there is no movement? If there was a real commitment he would have set up a commission like he did with AIDS (TACAIDS).

The MoH did not invite members of the group to the health sector review and when the issue was raised by donors it was supposedly said that they did not want activists at the table – however a last minute invitation was extended. This may be an impact!

Policy forum was also asked to nominate SWAP participants and YAV and TGNP were nominated to sit on technical committee.

At the Women Deliver conference the group was organized and traveled together as well as briefed the minister. YAV traveled with the Minister of Health.

Dorcas, as a result of her work with the group does not participate in meetings with the Govt as a rep of CARE. She has Tanzanian staff attend as there requires a political sensitivity.

In terms of the impact of the work of CARE, the post-project study to identify gaps found that the health workers who had been trained were still working and the transport system was still operating. This study was conducted by CDC.

There was also a project funded by Irish AID to test how to work with village health systems to increase safe motherhood. It is not only an issue of planning but do the village planners know how to plan and allocate money for MH? NO. Worked with three villages to develop plan for increasing MH. Also worked with the Prime Ministers Office for Local and Regional Governance to engender health planning and paired districts that had been trained with other districts to plan and budget together.

Out of this work a new initiative of CARE is now family planning. A CARE international initiative has also been created called "mothers matter". The initiative will work in 10 countries and create a boost for local level as well as policy level work.

There is also a shift now at looking at how human rights and legal centers can work with group to make explicit link between human rights, MM and the women's movement. How to do this more head-on is the question.

Dorcas also sits on the steering committee of the international initiative of MM and HR as a representative of the health equity group. This initiative came out of the Women Deliver conference. Paul Hunt (previous special rappoteur) launched group and now looking at how do we link and move agenda forward? The initiative is funded by DFID and they are now looking at technical support. For example, one area of their work will be looking at health facilities, another is gathering case studies etc.

Also involved in the International Budgeting Project.

Women's movement in Tanzania? Is there one? Many protagonists have taken on male power. For example, getting the sexual offences act in mid-1990's – this process helped to form key organizations. What kick started this process was a girl who committed suicide at the University because of sexual harassment. Women literally took to the street led by Dr. Gertrude Mongella (a long time activist and MP) which was quite spontaneous action.

FemACT – is a clearly defined feminist group. Unclear what that movement is and at what level. What makes a movement? TAMWA is clearly a feminist organization and also a household name in TZ. There is definitely a need to find a way to motivate people but it is unclear where that push is going to come from. A need for a culture of engagement = what can happen at the district level? There is an issue of villages unlinked with district-level officials.

There is a need to support institutional change and would like to do this from a human rights perspective. CARE has done work at national level but there exist more opportunities for engagement around accountability of Govt.

CARE USA has recently shifted to working from a RBA, however CARE does not use "rights" work/language in organization in TZ. Challenge of changing the working style of the team - people are already busy with implementing projects. They also decided to work for CARE as a service provider not as an advocate or lobbyist. There is a push from CARE USA to work from RBA but it is a challenge to implement.

Relative independence at CARE TZ as it is fairly decentralized. Though there has recently been a re-organization so that may change (in terms of administrative functions). Scorecards – could be used in an RBA project. The challenge is in how to include representatives from communities on the committees. This tool was in fact adopted from CARE Malawi.

CARE priority issues defined by the country office programme and structured around sectors. These sectors are however aligned with the country strategic areas which are linked with the CARE USA priority/strategic areas.

90% of funding is self-raised in TZ so donor priorities can also shape programming.

Attending international conferences/transnational women's organizations? No money. Can only travel to these events if they are included in project budgeting. For example, there is the AWID conference in Cape Town. CARE had a regional meeting and no one knew about it. Dorcas raised the issue and now there are a number of CARE reps attending. People are less aware of these opportunities and debate on what role to play occurred – go in and make speech or observe and learn – not actively engaged in such forums.

Role of Private Health Service Providers? Distinction between faith-based and For-Profit. For profit most often do not do MHS and are located in urban centers. FB Hospitals not particularly active on issue of MH. They are busy advocating for government subsidies – could lobby to have govt reimburse them for MH services. Christian Social Services Commission has office in Dar and they do advocacy and funding. Different constituents focus on different areas.

Name	Organization	Date
Goodwin Ndamugoba	Christian Social Services Commission (CSS)	11/08/08
Andreas Nshalla	Christian Social Services Commission (CSS)	11/08/08

Interview Questions – CSSC

1. Can you describe briefly the work or programs that the Commission is involved in with respect to health service provision in Tanzania?

2. How many FB health service providers are there currently in Tanzania? What is the relationship between the Government and FB health service providers?

3. What types of health services are provided by FB health service providers?

4. One of the key areas for the CSSC is health policy advocacy and research. In what areas do you focus your advocacy work?

5. Does the Commission play a role in advocating for maternal mortality reduction strategies? If so, how?

6. How in your opinion has decentralization of the Government affected your work?

7. Health infrastructure strengthening is a key issue related to safe motherhood – does CSSC play a role in supporting this in Tanzania (i.e. training health service providers etc.)?

8. Do you work with civil society organizations in your work? If so, how?

9. What role do you see civil society organizations playing in Tanzania on the issue of safe motherhood and reproductive health rights?

10. Is the CSSC linked with other Associations outside of Tanzania? If so, how?

11. How are priority issues for CSSC decided upon?

12. How is the CSSC funded?

Interview Notes:

Commission mainly deals with health and education, separate projects that are also health related that do not fall under the health department. These include HIV/AIDS and malaria as well as the ACCESS project that deals with maternal mortality.

The department coordinates the implementation of all health services by FB health facilities from the hospital to the dispensary level. This includes 2 consultant/teaching hospitals.

Districts request use of some hospitals as council or district level hospitals and provide the money and the manpower and run the facilities as public hospitals. This number keeps changing.

CSSC works with the Government through the MoH – the Ministry provides a staff grant for training as well as a medical grant for services (50,000 TSH/bed/year) though they did not pay for all beds (a proportion only). This is only partial funding and the other funding has to be found from other places.

FB health facilities operate under the MoH – they must follow policies, procedures and guidelines of MoH. The same health services are provided by FB health facilities as public facilities.

The Government at the Ministry level often works and speaks via CSSC or they will work through the DMO at the district level.

The health department also works in capacity building which involves staff training and funding for training which comes from development partners. They are also working on developing private-public partnerships and hold regional PPP meetings. These involve various stakeholders to see how they can improve health provisioning where there is a gap. They work to ensure that facilities are not duplicated in the same areas so as not to duplicate services and maximize resources.

CSSC is very much involved in MMR strategies – the Interchurch Medical Association has sub-contracted two CSSC staff to work on RCH activities.

Are FB facility delivery services free? The policy is in place that there should be free MCH service, antenatal and immunizations are provided free however the implementation of the policy to ensure free delivery does not come with money. This is needed to buy drugs, pay staff etc so a minimum fee is charged for delivery services to deal with financial shortages.

For District Hospitals (run by the district but infrastructure provided by FBO) there is no fee as the Gov't provides resources (?). Policy would work better if money came with it.

Decentralization? Should work better then it is working now. If the implementers understood what decentralization is then it could work better. Issue of low capacity of those charged with implementing reforms.

CSSC tries to mainstream activities with the Gov't they do not have the mandate to have parallel activities – this is why the PPP meetings are held. They help to allocate what roles are being played and by whom.

Service agreements are important to have between FB health facilities and Government. However, many agreements are in place but they are not receiving the resources promised. The concept is still not well understood or implemented well.

CSSC collaborates with CSO's – REPOA, NACP and work with others who support CSO's. It is difficult to work alone. The biggest stakeholder is CSSC however, and the relationship is mutual – the Government says that they can't manage without CSSC. They have many partners.

CSSC is the largest ecumenical body in central and east Africa. Other countries surrounding TZ have separate Pentecostal and Catholic associations, while in TZ there is one body that incorporates both groups.

CSSC also collaborates with other FB associations outside of TZ, for example, Inter-Church Medical Association has worked with CSSC. There are also others that CSSC works with. Government also uses the CSSC to communicate with FB sector.

CSSC is funded by development partners such as DANIDA, CORDAID and EED (German partner). Churches in TZ also provide funding.

National priority issues? The CSSC looks at how they can contribute to the national priorities based on statistics/government priorities. CSSC is also part of the team that helps to develop national priorities and plans.

Note: When arrived for interview, 2 nuns from Tabora running a dispensary were visiting to ask when $ from service agreement would be arriving for their health facility.

Dr. Andreas Nshalla (RCH Coordinator):

In terms of MNCH there are several projects running. The first is sub-contracted by the Inter-Church Medical Association, which is called the ACCESS project which is a large program with the MoH and JHPIEGO. IMA is a member of the consortium. The project includes scaling up activities in the FBO networks (including health facilities) and improving MNCH at all levels.

ACCESS project is linked to the Deliver Now campaign which is coordinated by the MoH. This is the last year of the project which ends in October. This involved money going to the districts to train workers on focused antenatal care.

There is also a malaria reduction project (USAID) with a major focus on women and children, capacity building in terms of training community health workers and access to interventions by health facilities. This project works at the community and district level.

Capacity building and training on antenatal interventions and malaria prevention for health workers. ADDO's have also been involved in training on proper dispensary of malaria medicines.

There are also other campaigns that CSSC works on as well.

There is no special funding for this type of work CSSC works on a project basis and they are looking for more social funding. CSSC has a very close relationship with the gov't, in a way they work for the gov't. There is a challenge of implementation though, policy is okay but no $ to implement and donors change priorities and interests.

Name	Organization	Date
Dr. Marina Alois Njelekela	Medical Women's Association of Tanzania	14/08/08
Dr. Mary Hawa	Medical Women's Association of Tanzania	14/08/08

Interview Questions – MEWATA

1. Can you describe briefly the work or programs that the Association is involved in related to reproductive health and reducing maternal mortality?

2. Why did the Association decide to focus on these issues?

3. What do you see as the root causes of maternal mortality in Tanzania?

4. You use the language of "rights" in describing one of your key thematic areas of your work - reproductive health and rights. How do you *use* rights and with whom? For how long and why have you chosen to do so?

5. Do you facilitate or support political mobilization of your members in your work around issues related to reproductive health? If so, how?

6. Is political mobilization a priority for your work? If so, what do you see are the opportunities and challenges to political mobilization in Tanzania?

7. Do you work with civil society organizations in your work? If so, how?

8. What role do you see civil society organizations playing in Tanzania on the issue of safe motherhood and reproductive health rights?

9. How do you work with the Government in Tanzania? At what levels and how? How do you see your relationship with regard to your work on reproductive health?

10. Is MEWATA linked with other Associations outside of Tanzania? If so, how?

11. How are priority issues for MEWATA decided upon?

12. Do you engage directly with rural women on reproductive health issues? How?

Interview Notes:

Please note: MEWATA completed the questions beforehand and provided a copy to me. These notes are to supplement the notes provided by MEWATA.

MEWATA is volunteer-based and members are full-time doctors who meet after hours to work on MEWATA activities. MEAWATA is guided by thematic areas outlined in their strategic plan. This plan was to end in 2008, however not all activities were completed so they are continuing on.

One of their big activities was implementing a breast cancer screening campaign across Tanzania. The public responded very positively to this campaign which involved TV/Radio fundraising/awareness-raising. This built the profile of MEWATA as well as political will to support campaign. The gov't is now funding the program. Breast cancer is the third leading cancer in women in TZ. The first is cervical cancer which is also going to be screened by MEWATA next year.

The members of MEWATA travel to do the screening (again on a volunteer basis). Members pay a registration fee and annual subscription fees. The organization holds an AGM each year.

MEWATA is working with the gov't to see how to add cervical cancer screening.

Three focus areas are Reproductive health and Rights, HIV/AIDS and Professional Development.

They mobilized professionals to train in safe motherhood – worked with the gov't to amend training and were able to fund training through the thematic focus of the AGM.

MEWATA is currently looking at how to find sustainable funding. They are also working with other CSO's on the same topic and assisting the gov't to deliver health services. So far the gov't has responded very positively to their work.

For example, MEWATA has worked with various levels of gov't on the screening campaign. Teams return to do surgery and also follow-up treatment. Campaign has covered many parts of the country. They work at the district level to coordinate campaign. Donated radio air time is used to let people know about the campaign and community leaders play key role. They also spread the word via FBO's and use microphones and speakers mounted on cars.

Women in the community are not aware of their rights. There is a policy in TZ of "free healthcare" for vulnerable groups. However there is a need to educate/empower women to demand health services. Even health providers do not understand/respect the rights of their patients. Part of the work of MEWATA is educate/sensitize before the campaign to talk about the rights of women in accessing health services. Women ask lots of questions and they have discovered that doctors are not screening for many health issues specific to women's health.

For example, in antenatal testing there is an HIV/AIDS test. However women often do not tell partners and have no way of protecting themselves.

They are also working with the Tanzania Women's Law Association who are providing women free legal services. This is a joint programme of the UN – looking at the legal aspects (including rights) of accessing health services.

Two prong focus of MEWATA is doing advocacy and providing services (on a volunteer basis).

Women in Medical profession in TZ? Only 30 women out of 150 in her program. The gov't is encouraging increased female enrollment in medicine. Gov't has different grade standards for men and women (it is slightly lower for women) to recruit more women.

There exists a challenge in retaining health workers due to $ and the gov't needs to focus on this issue. The theme of the upcoming AGM of MEWATA is fostering professionalism – 52% of doctors are working in DSM because of the lack of facilities up-country.

MEWATA is linked with the international association of medical women – there is a meeting in DSM next year for an international medical women's association.

MEWATA's patron is Mama Kikwete. They are currently looking for gov't support to build a well women's centre to provide treatment and a place to stay while receiving treatment. They have purchased the plot and are now looking at for funding to build the centre. This is where they would like to house a permanent office as well. East African Breast Care Program (EABCP) – looking to mobilize funds for centre.

Name	Organization	Date
Dr. Koheleth Winani	Ministry of Health, Reproductive & Child Health Section	13/08/08

Interview Questions – MOH

1. Can you describe briefly the work or programs that the MOH is involved in related to reproductive health and reducing maternal mortality? Is the MOH coordinating/funding the PMNCH/Deliver Now campaign?

2. What do you see as the key challenges and opportunities to implementing the Roadmap for Safe Motherhood in Tanzania?

3. How does the MOH work with other levels/ministries of the Government on these issues?

4. How does decentralization affect your work? Does the new system provide opportunities/challenges to reducing maternal mortality in TZ?

5. How would you describe your relationship with civil society organizations on the issue of safe motherhood? What role do you see civil society organizations playing in reducing maternal mortality?

6. There has been an increase in using the language of "rights" and linking with safe motherhood and reproductive health. Do you *use* rights in your work and with whom? Do you see more opportunities or challenges with using "rights"? Are other organizations using rights on this issue?

7. Some organizations that I have spoken with have talked about the need to increase demand for better access to reproductive health and delivery services at the village/district level. Do you see this as a priority area for improving safe motherhood in Tanzania?

Interview Notes:

The Ministry of Health is the coordinating body of the PMNCH. WHO sponsors the government of TZ and the gov't then reallocates funds in which the MoH spends. MDG 4 & 5 is the main area of WHO sponsorship money. The Ministry collaborates with the WHO to develop work plan as well as with other development partners such as UNFPA, USAID, UNICEF etc.

However the allocation of funds has not been adequate and the national budget has not been meeting requirements (i.e. Abuja declaration of 15% of budget spent on health). With health people continue to get sick and die because of lack of drugs. Dr. Winani has worked in the field and has felt the frustration – you must do something, even if its talking to people and trying to sort out money for drugs. The gov't keeps saying next year, next year but that doesn't do the people dying much good. What are you going to do sprinkle the drugs over the graves when they finally arrive?

Cost sharing has been implemented, though vulnerable groups are supposed to get free treatment. We should not deny medical care. For example, those in road accidents should not have to pay and should be exempted and treated. Post-treatment those that can afford to pay can pay.

The focus of the MoH for maternal mortality reduction is in 6 key areas:

1. Antenatal care (includes screening)
2. Skilled attendants at births
3. EMOC – training and capacity building of health providers
4. Care of newborns
5. Post-partum care for mothers (includes developing a training manual to ensure complications do not develop, revising antenatal card and advising on family planning and vitamin A supplementation)
6. Post-abortion care (Abortion is illegal, but in his experience people only reveal having an abortion when they are about to die. There is no law that requires health workers to report abortions to the govt. Part of the care provided includes family planning and counseling as well as completing the abortion – normally people arrive with incomplete abortions so MVA is being advocated for).

5 leading causes of MM in TZ are hemaerroage, eclampsia, infection, unsafe abortion and obstructed labour.

Big problem of HIV/AIDS as well – people receive ARV treatment and get healthy and then get pregnant and their health decreases dramatically. Issue of sexual activity – for those that feel healthy of course they want children.

Also FGM – purpose of the practice is to reduce the sexual urge but it does not work. i.e. prostitutes he has spoken to have said that they still enjoy sex (hormonal drive).
Practice causes big problems at delivery time – in some places (such as the place he comes from) it is simply a formality – a cut and some blood but no damage is done.

Big challenges to implementing MM reduction strategies include: 3 delays 1) not accessing treatment, 2) gender delay (i.e. family/husbands do not want to take women to the hospital) 3) communication issues: distance to health facilities, no staff, no drugs, resources, facilities

Problem can be divided into 2 levels – issues at the community level and at the health facility level.

The gov't has now committed to building a dispensary in every community and provide EMOC services at district-level hospital. However plans are one thing and implementation is another thing. There needs to be an allocation of $ - so far the money provided has not been enough.

Decentralization? We thought people would know their problems and they would be the best to identify and assist in planning to address these problems. However, implementation or decentralization by devolution has provided full power to the district officials without monitoring – this is not good. Politicians are using the money for other things.

There is a need to prioritize – priorities are different from the MoH, the health budget must now be a priority of district planning. MDG's are a challenge in TZ and therefore there must be

priority assigned to achieving them. However, there is no policy. Parliament has apparently assigned health budgeting as priority for districts but no formal figure is attached to this.

Cross-cutting issues require work across Ministries and different levels. For example, the issue of nutrition and anemia require work with the Tanzania Food and Nutrition Centre (TFNC). Also need to talk to other ministries to ensure that stakeholders are involved in advocacy and policies related to safe motherhood. MP's are also important to do advocacy as well. Even President is quite involved in advocacy work.

Civil society organizations – there is an issue of personality. He has not had good experiences with some NGO's in the field where implementation is lacking and money is not used well. There is a need to strengthen the existing system and not have many actors doing various projects haphazardly. Organizations must work with MoH and report to them and harmonize efforts. For example, CSO's have not done very much with some of their HIV/AIDS efforts. Need to weed out the organizations that are not transparent.

Work with development partners to plan together – for example the ICAP project (under Columbia) worked with the MoH well. There is also a need for negotiation and understanding so that projects are not implemented in Tanzania without consideration of the local context.

The Partnership does not include CSO's. Appreciative of advocacy organizations as the Ministry needs all the help it can get to secure more money. There is apparently restructuring happening in the big 3 hospitals because of a number of incidents (deaths?) that garnered public attention. People need to be reminded of their responsibilities and their jobs.

Rights? Women are not given their rights. Being pregnant is not a disease – this should not happen. There is a denial of rights. There is a document being revised (Road Map) that states that the biological role of women is becoming pregnant and that there is a need for community support. This is an issue of rights not being fulfilled. When a woman died in one of the hospitals he worked in he would go into his office and cry and cry and cry and ask what happened. For example, while working in Mtwara a woman from Mozambique traveled by donkey two or three days with eclampsia and died after arriving at the hospital.

This is the biological role of women and they should experience good care and have a good experience, if women experience bad care then it can be a terrible experience.

Name	Organization	Date
Mary Kapesa	Private Nurses & Midwives Association (PRINMAT)	5/08/08

Interview Questions – PRINMAT

1. Can you describe briefly the work of and the members of your Association?

2. Is the Association involved in work related to improving reproductive health and reducing maternal mortality in TZ? If so, in what way?

3. Why did the Association decide to focus on these issues?

4. What do you see as the root causes of maternal mortality in Tanzania?

5. Are most of your members working in urban centers? In what kind of facilities do they work?

6. Do you use the language of "rights" in your work? If so, how do you *use* rights and with whom? For how long and why have you chosen to do so?

7. Do you facilitate or support political mobilization of your members in your work around issues related to reproductive health? If so, how?

8. What do you see are the opportunities and challenges to political mobilization in Tanzania?

9. Do you work with civil society organizations in your work? If so, how?

10. What role do you see civil society organizations playing in Tanzania on the issue of safe motherhood and reproductive health rights?

11. How do you work with the Government in Tanzania? At what levels and how? How do you see your relationship with regard to your work on reproductive health?

12. Is PRINMAT linked with other Associations outside of Tanzania? If so, how?

13. How are priority issues for PRINMANT decided upon?

14. Do you engage directly with rural nurses and midwives on reproductive health issues? How?

15. How is the Association funded?

Interview Notes:

May is member of the Safe Motherhood committee (of the Deliver Now campaign coordinated by MoH and PMNCH). She is the Executive Secretary and chief spokesperson for national and international issues. She is also a Nurse/Midwife with a Bachelor of Science degree in Nursing.

PRINMAT founded in 1999 and May has been working there from the very beginning. Started with a needs assessment completed across the country looking at midwives and from the recommendations of this assessment PRINMAT was established. The organization will celebrate 10 years next year.

Private nurse/midwives are self-employed but coordinated by PRINMAT. Most of the nurse/midwives are retired and return to their communities where there is a high demand for delivery services. Therefore nurse/midwives establish private maternity homes that are managed and run independently. The MoH recognized that these homes were being established and that they should be formally allowed to do so (1994) (**SAP influence?) and should be coordinated officially. Many civil society organizations work with district level health facilities, however few people have access to these facilities. In addition, money from PRINMAT goes directly to PRINMANT facilities and this is an advantage as money does not need to go through the gov't and priority needs for the facilities are decided independently.

For example, Engender Health just made a statement that they will reduce MM in Tanzania – how when they are working at the district health level? How can they claim this when they are working within a gov't system and at a level which is inaccessible to many people? PRINMAT works to compliment the efforts of gov't.

Nurse/Midwives establish own maternity homes, manage themselves and PRINMAT provides standards that need to be met, monitors and evaluates the homes, provides training and service delivery standards.

There are 55 maternity homes under PRINMAT, with a goal of 100 by 2010. Some regions have more facilities, some have less. Takes time to sensitize and there are many midwives out there that are not working as midwives.

Focus of PRINMAT has always been on safe motherhood, antenatal care, family planning, post-natal care, and HIV/AIDS and PMTCT screening. The last components are new additions and were community-driven. Another key focus is on EMOC – referring women early enough that they can get to a higher health facility.

Work is at the community level - mostly rural areas with a few urban facilities. The idea is to bridge the gap between district level and the village/community where there is no access to health services. PRINMAT centers are established in areas where there is no dispensary level health facility. Other larger CSO's only focus at district level.

Interaction between TBA's and PRINMAT nurse/midwives? Focus of interaction tends to be on education to bring women to maternity homes – and not to deliver if women have not attended a prenatal clinic. The relationship is friendly as PRINMAT works in a grassroots capacity. PRINMAT provides a range of reproductive and safe motherhood services to the community including referring straight to the regional hospital if complications arise.

Rights? PRINMAT plays a role of helping women which May sees as a gender equality issue. In her dissertation she focused on reasons why women do not deliver at a health facility. Why? As a

community worker she visited women at the village level and talked to women who did deliver in a health facility and those that had not in the last 5 years.

Women said that they did not have a say in the matter. It was decided by mothers, in-laws, aunties and husbands who controlled the money. This would often result in midwives having to go to homes to deliver. Midwives spend a lot of time speaking with families in the home and this is one of the advantages of delivering with a midwife. They can help advocate on behalf of the mother. For example, in preparing a birth plan with midwives, women often say they do not know where they will deliver as they are not able to make a decision about that. This is an opportunity to work with women to fight for their right to deliver in a facility, to speak up. As well the midwives promote family planning/birth spacing and link this with women's ability to run a small income generating activity. Family planning is often hidden from male partners. This is some of the ways in which rights and empowerment are promoted.

Family planning increases women's choices. This has been one opportunity as well for the nurse/midwives to convince TBA's to release women to maternity homes. Midwives provide a wide range of contraception (aside from tubal ligation but they can refer women for that) Depo Provera and the implant are the most popular.

Community mobilization? There is a need to mobilize the community, this is done by talking to village leaders, asking for permission to speak with women in the community and explain what kind of things will be discussed (i.e. promoting safe delivery). A date and venue are then planned, it is advertised and women attend. Women are then educated about the issues, women to women discussions are promoted and this also increases midwives clientele.

There has never been resistance on the part of the village leaders in allowing these forums to occur. The leaders appreciate the services, everybody is very happy especially as people are concerned about the health of their children. There is no opposition. Midwives have a different approach then doctors – which is more caring and less mechanical.

At the community-level nurse/midwives may work with CSO's. At the Association level they work with TMARC to purchase and distribute family planning contraceptives (to top up what is distributed from the district (as there are regular short supply issues).

Also work with the gov't, and all health services (contraception, immunization, vaccine supply and fridges) are supervised and supplied by the CHMT at the district level. Is PRINMAT involved in budgeting at district level? Would love to be but PRINMAT receives no money from district – just supplies. There is no space for them at the moment to be involved in any budget discussions.

CORDAID is the main funder of PRINMAT. Main goal is to increase delivery health services and send clinical supplies.

PRINMAT is registered by the gov't by Tanzania Nurses and Midwives Council of the MoH. Deliver Now coordinated by MoH and PRINMAT is invited to meetings at the national level with the MoH. For example, there is currently a training of midwives on PMTCT by the Tanzania Aids Commission (TACAIDS) – so there is linking with a number of gov't agencies.

Civil Society organizations are doing good work – however there is a need for the Gov't to recognize and support this work. Even simple acknowledgement and appreciation would go a

long way in improving the work of CSO's. For example, Marie Stopes is doing their own job, have their own facilities.

Feel that the gov't biases organizations that have money (larger CSO's) versus those that have less funding. There is also a sense that gov't does not want orgs to work with UN agencies such as UNICEF or UNFPA – they want $ to go straight to gov't. It would be more helpful if they provided coordination/funding to compliment services.

International links? Know of many other associations in Africa – they all know of each other but there are no resources to work together. In PRINMAT's strategic plan there is reference to working with other Associations but they would need funding to link and meet together and create a stronger voice.

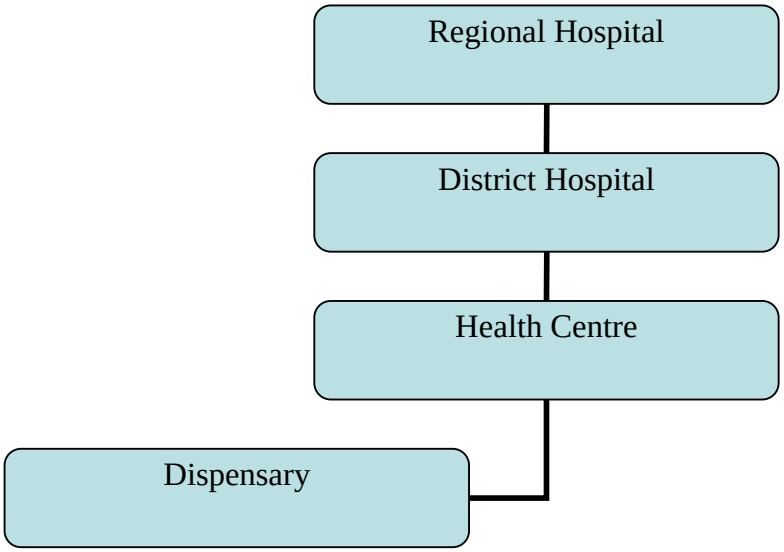
Clinics are divided into zones – each zone takes on 4 or 5 regions and there is a zonal representative who is also a Board Member. PRINMAT HQ is in touch with every clinic representatives who receive reports from clinic manager every quarter. In addition, with regard to standards, and service etc. the clinic manager is also able to report PRINMAT HQ directly. HQ also communicates by phone directly as well as at the AGM. There is also a board meeting every quarter. HQ has opportunity to follow-up with clinics if there are any discrepancies. HQ also facilitates referral information. Listing of all hospitals in vicinity of clinics that women can be referred to and how many kilometers away they are.

The challenge for referrals is the issue of transport – one woman for example arrived at clinic in an ox-driven cart. Sometimes loans are requested, money must be collected from family/community members. Midwives play an important role in advocating for transport.

Midwives charge fee for all services at an affordable cost as they work in low-income communities. (10,000 TSH for urban delivery). This is subsidized by CORDAID and women do not have to bring anything with them.

Recruiting? Midwives who take their own initiative are usually referred to zonal reps who put them in touch with PRINMAT. PRINAMT also encourages midwives to set up in areas where there is no district hospital. Also work through district-level to reach midwives who may not know about PRINAMT.

Notes from May:



PRINMAT CENTRES:

- ✓ Kilimanjaro
- ✓ Singida
- ✓ Dodoma
- ✓ Manyara
- ✓ Mbeya
- ✓ Mwanza
- ✓ Iringa
- ✓ Rukwa
- ✓ Ruvuma
- ✓ DSM
- ✓ Morogoro
- ✓ Mara

Name	Organization	Date
Festa Andrews	Women's Dignity Project	1/08/08

Interview Questions: Women's Dignity

1. Can you describe briefly how Women's Dignity was established and why the organization chose to focus on Obstetric Fistula?

2. WD focuses on three key areas – public information and debate, research and policy analysis and strategic partnerships. How were these three key areas identified?

3. In your mission you explicitly link your work to "enable citizens – particularly marginalized girls and women – to realize their basic right to health". Do you encounter challenges in using "rights" in your work? If so, with whom?

4. The right to health is reflected in the ICESCR but not reflected in the Tanzania Constitution. Is revising the constitution a focus of your policy work?

5. Do you use international and regional covenants and agreements on human rights in using "rights" in your work? If so, how?

6. Do you facilitate or support political mobilization of women in your work around issues related to reproductive health? If so, how?

7. Is political mobilization a priority for your work?

8. What do you see are the opportunities and challenges to political mobilization in Tanzania?

9. Do you see a women's movement in Tanzania? If so, how would you describe it?

10. Women's Dignity works at local, regional, national and international levels. Could you describe your work at the international level?

11. Do you see Women's Dignity as part of what some may call a "transnational women's movement" (such as participating in international conferences/forums and being involved in transnational advocacy networks)? If so, what role do you see Women's Dignity playing?

12. In what ways do you work with the Government? At what levels and how? How do you see your relationship with regard to your work on gender equity issues/reproductive health?

13. Being based in DSM how do you engage with rural communities on these issues?

14. Where does funding for WD come from? Does this affect your activities? If so, how?

Interview Notes:

Focus of WD is on health rights with a focus on obstetric fistula. Work is national however WD has identified regions where pilot work and research is conducted and dissemination efforts are focused. This is because of the size of Tanzania and limited human and financial resources. WD identifies regions to work in with their partners.

For example, 3 districts were identified to conduct fistula research and then the research was shared and expanded nationally.

WD was founded by Maggie Bangser (an American) who was working on a project with a hospital in Mwanza. She saw many women suffering from fistula and started the organization in 2002.

The key department is research which involves traveling to the field, collecting data and information. Public engagement department tries to share information from research. Strategic partnerships department works to move forward the WD agenda and take action to move issues by involving other civil society organizations, health workers, donors and concerned citizens.

WD is just starting to work with community on rights and empowering women using rights. Public engagement started in 2008. Trying to work at both levels – national levels as well as community level. Not using international treaties currently (i.e. trying to reform constitution).

Popular tribunal: purpose was to recognize that the gov't has ratified international conventions but now what? Three key issues were identified to address in the tribunal: 1) maternal health, 2) GBV, 3) house girls.

All of these issues directly affect the health of women and girls. Gov't is willing to address these issues but there is no action. The tribunal resulted in a list of demands, a review of the status of each issue in terms of what needs to be done and the challenges and issues as well as a way forward.

How did this work? Identified 11 organizations working with women and health rights, judicial representatives who sat as judges and supported the creation of test cases, debate around changing laws and witnesses came to testify. The tribunal lasted 3 days and each issue had one day assigned to it. The event was held in November 2007.

It was a very successful event. People would like to do it again. WD is currently in discussion about how to do it this coming year. It has been suggested that it should be witnessed by politicians/MP's to see and hear what is happening. Organizing was also a challenge – still identifying organizations to work with this year.

Strategic partnerships department is linking with policy-makers to share findings and research. WD has also shifted to budget advocacy/analysis. For example, the Gov't has committed to "free healthcare" for selected groups (i.e. pregnant women) and WD is trying to hold gov't accountable. The research is focusing on the "hidden costs" of accessing health care for these groups. This situation is also putting health workers in a difficult position as they are in a situation where they do not have the skills, resources and drugs to properly deliver care.

Budget analysis is conducted for MH as well as for general health budgeting which is then shared with MP's. The response of gov't is mostly positive. WD has a very good under-

standing/relationship with MoH as well as MP's. WD is also active in Policy Forum, FemAct, Health Equity Group and WRA to name a few alliances.

Challenges of working with gov't include the ssue of access to information. Can be challenging to access draft budgets (whether public or not). For example, they received the last budget too late to conduct an analysis so there was no space for contribution by CSO's. This makes it difficult to engage as a CSO. There needs to be a more transparent process where CSO's could provide input. It is difficult to effect change after process is completed. There is a need to be involved from the very beginning.

In terms of opportunities there is a very strong voice of CSO's currently in TZ. Gov't is more willing to collaborate – however there is the danger of gov't just wanting the "rubber stamp of CSO's without actually taking seriously their involvement.

Why are CSO's stronger? Recognition that the only positive development comes from a struggle. There is a need to face issues and challenges head on, call a spade a spade and deal with the problems at hand.

Gov't has previously seen CSO's as enemies. For example, Haki Elimu used very powerful advocacy messages and the gov't tried to ban them.

Is one strategy more effective than others? Festa thinks the gov'ts reaction is unpredictable – different strategies have unpredictable results.

Women's movement in TZ? FemAct is a feminist organization however it has been less active lately. This may be because of the shifting leadership which has affected the work of the coalition. Health Equity is also a feminist organization.

In terms of work on budget analysis, the focus previously was on getting women with fistula free treatment. The gov't responded positively and is now working on providing free treatment. Now WD is looking at budget analysis more generally and is collaborating with other organizations who are experts in this area. IBP provides TA to WD which includes identifying opportunities for learning and how tools can be applied to the TZ context. Festa recently attended a training in Kenya.

A result of this work is now a shift to budget analysis of MH spending to prevent women from developing fistulas. This issue is so big there was a need to narrow down one component which they chose as delivery kits. Created a budget for free delivery kits - what goes in it, the cost and number required as analysis. The findings were that it is within the capacity of the gov't to provide this to all women in TZ. They shared this finding at the Women Deliver conference.

Members of staff also attend international fistula meetings and a member of Health Equity attended global partnership for maternal health meeting in the U.S.

Decentralization? WD works at the national level to do advocacy work but there is now a shift to do advocacy and budget analysis at the district level. WD is starting with one district this year to understand the process of the CCHP. Who is participating in planning, decision-making, providing money for MH?

WD selected Singida to understand how plan is developed and understand process as well as conduct analysis. They have already identified lots of opportunities to do analysis and hold govt accountable. For example, if a dispensary is identified in a plan to be built – what is the plan? Who is the contractor? How is it progressing? What is the participation of village level officials with district health planning (i.e. budgeting)?

Also working at district level to use a scorecard process to learn about how the community sees issues and CHMT's see issues. This is an empowerment model for the community members involved.

Decentralization has created more opportunities for orgs as well as the involvement of local community members in participating in and holding accountable health systems.

For example, a chairman of a village came up with the idea of creating a local emergency fund to transport women to the hospital. Local level officials have an understanding of the needs of the community.

In terms of engagement with rural communities outside of research? Dissemination/public engagement plan identifies different districts to work in. Currently WD has identified 12 districts to disseminate information/research findings in. This is carried out through a photo exhibit that highlights the issues women face (i.e. lack of transport, health facilities etc.). Also show film called "Dead Mum's Don't Cry" a Chad-based film that shows the difficulties that women and health workers face. The situation is very similar to the TZ context and after the film is shown there is a discussion and many people share their own similar stories. Feedback meetings are also held to discuss action with district officials and health workers.

WD receives pool funding from various donors.

Role of PMNCH/Deliver Now campaign? Not sure but thinks that the MoH is coordinating this. There are many coalitions and partnerships popping up and it is unclear how to identify who to work with and how.

WD is working on organizing a tripartite meeting with gov't, health workers and community to share and discuss issues related to MH (as opposed to various actors meeting separately). They are trying to involve Ms. Mongella (TZ MP and Pres of Pan African Parliament) to hold meeting in the lake region with health workers as organizers.

Name	Organization	Date
Dr. Theopista John	World Health Organization	12/08/08

Interview Questions – World Health Organization

1. Can you describe briefly the work or programs that the WHO is involved in related to reproductive health and reducing maternal mortality? Is the WHO coordinating/funding the PMNCH/Deliver Now campaign?

2. How does the WHO work with the Government on these issues? At what levels?

3. How does decentralization affect your work with the Government – does it provide opportunities/challenges?

4. How would you describe your relationship with the Government on the issue of safe motherhood?

5. There has been an increase in using the language of "rights" and linking with safe motherhood and reproductive health. The WHO also uses the language of rights in its definition of reproductive health adopted at the ICPD conference. How do you *use* rights in your work in Tanzania and with whom? Do you see more opportunities or challenges with using "rights"? Are other organizations using rights on this issue?

6. Do you work with civil society organizations in your work? If so, how?

7. What role do you see civil society organizations playing in Tanzania on the issue of safe motherhood and reproductive health rights?

8. Do you see political mobilization as an important component of safe motherhood work? In what way? Is the WHO involved in this?

9. How does the WHO in Tanzania decide on its priority issues in Tanzania?

10. Does the WHO engage directly with rural women on reproductive health issues if so, how?

Interview Notes:

The PMNCH is not a WHO initiative; it is part of a global agenda and emerged from the various existing partnerships merging in 2005 at the global level. At this time there was a focus on maternal and newborn and child health in an attempt to put the health of these groups back on the world health agenda because of very little progress.

Since launch of report in New Delhi the "Road Map" was developed to address continuum of care.

The PMNCH secretariat is located in Geneva at the WHO office. Many constituents involved including UN agencies, bilateral donors/development partners as well as academic/research partners and NGO's (mostly international orgs).

The WHO in Tanzania was requested to establish a TZ partnership with a national agenda which is coordinated by the MoH. The WHO provides TA to MoH. The role of the partnership is to do advocacy and provide TA.

The WHO is supporting the Ministry with TA, developing guidelines, building capacity and conducting research. WHO contributed to the development of the Roadmap (with other partners).

In 2003/2004 a meeting with the Reproductive Health task force for the African Region looked at RH/MM issues within the region and the WHO/UNFPA were tasked to develop a framework for countries to achieve MDG 4 & 5. In 2004 the framework was developed and shared with countries – the Ministries of Health and the AU approved and agreed to implement (which includes roadmap). This is the background to the Road Map.

The "Road Map" was developed to address the issue of continuum of care for MNCH and has been revised and adopted.

NGO's need to organize themselves, there is space for them – how do they interact with their target audiences? They need to be focused and provide information – we are not talking at the same level. (Had not heard of the Health Equity Group or seen their flier).

Decentralization? Opportunities exist but so do challenges. National level plays the role of developing and adopting good policies, these are to flow down but then capacity building of the districts is also required for districts to implement. Money does not address main issues.

NGO's work at the district level however district level interaction does not always go smoothly.

WHO mandated to develop tools and guidelines – therefore only if there is particular testing/research does the WHO work at the district level. However they are focusing on intensifying support to a few districts as part of an EU/WHO partnership.

Rights? Uses rights, an area which Dr. John likes very much. Advocating for human rights and health is critical in her work, also provides focus on most vulnerable groups. Rights are critical.

CRC is coordinated through UNICEF and CEDAW is coordinated by the MoWC. There is a gap in the capacity of the government - to report timely is the main challenge. The WHO is part of Human Rights action and works with the government to report. NGO's have not approached the WHO to work on shadow report. Main focus on rights is with government and NGO's.

The WHO provides TA to NGO's. WRATZ and WD have worked with the WHO as well as various professional associations whom WHO has provided financial/technical support to.

There is a gap between advocacy and implementation/service delivery – what is the solution? Should NGO's be doing advocacy?

Partnership is currently not running very well. Each constituent can play its role but there are limited resources – WHO is not supposed to be supporting the PMNCH but they need to do so to see action. Policy dialogue/advocacy is needed to ensure that $ is directed to where it's needed.

Commitment of the government has grown – the critical issue is of human resources. This is a key issue that needs to be addressed and is the main challenge. There has been however, a tremendous achievement in terms of improvement of $ available for MNCH.

Human rights approach is 2 pronged (duty bearers and rights holders) and is a critical approach. Unfortunately, people are not meeting obligations – not demanding for or providing for rights. Advocacy is needed to improve the system.

Service may exist but if people are not informed then what? Work needs to be done to educate/inform that this is a women's right. Need to change through education campaigns.

The WHO global agenda is translated into national context, while at the same time the country strategy/programming must respond to country level priorities. Therefore, there is a merging in developing the strategic plan.

The WHO is made up of the world health assembly that is representative of all MoH's and therefore there is an element of responsiveness to country priority issues. The WHO collaborates with gov't to develop country cooperation strategy, planning and prioritizing with government bi-enniu (every 2 years).

Name	Organization	Date
Rose Mlay	White Ribbon Alliance Tanzania	28/07/08

Interview Questions – WRATZ

1. Can you describe briefly the work or programs that your organization is involved in related to reproductive health rights and reducing maternal mortality in Tanzania?

2. How was the WRA established in Tanzania?

3. What do you see as root causes of maternal mortality in Tanzania?

4. Do you use the language of "rights" in your work? If so, how and with whom?

5. Do you facilitate or support political mobilization of women in your work around issues related to reproductive health? If so, how?

6. Is political mobilization a priority for your work?

7. What do you see are the opportunities and challenges to political mobilization in Tanzania?

8. Do you see a women's movement in Tanzania? If so, how would you describe it?

9. WRA is present in a number of countries in Africa and worldwide. Do you integrate information between countries? How?

10. How are priority issues for WRA in Tanzania decided upon? Are these different from other countries' priority issues?

11. Do you participate in conferences and meetings of coalitions/networks *outside* of Africa (what some may call "transnational women's organizations")? If so, how do you integrate information collected at these meetings into your work in Tanzania?

12. Do you also share information about the issues you work on in Tanzania at these meetings? If so, how?

13. Do you work with the Government in Tanzania? At what levels and how? How do you see your relationship with regard to your work on reproductive health?

14. Do you engage directly with rural women on reproductive health issues? How?

Interview Notes:

WRATZ was launched in 2004 and Rose started as the Coordinator in 2005. Previously she was teaching at the University in the nurse/midwifery degree course.

WRATZ was established because of the high numbers of MM. Everyday over 24 women die so it was seen as a good thing to advocate for MNCH. Also as a woman, a nurse midwife, she knows how difficult it is to predict complications. Most deaths are preventable if there are skilled health workers present at delivery.

Rose attended a conference in India where she learned about the WRA. She came back from India in 2002 and started informal meetings with others in TZ about starting up an alliance. Another colleague also attended a conference in SA regarding the WRA who also returned and started to work with Rose on developing an alliance in TZ.

In 2004, they asked the first lady to launch WRATZ with the MoH. 5 core people were involved in the launch in collaboration with the MoH. They needed a "parent ministry" to formally invite the first lady.

The WRA works with the gov't but not as part of it as it is an advocacy organization. Seed money for the launch came from WRA globally. Member organization – CARE hosted the coordinator for year one and now is hosted by JHPIEGO. Salary for coordinator comes from ACCESS, a USAID project.

Most of the activities are completed by core committee volunteers. Advocacy was the main task of 2006 – launch campaign advocating for qualified # of health workers.
One success was the gov't agreed to employ all qualified health workers in TZ. There had previously been a freeze on hiring vis a vis the SAP.

Launched home based life saving skills campaign in 2007. This campaign involves encouraging women to give birth at facilities and to be able to do things at home to prevent complications and to encourage rushing to hospital in case of problems.

This year the WRA had a rally on WRD to stop MM and the President attended.

The WRA works with members to train advocates in order to influence changes. Coordinator also works to build membership. They started with 13 members and now have 900 member organizations (though not all active).

There are direct and indirect causes of MM: indirect causes include: lack of skilled birth attendants (major factor) which is shaped by distance/poor infrastructure/no $ to go to hospitals/gross shortage of health care providers. The issue of poor infrastructure in rural areas also influences lack of health providers in areas.

Issue of "qualified" health providers present for every birth would drastically decrease MM.

WRA uses a RBA to advocacy efforts. Safe motherhood is seen as a right of urban and rural women. WRA uses "rights" in campaigns both with the gov't and in speeches.

Some people think that TBA's should assist with births. WRA takes the position that these are not qualified health providers. This is also an HIV/AIDS era so there is the issue of transmission. It is not fair to leave women to give birth in homes where there is no light, water and no qualified health provider. Women in TZ have equal rights to access skilled health personnel.

White Ribbon Day – involves political mobilization. It is to commemorate all women who died and reflect and strategize on how to prevent MM. In 2006 it was held in DSM, in 2007 in Morogoro, in 2008 in DSM and next year it will be in a rural community near Lake Tanganyika.

Relationship with gov't? There is an opportunity for open discussion and open space as WRA is an NGO and not affiliated with the gov't or the UN. WRA can say whatever they want the gov't to do. Because leaders attend campaign days WRA can use speeches/statements to hold leaders accountable.

Opportunities to political mobilization? Many members all over the region, so when WRA does an activity they can use their network from across the country. The WRA has the advantage of working together as one force, as an alliance which is powerful.

Challenges to political mobilization? Advocating for the big elephant in the room. There are so many issues attached to issue of health worker shortage, budget as well, at all levels budgeting is needed to save women's lives but people are poor. It is difficult for people to save 200 TSH per month for 9 months. This money can help women with accessing health services. Trying to have people save but poverty is key barrier. There is a need to prioritize budgeting at district level.

Decentralization requires shift to district and work with PMOLRG to encourage prioritization of MH – but on what?! There is a need to be informed on how to prioritize.

Experience of involving district council and in turn they worked with village leaders which influenced posting of clinical officer at clinic. This was achieved through a letter written to families in the village encouraging women to go to clinic (even though there was no qualified attendant which pressured officials to place someone qualified there).

Advocacy work at both national and local levels. Still need to work with communities on demand side. There needs to be an increase in demand to hold gov't accountable otherwise the situation stays the same.

Women's movement? TGNP is promoting a women's movement. WRA is a grassroots movement for safe motherhood that inspires action.

Regional meetings convened by IWRA in Malawi and there was an international meeting in SA. Currently trying to formulate way of working together – all issues are decided at national level by members. Core committee meets 4 x year or as frequently as possible.

International forums provide opportunity for sharing and testimonies such as the Women Deliver conference. For example the issue of TBA was presented as a human rights issue which provides a new tool/strategy for their advocacy. The conference also presented the idea that development=the needs of all pregnant women being met (because of the many issues involved). This was a powerful and new way of looking at the issue of MM. It is also helpful to participate in forum to share experiences and successes and challenges between regional coordinators. Such as ways in which campaigns are carried out – use of media, drama, global ambassadors. WRA TZ has recruited famous singer to sing about MM. Share strategies in ways to carry messages forward.

Relationship with gov't? Very receptive, work together with core committee members and the department of MCH & RHS were involved in the launch of WRA. Need good working relationship with gov't to do effective advocacy. The gov't knows WRA is here for a good cause.

Sometimes they ask the MoH to sign letters instead of WRA. WRA assists gov't, shares information and also provides opportunity to advocate on issues on behalf of gov't reps who may not be able to do so within their official capacities.

However, their advocacy packages are grassroots. They also work with Tanzania Midwives Association who have a staff person at Muhimbili Hospital.

Name	Organization	Date
Christine Mwanukuzi-Kwayu	UNFPA	17/07/08
Dr. Chilanga Asmani	UNFPA	17/07/08

Interview Questions – UNFPA

1. Can you describe briefly the work or programs that your organization is involved in including reducing maternal mortality in Tanzania?

2. At what levels do you work with the Government?

3. Do you work with NGO's in your work? If so, in what way?

4. How are priority issues addressed by UNFPA's programmes/policy support in Tanzania decided?

5. What do you see, from your own experience working in Tanzania as the root causes of maternal mortality? Gender inequality?

6. Do you use the language of "rights" in your work? If so, how and with who? For how long and why have you chosen to do so?

7. Do you "mobilize" women in your work? How? How would you define mobilization? Is this a priority for your work? What do you see are the opportunities and challenges to mobilization of women in Tanzania? Do you see this happening in Tanzania around issues related to reproductive health? By who?

8. I assume that you (and other staff of UNFPA) travel outside of Tanzania to attend conferences, meetings of coalitions/networks or what some may call "transnational women's organizations"? If so, how do you integrate information collected at these meetings into your work in Tanzania? Do you find this helpful? Do you share information about the issues you work on in Tanzania? How?

9. How do you see your relationship with the Government with regard to your work on gender equity issues/reproductive health?

10. Do you engage with rural women on these issues? If so, how? In your experience, how do you think women from rural areas (if you could generalize) see the issue of Maternal Mortality? Does this impact your work?

11. Do you have any program documents specific to Tanzania that you could share with me?

Interview Notes

Christine Mwanukuzi-Kwayu, National Programme Officer: Gender

UNFPA Tanzania was previously working with NGO's in an ad-hoc fashion and only on campaigns focused on one day and issue. This is now the second year working with TGNP on GBV and the Gender Budget Initiative. UNFPA is also working with REPOA on capacity building of Government as well the National Family Planning Association (UMATI) and Tanzania Midwives Association.

UNFPA previously worked with the Government to provide financial support and they managed programs.

Now UNFPA provides financial support to NGO's which work on issues that connect with UNFPA's 4 year country program linked with the UN Agency Framework on:

1) Gender
2) Population & Development
3) Reproductive Health

In terms of Government they work with Ministry level only – the Ministry of Gender. Finance & Health. The UNFPA country program is linked with the national priorities of the gov't. All UN agencies link mandate and national program as well as international treaties that have been ratified.

What is a "root" cause? Simple answer could include poverty, different cultures, attitudes, relationships between men and women and between women (i.e. older generation and younger generation). For example the process of getting from home to a hospital for delivery may involve decisions of husbands and mothers-in-law.

Women cannot speak on issues that concern them, there exist economic constraints – money is required to take women to the hospital, attitude in Tanzania is that pregnancy is not a disease, a "god-willing" belief and attitude that pregnant women still have hands to work with.

Distance from health centers, time to reach health facilities, when they arrive no one is there or if they are there, they do not have the proper skills or facilities.

UNFPA works from an RBA and uses rights in their work with NGO's linking reproductive health and rights as well as monitoring and reporting. Legal human rights centre included reproductive rights in their annual human rights report. UNFPA also implemented training on RBA for partners including gov't. The Ministry of Gender also uses some language of rights (only gov't ministry to do so).

In terms of conceptual/theoretical aspect of using rights this is new however it has always been there in community development and gender work.

If speaking about political mobilization there is not much activism in Tanzania. TGNP talks much about activism and feminism. There are opportunities for this, especially now that people can speak their mind with regard to political freedom.

Does not travel much outside of Tanzania.

UNFPA has a good relationship with gov't. There are lots of challenges with gender issues though wherever you are. UNFPA tries to play a neutral role between NGO's and Gov't. The Gov't is responsive but it depends on the issues. In her experience the Gov't has been very responsive to MMR strategies.

Dr. Chilanga Asmani, National Programme Officer – HIV/AIDS:

The reproductive health component of work is a multi-sectoral approach which focuses on the health sector itself as well as on broader issues beyond the health sector.

From 2004-2005 UNFPA changed approach to a sector-wide approach. This was an attempt to harmonize work of actors in the health sector and develop a framework in order not to overlap on programs. This also involved a shift with working with the MOH, instead of working with reproductive health department to pooling money in basket fund. This provides UNFPA opportunity to participate in planning and monitoring and policy-making as well as provide TA. MMR is a priority of the gov't.

One of the challenges of the health sector is that national strategies and plans have to be implemented into actions at the district level. There are some allocation criteria in light of decentralization however, how is this translated? The challenge is that the district officials are on the ground and should be able to prioritize and often they do, but challenge is on HOW the money is spent with respect to MMR.

We try to make the planning process bottom-up but still challenges exist with operationalizing. For example, there is a challenge of collecting data with the decentralized system. National Ministry is now responsible for planning and this feeds into to regional health teams but there is a capacity issue. How can they see if interventions are being implemented if there is not appropriate data collection? The idea behind decentralization is to strengthen the health system and UNFPA has been looking at general health system strengthening through influencing policy and programming.

Building a system is more sustainable but also takes time. There are also barriers such as political will, $, time etc. However, the idea is to reduce dependency.

UNFPA is also engaged with NGO's which provides an added advantage of working with those on the ground and can help to increase demand and identify the issues on the demand side. NGO's are helpful in identifying the issues at the community level.

One intervention was with the Tanzania Midwives Association. The intervention was to strengthen the association itself, build its capacity to advocate for issues such as MH. UNFPA has been working with them for two years and they are a good source to feed issues from the ground.

Another NGO they work with is UMATI which looks at male involvement with reproductive health to increase MH.

UN partnership with different agencies to address MH in Tanzania including ILO which looks at working conditions for mothers, including current social, cultural research in Dodoma on why people seek maternal care/services to highlight other issues. Aim is to provide evidence to

highlight issues at higher levels as well as build on expertise of various agencies and partners/stakeholders.

UN programming is from a RBA and includes disaggregated data to focus on most vulnerable and develop interventions aimed at particular populations and working with NGO's to hear from the most vulnerable. For example, gender issues such as household dynamics influence family planning access and highlight human rights perspective. Also, why is MH a constant problem? Advocate for national processes to address wider issues related to MH.

Challenge of different understandings and ideas about how rights are used by different agencies. Certain aspects are constant but it can be difficult to integrate theoretical component. Challenging to implement RBA.

Role of UNFPA is not direct implementation. There is an assumption that NGO's provide perspective of most vulnerable. UNFPA focuses on supporting Govt and NGO's. Need to ensure that research conducted by these groups looks at various groups/regions and that is one way in which UNFPA influences partners.

Try to be bottom-up but sometimes UN agencies get too caught up at high/national level.

Name	Organization	Date
Irenei Kiria	Youth Action Volunteers	18/07/08

Interview Questions – YAV

1. Can you describe briefly the work or programs that your organization is involved in related to reproductive health or specifically reducing maternal mortality in Tanzania?

2. Why did your organization decide to focus on these issues?

3. What do you see as the root causes of maternal mortality lack of access to reproductive health services?

4. You use the language of "rights" in your mission and mandate. For how long and why have you chosen to use rights?

5. How do you see political mobilization around health issues in Tanzania? Do you "mobilize" young women in your work? How? If so, how? Is this a priority for your work? What do you see are the opportunities and challenges to mobilization?

6. Do you (and/or members of your organization) travel outside of Tanzania for your work? For example, to attend conferences, meetings of coalitions/networks. If so, how do you integrate information collected at these meetings into your work in Tanzania? Do you find this helpful? Do you share information about the issues you work on in Tanzania? How?

7. Do you work with the Government? At what levels and how? How do you see your relationship with regard to your work on reproductive health/access to healthcare?

8. Do you work with other NGO's on the issue of reproductive health? In what ways? What do you see the role of NGO's in improving access to reproductive health services and reducing maternal mortality?

9. Do you engage with rural women/female youth on these issues? How? In your experience, how do you think they see the issue of Maternal Mortality? Does this impact your work?

10. Is there something that you think I should have asked that I didn't?

Interview Notes:

YAV started off as a very small organization focused on HIV/AIDS awareness in one district in DSM. This work continued until 2004. They realized they could do more and have a greater impact if they looked at the issues that face youth and the broader community and position the organization to improve the health status of Tanzanians. This shift involved a year long process in 2005 of consultation, reviewing policies and talking to stakeholders. This resulted in a new focus on governance and policy formulation in the health sector.

New mandate addresses issue of resources being directed to the health sector in Tanzania but management of these resources is weak, need to focus on improving sector. Also work on increasing the participation of citizens in making plans, influencing policy and monitoring and holding accountable those in power.

National level: YAV works with MOH, MOF and PMOLRG as well as Parliament. YAV works at various levels, at the national level they look at the budget, formulation of national policies, participate in policy/legislation development, citizen participation and budget analysis.

District level: 4 focal districts, however, the same systems exist countrywide so they share process/learning/materials with other districts. Similar process as national level: working to encourage citizen participation, space for citizens to lodge complaints etc.

This is accomplished through youth volunteers in each district (20 x 3 and 10 x 1). There are 70 volunteers in total.

Some interventions involve working with community members. For example, school clubs are used to educate youth about health systems/structures and the status of health in the community with the assumption that the youth will share this information with their family.

Volunteers also work with administrative structures to disseminate information from YAV and to follow-up on health service delivery plans and supply issues.

To be honest, this has not been a friendly engagement. Those in power have not wanted to be followed-up on, to be questioned.

YAV also runs a radio programme across Tanzania which provides a forum for sharing issues across districts.

Decentralization a barrier or opportunity? If people became aware of their rights it would not be a problem, but if people are not aware of their rights it is difficult to hold service providers accountable. As well, service providers know nothing about health sector reform. Some people have been in the system for so long they are resistant to change and keep their own beliefs. Decentralization is an opportunity and challenge. Some service providers do not like reform, and do not inform about rights and provide access to information.

YAV will change its name to reflect new activities, but it is not decided yet. The switch to using rights and focusing on health system is to address wider issues than specifically HIV/AIDS such as the misuse of funds and bad/non-implemented policies that contribute to HIV/AIDS problem in Tanzania.

Root causes of MM – political will on many levels. Health is highly politicized – there are many plans and commitments however, nothing changes on the ground.

Access is another key issue. In 1994 a policy was adopted to provide free access to services to all pregnant women. The TZ constitution also includes the right to life. There are many statements, plans etc. Yet access is simple, to provide medicine, health workers, infrastructure which is not there.

Participated in health budget analysis and money for MH is missing from the current health budget even though the national Road Map plan outlines what should happen and the budget

required. YAV continues to keep asking questions in Parliament yet the answers are always political, year after year.

For example, a woman died in hospital on June 1, 2008 in DSM and when relatives complained, the media was involved and CSO's were mobilized. The gov't denied negligence and YAV requested an independent inquiry. Instead the regional commissioner for DSM set up a commission with no transparent terms of reference, no details on how the commission would operate etc. When the report was released it was instead a press release and when asked if there was a complete report the answer was no. YAV asked why this commission was formed without transparency and participation. Commissioner said he was entitled to do things his way and that YAV could make their own report. YAV alerted Parliament however they received another political response. The CSO group is currently waiting for an answer from the regional commission.

The issues include:

- ✓ The way the commission was set-up.
- ✓ Mwanymala Hospital where woman died received 174,000,000 TSH from MOH and 210,000,000 from the district earmarked for drugs. Where did this money go? The hospital should provide report. Furthermore, if they ran out of drugs they should have done something about it.

One of the reasons stated for her death was lack of a cheap medicine which was available at dispensaries around the hospital. The family was asked to purchase the drug for the woman which is a violation of the 1994 policy.

Need to work harder in Tanzania to increase political mobilization on all issues. This is in part because of historical reasons – a single party system which discouraged citizen participation and was characterized by a closed political environment. Things are starting in this direction, and this is the direction that CSO's are pushing. This is not something citizens feel – they do not take steps or action to challenge gov't. Though there are a few isolated examples in DSM where there have been some success stories and where citizens have managed to hold leaders accountable.

Irenei does some travel but they have to be very careful about what meetings/conferences they attend. For example, they are linked with the Centre for Social Accountability in SA. They are using their model and are the first group to pre-test this social accountability system.

They also work with the International Budget Project (IBP) in Washington. This is a group that supports organizations to monitor budgets. These are alliances that they have created with organizations with similar interests.

YAV is a member of WRA however not an active member. YAV is a Tanzanian organization run by Tanzanians for Tanzanians. YAV does not want to be driven by political issues, it has highly dictated activities and half of the message are crediting USAID.

YAV does participate in international conferences, need to be sure that interventions are appropriate. For example, YAV attended the Women Deliver conference however they were disappointed that it was just a meeting. (Women Deliver office has been set up in TZ). There was a follow-up meeting in DSM where the President said he would ensure that 15% of budget to health. However, currently only 11% of the budget is allocated to health.

Road Map for MM Reduction is missing from Health Budget.

Community members are fully aware that pregnant women need care in the situations they are in. The problem is with the health system structure, which has also been aired all over Sub-Saharan Africa. Health systems key and first problem – culture not the first issue. Access would prevent decisions over money and transport being an issue for women.

Appendix II – Focus Group Discussion Questions

Introduction: We have asked you to speak with us today because we are interested in your thoughts and experiences on access to reproductive health care in your community. We are not representing a specific project but rather we are collecting information about the issue of maternal mortality in Tanzania on behalf of TYC. We are very appreciative if you would spend an hour with us speaking freely about your thoughts and experiences as we feel that Tanzanian women's experiences and ideas are important and valuable to our research. We can only offer you a soda for speaking with us today. The information we collect will not include your names and is confidential so we hope you can feel free to speak openly.

(Please note that the highlighted questions were requested to be added by TYC).

Maternal Health:

1. How many children do you have?
2. How old were you when you had your first child? If in school, did you have to leave school?
3. Where did you give birth?
4. If at home, who assisted you? Why did you not go to a clinic?
5. How do you feel about childbirth?
6. Do you feel that women in your community have adequate health services for safe pregnancy and delivery? Why or why not?

Family Planning:

7. Did you plan in advance to get pregnant for each of your children?
8. Have you heard about family planning? If so, from where?
9. Are there challenges you face in deciding how many children you have?
10. What family planning methods are available in your community?
11. If you have used family planning were you happy with the methods available to you? If not, why?

FGM:

12. Have you heard of FGM? If so, how do you feel about it?

Entitlements/Challenges & Solutions:

13. Imagine you were the District Health Officer and you had all the money you could possibly need, would you change anything about the current system of health care for pregnant women? If so, what would you change? (List Problems)

14. Why do you think the problems you identified exist? (Problem Tree) Just like a tree needs rain and earth to grow, problems have root causes as well. What do you think causes the problems you have identified?

15. How do you deal with these challenges?

16. Is there anything that you think is missing on this tree?

Rights:

17. Have you heard of "rights"? If so, what does it mean to you?

Participation:

18. Have people from NGO's talked to you about these issues before? Do they provide support to you? If so, how?

19. Do District Health Officials talk to you about these issues?

20. Of all health issues – how important is reproductive health to you? Very important? Somewhat important? No feeling? Not important?

Appendix III – Transcribed and Translated Focus Group Discussions

Focus Group Discussion 1:

Location: Buigiri Village - Chamwino district
Date: July 23, 2008
Number of Women: 11

QN: How many children do you have?

ANS: 4, 2,3,2,1, 2, 2, 2

QN: How old were you when you had your first child?

ANS: 18, 18, 18, 18, 20, 18, 32, 25, 18, 18

QN: Why have so many of you had children at age 18? Is there any tradition or cultural value that leads women to having their 1st child around 18 years of age?

ANS: It is because we go through school until we complete standard seven.

QN: Where did you give birth? (Your first born, 2nd, third, etc).

ANS: My 1st born in the hospital, it's this one (*pointing to a girl on the bed in dispensary)*

ANS: Laughter!!

QN: So you mean you have a grandchild?

(Note: *the one said to be her 1st born was lying on the bed, as she was in the dispensary due to a miscarriage. She also had a baby at home as the miscarriage was from the second pregnancy*)

ANS: Oh yes, I have a grandchild we two (pointing to a fellow) have grandchildren.

ALL: Laugher!!

(Woman continues …) I had my first born in 1988, she is now 20 (see here lying on a bed) she has a child at home and she was expecting second one but she unfortunately had a miscarriage.

QN: How long was the pregnancy?

ANS: Three months

QN: Well, how about you? Where did you give birth?

ANS: *Another respondent* - Hospital

ANS: *Another respondent* - Dispensary

ANS: *Another respondent* - dispensary

ANS: *Another respondent* -Here (dispensary)

ANS: *Another respondent* -Here (dispensary)

ANS: *Another respondent* -Here (dispensary)

ANS: *Another respondent* -Here (dispensary)

QN: How do you feel about child birth? Just give me your experience, tell me anything you want to share with me about child birth.

ANS: I had labour pains for 5 days. The fifth day I was brought here and I delivered.

QN: What do you think was the problem?

ANS: Mh! I don't know

QN: Had your due date passed or was it someday before?

ANS: My due date had passed.

ANS: *Another respondent* - My experience, was that all babies were delivered at the hospital (a total of four). However for the third and fourth ones we were taken to the regional hospital.

QN: What complications did you have?

ANS: The placenta wouldn't come out so I was taken there to remove it. In my fifth pregnancy, I delivered in the sixth month and the baby was not completely developed and died. After that I decided to have my tubes tied.

ANS *Another respondent* - My deliveries were safe and I come here for services.

QN: Do you wait until you feel your labour pain before arranging for hospital or you just go ahead?

ANS: I do wait until I feel something.

QN: Is your place far from her?

ANS: No it's just nearby.

QN: Do women feel they have adequate heath services.

ANS: We are fine! No problem.

QN: Generally, do you see anything as a problem related to services that you would suggest for changes?

ANS: No problems.

QN: How about if someone has complications and needs to be taken to Regional hospital do you experience transport problems?

ANS: If that happens, they (heath workers) call the ambulance from Chamwino hospital (Health centre) and it comes just in time!

Another respondent - sometimes they use transport from the blind school in case the ambulance is not available.

QN: Blind school?

ANS: Yes, Buigiri School for the Blind.

QN: Oh! Ok! The school for the blind that is in this village?

ANS: Yes, laughing.

QN: OK so you think your health needs are satisfactorily meet?

ANS: Yes.

QN: Any other problems? Can anyone tell us?

ALL: Silence.

QN: How about the way the health providers treat you?

ANS: We don't have complaints on that

QN: Well you all seem to have adequate information about health services and you are satisfied with the services here. Does anybody have anything to add in that discussion before we move on?

ANS: Oh yes normally the first baby should be delivered at the hospital the 2nd 3rd and 4th may be delivered at home but for the fifth onwards you also need to go to hospital.

QN: Why do you have to go to the hospital for the 1st delivery and the 5th and on for delivery?

ANS: Because with the 1st delivery there may be complications: the path for instance might be too narrow.

QN: And for the fifth onwards what is the problem?

ANS: Imagine the "path" enlarged as you go on, it takes strength to push which is reduced because you are no longer young and strong. At the hospital they can take care if you fail to push a baby out.

ALL: Laughter!!!

QN: Do you practice family planning?

ALL: Laughter!!

QN: Why do you laugh?

QN: Give me your experience. Sister there! Have ever planned in advance?

ALL: Laughter!!

QN: Ok, let's go one by one. Do you plan to have children or it just happens?

ANS: I don't plan.

ANS: *Another respondent* – (laughing) I don't.

ANS: *Another respondent* – No.

ANS: *Another respondent* – We only go forward to conceive and give birth, I don't plan.

ANS *Another respondent* – I do plan.

QN: Enhe! Can you explain to us? How do you go about this?

ANS: For instance if I don't want to conceive, I use preventive methods, and when I want to conceive I stop using the methods.

QN: OK, who advised you on the methods? I *mean* how did you come to know about family planning?

ANS: Here in the dispensary.

QN: How did you know that you needed to use one method and not another?

ANS: They (the nurses) advise you about all methods then you choose which one you would like. If after a time you find it gives you problems you come again here and they advise you to change.

Facilitator: Thanks very much.

QN: Well, who else does plan for her children?

ALL: Silence.

QN: Please tell me, who else here uses family planning methods? Has anyone of you decided that she does not want to conceive at a certain period and succeeded not to conceive?

ANS: Yes we do, but it happens that we conceive.

QN: Do you use the family planning methods?

ANS: *Another respondent* - I have not yet used.

QN: Do you know the different Family Planning Methods?

ANS: Yes, I do know them

QN: Enhe! Who else knows?

(Note: All participants raised their hands that they know the FP methods)

QN: Ok, so you know the methods but only very few here tried to use them.

ANS: Yes!

QN: Can you mention the methods you know?

(Note: The following were mentioned)

1. Vitanzi (IUD)
2. Vijiti (Implants)
3. Condoms (*people laugh as condom is mentioned*)
4. Pills
5. Injection

QN: Why laughing about condoms?

ALL: Laughing!!

QN: Has anyone used condoms here?

ANS: Men don't like condoms.

QN: OK, but do you know there are female condoms?

(Note: 8 people said yes)

QN: Who have ever used the female condom?

ANS: I have used *(*one respondent).

QN: Did your partner know that you have it?

ANS: Yes.

QN: Did you reach agreement to use it, or you just decided by yourself?

ANS: We agreed to use.

QN: Suppose you don't agree and use it, can men know that you have a condom?

ANS: Yes, he can know.

All: Laughter!

QN: How about other methods - do men know when you use other methods?

QN: They may know if you want them to, BUT if you don't want him to know you can you use any other method without his knowledge.

ANS: If he wants 10 children while you want 4 and he doesn't seem to understand, you don't need to quarrel. You can choose a method other than condom and go ahead.

ALL: Laughter!

QN: Where did you hear about family planning?

ANS: Here at the dispensary, every time we come for clinics they first educate us on family planning.

QN: Are there challenges you face in deciding how many children you want to have?

ANS: Husbands/ life partners don't like the family planning methods, they want us to go on and on getting children.

ANS: The major challenge is husband.

QN: What family planning methods are available here in the village/ community?

(Note: the following were mentioned)

1. Vitanzi (IUD)
2. Vijiti (Impants)
3. Pills
4. Injection

QN: To those who have used family planning, what methods have you used?

ANS: Injection.

QN: What are the positive sides and negative sides of this method to you?

ANS: No problem; I have always found them good, so I m happy to use it.

ANS: I have been using the pills.

QN: Enhe, any problems with the pills?

ANS: No problem at all.

ANS: I have been using pills but I developed complications so I stopped.

QN: What are those complications?

ANS: I have been getting my monthly circle more than I used to i.e. twice a month. I therefore decided to change to injections.

ANS: I have been using pills but would experience changes in my periods (more than once per month).

QN: Enhe, so you changed too?

ANS: I stopped completely, now I am pregnant

Facilitator: Well, so some of you have been using pills and experienced monthly circle changes so opted to change to injection, and vice versa.

QN: So guys; please tell me, are you happy with the family planning methods that you used before?

ANS: Yes, we are happy.

QN: Can someone tell me about the method she uses?

ANS: Yes here! I used injection for a month and changed to pills because injections brought up complications.

QN: What are the complications?

ANS: I have been "using" for a longer period

QN: Using…?

ANS: My Circles have been long!

ALL: Laughing!

Facilitator: OK, today I have learnt from you friends a new term -"using".

QN: Have you heard of FGM (Female Genital Mutilation)?

ANS: We all know that!

QN: Well, have all of you gone for FGD?

ANS: Yes (4 people).

ALL: Laughter!

Facilitator: Let me remind you guys, I went to school in this region, from grade 3 onwards and I also did my advanced level secondary devotion, here! In those times, every

girl and boy should go for circumcision, if your colleagues in school knew you had not gone for it there was stigma. Now friends, you who happened to live in those times (I may call you the old generation, or seniors!) what do you think? Was FGM good or bad?

ALL: Silence.

QN: OK, let me hear from one by one. So we have "new' generation and the former ones-seniors!

ALL: Laughter!

QN: Did you go for FGM? Whether a senior or new generation!

ALL: Laughter!

QN: Tell me, I want your opinions, was it a bad thing or should it be encouraged to be practiced?

ANS: No, it was not a good thing: it was harmful

QN: Do you all think so?

ANS: Yes.

QN: Let's hear from the ones who went for FGM. You have said it was a harmful practice, did it harm you in anyway that makes a difference from those who didn't go for FGM?

ANS: Mh! I think they (the new generation) also experience problems in delivery but it is not the same as those who went for FGM.

QN: What do you feel now about FGM? Do you regret that it was done to you?

ANS: No, we don't.

QN: New generation, please don't you think there are some good things you missed only because you were not taken for FGM?

ANS: No, we don't, we are happy that it is no more!

QN: Do you know Dr. Kongola? Imagine you were Dr Kongola or someone else with some decision-making power in the health system. OR imagine you were the advisor to Dr. Kongola (DMO) what would you advise him to change about the current system of health care for pregnant women?

(NOTE: TAPE RECORDING ENDED HERE)

Flip Chart Notes:

Current Challenges:

1. For the delivery of the first child we are advised to go to the district hospital but we would prefer to deliver nearby as it costs too much to travel.
2. Early age of childbearing (14 & 12) and girls are unable to take care of children.
3. Problem of child spacing.
4. Too many children.
5. Drinking pombe (alcohol) (the place where people sell goods often requires them to stay past dark but the men are drinking and the environment is not safe. Young people spend time there and mothers are not role models by going there).
6. HIV/AIDS

Causes of Problems:

1. Lack of basic needs, women cannot fulfill for herself.

Proposed Solutions:

1. Talk to daughters about these issues.
2. Parents try to engage in income generating activities to better their situation.
3. Advise young people to return from drinking spot regardless of whether they have sold all of their goods.
4. Mothers should not go there and be better role models.
5. Family should do the best they can to earn a living and accept what they have.

Focus Group Discussion 2:

Location: Chinangali I - Chamwino district
Date: July 24, 2008
Number of Women: 13

(Please note that questions one and two were asked at the end of the interview as more women joined the discussion late.)

QN: Where did you give birth to your children?

ANS: At home (one respondent).

QN: Who helped you?

ANS: Traditional birth attendant (TBA).

ANS: A*nother respondent* - First baby at home, the second at hospital and the 3rd at home.

QN: Why didn't you go to the hospital for 1st baby?

ANS: I had complications in the first pregnancy, so I was just helped by TBA at home.

ANS: *Another respondent* - The first child at hospital, the second at manchali dispensary, and the third at home.

QN: Why did you deliver your third child at home?

ANS: The labour pains were so quick that it didn't take very long before I delivered.

QN: Who helped you with delivery?

ANS: My mother.

QN: Is your mother a TBA?

ANS: No, she is just experienced but not a TBA.

ANS: *Another respondent* - First kid at home, the second at the dispensary.

QN: Why the first kid delivered at home?

ANS: I had labour pains in the night, around 3.00 am and I delivered early in the morning before we could go to the hospital.

ANS: *Another respondent* - I gave birth at the hospital.

QN: Why at the hospital?

ANS: I had complications.

QN: You said you had your first child in your 30's why was it that you were at this age?

ANS: I had problems with conceiving. I had been married for several years but could not conceive

ANS: *Another respondent* - The first at the hospital the second at home.

ANS: *Another respondent* - The first at the hospital, second one at home.

QN: Why the second baby at home?

ANS: It was also in the night.

QN: Who assisted you?

ANS: TBA.

ANS: *Another respondent* - The first at the Hospital, and the 2nd at home.

QN: Why at Home?

ANS: I had problems that the TBA couldn't manage.

QN: What was that problem?

ANS: The baby was coming out legs first.

QN: Is this a problem that the TBA would help best then in the hospital?

ANS: Yes.

QN: How did you know that the TBA would be best?

ANS: Because of my health problems.

QN: How did you know that the baby would come with legs first and therefore decide to go to TBA then to the hospital?

(Note: Everybody else is laughing and the respondent does not have an answer.)

QN: *Another respondent* - Where did you give birth auntie?

ANS: All of my children were delivered at home (4).

QN: Who helped?

ANS: Traditional birth attendants.

QN: Did you plan to give birth at home?

ANS: Yes, all of my kids I never thought of the hospital (Laughing).

QN: Why so? Why didn't you think of the hospital for your delivery?

ANS: From the first baby to the last; I did not experience any problems with delivering.

QN: How about you mama?

ANS: *Another respondent* - All my babies were born at home, with the help of traditional birth attendants.

QN: Why all at home?

ANS: There were no hospitals in those times

QN: When was that my friend?

ANS: I mean, I didn't know much about the hospital!

ANS: *Another respondent* - I gave birth to all of my children at the hospital. The fourth birth was twins and I was operated on with scissors.

QN: So you got twins ehe!?

ANS: No, one died.

Facilitator: So sorry. How old is the remaining baby?

ANS: She was born in 1990.

ANS: *Another respondent* - All of my children were born at the hospital.

QN: How old is the 1st born?

ANS: Eight years.

ANS: A*nother respondent* - All children born at home and helped by Traditional Birth attendants.

QN: It looks like most of you like to give birth at home, helped by TBAs. Can you explain to me why it is so?

ANS: Distance from home to hospital.

QN: Thanks, any other reasons?

ANS: Only distance.

QN: How about health providers, nurses, etc. Do they, treat you fairly?

ANS: They are good.

QN: Mh! I thought they sort of look down on you! Don't you feel ashamed to be attended to by girls who may be the same age as your daughters?

ANS: No, that is not the reason. I do deliver at home but I would sincerely like to go to hospital for child birth. Distance is the main hindrance but for me really, hospital would be the best choice if distance was not a matter.

ANS: *Another respondent* - It is better in the hospital because privacy is observed. With birth attendants in the village there is no privacy. A lot of women just come and watch you, they may even shout at you!

ANS: *Another respondent* - We don't care whether the nurse is too young or old, as long as at the end of the day we have our babies with us.

ALL: Laughing!!!

QN: How do you feel about child birth? Please give me your experiences.

ANS: My first experience was very painful. They (people) left me in pain, they did not take me to the dispensary but they later called the TBA. It took the whole night with the TBA until it was the next day but the TBA's couldn't manage, the baby wouldn't come out so they finally decided to take me to the hospital. When I got

to the hospital the nurses helped me but when the baby came out it was already dead.

The second baby I went to the hospital. The third also to the hospital but the fourth I delivered at home.

So my emphasis is that the hospital is the best place for delivery services. We ought all to go for delivery to hospitals, only that it is the distance from where we live to the hospital that is the barrier. If you have complications while delivering at home this can be dangerous. TBA's may fail to come up with solutions and I advise that because I had a bad experience and I lost my first baby!

ANS: *Another respondent* - I gave birth to my first baby at the regional hospital because I had complications. The second, I went to Manchali dispensary, when I got there, the nurse was absent. The labour pains increased and I gave birth without assistance from the nurse. It was a safe delivery but I did have problems in that the placenta didn't come out until after 3 hours. This is the reason I prefer the hospital for delivery. I also thank God that my labour pains come quickly and don't exist for long. The maximum it takes is only 3 hours.

QN: So what happens with the placenta if you give birth at home?

ANS: Three hours later the traditional birth attendant helps to get it out.

ANS: *Another respondent* - I always give birth safely.

QN: Can you explain your experience?

ANS: Silence.

QN: Imagine you are to counsel a friend or your lovely daughter about child birth, what experiences and advice would you give?

ANS: Silence.

Facilitator: Next person please!

ANS: *Another respondent* - My first born at home, second at home but for sure it has been safe.

QN: What would you advise someone who is expecting?

ANS: I would insist she goes to the hospital because there they take measurements, while TBA's just wait until you have labour pains. In this manner, you may be having complications but the TBAs may not know it.

ANS: *Another respondent* - I gave birth to my child at the dispensary. I'd advise the same to anyone who is expecting.

ANS: *Another respondent* - All of my babies I gave birth at home and there is no problem.

ANS: *Another respondent* - All at home, safely.

Facilitator: Who can tell us some different experiences?

ANS: *Another respondent* - It was safe with all of my children.

ANS: *Another respondent* - All have been safe.

ANS: *Another respondent* - It was safe with my first born, the 2nd was safe, but the third is this one! (Pointing to a baby at her feet)

ALL: Laughing!!!

(*she continues*) his head was very big as you can see (pointing to child's head) and it was at home, so I was taken to hospital after TBA's failed to get the baby out.

ALL: Laughing!!!

(*she continues*): so they found a "cart" to carry me to the hospital (laughing) when they lifted me up ready for departure the baby came out.

ALL: Laughing!!

(s*he continues*): they dropped me down, and I gave birth (laughing). So this one gave me such problems but all others were safely delivered!

Facilitator: I can't imagine how long it would take to get to the hospital, on the "cart".

ALL: Laughing!!

ANS: *Another respondent* - All my deliveries have been troublesome; the first to fourth baby I gave birth at the hospital, and the fifthly delivery I was operated on.

QN: What do you mean by problems I thought you were operated during the first to the fourth children?

ANS: I mean, the labour pain is severe, and the baby comes out in an abnormal way. For instance with the twins, one came out in a normal position and the other came out side by side and it was a big problem

QN: *Another respondent* - I gave birth to all my babies at the hospital.

QN: How do you manage? Is your home close to the hospital?

ANS: It is not close, it is very far, but once I start feeling pain I rush, I don't want until it is too late.

ANS: *Another respondent* - All babies were safely born, at home with the assistance of a TBA. Never have I experienced any problems.

QN: What would you advise someone who is expecting? Would you like to recommend your TBA to her?

ANS: The TBA's are good but whenever possible hospital is the best.

QN: Most of you mention TBAs here to assist them, I want to know whether there is a famous TBAs in the village?

ANS: There are several TBAs but everyone has her preference.

QN: What do you give to the TBA (if any) for her assistance?

ANS: Money.

QN: How much?

ANS: 3000 Tsh ($3 USD) is the common amount but she (TBA) may be kind to you and take less than 3000.

QN: What do you understand by family planning?

ANS: When you give birth, you breastfeed for 2 and half years. Then you prevent yourself from pregnancy for 3 to 4 years and gain strength in your body, so when you decide to conceive you will have no health problems.

QN: Do you plan?

ANS: Yes.

QN: Are you married?

ANS: I was married but my husband passed away.

QN: Did you practice family planning with your husband or after you lost him?

ANS: When we married I gave birth to one child (who is alive) and planned with my husband, but before it was the time we had set forth, my partner passed away

QN: Is it a common practice that husbands and wives do agree on family planning in your community?

ANS: It is not common. There are a few people who do that but most men don't like it. In those cases a woman should be brave and plan for herself.

QN: Who else have also used family planning?

ALL: Silence.

QN: (Pointing to one woman) - Do you practice family planning or have you ever done so?

ANS: No.

QN: As our fellow explained about family planning she referred to child spacing, that is what should be an interval from one child to another, but it also addresses the number of children you need in your family. Has anybody here planned with her partner or herself to get two or three children only? Or any number of their preference?

ANS: No.

QN: Did anyone practice Family planning?

ANS: Silence.

QN: Did any of you plan the space between one child to another? (Pointing to one by one)

ANS: No (responses by 5 people)

ANS: *Another respondent* - Yes, I tried but failed.

ALL: Laughing!

QN: How did you fail? Please tell us!

All: Laughing!

ANS: I managed for the first two children, but when the 2nd child was only 2 years I conceived and got this (pointing to child). Laughing!!!

ALL: Laughing!

QN: What happened?

ANS: I was using pills which were effective but I later overdosed. Laughing!!!

QN: How did you overdose?

ANS: Sometimes I would forget to take the pills for some days, and sometimes I would take more to compensate!

QN: Oops! Sorry.

QN: Pointing to others (one by one) who else ever tried to family plan?

ALL: Silence.

QN: Do you know of family planning methods (even though you have not used them)?

ANS: Yes!!

QN: Can you mention the methods?

(Note: methods mentioned)

1. Kitanzi (IUD)
2. Vijiti (Implants)
3. Condom
4. Pills

QN: Where did you hear/learn about family planning methods?

ANS: From Nurses when we go for clinics.

ANS: *Another respondent* - Hospital, my mama goes for seminars and comes to tell me.

QN: Why do you know about family planning but have never tried it?

ANS: I have not yet seen the need. And I don't like it.

QN: Do you hate it, or do you think it may not be good for your health?

ANS: I am not sure whether it may not be good or not, and also I have never thought they may be harmful to me. The only reason I have not used them is because I have not felt the need for family planning.

ANS: *(another respondent)* I have not tried the FP methods because I'm scared of them.

QN: What scares you?

ANS: I know some women who have been using injections and they affected them.

QN: Have you ever sought advice from a health worker about it?

ANS: It has been explained to me by nurses, but I have not yet tried.

QN: Even after explanations do you still feel afraid or scared of family planning methods?

ANS: I understood the explanations but I have never taken the initiative to try them.

QN: To those who have used the FP methods, are you happy about family planning methods?

ANS: 1ST person: Yes.

ANS: 2nd Person: Yes but I need to learn again so that I don't mess up as before.

QN: Is there anybody here who has not heard of FGM?

ANS: Not at all, we all know that.

QN: Give me your opinions, was it good at those times that girls used to go for FGM, or is it better nowadays that the government has prohibited it?

ANS: There has been no good with FGM, for example they used to tell us that if a girl is not mutilated she would not be good for marriage and child bearing, but we have found out that it was not true. In fact girls were tortured for nothing.

ANS: A*nother respondent* - It is even the verse versa. For example those girls who were mutilated when they go for birth, they rupture, while those ones who have not been mutilated don't.

QN: I have been told that in those days when girls were mutilated teenage pregnancies were rare. If this is true, don't you see that abandoning the FGM leads to a lot of teenage pregnancies?

ANS: Not at all. Those young girls get pregnant, even when they were being mutilated. Early pregnancy depends on the child's behavior, and how she was raised.

QN: Some more opinions?

ANS: *Another respondent* - It is better now than in those days.

(Note: the following are responses from the rest of the women except four who said that they don't see any difference. Whether mutilated or not it is just the same).

QN: To the four women: if the government allowed whoever wants to take her girls for FGM to do so, what would you do?

ANS: 1. I would take them to FGM.
2. I would, but now I can't because I should obey the government.
3. I would take them if they (the girls) also like to.
4. I would take them.

QN: If you were in the District Health office and had all the money you need what would you change in the health system or what would you do to improve health care for pregnant women?

ANS: Silence.

QN: If you are asked to suggest anything for improvement of health care for pregnant women in this village, what would you suggest?

ANS: I would suggest that they build a dispensary here in our village because we face many problems now.

ANS: *Another respondent* - I would suggest a dispensary, with service providers and transport, because there might be a dispensary here but some complications require being taken to town (to the regional Hospital), so there is a need for quick transport.

ANS: I suggest clinic services.

QN: But you have clinic services here, is it?

ANS: It is not enough because we only come for child weighing and it is only once per month.

ANS: *Another respondent* - I suggest a clinic.

ANS: *Another respondent* - I'd suggest for a hospital in the village.

ANS: *Another respondent* - Hospital here in the village.

QN: If you have a hospital here, is it all that you need? Any other suggestions to improve your health care?

ANS: We need the following (response from one woman): a hospital, good number of health providers, an ambulance, water: water is a big problem here. You can't imagine how a pregnant woman goes long distances to search for water, so we need water here in the village.

QN: Anything else to improve health care for pregnant women?

(Note: answers were just repetitions of the previous ones).

QN: Some of you mentioned teenage pregnancies. Do you think this is a problem in your villages?

ALL: Silence.

QN: How about HIV/AIDS-is it a problem here?

ANS: It might be existing but we can't know because it is confidential to oneself.

QN: Have any of you had a child/girl that got pregnancy in her teens?

ANS: I have. She got pregnant at age 15.

QN: Did you see it as a problem?

ANS: At that time we felt bad and thought it was a big problem but God helped her, and because she did not go for FGM she gave birth safety.

QN: Any other problems you would like to mention, that exist in your village?

ALL: Silence.

QN: Have you ever heard of rights?

ALL: Yes.

QN: Can you mention the rights you know? (One by one).

1. Right to employment
2. Right to inherit properties of the family (parents, husbands) when they die.
3. Right to contest for leadership for government positions.
4. Right to expression.
5. Right to work.
6. Anything you get is your right, like job, farms, building a house etc.

(Note: Other responses were just repetitions)

QN: How did you know that these are your rights?

ANS: Mentioned sources:

1. Radio adverts.
2. Government officials (through the radio) say both men and women have equal rights.
3. Members of parliament during parliamentary seats/meetings.

QN: Have people from Non Governmental Organizations talked to you about your rights?

ALL: No.

QN: How about health officials (District health officials, etc)? Have you heard from them about rights?

ALL: Silence.

QN: How important is reproductive health to you?

ANS: (One by one): all mentioned "very important".

QN: Can you mention any other issues that you would consider important (however they may not be as important as reproductive health)?

ANS: Issues included:

1. Sanitation especially home surroundings: this will prevent women from many health problems.
2. Malaria: this is a big problem that's why we need a dispensary here.
3. Eye problems.
4. Paralysis.
5. Leprosy.
6. HIV/AIDS.
7. TB that is the reason we insist, if we get a hospital here, it will be very helpful.

Q1 and Q2**:**

	What is your age?	How old were you when you had your first child?	How many children do you have?
1	Don't know	Don't know	6
2	25	18	4
3	24	18	4
4	Don't know	It was in 1975	4
5	32	22	4
6	24	19	3
7	29	15	3
8	36	32	2
9	31	18	1 (gave birth 4 times)
10	36	18	3 (gave birth 6 times)
11	32	22	4
12	Don't know (approx. 17 or 18 yrs and did not go to school at all).	Last year	1
13	28	19	3

Appendix IV – List of Interviewees

1. CARE Tanzania/Health Equity Group
   Ms. Dorcas Robinson, Health Sector Coordinator

2. Youth Action Volunteers
   Mr. Irenei Kiria, Executive Director

3. Private Nurses & Midwives Association (PRINMAT)
   Ms. May Kapesa, Executive Director

4. United Nations Population Fund (UNFPA)
   Dr. Chilanga Asmani, National Programme Officer
   Ms. Christine Mwanukuzi-Kwayu, National Programme Officer HIV/AIDS

5. Medical Women's Association of Tanzania (MEWATA)
   Dr. Marina Alois Njelekela, Chairperson
   Dr. Mary Hawa, Member

6. World Health Organization (WHO)
   Dr. Theopista John, National Officer

7. White Ribbon Alliance for Safe Motherhood in Tanzania (WRATZ)
   Ms. Rose White, Coordinator

8. Women's Dignity Project
   Ms. Festa Andrew, Assistant Program Officer, Strategic Partnerships

9. Christian Social Services Commission (CSSC)
   Mr. Godwin Ndamugoba, Health Services Coordinator

10. Ministry of Health – Reproductive & Child Health Section
    Dr. Koheleth Winani, Coordinator for Safe Motherhood