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

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Framing and Claiming Reproductive Rights: A Case Study of Civil Society Actors in Tanzania[1]

Rebecca Davidson

Abstract

This article focuses on the issue of maternal mortality in Tanzania from a human rights perspective. It deals with the findings of a study conducted in 2008, which examined the role of civil society actors in framing and claiming rights. During the research process, qualitative interviews were carried out with non-governmental organizations and focus group discussions were held with rural women in Tanzania. A key thrust of the research was to examine how reproductive rights are translated into the local context and how they are in turn used by civil society actors.

The author argues that the way in which rights are framed with respect to the issue of maternal mortality also informs the way in which rights claims are made. A distinction was found in the research between those organisations that take a 'social service approach' to human rights promotion and those that take a 'human rights advocacy approach' (Merry 2006a: 138). Although both approaches converge in important ways, the author concludes that the chosen approach influences the way in which organisations' work is carried out and their relationships with other actors.

About the author

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INTRODUCTION

While much has been written about the theoretical debates on the origin, value and ethnocentrism of human rights as a general concept, from the outset, this research aimed to go beyond theoretical debate. My interest in the subject matter 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 about how organisations working at a local level were engaging with, understanding and using human rights. While my research was conducted in the context of a particular setting and on a particular issue, I argue that my dual inquiry approach to exploring how organisations frame and, in turn, claim rights could be applied to other contexts and issues.

In this article I describe this dual inquiry method and my research findings with respect to the issue of safe motherhood in Tanzania. To achieve the research objective of exploring the current dynamics of framing and claiming reproductive rights by civil society actors, my field work involved speaking with organisations[2]—in this case, local and international non-governmental organisations (NGOs) in Dar es Salaam—and tracing their relationships with both external and internal actors. I also included two multilateral organisations and one respondent from the Ministry of Health in the interviews because of the key roles they play in promoting safe motherhood in Tanzania.

This research, conducted during July and August 2008, also took me to a rural community in Dodoma[3] in Central Tanzania where I contextualised my conversations with civil society actors by speaking with women they generally claim to serve. My key research question was: 'How do these actors frame reproductive rights and make claims based on these rights?'

This 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 about the current development context in which many civil society actors have adopted a 'Rights Based Approach' (RBA), to hear how rights were being *used* by civil society actors in Tanzania and how this came to be. A number of international initiatives and organisations 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 discrepancy between their articulations at the international level and how they are understood, experienced and

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[2] 10 in-depth interviews were conducted between 14 July and 17 August 2008 with one representative from the World Health Organization (WHO), 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 Private Nurses and Midwives Association of Tanzania (PRINMAT) and the Ministry of Health, Reproductive and Child Health Section. Two representatives were interviewed from the United Nations Population Fund (UNFPA), The Christian Social Services Commission (CSSC) and The Medical Women's Association of Tanzania (MEWATA).

[3] Dodoma region was chosen to conduct two 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 Tanzania Demographic Health Survey (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 for me to travel in one day to the region.

translated into the Tanzanian context. While my research interest focused on civil society actors, I felt it was important to hear about women's lived experiences of access to reproductive health services beyond the city limits of Dar es Salaam where most of these organisations are based.

Moving from understanding how rights related to reproductive health are framed in Tanzania, I also wanted to understand in what ways organizations claim rights within the context of the their work. This method of dual inquiry which explores 'framing' and 'claiming' allowed me to examine first the articulation of maternal mortality—what is included and excluded in this articulation—and then the associated action that may follow in terms of claiming rights. 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 organisations involved? Is mobilisation a key area for rights claiming in Tanzania?

This article begins with a brief explanation of the theoretical framework that provided the foundation for this research, followed by the presentation of the key findings. It concludes with a reflection on the questions raised that inspired this research and how this method of dual inquiry of framing and claiming rights could be adapted to other contexts.

APPROACH TO THE RESEARCH

The theoretical framework for this study was broadly grounded in a human rights approach that explicitly acknowledges the issue of high maternal mortality in Tanzania as inextricably linked with a number of human rights violations.

The underlying assumptions of this investigation into how reproductive rights are framed and claimed in Tanzania are that all Tanzanian women are rights-holders and that the state is the primary 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.

An additional component of this framework includes socio-legal theory drawn from the work of Sally E. Merry. This provided an exploration of the relationship between international human rights norms and how these are understood, experienced and practised in the Tanzanian context. Particularly useful to this research has been Merry's conceptualisation 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[4] (Merry 2006a).

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[4] The term 'vernacularisation' was initially developed to describe the process in which national languages, in the 19th century, moved 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).

Tanzania Context: Maternal Mortality

The indicators related to maternal health in Tanzania reflect the barriers poor women face in accessing health services. 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 (TBAs) and 3% of women deliver without assistance (TDHS 2004/05).

Although the Tanzania Demographic Health Survey (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 that for 2005 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 barriers perceived by women in accessing facility-based delivery services included lack of money (40%), long distance (38%) and lack of transport (37%). Socio-economic differences in health care utilisation 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 caesarean 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).

The Tanzanian government has developed various health sector policies and plans to move safe motherhood strategies forward, though it should be noted that the most recent 'Road Map' to reduce maternal mortality is missing from the health budget. The health allocation in the budget for 2007/08 was 10.3%, well below the 15% pledge at Ajuba in 2001 (HEG 2008).

Recognising 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 realising these rights, socio-legal theory helped 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. Organisations with international links were sought out to explore their role in transforming internationally articulated reproductive health rights into the Tanzanian context as well as in lobbying the state to implement them at a policy level.

Aside from 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. I felt it was important to explore the lived realities of women and how these experiences linked with the work of civil society actors. To do this I borrowed from the work of the International Reproductive Rights Research Action Group (IRRRAG) as discussed by Petchesky and Judd (1998). Between 1993-1996 the IRRAG conducted a multi-country study on reproductive rights, and their framework was helpful as a tool in developing my focus group questions on the issues of perceptions and power relations and the concept of 'entitlements'.

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 within the context of what they think these rights ought to be. By using the entitlements approach, the main emphasis of the focus group discussions was not on formal laws but on 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 spheres in accessing reproductive health services.

RESEARCH FINDINGS & ANALYSIS

The key findings of this study begin with the lived realities of women in Tanzania that came out of the focus group discussions. Following these are the key findings of how rights claims related to safe motherhood are framed and, in turn, claimed by the organizations I spoke with.

Lived Realities of Reproductive Health

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 contextualise my research with some discussion of women's lived experiences and the barriers they face as well as 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.

In Dodoma,[5] how women framed issues related to reproductive health was shaped by the level of access to reproductive health services in their community. 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).

In Chinangali I, where health facilities are non-existent, 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 found upon arrival that there were no health staff, and she was therefore forced to deliver alone. Many of the women, especially those who had experienced complications, stressed that their preference was to deliver in a health facility rather than with a traditional birth attendant (TBA).

A clear sense of 'entitlement' and the desire for skilled assistance in delivery was identified on the part of most participants. I use 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

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[5] The focus groups were held in two villages in the district of Chamwino in Dodoma region. The first focus group was held on 23 July in Buigiri Village with eleven mothers participating. The second discussion was held on 24 July in Chinangali I with thirteen women participating.

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' (ibid.: 14). This approach situates claims of entitlement within women's social, cultural, economic and family relationships and 'as a form of rights discourse that is more complex and multi-layered than conventional Western notions of "privacy" and "individualism" ' (ibid.: 15). Women's role of mother and caregiver therefore shapes her responsibility for the well-being of her babies. While the key barriers to facility-based delivery services were identified to be distance and inadequate—or lack of—transport facilities, where access to delivery services existed, as in the case of Buigiri, women accessed these services.

The finding that the existence of health facilities determines whether or not women access delivery services 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 barriers such as transport and distance exist, the women's testimonies above suggest that they often still attempted to access facility-based health services, overcoming great obstacles to do so. 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).

In the village of Buigiri, where health facilities exist, women said they were fairly satisfied with their access, and 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 ages 12 and 14 having children. They also felt that families in their community were having too many children. The indirect but important cause of these problems was indicated as an inability of women to meet basic needs and 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 places 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', and yet, one of the solutions indicated to counter the birth of too many children was 'to engage in income-generating activities to better their situation'. This demonstrates situations in which the notions of women's identity as a mother and as provider through economic activities conflict with one another. She is at once a good and bad role model when she undertakes these economic activities that puts her at such risk.

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 as community leaders as well as to proffer ideas and express themselves in their communities.

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 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.

The women I spoke with had very limited direct contact with NGOs working on reproductive health issues. While the question of their representation by NGOs was not asked directly, the subject of assistance to access reproductive health services or information by NGOs did not come up in any of the discussions with grassroots women. This may be in part because the focus of the organisations I spoke with was on working with district-level health officials, with respect to reproductive health services and rights promotion as opposed to working directly with women at the local level.

The focus group discussions identified women's sense of entitlement, a clear need and desire for quality delivery services, as well as knowledge and understanding of the concept of rights—though not necessarily linked to health—as vital issues. These discussions also highlighted the importance of contextualising women's reproductive health within the larger framework of their lives. A clear need for increased economic independence was highlighted as key to increasing women's own—as well as their children's—access to health services.

Framing Reproductive Rights

When civil society actors were asked about root causes of maternal mortality, almost all key informants (including one multilateral organisation) 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 in general, was highlighted by seven out of the twelve respondents. This included one representative from a multilateral organisation and a key informant from the Ministry of Health (MOH). Five respondents (including one informant from the MOH and one from a multilateral organisation), who articulated the root causes of maternal mortality, distinguished between direct and indirect causes, or between health system and non-health system-related contributing factors.

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 [of where they delivered]' (PRINMAT). Another respondent indicated that the 'attitude in Tanzania is that pregnancy is not a disease, but 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 that 'community members are fully aware that pregnant women need care in the situations they are in … health systems are the key and first problem—culture is not the first issue. If there were access, neither money nor transport would be 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 in print materials reviewed. Instead of seeing culture as 'a fluid and changing set of values and practices' (Merry 2006a: 14), culture or 'sociocultural 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 cited as a critical challenge in reducing maternal mortality (Government of Tanzania 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 women who live and work in communities in Tanzania assisting women in delivery as 'traditional' birth attendants (TBAs). The connotation attached to the label is that of 'unskilled' as opposed to 'modern' medicine. Although the role of TBAs is a highly contested subject within the safe motherhood discourse, I raise the issue only as an example of how culture and tradition are conceptualised within this paradigm. If we are to think about cultural practices as shaped by their traditional 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)

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 organisations 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, that '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-à-vis health inequality and vis-à-vis reproductive health and maternal health'. This work is focused on monitoring and analysing 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 organisations' 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). This included a recent costing exercise that determined that 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—in which funds flow 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 organisations working to complement government services by 'gap-filling' and advocating for increased funding for health services in a non-confrontational manner, and those working to challenge current health system structures and promote government accountability. A member of the Health Equity Group suggested that those advocacy organisations 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'. This framing of the role of civil society actors—of either service deliverer in lieu of the state, or advocate for reform of the health system on behalf of its constituents—is also reflected in my investigation of translators.

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 their local context—to translate these norms into the vernacular (Merry 2006a). In my research I found more evidence of *translation* than translators, or what Merry describes as programmes and strategies that are transplanted from one social context to another (Merry 2006a). Evidence of translations in Tanzania included the adoption of various models, projects and tools by civil society actors. Multilateral organisations (such as the UNFPA and WHO) played a role of 'translator' of global agendas more than did the civil society actors who were interviewed.

Those actors that were interviewed, however, could very much be considered 'translators' working between the national and local context. For example, according to the respondent from MEWATA the role of civil society is 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'. The respondent from CARE and an active member of the Health Equity Group explained that the HEG 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 through advocacy for space for civil society 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.

Aside from the multilateral organisations, all the organisations interviewed had some international links, although opportunities to engage with like-minded organisations 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. 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. This finding raises questions about the inclusion and exclusion of civil society actors at the international level—whose voices are being heard and whose are silenced because of lack of access to such forums?

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 operationalised (even though training was provided by UNFPA). Although the key informant at UNFPA suggested that the organisation 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 marginalised. A plurality of rights-based approaches, I would argue, provides further evidence of how rights are appropriated and adapted into a local context.

Claiming Reproductive Rights

Seven out of the twelve respondents identified their work as relating to the right to health. For example, the respondent from YAV suggested that their work involved increasing the understanding of rights among health service providers and rights holders: 'If people became aware of their rights it [decentralisation 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. They described using megaphones and radio PSAs 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 civil society actor—suggested there is a need to increase both supply of and demand for health services in relation 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 the 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 in their definition of reproductive rights as '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.

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 civil society to participate in the health sector reviews and Women's Dignity organised 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 in her research that organisations took one of two approaches in translating human rights—a 'social-service approach' and a 'human rights advocacy approach' (Merry 2006a: 138)—which I have applied to the Tanzania context. In her study on violence against women, she found that organisations focused either on transplanting social service programmes or on changing national laws and institutions (Merry 2006a: 138), although they could be involved in both areas, as suggested by many of the respondents. The Health Equity Group, for example, 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.

As Merry argues, both approaches 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)

Tanzania Context: Political Space

Political space has opened considerably in Tanzania for civil society actors since a multiparty system was introduced. The easing of restrictions in 1985 for organising and registering civil society organisations as part of democratic reforms has allowed for greater opportunities for organisations to mobilise politically (Brown 2001: 78). While key informants point out that more open political space exists (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 organisation, had been using the media as a key tool in their work. In addition, key informants suggested that certain actors had more access to ministries than others.

All of the organisations 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 actor and the type of work that they were engaged in. Interestingly, although WRATZ is not a social service delivery organisation, its close ties with the government since its inception have most likely influenced its positive description of their 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 civil society actors, 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'.

Eight out of the nine civil society actors identified mobilisation as part of their work, though how mobilisation was conceptualised varied by respondent. In terms of opportunities and challenges to mobilisation, both MEWATA and WRATZ's respondents highlighted the role of decentralisation of the health system in Tanzania. MEWATA's informant suggested that decentralisation provided an opportunity for implementation of action plans but that competing priorities and limited funds were a barrier at the district level. The respondent from Women's Dignity commented: 'Decentralisation has created more opportunities for organisations 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.'

> ### Tanzania Context: The Legal Sector
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> While Tanzania's law system reflects the culturally and religiously diverse population and allows customary law to exist alongside statutory secular law, this binary system has disadvantages for women whose rights are sometimes left unprotected under customary law. 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.

Building citizenship engagement required for mobilisation 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 organisations 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 organisations; 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).

The respondent from YAV also suggested that the push to mobilise in Tanzania currently comes from NGOs and not from citizens: '[we] need to work harder in Tanzania to increase political mobilisation on all issues. This is in part because of historical reasons—a single party system which discouraged citizen participation and was characterised by a closed political environment.' UNFPA also agreed that political space has opened up: 'there are opportunities for this [political mobilisation] especially now that people can speak their mind with regard to political freedom.'

From the interviews conducted in Tanzania, it appears that mobilisation is often connected to programmes or strategies, some of which are transplanted from other parts of the world. Widespread mobilisation or movements calling for change that are common in parts of Latin America are not currently happening in Tanzania. Instead it appears that mobilisation

often occurs in isolated ways and mass mobilisation is not the focus or priority of the organisations I spoke with.

The last theme that emerged was law and legislation. The Health Equity Group was the only organisation 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.

Claiming of rights around the issue of maternal mortality suggested 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. 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.

The study found that actors primarily took one approach to claiming reproductive rights over another—either that of providing services where the state does not provide them and building rights consciousness among the constituents they serve, or taking a human rights advocacy approach which aims at challenging current health systems and structures and increasing citizen participation. It was found that the choice of approach had repercussions with regards to organisations' relationships with the state: those organisations providing services have a more amicable relationship with their colleagues in the government than those who focus on advocacy.

CONCLUSION

In this research I have found that civil society actors have taken two different approaches to promoting safe motherhood in Tanzania within a human rights framework. I have found that how an actor frames the issue of safe motherhood influences how rights related to this particular social justice issue are claimed. While a social service approach delivers much needed services for women 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 Jakaya Mrisho Kikwete has recognised 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. In addition, I would argue that most of the work by the government to date has been in response to bilateral and multilateral pressure, 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. Clearly a need to transform the current systems and structures is required for real change for women in Tanzania.

If the process of framing safe motherhood as a human rights issue influences the action of actors in claiming rights at the local level as I have argued, the exclusion of local organisations from international and regional forums where this articulation originated has repercussions for the translation of rights beyond the level of mere discourse to what Merry calls human rights advocacy. Moving beyond this study, creating more opportunities

for local organisations to attend international and regional forums and supporting 'translators' from the local level is encouraged of donor and funding agencies.

In addition, I have argued that the way in which culture and tradition are framed within current safe motherhood discourses in Tanzania—often as a barrier to women's access to safe delivery—is a monolithic and static presentation of culture which makes it difficult to see women's agency and local opportunities for rights promotion. Theorising culture and tradition as an open and flexible system provides a lens to see the capacity of social arrangements as an opportunity and not only as a potential barrier.

Finally, keeping in mind the layered and complex realities of women's lives, a human rights framework addressing maternal mortality requires organisations not only to address the pressing need for increased access to safe delivery services— such as emergency obstetric care and skilled attendants during delivery—but it also requires organisations to link these infringements with wider inequities within the health system and for women generally in Tanzania. The women in the focus group discussions clearly articulated and linked their limited opportunities for increased economic empowerment and self-sufficiency with barriers to health services. Therefore, locating reproductive health rights within the larger context of women's lives is important in any safe motherhood strategy.

The method of dual inquiry used in this research has been helpful in exploring how rights are framed and how this framing may influence how rights are claimed with respect to a particular social justice issue: maternal mortality. Understanding how to influence and broaden this framing is important not only in understanding and exploring innovative and effective ways of using rights but also in recognising the implications for actors' relationships with the state and other stakeholders. This study 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 actors 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 a little bit closer to **realising** such rights.

References

Brown, A.M. (2001) 'Democratization and the Tanzanian State: Emerging Opportunities for Achieving Women's Empowerment', *Canadian Journal of African Studies* 35(1): 67-98.

Chatterjee, M. (1998) *Access to Health*. New Delhi: Manohar Publications.

Government of Tanzania (2008) 'National Road Map – A Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania'. Dar es Salaam

HEG (2008) 'National Health Budget Analysis 2007-08'. Dar es Salaam: Health Equity Group.

LHRC (2007) 'Tanzania Human Rights Report 2007'. Dar es Salaam: Legal and Human Rights Centre.

Merry, S.E. (2006a) *Human Rights and Gender Violence: Translating International Law into Local Justice*. Chicago: University of Chicago Press.

Merry, S.E. (2006b) 'Transnational Human Rights and Local Activism: Mapping the Middle', *American Anthropologist* 108(1): 38-51.

Musa, R. and A. Ndomo (eds) (2007) *Reproductive and Sexual Health Rights in Kenya, Tanzania and Uganda*. Nairobi: Femnet. Accessed 7 October 2008 http://www.humanrightsimpact. org/fileadmin/hria_resources/FEMNET_SRHR__report_Kenya__Tanzania__Uganda_2007. pdf>.

Petchesky, R. and K. Judd (eds) (1998) *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*. London: Zed Books Ltd.

van Eerdewijk, A. (2001) 'How Sexual and Reproductive Rights can Divide and Unite', *European Journal of Women's Studies* 8: 421-39.

WHO (2007) 'Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank'. Geneva: World Health Organization.

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