FACTORS THAT INFLUENCE PROVISION OF SEXUAL AND REPRODUCTIVE RIGHTS AND HEALTH EDUCATION IN MCH SERVICES BY THE MCH PERSONNEL IN ILALA MUNICIPALITY

BY

DR. AISA NKYA MUYA, MD

A DISSERTATION SUBMMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH

UNIVERSITY OF DAR-ES-SALAAM

SEPTEMBER 2003

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance a dissertation entitled:

Factors that influence provision of sexual and reproductive rights and health education in MCH services by the MCH personnel

In partial fulfillment of the requirements for the degree of Masters of Public Health.

Prof E.P.Y. Muhondwa .....

Supervisor

Date: 19th Oct 2003

STATEMENT OF COPYRIGHT

"This dissertation is copyright material protected under the Berne Convention, the Copyright Act 1966 and other international enactments, in that behalf, on intellectual property. No part of this dissertation may be reproduced, stored in any retrieval system, or transmitted in any form by any means: electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the author or the University of Dar es Salaam in that behalf".

DECLARATION

I declare that this is my original work and it has not been submitted for a similar degree in any other University.

Dr. Aisa Nkya Muya .....

Candidate's signature

Date: 10th, October, 2003

ACKNOWLEDGEMENT

I am very grateful to SIDA/Sarec for their full financial support which enabled me to complete this course successfully. I also would like to express my sincere gratitude to my supervisor, Prof. E. P. Y. Muhondwa, whose patient and systematic guidance made this study successful. He had keen interest in this study and his criticism was constructive.

I am grateful to all my teachers during the Masters in Public Health course whose guidance and teaching provided me with the skills to write this dissertation. I am also grateful to Mr F. Mayunga for his useful guidance during data management. I would like to thank all the secretarial and support staff at the Institute of Public Health who made my tasks a bit comfortable.

Special thanks to the DMO and the authorities of Ilala municipality for their permission to carry out the study and for all the support and encouragement they provided.

I am grateful to my assistants who worked very hard under difficult situations during data collection.

To all the MCH service providers in Ilala municipality as my study sample, I am deeply indebted. They cooperatively volunteered some raw information that was useful and has been analysed in this dissertation.

I am deeply indebted to my beloved husband who gave me moral support and encouragement throughout my study period. I am very grateful to my children who patiently bore the very busy study period during which I could not give them adequate attention.

To my colleagues and friends who supported my family and me during my full-time study period, I say thank you.

DEDICATION

I dedicate my dissertation to my beloved parents who instilled in me love for education and skills improvement for the sake of humanity and to my beloved husband and children.

ABSTRACT

An exploratory study among 114 MCH personnel working in Ilala municipality of Dar es salaam region was carried out during June 2003. The study sought to determine the factors that influence provision of SRRH education in MCH services by MCH personnel. Most of the respondents were married. Their mean age was 40 years. A slightly higher proportion (51.8%) works in public clinics. Majority was MCHA with a working experience of more than ten years. Most of respondents appear to know about SRRH and have positive attitude towards issues concerning SRRH. Majority of the respondents also understands the importance of SRRH in raising women's status in the society. They are also aware of the importance of some factors that contribute significantly towards denying women their SRRH. They reported that in most cases clients raise issue concerning their sexuality during MCH sessions. A high proportion of the respondents reported that they have skills to provide SRRH education to their clients which most of them acquired through on job training. However, the quality of their skills was not assessed.

It was concluded that most MCH personnel understand the importance of SRRH and are willing to provide SRRH education, but the source of their knowledge and skills is not formal. Lack of privacy due to inadequate rooms for consultation in MCH clinics is also regarded as a contributing factor towards inadequate provision of SRRH education. It is recommended therefore that, in order to facilitate the provision of SRRH education in MCH clinics, the MCH personnel should be trained for skills to provide SRRH education as well as the MCH clinics should be redesigned by creating adequate rooms for consultation.

TABLE OF CONTENTS:

Certification.....ii

Statement of copyright.....iii

Declaration iv

Acknowledgement.....v

Dedication.....vii

Abstract.....viii

Table of Contents.....ix

List of Tables.....xi

List of Figures.....xiii

List of Abbreviations and Acronyms.....xiv

Introduction..... 1

Background Information 1

Statement of problem 14

Study Question 14

Rationale 15

Literature Review 16

Study Objectives 20

Methodology 21

Results 25

Discussion 48

Conclusions 59

Recommendations 60

References 61

Appendix 1 – Questionnaire –English version 68

Appendix 2 – Questionnaire –Kiswahili version 77

LIST OF TABLES

Table 1: Distribution of number of MCH personnel working in one MCH clinic.....25

Table 2: Age distribution of MCH personnel.....26

Table 3: Distribution of number of children among MCH service providers.....26

Table 4: Marital status among MCH service personnel.....27

Table 5: Level of education among MCH service personnel.....28

Table 6: Working duration in MCH clinics.....30

Table 7: Relationship between the type of institution MCH personnel trained and how they first learned about SRRH.....32

Table 8: Respondents perception of whether men are brought up to coerce and to dominate.....34

Table 9: Respondent's opinions on how the society can change the behaviour of men being coercive and violent to women.....36

Table 10: Perception of the importance of factors that contribute in impediment of SRRH of women in our society.....37

Table 11: Relationship between the context in which MCH personnel give SRRH education and type of MCH clinic they work.....40

Table 12: Respondents that provide SRRH in relation to type of cadre.....41

Table 13: Association between attendance of on job training and provision of SRRH education.....42

Table 14: Relations between respondent's type of MCH clinic and the perception that lack of privacy prevents provision of SRRH education in MCH services.....46

LIST OF FIGURES

Figure 1: Cadre distribution among MCH personnel.....29

Figure 2: Distribution of cadres in public and private clinics.....29

Figure 3: Reasons given by respondents as to why men are coercive to women in sexual acts.....35

Figure 4: Respondent's views on changes in the community that would occur if women enjoyed their sexual and reproductive rights.....38

Figure 5: Respondents perception of the MCH session to provide SRRH education..... 43

Figure 6: Skills to educate SRRH in relation to type of cadre.....45

Figure 7: Respondents opinion on how to improve function of MCH clinics in providing education on SRRH to the community.....47

ABBREVIATIONS AND ACRONYMS

AIDS	- Acquired Immunodeficiency Syndrome
ANC	- Antenatal Clinic
DMO	- District Medical Officer
FGM	- Female Genital Mutilation
FIGO	- International Federation of Gynaecology and Obstetrics
FP	- Family planning
GBV	- Gender based violence
GTZ	-Deutsche Gesellschaft fiir Technische Zusammenarbeit
HIV	- Human Immunodeficiency Virus
ICPD	- International Conference on Population and Development
IEC	- Information, Education and Communication
MCH	- Maternal and Child Health
MCHA	- Maternal and Child Health Aide
MMR	- Maternal Mortality Rate
MoH	- Ministry of Health
NA	- Nurse assistant
NGO	- Non-governmental Organization
NM	- Nurse midwife
PHN	- Public Health Nurse
POA	- Program of Action
RCH	- Reproductive and Child Health
RH	- Reproductive Health

SRRH	- Sexual and Reproductive Rights and Health
STD	- Sexually transmitted diseases
TAMWA	- Tanzania Media Women Association
TAWLA	- Tanzania Women Lawyer Association
TRCHS	- Tanzania Reproductive and Child Health Survey
UN	- United Nations
UNFPA	- United Nations Population Fund
UNICEF	– United Nations Children Fund
USAID	- United States Agency for International Development
WHO	- World Health Organization

1. INTRODUCTION

1.1 BACKGROUND INFORMATION

Gender equality has been accepted as a fundamental principle of human rights since adoption of the UN charter in 1945. (UNFPA, 2000) The goal is that each person should live a fulfilling, risk free sexual life.

Since sexual and reproductive rights are part of human rights, some international organizations like UNFPA whose primary activities are reproductive health services and population control, have also recently sought to promote both reproductive rights and women empowerment. In the UNFPA's "State of world population report" of 2000, it is stated that "if women had the power to make decisions about sexual activity and its consequences, they could avoid many of the 80 million unwanted pregnancies each year, 20 million unsafe abortions, some 500,000 maternal deaths (including 78,000 as a result of unsafe abortion), and many times that number of infections and injuries. They could also avoid many of the 333 million new STDs contracted each year." (UNFPA, 2000).

As a foundation on which to base the global strategies to promote reproductive health and rights, the issues of gender roles and sexuality as a whole have to be unraveled.

Gender and Sex

Gender and sex are two words that are used to differentiate between male and female. Sex is a physical and biological difference between a male and a female. Women's ability to menstruate, conceive, and give birth as well as breastfeed after birth are sex roles of females and they are different from those of male, which include the ability of men to produce sperms and fertilize the female's egg.

Gender is a social character of being a male or a female. Gender roles are socially and culturally constructed behavioral differences between men and women. Parents and society as a whole influence the process of acquiring gender identity by portraying stereotypes of what it is "to be male" or "to be female". In most African cultures, boys are encouraged to be active, to be less sensitive and to have decision making ability. A weak boy is regarded as girlish, whereas girls are encouraged to show obedience, respect, and affection to others. Girls will be taught to deal with domestic and household activities whereas boys will be forbidden to do the same kind of activities. The kitchen is considered as "women's place" and boys are not expected to stay there. At the same time boys are expected to do other outdoor activities. These conceptions begin to shape gender roles from childhood.

Gender roles however have cross-cultural variation and there are changes over time in gender linked behavior patterns within the same society, but still they generally reflect inequality.

Gender influence on Sexual and reproductive health

Reproductive Health is defined by WHO and ICPD as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes" (ICPD 1994). Reproductive health is a comprehensive approach to women's health and well being, which includes fertility and infertility, contraception, abortion, child bearing, maternal morbidity and mortality, sexuality, STD, menstruation and menopause (WHO 2002).

Sexual health requires a positive and respectful approach to sexuality and sexual relationships. It allows for the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

WHO defines sexual health as a "state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity". Sexual health is usually regarded as part of reproductive health; but with the emergence of HIV/AIDS pandemic, the increasing attention to Gender based violence (GBV), and extent of sexual dysfunction, there is a need to focus more explicitly on sexuality in promotion of sexual health. So when talking of sexual health, one needs a full understanding and appreciation of sexuality, sexual relationships and practice, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

One can say that, sexuality includes all dimensions of sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction; that can be

experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, behavior and practices. How ever not all of these dimensions are always experienced or expressed in relationships. In understanding the comprehensive dimensions of sexuality, one will be able to understand how sexuality affects health and reproduction.

The public health professionals focus on unraveling the clues not only about everyday sexuality and sexual behavior, but also about social, cultural, religious and economic factors that affects women's sexuality. They also unravel sexual problems in relationships that make women vulnerable to sexual related health problems.

Sexual problems in relationships are commonly caused by poor communication about gender role expectations. Many cultural beliefs and socialization bring about gender stereotypes in sexual relationships whereby, men are expected to know more about the sexual act, to initiate it and to have multiple sexual partners and women are expected to be passive recipients, and have to please a man. They are not expected to refuse sexual proposal from men and are not even considered whether they get sexual satisfaction during the sexual act.

Brutal cultural practices such as female genital mutilation (FGM) portray female gender suppression in sexual relationship. In Tanzania, FGM is estimated at 18% (TDHS,1996). This procedure involves cutting away part or all of the female external genitalia, with a reason to prevent women's sexual enjoyment. But this procedure is commonly carried out under unsterile conditions and without anaesthetic. FGM results in adverse health problems like extreme pain, excessive bleeding and

transmission of infectious diseases. The excessive bleeding can result in shock and even death. Women, who survive, may experience painful sexual intercourse. They may even encounter serious problems during child delivery. WHO estimates that 100-132 million women and girls world wide have been subjected to female genital mutilation. In Sudan it affects 90% of women. (Hassan, 2002)

Women have no power to negotiate safer sex with their partners to prevent transmission of STD such as HIV/AIDS. In most practices, men dominate and decide upon use of condom. Rape and sexual abuse also portray women's unequal sexual relations with men. In some countries sexual abuse is so widespread that it contributes significantly to the HIV epidemic. In South Africa alone, 240 per 100,000 women report rape each year. That is estimated to be one twentieth of the actual number. (Jackson, 2002). WHO estimates that up to 52% of women worldwide suffer physical violence from their male partners, and that at least one in five women suffers rape or attempted rape during their lifetimes (Schmidt and Nice, 2002). In Egypt 69% of women in one survey said a husband could legitimately beat his wife if she refused sexual intercourse (Jackson, 2002).

It is also estimated that 60 million females are missing worldwide as a result of feticide (selective abortion), female infanticide, selective malnourishment and lack of investment in women's health. .(Schimdt and Nice, 2002). Several other studies have shown that there is poor knowledge of sexual and reproductive health especially in terms of sexual and reproductive rights.

Rights-based approach

Human rights can be applied to remedy discrimination against women in access to appropriate health care, and also to challenge women's social, cultural and economic inequality. (WHO, 2001). Ensuring sexual and reproductive rights and health serves as significant input to promote safe motherhood and to improve the quality of life of women. Men can advance gender equality and improve the family's welfare by protecting their partners' health and supporting their choices, confronting their own reproductive health risks, refraining from gender violence, and practicing responsible fatherhood.(UNFPA,2000)

The International Federation of Gynecology and Obstetrics'(FIGO) 1994 World Report on women's health concluded that improvements in women's health need more than better science and health care. The improvements require state action to correct injustices to women. (Cook and Fathalla, 1996)

In 1994 the International Conference on Population and Development (ICPD) in Cairo, made a turning point for reproductive health. The Cairo ICPD- Program of Action (POA) for the first time recognizes the importance of human rights in protecting and promoting reproductive health. (Hempel,1996). Different from the previous ICPDs which had demographic targets; the Cairo program strongly endorses a new strategy for addressing population issues, focused on meeting the need of each woman and man. A key to this approach is empowering women, and protecting their human rights, particularly those relevant to reproductive health. The goal was to eliminate all forms of discrimination against women to enable them to

exercise their rights to sexual and reproductive health, and promote their equal representation at all levels of political and public life (Alcala, 1994). The ICPD also aims to encourage and enable men to take responsibility for their sexual and reproductive behavior, and their social and family roles. (Cook and Fathalla, 1996). In 1995 the fourth World Conference on women, held in Beijing, produced a declaration and Platform for Action. The Beijing Platform reaffirmed the Cairo ICPD-POA, and took into account women's wider interest of reproductive rights as part of human rights.

Sexual and reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents.

The reproductive rights, rests on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. They include the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction, free of discrimination, coercion and violence (WHO, 2003).

Sexual rights are basically included within reproductive rights, as the rights of all persons free from coercion, discrimination and violence, to:

- Attain the highest standard of health in relation to sexuality.
- Seek, receive and impart information in relation to sexuality;
- Receive sex education;

- Have a choice of partner;
- Decide to be sexually active or not;
- Have consensual sexual relations;
- Decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life. (WHO,2002)

These rights will mean very little to the well being of women and men if national, regional, and international human rights instruments do not ensure governments' compliance with their Cairo and Beijing commitments.

SITUATION IN TANZANIA:

Women's Status

The large majority of the Tanzanian population including women does not as yet distinguish sex roles from gender roles. Women in Tanzania have low status compared to men and they are regarded as appendages of men. The low status of women is manifested in various forms including traditional practices like wife inheritance, polygamy and bride price. Most girls are pressured into marriage to their father's bride wealth while a significant number of women are continually being mistreated either by husbands or in-laws who have contributed to the bride-price (Mukangara and Koda, 1999). The Zaramo and related sub-tribes still have traditional puberty rites of "Jando na Unyago". The sex education imparted during these functions put great emphasis on the subservience of wives for the exclusive sexual satisfaction of husbands (Muhondwa, 1997, Mbunda, 1991)

In the event of a husband death, it has become fairly common that the wife does not deserve the inheritance. She either has to leave everything, or rely on the good conscience of her children if she has any.(Muhondwa, 1997). This practice make women feel low esteemed and regarded men's commodities for reproducing children rather than their equal partners in life.

Women in Tanzania have less opportunity in education than men whereby, 40% of women in Tanzania have not been to school compared with 31% of men who have not been to school. (TRCHS, 1999). Women are mostly engaged in small scale agricultural activities. "Women comprise only about 20% of the wage and salary employment and they are mainly employed and clustered in women stereo-type occupations such as nursing, midwifery, stenography, typing and in such other activities which require minimum qualification" (TDHS, 1996). Even though the constitution gives women and men equal right to be elected into public office there are still very few women elected for public services.

Women's denial of SRRH

In our country, in various forms, men deny women their sexual and reproductive rights. This is portrayed through the persistent negative indicators of health such as high morbidity and mortality. Maternal mortality ratio [MMR] is still a burden to our country whereby it is currently estimated to be 529-1100 per 100,000 live births. (WHO, UNFPA, 2001). Most maternal deaths occur due to complications of pregnancies and childbirth. Unplanned pregnancies which end up in abortions, greatly contribute to maternal mortality and morbidity. One study found that 25% of

the pregnancies occur unplanned. Of those, 71% were accepted and 29% were unwanted and hence end up in abortions.[Ng'walida, 2001]

Rape events contribute into unplanned pregnancies. Rape incidents are still very high in Tanzania. Many rape cases are not reported due to stigma. Available figures indicate that the reported cases increased by 48 percent from 497 cases in 1991 to 736 cases in 1992 (Mukangara and Koda, 1999). A study done in Tanzania on sexual violence against women showed that 19.7% were raped at least once in their lifetime. 71.7% of these incidents have occurred in the past two years. (Muganyizi, 2001). One study on adoption of female controlled preventive measures against transmission of HIV among barmaids in kinondoni district, revealed that only 7% of the women were able to negotiate safer sex with men.(Mbaga, 2000)

Sexual abuse and female genital mutilation have also raised a major concern in our country regarding violation of women's sexual rights and health. It was not until after the Amnesty's first East African human right awareness raising seminar on FGM, when it was found that FGM practice is far more prevalent than had been previously thought. It affects an estimated 65% of females in the country. (Robson, 1997). A study done among Meru women in Tanzania showed that 74.6% of the respondents were circumcised (Kitambi, 2001). Their parents were pressurized by potential future husbands to get 57.7% of these women circumcised. These results portray the fact that violation of women's rights is widely practiced, thus a lot of effort is required in promoting gender equality in the community.

Women's empowerment

The movements towards women empowerment have been gaining momentum in our country. There is emergence of bodies that fight for women rights. The Tanzania Media Women Association (TAMWA) and Tanzania Women Lawyers Association (TWLA) are some of the associations that play an important role in raising status of women. They try to change the discriminatory laws that oppress women and sensitize the society to allow women to have equal opportunities like men in all aspect of socialization. In health, there has also been some efforts to give women equal opportunities in health with emphasis on sexual and reproductive health.

Integration of sexual and reproductive rights in MCH clinics

Tanzania was one of the states that attended the Cairo ICPD, and endorsed the comprehensive approach to Reproductive Health. Since 1974, the government has been providing 75 percent of reproductive health services through MCH/FP clinics, which operate as units in hospitals, health centers and dispensaries (GoT, 2001). The Ministry of Health in collaboration with other NGOs made strategies for delivery of Reproductive Health Service, one of which is to reorient MCH/FP clinics so that they can provide gender sensitive, comprehensive reproductive services. (MOH, 1997). Health education on SRRH was integrated in this comprehensive reproductive health services. The activities include training of MCHA, PHN, and NM in counseling and health education skills for comprehensive reproductive health service. The curricula for pre- and in-service training of MCH personnel was reviewed and updated to incorporate and strengthen the Reproductive Health component. This would enable Tanzania to provide a comprehensive Reproductive Health service that include;

family planning services, pre-natal, safe delivery and post natal care, counseling on infants' breast feeding, prevention and treatment of infertility, including prevention of abortion and its consequences and treatment of reproductive tract infection. It was expected that clients would be men and women, rather than the traditional MCH services, which dealt only with antenatal follow-ups and child growth monitoring with clients being only women and children under fives. However this has been difficult due to structural problems of lack of privacy in RH clinics and the attitudes of MCH service providers that are not men friendly.

MCH clinics can be an entry point into the community with gender role sensitization. The issues can be introduced in ANC when couples start attending the clinic, in post delivery sessions and in Family planning clinics. During the sessions couples can be encouraged to,

- Have better understanding of each other's needs and to respect each other;
- Allow people to adopt sexual behavior that is mutually pleasurable,
- Promote shared responsibility for domestic activities especially when the woman is not physically fit during pregnancies and after delivery
- Care for their children, as well as making joint decisions and choices concerning contraception.

This integration can also be used to change the pattern of child rearing whereby men will support their partners in child rearing, and teach their sons respect for women's needs and perspectives and develop self-esteem in their daughters so that they do not become too subservient to men. In order to make this scenario a reality, society as a

whole and at all levels must become sensitive to and reassess the values that underlie the gender socialization and the way it affects women's health.

1 . 2 STATEMENT OF THE RESEARCH PROBLEM

Despite the social, cultural, political, and economic constraints that may discourage women's empowerment in relation to sexual and reproductive rights and health (SRRH), it is women who suffer most the brutal consequences of SRRH violation. They are the ones who get pregnant and give birth but they cannot decide on their reproductive career i.e. when to have children and how many children to have etc. Most of women rely on MCH clinics to get information not only about reproductive health but also about sexual and reproductive rights.

Tanzania was one of the states that have adopted the program of action of the Cairo ICPD, by providing more comprehensive reproductive health services that include SRRH education as part of MCH services. However, factors that promote and those that prevent provision of SRRH education by MCH personnel have not been considered.

Study question;

What are the factors that influence provision of SRRH education in MCH services by MCH personnel?

1 . 3 RATIONALE OF THE STUDY

Most of the health service providers in MCH clinics are the prime sources of education and information about health in the communities. Since the government is committed to comply with the Cairo ICPD-POA, MCH clinics should mount advocacy for issues of women's SRRH in the community. MCH personnel are expected to have knowledge on sexual and reproductive health and rights, and the skills to provide SRRH education which could lure as one of the means for empowerment for women and hence of promoting gender balance which would prevent gender based violence.

This study aimed to unravel the factors that influence the provision of SRRH education which is an important women empowering role and gender sensitization. Therefore we would know how to improve and promote SRRH education to the community through MCH services.

With women and the community as a whole accepting sexual and reproductive rights and applying them, we would expect improvement in women's quality of life and reduction of some of the risks for maternal mortality in the country.

1. 4 LITERATURE REVIEW

The Beijing platform recognizes that women are tortured sexually and otherwise, because of their low status in society and their sexual vulnerability. The platform condemned the torture, and all types of sexual abuse. The Cairo program condemns the bad practice of sexual violence and urges governments to integrate methods and techniques that will contribute in improving RH and well being of women. (Cook and Fathalla, 1996). Implementing the integration of comprehensive reproductive health service needs political commitment into public health expenditure. In a country like Kenya, donors contributed 74% of public health expenditure (Njeru and Njoka, 1998).

In 1997, Tanzania through its ministry of health developed strategies to improve the quality of reproductive health services provided in the MCH services. In one study a high proportion of respondents (94.8%) identified the MCH clinic as an ideal place for obtaining modern family planning methods. Among the reason for choosing this particular place, was good quality of service and confidentiality.(Mgema, 2000). The integrated comprehensive reproductive health services at MCH clinics make the MCH clinic an ideal place for providing education about, and services in support of SRRH, hence changed to Reproductive and child health clinics. The RCH program in Tanzania focuses on five thematic areas, namely: Maternal health, Family planning, Adolescent Reproductive Health(ARH), infant and child health, STIs/HIV/AIDS. (MOH, 2001).

One review found that Latin American countries had generally progressed further than sub-Saharan Africa in integrating services, especially in counseling.(Lush, 2002). Several opportunities for reaching men to attend the reproductive health services are now considered, but very few efforts have been done to test and evaluate the opportunities. (Askew, Maggwa, 2002).In Zimbabwe, they designed a family planning communication campaign that can reach everyone including men, and it was found that men exposed to the campaign were more likely to change their behavior, particularly in terms of communication with their partner (Zinanga, 1996). In Tanzania, there are multifaceted factors that influence male involvement in MCH/FP services, whereby lack of formal education was one them. (Chuwa, 2001)

Effect on the existing comprehensive reproductive health services

There are some limitations in delivery of a comprehensive reproductive service, which vary with type of health facility. In district hospitals it was found to be more possible to provide comprehensive reproductive health services due to availability of different cadres, compared to the rural health posts or dispensary where the service provision may not be feasible due to understaffing. (Lush, 2002). This indicates that poor staff distribution in low level health facilities, such as dispensaries and health posts, is one of the constraints in providing reproductive health services.(MOH,2002). Other main constraints that have been found include low pay, poor morale and lack of motivation among providers, and lack of appropriate physical infrastructure and equipment for expanding services (Lush, 2002).

One study done to assess the quality of service in primary health care facilities in Moshi rural district, found that the service providers in public health units were

working under very constrained conditions. Lack of motivation, with low salaries, insufficient working gears and poor infrastructure were reported as important contributing factors, hindering provision of required health services.(Adam, 2001)

Effective communication on reproductive health issues is an essential and integral element in the process of influencing desired behavior change in targeted individuals, groups and communities. (MOH, 2001).

However one study revealed that, less than a half of the dispensaries (46.6%) had IEC material and only 12.6% had job aids. In that particular study MCH service providers also lack some technical competence especially in counseling sessions. Suggestions from service providers were that regular seminars and on the job training would improve that situation, hence better quality of family planning services.(Gabone, 2001).

Another study similarly showed that MCH personnel also had poor communication skills. The study recommended that MCH workers should be trained on the dynamics of family planning counseling and communication skills, as well as promoting a conducive environment to offer family planning and other reproductive health services for male clients, within the health facility or outside (Mgema, 2000). However, this study did not look into the MCH provider's competence in counseling on SRRH to the clients.

Since 1994, neither governments nor donors have met their commitment for proper integration of comprehensive reproductive health services in the MCH clinics.(Lush, 2002). There may well be a need, however, for more systematically collected information concerning the implications of integrated approach on the way in which clinic services are organized and how providers spend their time.

Only two such studies exist, both of which suggest that the issue is not the amount of time that is spent in providing MCH service, but how this time is used during the day (Askew and Maggwa, 2002)

However the results reflect the need to explore further factors that prevent SRRH integration by MCH providers.

2. THE STUDY OBJECTIVES

BROAD OBJECTIVE:

To explore factors that influence provision of sexual and reproductive rights and health (SRRH) by MCH personnel in the MCH services in Ilala municipality.

SPECIFIC OBJECTIVES:

1. To assess the MCH personnel's awareness of sexual and reproductive rights as a tool for reducing gender inequality in sexual relationships.
2. To assess the MCH personnel's perception of factors that prevents the use of sexual and reproductive rights by the society
3. To determine willingness of the MCH personnel to educate clients about women's sexual and reproductive rights
4. To determine factors that prevent MCH personnel from providing SRRH education to their clients

3. METHODOLOGY

Study Area:-

The study was conducted in Ilala district in Dar es Salaam. The district has 3 divisions,which are Ilala, Ukonga and Kariakoo with 22 wards and 9 villages. The district shares borders with Kinondoni municipality of Dar-es-salaam region to the north, Temeke municipality of Dar es Salaam region to the south, Coast region to the west and Indian Ocean to the east.

As result of urbanization, the municipality comprises of various tribes that have migrated from all over the country with a diverse cultural background.

Health services delivery

The district has a total of 147 health facilities. One is a consultant hospital, one district hospital and 5 private hospitals. It has a total of 6 health centers of which one is government, one is parastatal, and 4 are private. There are 134 dispensaries of which 99 are run by private organizations, 17 are public and 18 are run by parastatal organizations. There are 48 health facilities that provide MCH services in the district. Of these, 16 are public and 32 are private.

Study design:-

A cross sectional, descriptive study was done for the duration of one month in June 2003. Because of the exploratory nature of the study the research instrument contained both closed and open-ended questions to allow probing into the issues of relevance to the research objectives.

Study population: -

The population under study was all health service providers working in MCH clinics in the health facilities of Ilala municipality.

Sample size estimation: -

With only 48 health facilities that provide MCH services in Ilala municipality, total coverage of all health facilities that provide MCH services was done in order to get enough sample size. All the MCH personnel who work in the clinics were included in the study.

Assumptions:-

1. We assumed that almost all the MCH clinics in Ilala municipality would be reached within the specified time for data collection.
2. We also assumed that all MCH personnel that work in Ilala municipality would constitute an adequate sample for analysis.

Methods: -

The structured interview schedule was formulated in English and then translated into Swahili, the national language that is widely spoken and more understandable to the respondents. It had two parts. The first part sought to elicit respondent's socio-demographic characteristics, while the second part delved into substantive issues of interest. It was pre tested and modified for formal administration.

Data collection procedure: -

Two research assistants assisted the investigator. They were trained for two days before the study was conducted. They were specifically trained to administer the interview schedule in accordance with the instructions, to observe privacy and to obtain the consent of the respondents.

The interview was conducted in a face-to-face interaction after establishing a good rapport with the respondents.

Data analysis: -

The interview schedules were checked for completeness after each working day, the responses were coded, and then entered into the computer for processing, and analyzed using the Epi info 6 program.

Data is presented in the form of text, tables and figures.

ETHICAL CLEARANCE AND OTHER ETHICAL ISSUES

Ethical clearance was obtained from MUCHS director of postgraduate studies and permission to conduct the study in Ilala municipality was obtained from the Ilala district Executive Director's office.

The selected MCH service providers were assured privacy and asked for informed consent. This was maintained by signing a consent form before the interview started.

Anonymity was maintained, as respondents were not asked about their names.

4. RESULTS:

4.1 RESPONDENTS' SOCIO-DEMOGRAPHIC CHARACTERISTICS

Of the 114 respondents that were interviewed 59 (51.8%) work in MCH clinics in government health facilities and 55 (48.2%) work in private health facilities.

The number of MCH clinics in the district was 48. Only 16 were public clinics and 32 were private health facilities. Results showed that 29% of all the clinics have only one MCH personnel. However 50% of the public MCH clinics have more than three MCH personnel, compared to 15.6% of the private MCH. (Table 1)

Table 1: Distribution of number of MCH personnel working in MCH clinic

No. of MCH workers in one clinic	Government clinics		Private clinics		TOTAL	
	Number	(%)	Number	(%)	Number	(%)
1	2	12.5	12	37.5	14	29.0
2 – 3	6	37.5	15	46.9	21	43.8
>3	8	50.0	5	15.6	15	31.2
TOTAL	**16**	**100.0**	**32**	**100.0**	**48**	**100.0**

4.1.1 Age:

The age range of the MCH personnel interviewed was 20 – 60 years, with a mean age of 40 years and a median of 39.5 years. The highest proportion (43.0%) was between 30 – 39 years. Only 16.7% were above 50 years. (Table 2).

4.1.4: Marital status

Most of the respondents (78.1%) were married, while only 3.5% were divorced. (Table 4)

Table 4: Marital status among MCH service providers:

Marital Status	Number	Percentage (%)
Married	89	78.1
Never married	15	13.2
Divorced	4	3.5
Widowed	6	5.3
TOTAL	**114**	**100.0**

4.1.5 Education level

Most of the MCH personnel (63.2%) have only standard VII education and 36% have form IV education. Most MCH personnel went to train for MCH soon after completion of primary education; very few joined the MCH services after completing secondary education. (Table 5)

Table 5: Level education among MCH service providers

Education level	Number	Percentage (%)
Standard VII	72	63.2
Form IV	41	36.0
Form VI	1	0.9
TOTAL	**114**	**100.0**

4.1.6 Cadre distribution

Among the MCH service providers, 44.7% were trained MCH Aides and 34.2% were nurse midwives.(Figure 1). Similarly Figure 2 shows that 49.2% of MCH personnel that work in public clinics are MCHA while MCHA in private clinics constitute 40% of the MCH personnel.

Most of the MCH personnel (81.6%) were trained in government institutions while 17.5% and 0.9%were trained in mission and private institution respectively.

Only 20.2% of the MCH personnel had upgraded their cadre.

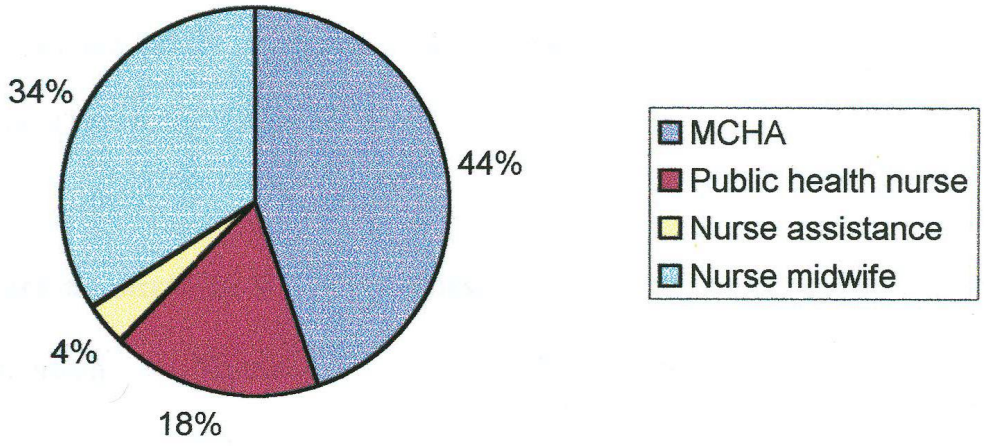


Figure 1: Cadre distribution among MCH personnel

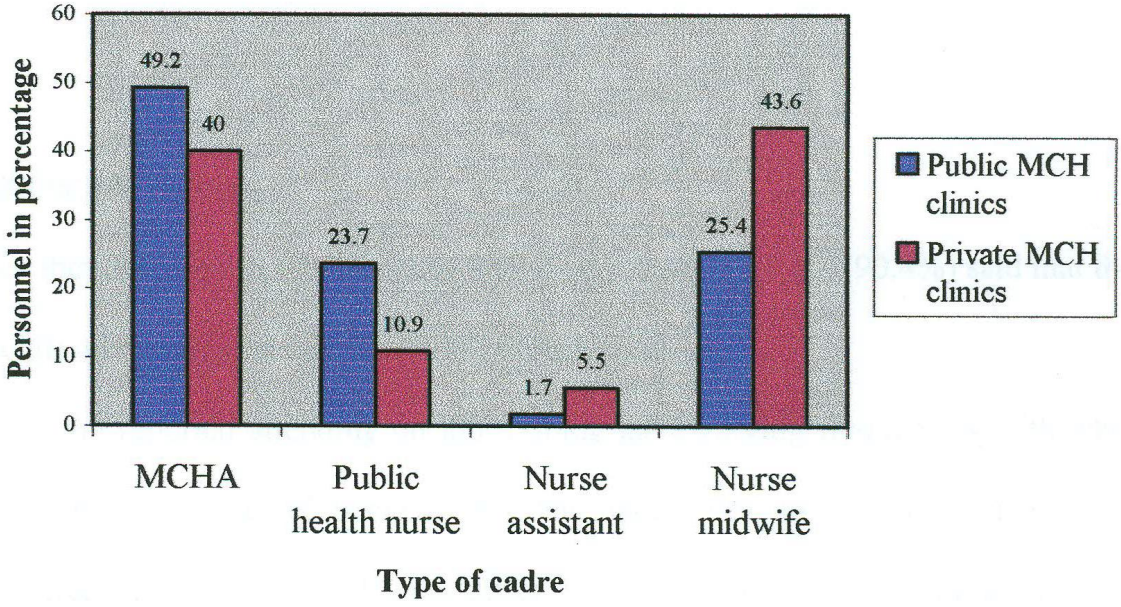


Figure 2: Distribution of cadres in public and private clinics

4.1.7 Working experience:

The majority of the MCH service providers have worked more than ten years in MCH services. (Table 6)

Table 6: Working duration in MCH clinics

Working duration (Years)	Number	Percentage (%)
≤ 5	29	25.4
6 – 10	22	19.3
11 – 15	29	25.4
> 15	34	29.9
TOTAL	**114**	**100.0**

4.1.8 On job training

When they were asked whether they attend on job training, 103(90.4%) said that they do while 11(9.6%) said that they don't attend.

Those who reported attending on job training gave varying frequencies with which they attend. These ranged between less than once a year to more than once a year. These frequencies however did not differ when those for MCH personnel in public and private facilities were compared.

Summary:

A total of 114 MCH personnel were interviewed in 48 MCH clinics in Ilala municipality. It was found that 59(51.8%) work in public MCH clinics and 55 (48.2%) in MCH clinics of private health facilities. The mean age of the MCH personnel is 40 years, and the highest proportion (43%) of the MCH personnel are in the 30 – 39 years age group. Most of MCH are married (78.1%), and the large majority have standard VII education. Furthermore the majority of the MCH personnel have a working experience of more than 10 years.

4.2: RESPONDENTS' AWARENESS THAT SRRH IS A TOOL FOR REDUCING GENDER INEQUALITY IN SEXUAL RELATIONSHIPS

The results showed that 94.7% of the respondents answered correctly all the six knowledge questions referring to sexual and reproductive rights and health, while the remaining 5.3% answered correctly three to four questions. This shows that most of the MCH providers know about the sexual and reproductive rights and health of a woman.

Only 38.7% of those who have trained in government institution said that they were taught about sexual and reproductive rights as part of their curriculum, while a slightly higher proportion (42.9%) of those trained in other institution said the same.(Table 7)

Table 7: Relationship between the type of institution MCH personnel trained and how they first learned about SRRH.

	Training institution					
How she first learned about SRRH	**Government**		**Other institution**		**TOTAL**	
	(N)	**(%)**	**(N)**	**(%)**	**(N)**	**(%)**
During initial training for MCH course	36	38.7	9	42.9	45	39.5
During on job training And seminars	31	33.3	5	23.8	36	31.5
Through media	26	28.0	7	33.3	33	29.0
TOTAL	**93**	**100.0**	**21**	**100.0**	**114**	**100.0**

Most respondents showed positive attitudes towards SRRH. They agreed strongly that if women are not satisfied with sexual act they should let their partners know (96.5%), women have the right to refuse sexual intercourse (93.9%) and women should be able to decide whether to use condom during a sexual act (86.8%).

The results also showed that most of the respondents were aware that there is gender inequality in most sexual relationships. They strongly agreed that, women are brought up to obey and respect men (97.4%), men force women to engage in sexual acts (94.7%) and men don't care for the sexual and reproductive health of their women (93%).

However when asked whether they think how men are brought up in our society influenced them to become coercive and to dominate women, only 48.3% agree while 45.6% disagree. (Table 8). There is no significant statistical association between these responses and age of MCH personnel, number of children they have, marital status, education level, or type of cadre.

Table 8: Respondent awareness of whether men are brought up to coerce and dominate women

	Number (N)	Percentage (%)
Agree	55	48.3
No opinion	7	6.1
Disagree	52	45.6
TOTAL	**114**	**100.0**

Each respondent gave several reasons why in most cases in our society men often force women to have sexual intercourse. Majority of the respondents (65.8%) mentioned that men feel they have more rights than women, whereby 21.1% think that men do this when they are drunk (Figure 3).

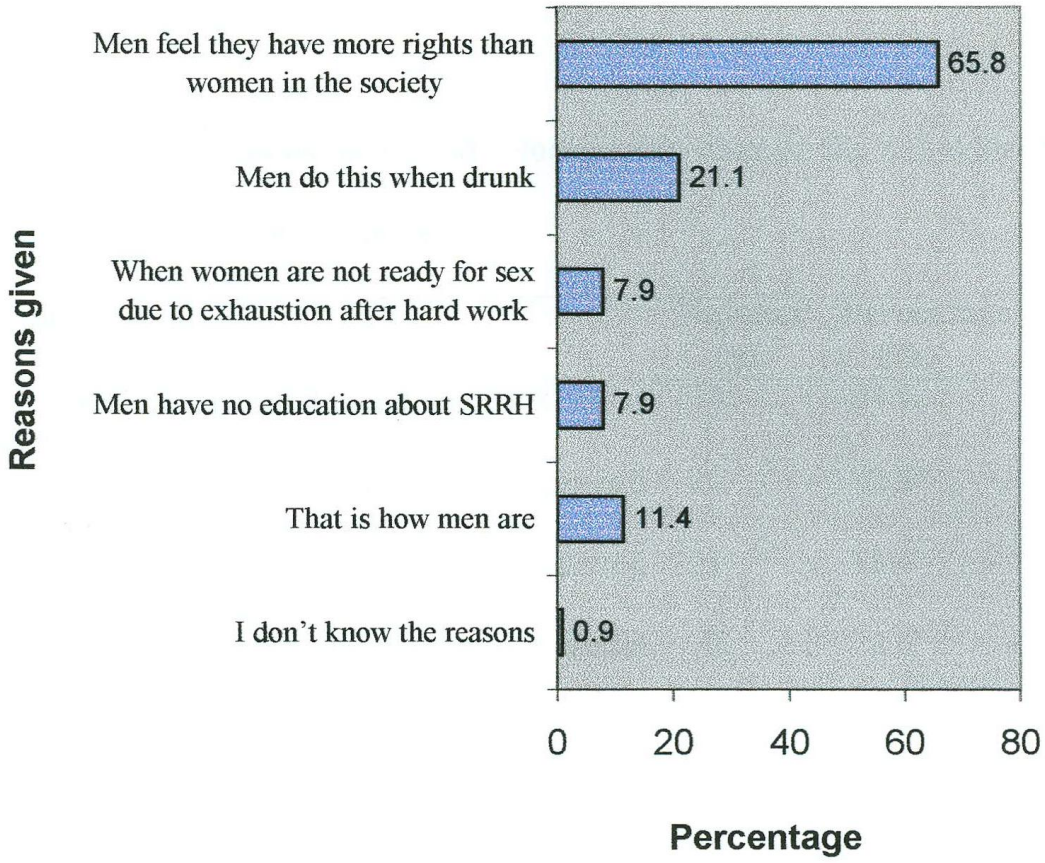


Figure 3: Reasons given by respondents as to why men are coercive to women in sexual acts

In order to change the behavior of men from being coercive and violent to women 64.9% of the respondents suggested that men should be sensitized about sexual rights of women through the media and special seminars. (Table 9)

Table 9: Respondents' opinions on how the society can change the behavior of men being coercive and violent to women

Opinion	Number (n)	Percentage (%)
Men to be educated through media and seminars about rights of women	74	64.9
Both men and women to be educated about sexual and reproductive rights	26	22.8
Sexual and reproductive rights education to start during child rearing in homes and schools	21	18.4
To make laws against men who violate women's sexual and reproductive rights	3	2.6

Summary:

Most of the respondents (94.7%) appear to know about SRRH. Most of them also have positive attitudes towards issues concerning SRRH. They are also aware of gender inequality in sexual relationships. They however don't seem to agree that the way men are brought up instills in them ideas that make them to become coercive and feel superior to women. Majority of the respondents (64.9%) suggested that men should be sensitized about sexual and reproductive rights of women through media and seminars, so that they can change their behavior from being coercive and violent to women.

4.3: RESPONDENTS' PERCEPTION OF FACTORS THAT PREVENT THE USE OF SEXUAL AND REPRODUCTIVE RIGHTS BY THE SOCIETY

There are several factors that contribute towards denying women their sexual rights. Most of the respondents think that cultural beliefs, women's lack of education and unemployment and general poverty constitute important contributory factors. (Table 10). Whereas only 48.3% think that religious belief is an important contributing factor.

Table 10: Perception of the importance of factors that contribute in impediment of SRRH of women in our society

	Cultural belief		Unemployment of women		Religious Beliefs		Women's lack of education		General poverty	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Important	93	82.1	74	65.0	55	48.3	96	75.4	90	79.0
Not important	20	17.5	40	35.1	51	44.7	28	24.6	22	19.3
No opinion	1	0.9	0	0.0	8	7.0	0	0.0	2	1.8
TOTAL	**114**	**100**	**114**	**100**	**114**	**100**	**114**	**100**	**114**	**100**

Respondents had their views on changes that would occur in the community if SRRH were used. Whereby 60.5% believed that family planning practice would improve. However only 14.9% believe that maternal mortality and morbidity will be reduced. (Figure 4).

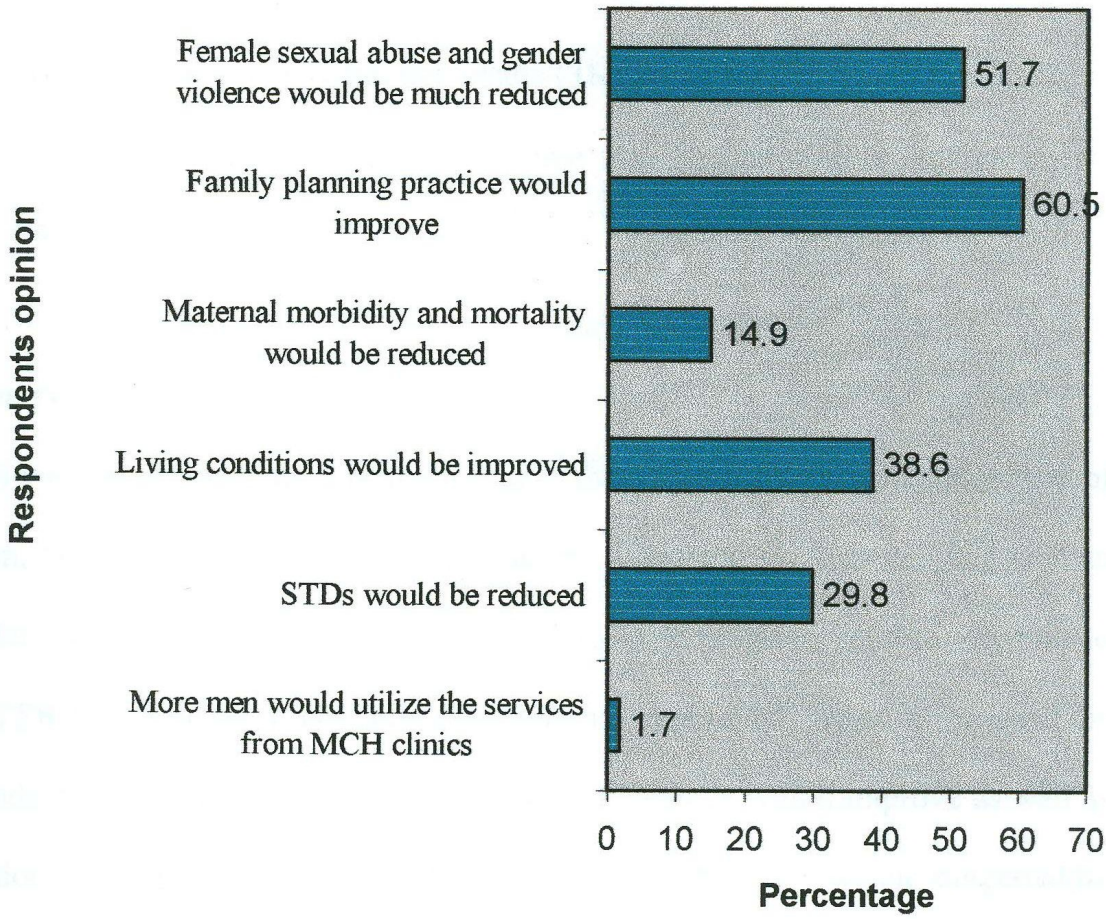


Figure 4: Respondent's views on changes in the community that would occur if women enjoy their sexual and reproductive rights

Furthermore MCH personnel suggested some avenues that can be used by health professionals to introduce the issue of SRRH to the society. The opinions that they gave were;

- Giving education about sexual and reproductive rights through seminars in schools, institutes and working places is the best avenue to educate the society on SRRH. (63.1%)
- To educate the society through various social activities e.g. dramas and songs (6.1%)
- To give education during clinic sessions in hospital (43.8%)

- To educate the society through media (31.6%)
- To educate health workers first so that they will be able to educate clients (5.7%)

Summary:

Majority of the respondents appears to believe that cultural beliefs, unemployment of women, lack of education and general poverty contribute towards denying women their SRRH. A lower proportion (48%) also thinks that religious beliefs contribute to this. If SRRH would be successfully practiced in sexual relationships, majority of the respondents (60.5%) believe that family planning practice would improve as well as reduction of female sexual abuse and gender violence. The best avenue suggested by the respondents for educating the community on SRRH is to provide the education through seminars in schools, institutions and working places.

4.4: WILLINGNESS OF MCH PERSONNEL TO EDUCATE CLIENTS ABOUT WOMEN'S SRRH

Most of the MCH personnel in public clinics (88.1%) and the majority of MCH personnel in private clinics (69.1%) reported that they give education on sexual and reproductive rights of women during their teaching sessions. This difference was statistically significant with p-value=0.01 and $X^2 = 6.21$.

Table 11 shows the different contexts in which this is done and some of the respondents reported more than one context. While 86.4 percent of those working in public clinics give education to all clients together, a slightly lower proportion (28.2%) of those in private clinics do so. Results also showed that only 8.5% of those in public clinics get time to talk with clients individually in private rooms, compared with 47.3% of those in private clinics.

Table 11: Relationship between the context in which MCH personnel give education and type of MCH clinic they work

Context	Public		Private	
	(n)	(%)	(n)	(%)
At the start of clinic sessions to clients together	51	86.4	43	78.2
Individually during consultation	5	8.5	26	47.3
During home visits	10	16.9	2	3.6

Results displayed in table 12 show that there is significant association between whether MCH personnel provides SRRH education and type of cadre. Majority of the MCHA (82.4%) and PHN (85.0%) provide SRRH education.

Table 12: Respondents that provide SRRH in relation to type of cadre

Whether they provide SRRH education	MCHA		PHN		Nurse assist.		N/Midwife		TOTAL	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Yes	42	82.4	17	85.0	1	25.0	30	76.9	90	78.9
No	9	17.6	3	15.0	3	75.0	9	23.1	24	21.1
TOTAL	**51**	**100.0**	**20**	**100.0**	**4**	**100.0**	**39**	**100.0**	**114**	**100.0**

$X^2 = 7.94$ p value= 0.04 degree of freedom =3

There is significant association between frequency of attending on job training and whether they provide SRRH education. Results show that 84.5% of those who attend on job training more than once in a year said that they provide SRRH, while 68.7% of those who attend on job training once or less than once a year said that they provide SRRH. (Table 13). Similarly 81.8% of those not attending provide SRRH.

Table 13: Association between attendance of on job training and provision of SRRH education

Provision of SRRH education	Attendance of on job training: More than once a year		Once or less than once a year		Not attending		TOTAL	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Yes	60	84.5	22	68.7	2	18.2	84	73.7
No	11	15.5	9	31.3	9	81.8	30	26.3
TOTAL	**71**	**100.0**	**32**	**100.0**	**11**	**100.0**	**114**	**100.0**

X^2= 10.85 df= 3 p-value= 0.01

The difference in education level of the respondent, duration of years working MCH clinics, number of MCH clinics one has worked and type of institution she has trained in association with whether they provide SRRH education were not statistically different.

It was also found from the results that majority of the MCH personnel (92.1%) said that clients talked to them about their sexuality related problems during some sessions and expected to get advice from them. They also reported that such disclosure occurs in the privacy of the consultation rooms.

Majority of the respondent agreed with the proposition that during antenatal visits, family planning sessions and post natal follow ups, were the right times to introduce SRRH education to clients, as shown in figure 5.

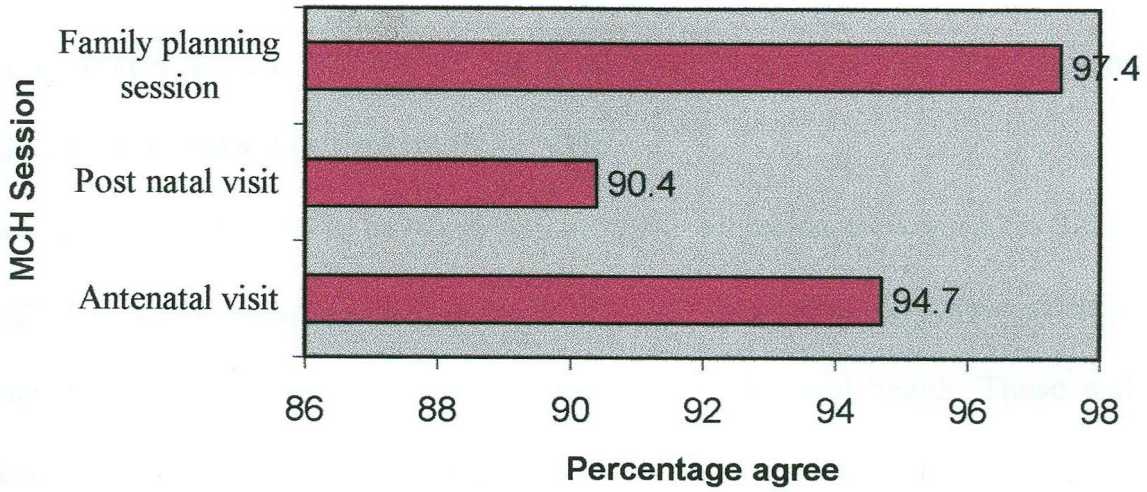


Figure 5: Respondents' perception of the MCH session to provide SRRH education

Summary:

A statistically significant higher proportion of the MCH personnel in public health facilities said that they provide SRRH education compared to those working in private health facilities. However the majority of MCH personnel in public clinics (86.4%) give health education to all clients together compared with those in private clinics (47.3%) who give education to clients individually in consultation rooms. A very low proportion (25%) of nurse assistants provides SRRH while most of other cadres said they provide SRRH. Those attending on job training are more likely to provide SRRH education. Furthermore, most of the respondents (85.9%) said that their clients request for privacy when talking about their sexuality. Finally the majority of the respondents said that family planning sessions were the right context for providing SRRH education to their clients.

4.5: FACTORS THAT PREVENT MCH PERSONNEL FROM PROVIDING SRRH EDUCATION TO THEIR CLIENTS

Respondents who claimed to have no skills to give education to women on SRRH were 29.8%. Most of the MCH personnel (70.2%) claim that they have skills to educate their clients about sexual and reproductive rights and health. Those with skills were asked how they had acquired their skills, the responses were:

- From various on job training and seminars concerning reproductive health (82.5%)
- Taught those skills in school (45%)
- Got through working experience (8.7%)

There was no statistically significant association between skills to educate SRRH and level of education, type of institution they trained, duration of years working in MCH clinics, number of clinics that the respondent has worked and whether she attends on job training.

Results showed that 100% of the nurse assistants had no skills to educate SRRH, while 15% of the public health nurses and 28.2% of the nurse midwives had no skills. (Figure 6)

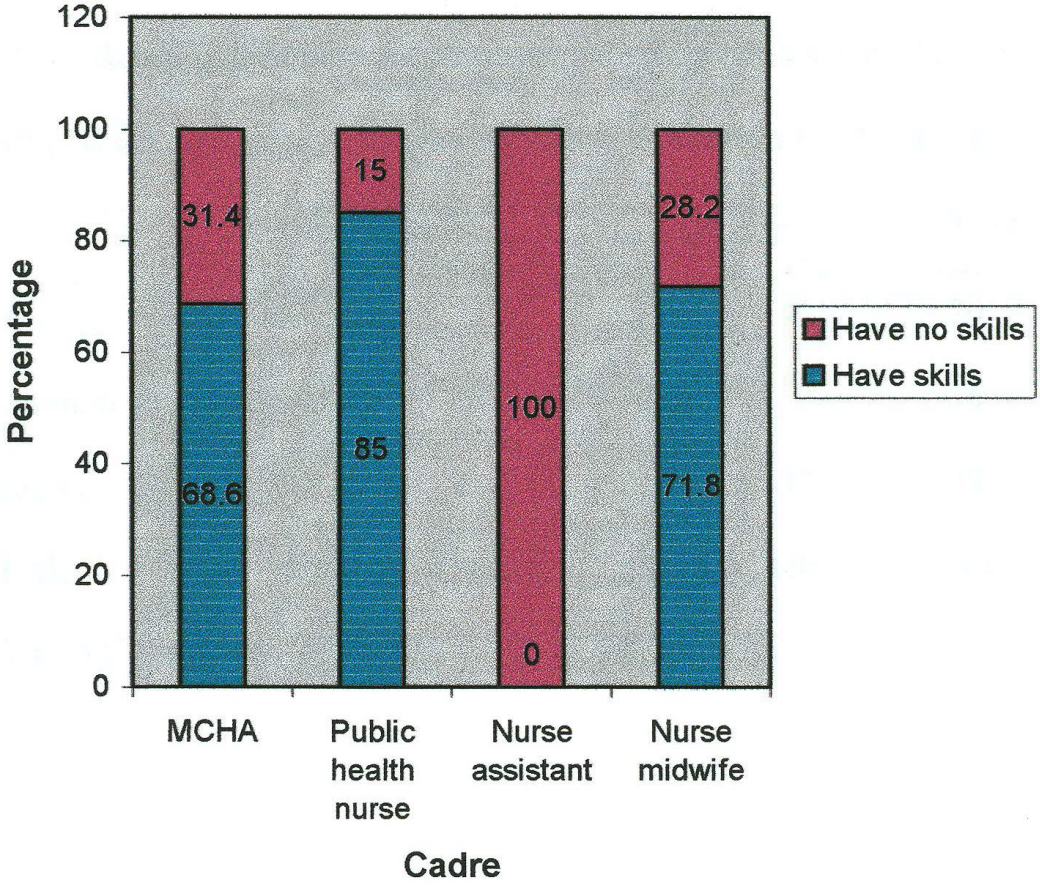


Figure 6: Skills to educate SRRH in relation to type of cadre

Results show that there is significant relationship between type of MCH clinic they work and their perception that lack of privacy prevents provision of SRRH education in MCH services (Table 14). Similarly 72.9% of the MCH providers that work in public MCH clinics agree that lack of privacy in the clinics prevents provision of SRRH education MCH services. Only 49.1% of those in private MCH clinics agree.

Table 14: Relationship between the type of MCH clinics and the perception that lack of privacy prevents provision of SRRH education in MCH services

	Public clinics		Private clinics		TOTAL	
	(n)	(%)	(n)	(%)	(n)	(%)
Agree	43	72.9	27	49.1	70	61.4
No opinion	3	5.1	2	3.6	5	4.4
Not agree	13	22.0	26	47.3	39	34.2
TOTAL	**59**	**100.0**	**55**	**100.0**	**114**	**100.0**

$X^2 = 16.25$ degree of freedom = 4 p-value = 0.002

The respondents gave multiple suggestions on what can be done to facilitate MCH clinics in providing the required SRRH education to the community. 56.1% of the respondents suggested that men should be encouraged through various ways to utilize MCH services with their wives. Furthermore 36% suggested that the clinic structure have to be improved by providing more private rooms for consultation and counseling. (Figure 7).

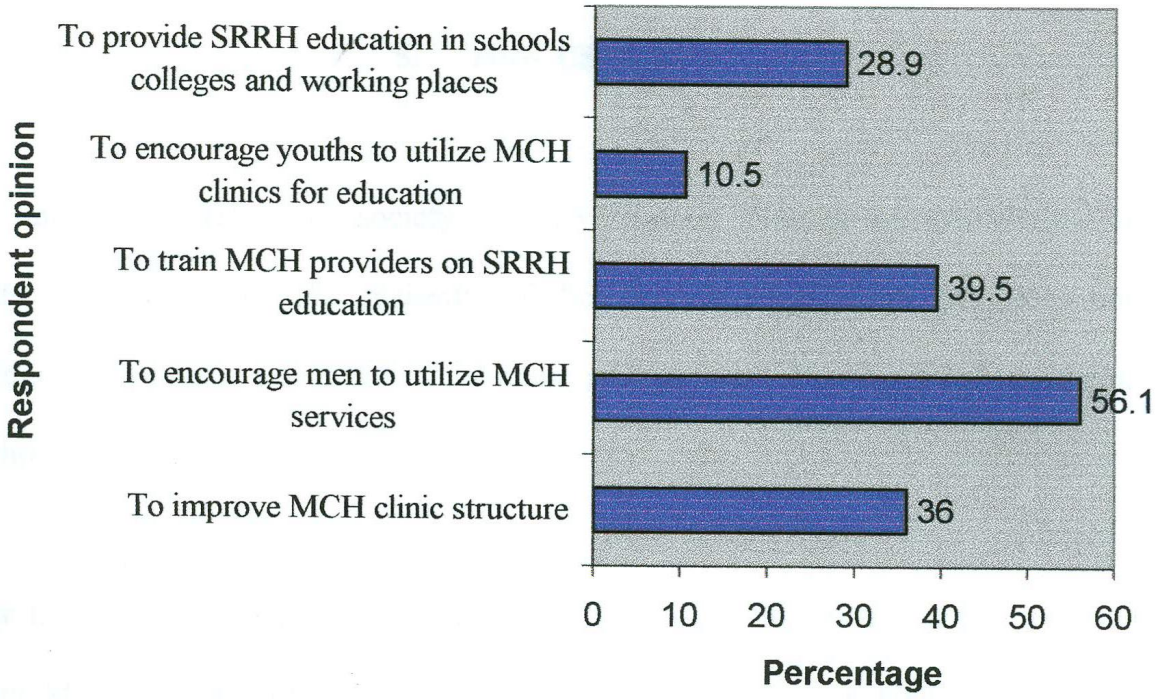


Figure 7: Respondents' opinion on how to improve function of MCH clinics in providing SRRH education to the community

Summary:

Majority of the respondents (70.2%) reported they have skills to provide SRRH education, and that they acquired the skills through various sessions of on job training. All of the NA that work in MCH claimed that they have no skills while for the other cadres, more than 50% claim to have skills. Majority of MCH personnel in public clinics perceive that lack of privacy prevents provision of SRRH education by MCH services, however the majority suggested that men have to be encouraged to utilize MCH services in order to introduce SRRH to community.

5. DISCUSSION

The status of SRRH in our society is still very poor. Women are still victims of gender discrimination. The majority of the Tanzania population still does not distinguish between sex roles of women and gender roles assigned to them. (Muhondwa, 1997).

After the Cairo ICPD program and Beijing platform, the governments agreed to reduce MMR by one half of their 1990 levels by year 2000. This would be achieved by dealing with all the root causes of maternal mortality which range from lack of contraception to women's unequal status in the society (Cook and Fathalla, 1996) and by incorporating the more comprehensive reproductive health services. However after the Cairo ICPD and Beijing platform, the integration of SRRH education in MCH clinics as part of the comprehensive reproductive health service to the society continues to be inadequate.

Research has consistently shown that women's education strongly influences improved reproductive health (Hobcraft, 1993). The International Planned Parenthood Federation (IPPF) in 1992 put forward a 'Vision 2000', which was a broad approach to reproductive health that included gender relations and sexuality, and promoted attention to these issues throughout a woman's life cycle (Hempel, 1996) and by incorporating the reproductive health with greater attention on gender dynamics.

Tanzania through its Ministry of Health, with support from other donors like UNFPA, USAID, GTZ etc has made some headway in implementing the more comprehensive reproductive health service that include integration of SRRH education to be provided by MCH personnel.

This study sought to explore the factors, which might impede or facilitate the effectiveness of MCH personnel promoting SRRH among their clients. The study looked into challenges facing them in providing the services. These factors are discussed here.

The first objective sought to determine respondent's awareness of SRRH as a tool for reducing gender inequality in sexual relationships

In this study most of the respondents appear to know about SRRH. But, it seems they did not learn for the first time during their basic training for MCH or during on job training. They acquired the knowledge through media. It appears that the issue of reproductive and sexual rights is not part of the curriculum for MCH personnel and it does not feature during on job training. But since most of them were trained more than ten years ago, that means before the integration whereby the SRRH was not by then integrated.

Surprisingly there are still no indicators that can assess progress in promoting reproductive health at the national level. (Hempel, 1996) Changing the curricula for training health workers to prepare them for the role of promoting SRRH would be one useful indicator.

In many nations including Tanzania, there is poor emphasis on the SRRH education in reducing gender inequality. The Earth Summit Report reviewers, working with developing country colleagues, found that in many cases it was not clear who or which departments within national governments had the responsibility for following up the ICPD. (Hempel, 1996). Since Tanzania managed to transform its family planning and MCH units, into one Reproductive and Child Health Section one would have expected that such a change would have been reflected in the contents of the programs and activities of this new section by promoting SRRH through appropriate training and integration of SRRH in the services it provides.

Lack of knowledge can lead to negative attitude towards SRRH. In improving reproductive health services, one has to consider the attitude of the health service providers. Changes in behavior and social attitudes are often important in order to achieve improvement of health (WHO, 1987)

More than 90% of the MCH personnel agreed with the proposition that some practices like men forcing women into sexual acts and men not caring for the health of their women, manifest gender inequality in our society. Surprisingly they did not think that the way men are brought up, prepares them to perform gender roles, which affect women adversely. Only very few of the respondents said that sexual and reproductive rights education should start during child rearing in homes and schools. This reflects how MCH personnel like other women, perceive that upbringing of their children has no gender discrimination and as such they may not be effective advocates to SRRH. Other researches have indicated that girls are treated differently

from boys in terms of how much nutrition they are given, as well as in terms of the amount of care they receive when ill. In the latter boys tend to be favored, as evidenced by the fact that they are taken in for consultation sooner after the onset of their symptoms than are girls. (WHO and UNICEF, 1986). Contrary to those results less than 50% of the respondents in this study agreed that, boys' upbringing significantly contributes to their coercive behavior over women during adulthood. It appears that despite the respondents, knowledge of the importance of SRRH, they are still embedded within the rigid gender roles that are traditionally centered whereby most women face and accept the legal inequalities without realizing that.

Furthermore 65.8% of women endorsed the proposition that men feel that they have more rights than women. Even one study found that when mental health professionals were asked to list the traits of a healthy adult, a healthy man and a healthy woman, they equated traits listed for males with those for healthy adults; but the traits for a "healthy" woman were seen to be different from and often contraindicated those for a healthy adult (Doress and Wegman, 1992). This explains how the women gender is regarded inferior to men even by health professionals themselves.

Since the MCH personnel are just a part of typical women in the society with the same cultural upbringing it is only to be expected that they will have the same attitudes of accepting that men are superior and women are inferior. Studies that have been done on sexuality have shown that taboos and myths about feminity and

masculinity are common. (Basso, 1993). MCH service providers need to be well educated so that they can give proper information to other women in the society.

In Tanzania 47% men are exposed to the mass media (TDHS, 1996) therefore educating men through media can be an efficient way of getting them to change their superiority complex and stop being coercive and violent to women. In this study the large majority of the respondents expressed similar ideas of educating men through media to stop violence and coercion to women.

It would appear therefore that even though MCH personnel are aware of the SRRH they might not be strong advocates for its promotion because they have same attitudes as other ordinary women in Tanzania. Concerted educational interventions have to be undertaken in order to empower them for this role.

The second objective sought to determine respondents' perception of factors that prevent the use of sexual and reproductive rights

In the literature various factors have been found to contribute towards denying women their sexual and reproductive rights. It appears that majority of the MCH personnel in this study perceive that cultural beliefs, women's lack of education and unemployment to be important factors that contribute towards denying women their sexual and reproductive rights. This is consistent with what is known about cultural practices. For instance where polygamy is allowed and men are paying bride price for their wives, one finds that men tend to dominate their wives even in sexual and reproductive decisions (Muhondwa, 1997). The cultural practice of inheriting

widows also reflects how women are denied their right to choose their sexual partners.

Some religions deny women their sexual and reproductive rights. The Roman Catholic Church expresses negative attitudes towards modern methods of contraception. This is denying women and men their reproductive rights. They cannot decide to use convenient and effective methods to regulate when to have children and how many children to have (Muhondwa, 1997). Other religions like Islam permits polygamy as well as women getting married at a very young age. It also espouses liberal attitudes towards divorce. Surprisingly a substantial proportion of the respondents in this study did not seem to accept that religion is an important contributing factor in denying women their sexual and reproductive rights.

Majority of the MCH personnel said that if the SRRH were practical in the society, then the use of family planning methods would increase and this would in turn improve women's health. Family planning use is still very low. The contraceptive prevalence rate (CPR) was estimated to be 22% in 1999 and 16% for modern methods (MOH, 2003) .It was found in one study that, the prevalence of family planning use in Moshi rural district was 47% (Chuwa, 2001). If men were well informed about SRRH they would definitely know that spacing of children improves their women's health. The fact that many respondents recognized this hypothesis shows that most MCH personnel know the importance of SRRH.

Some 52% of the respondents endorsed the proposition that female sexual abuse and gender violence would be reduced if women were not denied their sexual and reproductive rights. MCH providers should know that sexual violence especially rape is a denial of women's sexual rights. Providing SRRH education to men is an important strategy for reducing sexual abuse and rape.

The majority of the respondents (63.1%) said that education on SRRH through seminars in schools, institutions and working places is the best way to reach the wider society with SRRH messages. It is reported that in South Africa, a Masimanyane Women's support center was established to eliminate domestic and sexual violence. Through public education and training, the center helped communities to understand the impact of violence at the personal, family and community level, and is contributing to the transformation process of South African society. (Foster, 2002). TAMWA's initiative for a similar center in Dar es salaam "The Crisis Centre" does not appear to have the same impact (TAMWA, 1992).

It would appear therefore that most of the MCH personnel interviewed in this study are aware of the important factors that contribute to denying women their SRRH, even though some of them do not appreciate that women's sexual abuse can be reduced if SRRH would be practiced in the society.

The third objective sought to determine the willingness of MCH to educate clients about women's SRRH:

Most of the MCH personnel in public clinics and a lesser proportion of MCH personnel in private clinics reported that they give education on SRRH to clients. The content of that education was not observed. This means that there is a chance that a person can say that she provides education on SRRH while she doesn't do or worse still what she teaches may not be correct. In a study to assess quality of family planning service, providers were found to lack some technical competence especially in counseling (Gabone, 2001).

The situation of public MCH clinics is different from the private ones. In private clinics they normally have fewer MCH personnel, and they are expected to do other hospital duties. This is because MCH services are supposed to be provided free of charge and therefore the private health facilities are not willing to pay their personnel for free services. This is why in this study 50% of the public MCH clinics have more than three MCH personnel, while only 15.6% of private had more than three MCH personnel.

Respondents who said that they attended on job training were more likely to provide SRRH education than those who do not attend. Strategies to improve quality of reproductive health services should include training the MCH service providers on how to counsel and educate their clients on sensitive issues such as sexuality and gender. This can be done through continuing education program as well as in the basic training. The fact that those exposed to on job training reported addressing

SRRH issues in their work is a sign that somehow there is implementation of the Cairo ICPD program of action in Tanzania. This however should also be a common practice in both the public and private MCH clinics.

The results also show that the majority of Public health nurses and MCH aides provide SRRH education. This partly shows that public health nurses have more orientation to the reproductive health matters and they have been trained more on counseling and provision of reproductive health. Public health nurses are expected to be the standard cadre to provide reproductive health services after phasing out the MCH personnel in the future. The low proportion of nurse assistants who reported as providing SRRH is not surprising since nurse assistants are trained to assist trained nurses and not to be their substitutes. They are not trained to provide services in MCH clinics.

The family planning education was introduced much earlier in the 1970s, such that the clients are used to present their sexual and reproductive problem during family planning sessions rather than when they come for antenatal clinic and postnatal services. This is why most respondents (97.4%) have agreed that during family planning sessions it is the best time to provide SRRH education. It appears that the integration of these services is not yet complete. According to the findings of this study the majority of the MCH personnel provide SRRH education, though the content of the education they give was not assessed.

The fourth objective sought to determine factors that prevent SRRH education by MCH personnel

Do they have skills?

Skills to provide health education are crucial. Counselors and health education providers may claim that they have skills to provide health education to their clients when they don't. The MoH in 1997 had the objective to improve the quality of reproductive health services in health facilities especially in areas of counseling and providing SRRH education to clients by training various service providers, including MCHA, PHN and nurse midwives for five consecutive years (1997 – 2001) (MOH, 1997). However about 70% of the respondents said they have the skills. After these five years we expect a higher proportion of MCH personnel to have skills to provide SRRH education. Even those who reported to have skills, the quality of skills is doubtful, since the quality of their skills was not assessed in this study. They may say they have skills while the quality of skills is poor. In one observational study done on the quality of counseling it was found out that despite the great satisfaction with services they offered, the quality of service was lower than what was reported by counselors. (Kisesa et al, 2002) If MCH personnel are expected to address SRRH education all of them must be properly trained in order to change their attitudes towards rigid men gender roles, in order to impart the required knowledge to the clients.

Lack of privacy

Privacy is crucial for SRRH education and services. Majority of the public health clinics have poor facility infrastructure to provide privacy. This is also associated

with women delivering at home (Nzali, 2001). Most of the MCH personnel said clients are free to discuss about their sexual and reproductive problems only when they are assured of privacy, especially in a consultation room. This is reflected in MCH personnel working in public clinics saying that they provide SRRH to all clients together while most of those in private clinic report giving SRRH individually in consultation rooms. This shows that private clinics have adequate rooms for consultation and can ensure privacy.

Improving MCH clinics to provide SRRH education

Encouraging men involvement in reproductive health programs was one of the themes in the seminar held in Addis Ababa to assess the success of implementation of Cairo ICPD-POA. Many countries, presented their programs on how they involve men in reproductive health programs. In Ghana, "Daddies clubs" male groups were established to improve communication between partners and encourage males to participate fully in reproductive health programs. It was found that "Daddies clubs" members appear increasingly to accompany their partners to the clinic or collect supplies. (Mensah, 1996). Even in Zimbabwe, men that were exposed in family planning communication campaigns were likely to change their behavior in terms of communication with their partners (Zinanga, 1996). In this study 56.1% of the MCH providers expressed the views that encouraging men to utilize MCH services, will make the SRRH message to reach the wider community.

This means that MCH facilities have to be redesigned to provide for privacy so that MCH personnel are able to provide SRRH education and services appropriately to all type of clients.

6. CONCLUSIONS

It was concluded from this study that:

- MCH personnel understand the importance of SRRH as a tool to reduce gender inequality and raise the status of women.
- MCH clinics are proper places in which to provide SRRH education since clients demand to get information concerning their sexuality during MCH services.
- MCH personnel are willing to provide SRRH education and most of them do, but their ability to do so is doubtful, as their source of knowledge and skills is not formal.
- Inadequate rooms for consultation especially in public MCH clinics contribute to provision of low quality of SRRH education to clients.

7. RECOMMENDATIONS

To health planners:

1. There should be more emphasis in providing skills for SRRH education during MCH training so that MCH personnel are competent in promoting SRRH.
2. MCH clinics should be redesigned by creating adequate rooms for consultation to facilitate provision of SRRH education

To researchers:

1. An observational study to assess the quality of SRRH education provided by the MCH personnel is recommended.
2. Research should be carried out to determine the awareness of SRRH by the ordinary community members.

REFERENCES:

Alcala, M.J. (1994) Action for the 21st Century/ Reproductive Health and Rights for all. A summary report of Cairo ICPD. *Family Care International.*

Askew I and Maggwa N B, (2002) Integration of STI Prevention and Management with Family Planning and Antenatal Care in Sub-Saharan Africa- What more do we need to know? *International Family Planning Perspectives*, 28(2): 77-83

Basso S.C. (1993) Health and Sexuality from a gender perspective. Gender, Women and Health in the Americans. *A PAHO/WHO Scientific Publication* NO. 541; Washington DC, . pp 112-114.

Chuwa M. J.(2001) Factors influencing male involvement in family planning practice in Moshi rural district. *Masters of Public Health dissertation*. University of Dar-es-salaam.

Cohen, S.A and Richards, C.L (1994). The Cairo consensus: Population, Development and Women. Special report in *International Family Planning Perspectives*. 20(4): 150-155

Cook R. J and Fathalla M. F (1996) Advancing Reproductive Rights Beyond Cairo and Beijing. A comment in *International Family Planning Perspectives.* 22(3): 115-120

Evans T, Whitehead M, Wirth M, Epstein H (2001). Summary: Challenging Inequities in Health: From Ethics to Action. *Swedish International Development Cooperation Agency and the Rockefeller Foundation*. pp14

Faundes, A (1996) The Cairo consensus and women's reproductive health in less developed countries. International Conference on population and development, Cairo, 1994. *The Health Review,*6(1): 87-91

Gabone O. G(2001) Assess of quality of family planning services at dispensary level in Iringa rural distric. *Masters on Public Health dissertation*. University of Dar-es – salaam. pp3-17

Girard,F (1999) Cairo + Five: Reviewing progress for women five years after the International Conference on population and development. *Journal of women's health and law*,1(1)pp 1-14

Government of Tanzania (GoT) (2001) A draft of National Population Policy. Pp 14 - 23

Hempel, M. (1996) Reproductive health and rights. Origins of and challenges to the ICPD Agenda. Forum in International Conference on Population and Development, Cairo 1994, *Heath transition review*,. pp73 – 83.

Hobcraft J. N. (1993) "omen's education, child welfare and child survival: A review of evidence". *A health Transition Review* 3:150-175

Jackson, H (2002). AIDS Africa- Continent in crisis. SaFAIDS,Harare. pp 89-97

Lush L,(2002) Integrating HIV/STI and Family planning Services. Service Integration: An overview of Policy Developments. *International Family planning perspectives* 28(2):71-75

Lwihula G. K. (1989). Socio-cultural factors associated with the transmission and control of HIV/AIDS with focus on Kagera region.

Mbaga F. S. T(2000). Women Sexual Empowerment: Adoption of Female-controlled preventive measures against transmission of HIV infection. A case study perception of the female condom as a means for sexual empowerment for protection against HIV infection among barmaids, Kinondoni district. *Master of Public Health Dissertation*. Pp 20- 31

Mensah, R. K. (1996) Ghana's experience in male involvement in family planning. A report on International seminar: Managing Quality Reproductive Health Programs:After Cairo and beyond. pp 70

Mgema, S. G. (2000) Use of modern methods of family planning and associated facors among women of reproductive age with at least one living child in Korogwe District, Tanga. *Master of Public Health dissertation*. University of Dar-es-salaam.

Ministry of health (1980). Evaluation of the Health sector 1979,Dar es salaam

Ministry of health Tanzania (1999). Health Statistics abstract 1999: Volume 2, Issue No 2, pp 54 and 59.

Ministry of Health Tanzania (1997). Strategy for reproductive health and child survival 1997-2001: Improvement of the quality of Reproductive Health services in health facilities: pp 18-21

Ministry of Health Tanzania (2001).National Reproductive and Child Health. Tanzania National Reproductive and Child Health Communication strategy 2001-2005. pp 5-6

Ministry of Health Tanzania (2003), National Policy guidelines for Reproductive Health Services. pp 2

Muganyizi, P. S (2001). Sexual violence against females in Dar-es-salaam: Magnitude associated factors and disclosure of events. *Master of medicine dissertation (Obstretics and Gynaecology).* University of Dar-es-Salaam. Pp 24-26.

Muhondwa, E. P. Y (1997). Tanzania's Social Structure and the AIDS epidemic. Paper prepared for the Tanzania National AIDS control programme, Institute of Public Health.

Mukangara F. and Koda B. (1999) Beyond Inequalities- Women in Tanzania. Pp 52-56

Ng'walida N. N. M (2001). "Unplanned pregnancies: prevalence, outcome and contraceptive use, in an urban area in Dar-es-salaam". *Master of Medicine dissertation (Obstretics and Gynaecology)* University of Dar-es-salaam.

Njeru E and Njoka J, (1998) "Barriers and Opportunities for integrating HIV/STD and MCH/FP services in Kenya", Nairobi: Sociology Department, University of Nairobi.

Nzali A.J.O. (2001) "Characteristics of women delivering at home in Songea rural district, Ruvuma region". *A dissertation for Masters in Public Health.*

Olsen B J, (2002) Motherhood- a hazardous endeavor: Maternal deaths and urinary tract infections in pregnancy, in rural northern Tanzania. pp 10-20

Oomman N(1998). Sexuality: Not just a reproductive health matter. *In Reproductive Health Matters*, Volume 6, Number 12, November. Pp 10-12

Richters J (1998). Sexuality today: Research and practice. *Reproductive Health Matters,* Volume 6, Number 12, November. Pp 13-18

Schimdt B. F. and Nice A(2002). Challenging gender-based violence. *Sexual Health Exchange* volume 3, pp 2.

Stanford W, Howley N P and McGee E.(1992) The new our bodies, Ourselves *The Boston Women's Health Book Collective*:. Sexuality pp 227

Tanzania Media Women's Association(TAMWA) (1992) Tanzania Women organizing to break free of violence (March 1990 – December 1992).

Tanzania Demographic health survey-TDHS (1996). Bureau of statistics- Dar-es-salaam and DHS- Macro International Inc

Tanzania Reproductive and Child Health Survey –TRCHS (1999) . Bureau of statistics- Dar-es-salaam and DHS- Macro International Inc

Thoran C. (1996), Promoting gender sensitivity and responsiveness of family planning programmes. After Cairo and beyond. pp 68

UNFPA (2000) An overview. 'Annual report of 2000' Also available at http://www.unfpa.org/

UNFPA (2000) State of World Population' Report of 2000. Chapter 4. Also available at http://www.unfpa.org/swp/2000/english/ch04.html

U.N. (1992), Report of the committee on elimination of discrimination against women. Doc. A/45/38

WHO and UNICEF (1986). Health implications of sex discrimination in childhood. A review paper. Doc. WHO/UNICEF/FHE 86.2

WHO publication on Gender and rights. Also available at http://www.who.int/reproductive-health/gender

WHO (2001) "Maternal Mortality in 1995" Estimates developed by WHO, UNICEF, and UNFPA. Doc. WHO/RHR/01.9. Also available at: http://www.who.int/reproductive_health/publications/RHR_01_9_maternal_mortality_estimates/index.en.html

Zinanga A. (1996) "The male motivation and method expansion project" Managing Quality Reproductive health programs: After Cairo and beyond. pp 70