# Health Equity Project
# Final Evaluation
# April 2011

## Contents

# 1. Introduction

The Health Equity Group (HEqG) is a network of four NGOs: Tanzania Gender Networking Programme (TGNP), Women's Dignity (WD), Sikika, and Care International. Formed in 2004, the HEqG holds a collective vision for civil society engagement and advocacy in the health sector.

The goal of the HEqG is create a popular health movement, which advocates for the right to health for all Tanzanians and generates commitment to equity in health as a visible priority for citizens and their elected representatives. The group's strategy focuses on the situation of maternal and newborn health as an indicator of persistent inequities in health and health service delivery. HEqG uses maternal and newborn health as an entry-point to advocate for policies, plans, budget allocations and utilization of resources for equitable access to quality health services for all Tanzanians.

The HEqG received basket funding support from Irish Aid (2007-2010) to support HEqG members to contribute to a collective work plan and to strengthen their institutional capacities to sustain their health equity policy engagement and advocacy. This formed the basis of the four year Health Equity Project (HEqP), for which an annual plan and budget were developed each year.

This report is CARE's final evaluation for the HEqP. This report has been commissioned to assess and evaluate the impacts of this advocacy project and focuses only on CARE's respective role under the HEqP. Specifically, this report presents key findings, especially as relates to the outcomes and impacts of the project, as well as challenges encountered during project implementation. Finally, this report provides a set of recommendations to inform approaches in the next round of project funding. This report is intended for use by CARE and its advocacy partners, project beneficiaries and the project donor.

# 2. Background

Tanzania has a strong platform of policies aimed at reducing poverty, creating equitable access to health services, and improving health outcomes. Tanzania's second poverty reduction strategy, the MKUKUTA reflects Tanzania's commitment to achieving the Millennium Development Goals and includes commitments to address several important health outcomes, including maternal health. MKUKUTA establishes Tanzania's commitment to reducing inequities and ensuring all Tanzanians have good health and well-being with a stated goal of "Improved health and well-being of all Tanzanians with a special emphasis to children, women, especially vulnerable groups through reducing infant, child, and maternal mortality, morbidity." Strategies to achieve this goal include improving access to quality maternal health services and promoting and protecting

reproductive health rights, while also ensuring broad representation of marginalized groups under established Health Boards and Health Facility Committees to monitor quality and accessibility of health services. In addition, the focus of Tanzania's Health Sector Strategic Plan I (July 2003-June 2008) was the provision of equitable quality health services and client satisfaction.

Despite Tanzania's current health policy commitments to equitable access to quality health services and improving people's health outcomes, significant challenges exist in the effective implementation of these high level policy commitments. Tanzania's DHS (2004-5) points to marked and persistent inequities, with a sharp urban-rural divide and a clear difference in access to key services across the socio-economic quintiles. For example, the total fertility rate for rural women is 6.5 compared with 3.6 for urban women. Many barriers exist in the realization of equitable access to quality health services by all Tanzanians. These include informal payments even for mandated free services, disrespectful treatment of patients by health workers, lack of drugs and supplies, poor in-service training and supervision. But the most compelling barrier is perhaps the lack of political will and capacity to realize the effective implementation of health policy commitments.

District level officials are challenged to develop comprehensive local plans that integrate the various components of essential health packages, such as focused antenatal care, prevention of mother to child HIV transmission, integrated management of childhood illnesses, that are pushed to the district level through vertical programs from the MoHSW. There is a vital need for the District health system to develop integrated services that enable clients to access a comprehensive set of services around the reproductive, sexual and child health continuum. District health needs and budgets can also be hampered by the limited awareness of local non-health leaders (such as the District Executive Directors and planners) of the need to prioritize health in the local government plans and budgets, and of the possible strategies for doing this.

Another major gap is lack of an organized and effective demand for better quality health services. There is limited involvement of CSOs in the arena of health sector policy and governance. There is a need to expand the space for civil society engagement in the health sector. There is also a need for community leaders and groups to develop a shared idea of what they should be demanding with respect to better service provision.

## *2.1 Health Equity Project Approach*

In response to this situation of inequitable service delivery and access to health services in Tanzania, the HEqP envisions the creation of an emerging popular health movement promoting the progressive realization of the right to health and health care services for all

Tanzanians by 2010. Through extensive engagement with political leaders and decision makers at all levels this popular health movement will result in: Increased public participation in health planning, financing and governance; and increased national level political commitment and leadership in ensuring health equity as a national priority.

The group's strategy focuses on the situation of maternal and newborn health as an indicator of persistent inequities in health and health service delivery. HEqG uses maternal and newborn health as an entry-point to advocate for policies, plans, budget allocations and utilization of resources for equitable access to quality health services for all Tanzanians.

### 2.1.1 Health Equity Project Strategic Objectives

1. Equity in health sector financing and financing for equitable impact
2. Equity in health sector planning and planning for equitable impact
3. Equity in governance in the health sector and governance for equitable impact

Progress towards these objectives will be evident in:

- Increased public voice about health and health equity
- More effective participation of Tanzanian citizens, health workers and political leaders in setting the agenda, holding decision-makers accountable, and making information more readily available, in the interest of building quality and effective access to basic integrated primary health services that protect, promote and uphold the health of all Tanzanians
- Plans, budgets and actions that explicitly focus on addressing health inequities, in particular in relation to reproductive, child and sexual health

The HEqG works from the shared understanding that equity in health and well-being and in access to quality health services, can only be achieved where underlying gender relations and structures of patriarchal power are challenged to enable social justice. One of the major themes of HEqG's work is the promotion of awareness about gender inequities in access to health and welfare, and the strengthening of community-based initiatives to empower women and young people so as to demand their rights and entitlements in health and related areas of concern.

### 2.1.2 Health Equity Project Target Groups

The HEqG is working to mobilize a popular health movement, and to build the political will and commitment to invest in equitable access to quality health services. The target groups include: civil society, government, and elected leaders.

#### 2.1.2.1 Civil Society

The HEqG will target civil society by 1) actively linking with the organizations and coalitions that form part of a wider Health Equity network, including FEMACT, TAMWA, MEWATA, TNCHF, Kivulini, and HAPA and 2) engaging with the Tanzanian public through media, including radio, newspapers, television, and community theatre groups and public events, such as the Gender Festival. The intention of building these linkages and platform for engagement is to share information, advocacy tools, and build coalitions that increase consciousness that good health and health services are rights that can be demanded and lobbied for. These actions are aimed at motivating Tanzanian citizens towards lobbying activities and generating advocacy action on the part of coalitions and associations to put pressure for the prioritization of health and health services and for monitoring to ensure implementation and expenditures are in line with plans.

#### 2.1.2.2 Government

The HEqG focuses on three aspects of government. The first is the national level, as represented by ministries and departments. The second is the Local Government Authority (LGA) level. And the third is the donor partners, which represent the bi-lateral and multi-lateral engagement of other governments in the policy and resourcing process in Tanzania. The HEqG's primary concerns are that priorities, plans, budgets and guidelines should be working towards health equity, and that government bodies are held accountable for these.

At the national level, a key engagement of the HEqG is with the Ministry of Health and Social Welfare, through the Technical Committee, engagement in MoHSW processes such as the Annual Joint Health Sector Review or the Health Sector Evaluation, and engagement with Departments, such as Reproductive and Child Health Services or the Budget section. The HEqG lobbies for the Health Sector to gain a greater share of the national budget. It also lobbies for a greater share of the health budget to be demonstrably allocated and spent on the basic health care services that all Tanzanians need access to. Other key ministries that members of the HEqG engage with include the Ministry of Finance, the Ministry of Community, Gender and Children, and the Ministry of Planning, Economy and Empowerment.

The Prime Minister's Office Regional and Local Government is a key target at the national level, because of its central role in leading the design of planning guidelines (such as Opportunities and Obstacles to Development for village planning, and Council Comprehensive Health Planning guidelines), as well as in providing planning and budget guidance through the Regional Secretariats. As HEqG increasingly works to expand

opportunity for health equity work at the level of the LGAs, engagement with PMO-RALG is vital.

The development partners in (health) group currently interacts with the HEqG in MoHSW events and meetings, such as the SWAP Technical Committee. The HEqG informs the DPG and to raise issues of concern in DPG approaches where these are seen to be compromising the movement to greater health equity in Tanzania.

#### 2.1.2.3 Elected representatives

The HEqG targets elected representatives in Tanzania to play a more effective role in debating priorities, plans, budgets and actions, in the interest of greater health equity.

A primary group of elected representatives is Members of Parliament. HEqG has a track record of working annually with the Social Service Committee as well as participating in events such as the Civil Society Parliamentary exhibition. This activity has been expanded to include the Social Welfare Committee and the Economic and Finance Committee, and HEqG has been focusing on the Women Parliamentary Members group to emphasize the need for their support for women's health rights.

As HEqG increasingly focuses on analysis, information and tools for use within the LGA context, the importance of working with elected Councillors increases, as the *madiwani* play a similar role to MPs at the level of the District Council.

Also key are elected representatives at the village and ward levels – which includes members of Village Councils with the mandated sub-committees. These are the bodies that play a key role in leading village planning within the LGA system. These bodies are also responsible for and interact with newly forming health governance bodies such as the Community Health Funds, the District Health Boards, and the Health Facility Management Boards. These bodies are intended to expand the space for citizens engagement in planning, financing and monitoring for improved quality health services. However, they remain nascent and extensive support is required to institutionalize the bodies and ensure that they are truly representative and working in the interest of health equity.

### *2.2 CARE's Approaches and Strategies Under the HEqP*

CARE's collective HEqP activities were implemented to generate evidence of inequitable differences in health access and outcomes; this evidence was later used to inform advocacy approaches for change at different levels of the Tanzanian health system.

CARE worked to increase capacity for grassroots organizing and networking to influence the prioritization of health resource allocation to increase equitable access to quality

services through the community score card (CSC) process. The CSC process is a participatory tool designed to enhance the participation of communities in monitoring health service provision. Through interactive meetings between districts leaders, men, women, and service providers, the CSC process functioned as an entry point for communities to more effectively engage in health governance processes.

To support increased capacity for evidence-based planning, resource allocation and utilization at the LGA and national levels, CARE carried out the following activities:

- Conducted health budget analysis
- Designed and printed a policy brief based on the budget analysis
- Conducted advocacy using the health budget analysis
- Conducted research to inform advocacy campaigns, including the barrier study and people's voices
- Engaged with district councils to use the CCHP guidelines to plan for maternal health
- Conducted a training on the CCHP on approaches and methods to include maternal health in district level budgets
- Documented strategies used by various actors for citizen engagement on maternal health
- Documented stories/testimonies/experiences of health service usage using the most significant change methodology
- Conducted media campaigns, including television and radio spots and newspaper articles to raise awareness on the right to health and the social position of women and girls
- Met with the Social Services Committee of Parliament to push to raise maternal health issues in parliament
- Participated in national level consultations – Cluster Working Group II, Safe Motherhood Working Group, Policy Forum Budget Working Group, Sector Wide Approach – MoHSW (SWAP)
- Developed a policy pack for planners and policy makers on key research to inform health policy making and budget resource allocations

# 3. Methodology

This evaluation report seeks to understand to what extent CARE's technical approaches, methods and activities helped the project to achieve its goals and objectives. This evaluation report is designed to assess incremental successes towards achieving the project goal, why these steps were successful, whether there have been any positive changes recorded as a result of this programming, and how CARE's advocacy efforts contributed to these changes. This report also seeks to understand what project approaches worked and which ones did not, as well as explore some of the challenges

that arose during project implementation and how CARE worked to overcome these challenges. Finally, this report seeks to identify any lessons learned from project implementation and how these lessons can be used to inform approaches and activities in the next round of HEqP programming.

### *3.1 Project Documentation Review*

During the initial consultations for this evaluation, available project information was gathered for review, including the original project proposal and annual project reports, to understand the background relevant to this research study. One limitation in the HEqP design is that the project did not have a logical framework to guide activity implementation nor a monitoring and evaluation plan with measurable outputs or targets articulating benchmarks towards realizing the overall project goals and strategic objectives. Further, there was no baseline conducted to quantify and assess the "before" situation.

### *3.2 Literature Review*

In light of this, an extensive literature review was conducted to inform the design of the research approach, particularly to understand evaluation methods that can help to compensate for a lack of baseline information about the project impact area and beneficiaries. The findings of the literature review were used to design the evaluation approach. In addition, the literature review was conducted to understand international best practices in health equity and advocacy programming. These findings were later used to guide the development of a specific set of recommendations for this project.

### *3.3 Key Informant Interviews*

Evaluating without indicators meant a deep assessment of project history and consolidation of the information taken in the monitoring reports produced during the project life time. However, given that the project lacked a robust monitoring and evaluation plan and specific activity reports to assess actions and progress towards the project goals and objectives, gaps in project documentation were filled through key informant (KI) interviews to collect primary source data from different stakeholders involved in the implementation of the HEqP.

Choosing criteria for the selection of the KIs was important given that the final evaluation had limited time and resources. KIs were selected on the basis of their "knowledge" of the project either through historical or more recent involvement during project implementation. The final KI list included 10 participants representing CARE's HEqP consortium partners, select CARE staff involved in the implementation of the HEqP and project stakeholders from other NGOs. The KI interviews were deigned to gather qualitative information related to KI perceptions on the impacts and successes of the

project, challenges encountered during project implementation, lessons learned, and recommendations for future programming.

### *3.4 Data Analysis and Documentation*

As soon as the data was collected, the analysis of the KIs' interviews commenced. The final step in the evaluation was reporting the findings of the KI analysis and integrating the findings with the desk review and literature review to develop a set of specific recommendations for the way forward.

## 4. Key Findings

### *4.1 Literature Review*

The literature review was conducted to explore international best practices in health equity and advocacy programming. These findings established a working definition of "health" and "equity," informed an understanding of broad equity-based programming principles and best practices in designing health equity and advocacy programs and designing monitoring and evaluating advocacy programs.

#### 4.1.1 Definitions of "Health" and "Equity"

The concept of "health equity" is guided by several overarching international standards and definitions. The 1946 Constitution of the World Health Organization (WHO) preamble defines ***health*** as: "a state if complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Based on that definition of health, the WHO Constitution establishes the ***right to health*** in the following statement: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." A situation of ***health inequity*** exists when membership in one group is associated with lower health outcomes for that group as compared to other groups. A group can be disadvantaged by health inequity on account of their ethnicity, religion, poverty, geographic area, gender or some other shared trait. Experience has demonstrated that women, newborns, and young children under five years of ago are particularly susceptible to socioeconomic inequities due to their dependence on others. (USAID, 2010).

These international policy commitments make clear the state's obligations in respecting, promoting, and fulfilling health care obligations, including preventive and treatment services, but more importantly, these international policy commitments make clear the state's obligations in addressing the underlying preconditions for health for all people, *without discrimination* (USAID, 2010). This framework also provides a means for non governmental actors to hold governments accountable to these policy commitments.

These definitions will be the working definitions for the purpose of this evaluation report, unless otherwise noted.

### 4.1.2 Equity Programming Principles

As explained above, a group can be disadvantaged by health equities on account of a various reasons. Therefore a holistic understanding of health equity is required. "PROGRESS" is a clever acronym developed by Timothy Evans and Hilary Brown, to summarize the characteristics of all the different groups health equity projects can focus on including, "place of residence, race, occupation, gender, religion, education, socio-economic status" (USAID, 2010). In other words, health equity programming requires a focus on power and structural dynamics that determine policy and underlying social determinants of health, including cultural/social norms, power relationships, community structures, education levels and allocation of wealth (USAID, 2010).

Equity must be intentionally pursued as a strategy, it will not necessarily happen as a byproduct of other development efforts. A project can legitimately claim an "equity focus" if the project is *actually* reaching a most disadvantaged group within a project area, rather than just working in a project area where disadvantaged groups are known to exist. It is not sufficient to say that the project is addressing equity issues solely because it is working in a disadvantaged geographical region of the country. For example, health economists have pointed out that it is possible to achieve the Millennium Development Goals while widening the gap between the rich and the poor (USAID, 2010).

Once it is decided that health equity will be pursued as a program strategy, it is important to identify a specific inequitable issue, determine how this inequitable issue affects health outcomes, and design effective interventions that affect both equity and health outcomes (USAID, 2010).

### 4.1.3 Designing Health Equity and Advocacy Programs

General components of a sound project design include the following:

- Clear statement of the *broad development problem* to be addressed;
- Clearly focused specification of a more limited development *objective or goal*;
- Properly articulated objectives and *activities*, which follow logically from the development objective, along with *expected results*;
- An implementation strategy, accompanied by a *detailed work plan*, to be updated annually;
- A *staffing plan*, associated with the work plan;
- A *management plan*, with clearly stated roles and responsibilities for all project partners and principals.
- A systematic *monitoring and evaluation plan*.

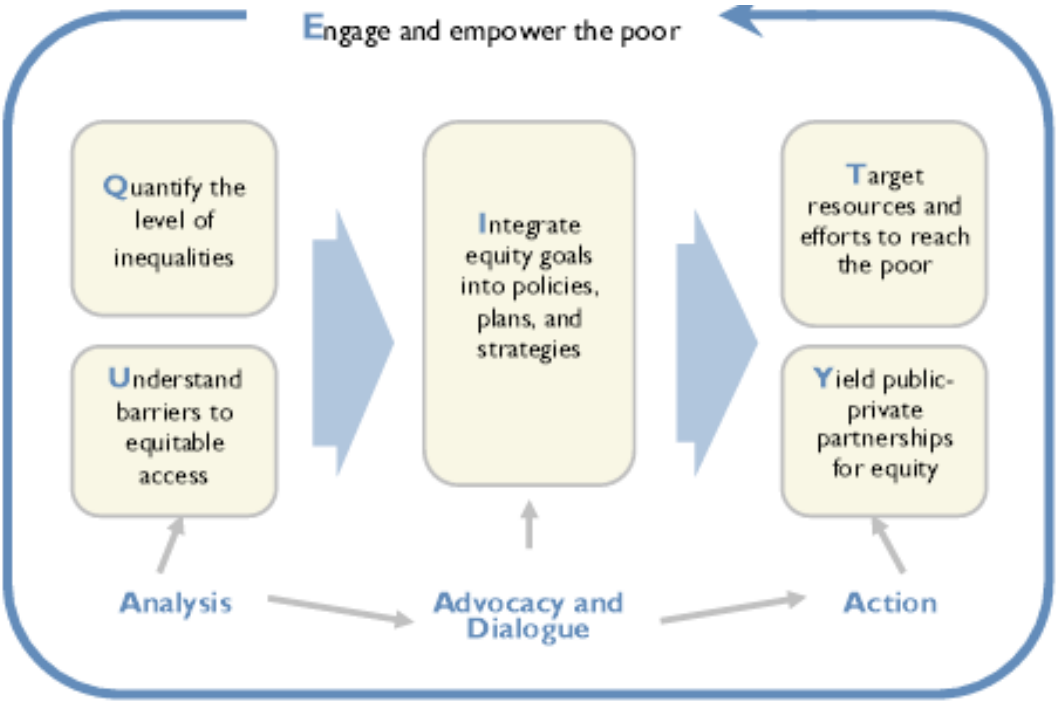
Programs design without inclusion of baseline information, milestones, and performance indicators make it extremely difficult to monitor project performance properly. Resources should be allocated from project onset for monitoring activities. (http://www.undp.org/evaluation/documents/chap4.htm).

More specifically, in any programming with an aim to increase equity, it is important to define and clearly articulate the following (USAID, 2010):

- How equity is defined within the context of the program
- What specific actions are aimed at improving equity
- How these improvements will be demonstrated
- How these actions, if successful, might be sustained/institutionalized and scaled up in programs and policies (USAID, 2010)

In line with the components of sound project design noted above, the M&E system should be set up to track changes in both equity and its underlying conditions and health outcomes throughout the life of the program. (USAID, 2010)

The USAID-funded Health Policy Initiative (HPI) developed an Equity Framework for Health:




### 4.1.3.1 Analysis Stage

Programs that aim to have health equity outcomes need to account for:

- What the health inequities are
- The magnitude of the problem
- Who is affected by the inequities
- The underlying socioeconomic issues and barriers that lead to inequity
- How gender relationships affect inequities in health outcomes

Because secondary data sources, such as the DHS, will not always reveal the true extent of health inequities in any given area, communities themselves, including members of disadvantaged groups, local health service providers and any other local stakeholders should be involved in providing this information (USAID, 2010). Specifically, such an analysis may involve exploring potential barriers to equitable access, and when possible, quantifying the level of inequity, according to the following:

- Harmful cultural norms and practices
- Burden of care
    - Women's duties are too time consuming to practice healthy behavior
    - Women cannot leave livelihood activities or other children for preventive care or to take care of illness
- Low literacy
- Barriers in accessing services
    - Economic
    - Distance/lack of transportation
    - Language
    - Health service not culturally acceptable
    - Poor treatment by health staff
    - Poor understanding of health messages given by health staff
- Stigma or violence against group
- Unequal power relationships between disadvantaged and advantaged groups
    - Unequal decision making power within a family or community
    - Unequal representation in community structures, i.e., community heath development committees

Once you have quantified the level of inequities and the barriers to equitable access are well understood, then the project is ready for the advocacy and dialogue for action stage.

#### 4.1.3.2 Advocacy and Dialogue for Action

Advocacy for policy change and improved health equity outcomes is an incremental process that can take years to achieve the desired goal (Constella Futures). This is because advocacy takes place in a dynamic and changing environment, in which external factors can affect your ability to achieve your goal. However, the development of an action plan, including specific activities to achieve your advocacy goals and objectives

within a defined timeline, can help you ensure progress towards your desired goal, including the ability to measure and demonstrate incremental successes towards your desired goal over time (Constella Futures).

***Identify advocacy issues, goals and objectives.*** Plans and strategies for advocacy and dialogue should be informed by the analysis stage. During the analysis stage, advocacy issues, goals and objectives should be identified. Recognizing that no project will have unlimited time or funds for implementation, it is necessary to clearly articulate and define how equity is defined within the context of your program (USAID, 2010). It is important to develop and maintain a project-specific definition of equity; one that prioritizes a specific situation of health inequity and concentrates its efforts on addressing that situation.

***Determine target audience(s)***. Given that many underlying factors contribute to health inequity, strategies for improving equity must reach beyond the intended beneficiary group in order to create a more favorable environment for improving health outcomes of the disadvantaged group. For example, if women are not accessing maternal health care because they are not able to make decisions on their own, then the project needs to work with men to strengthen their role in supporting the health of their wives or partners, or if disadvantaged groups do not access health services because certain cultural practices are not followed by health care providers, then the project needs to work with health care providers to help them adjust services accordingly (USAID, 2010).

***Develop advocacy and implement strategies.*** The project needs to be clear about what specific actions are aimed at improving equity. Strategies can address underlying conditions and barriers directly or indirectly. The project resources and timeframe available should clearly align to the magnitude of the health inequity situation and the potential to take realistic actions to improve the situation. Communication channels should be selected accordingly. Project strategies need to clearly align with the barriers identified in the analysis stage and baseline information about the situation of health inequity.

***Monitor progress and outcomes***. It is important to be purposeful about how improvements in the equity situation will be demonstrated through a plan to monitor progress and outcomes along the way. Outcomes and impact should be rigorously evaluated. If successful in achieving improve health equity outcomes, the project should articulate how these actions can be sustained and scaled up. Building support for sustaining and scaling up successes is paramount.

#### 4.1.3.3 Monitoring and Evaluating Advocacy Processes

It has been argued that traditional evaluation processes are not a good match for advocacy and policy work (Reisman, 2007). Some even claim further that advocacy work cannot be measured and that any attempt to do so diminishes the power of their efforts (Reisman, 2007). This rather cynical argument obscures several compelling reasons to monitor and evaluate advocacy processes.

Often considerable resources and effort can be wasted without achieving tangible impact because efforts are not guided by evidence. Appropriate and targeted interventions are essential to achieving intended outcomes and impacts, which must be guided by evidence on what we know works and what needs to be done to address structural barriers to equitable access to health services. Evaluation can clarify what are meaningful and appropriate expectations for advocacy and policy work, but more importantly what specific strategies are most effective for achieving desired goals. Donors and implementing organizations hold the desire to make the case that their investment of resources, time, and efforts are making a significant difference (Reisman, 2007); it is only through rigorous M&E processes that this determination is possible. Finally, a systematic M&E system provides the methods, tools and processes necessary to understand what is working and what is not working and to assess whether you are on track to achieve your intended outcomes. The results of M&E processes should be used to inform adjustments in advocacy strategies to better help a project move towards its goal.

Despite these strong and compelling reasons to monitor and evaluate advocacy process outcomes and impacts, there are several challenges that arise in doing so. These include the role of external forces or conditions that may affect the achievement of your goal. Moreover, most organizations tend to work towards advocacy aims in partnerships or coalitions making it difficult to attribute any change to your specific set of actions. Another challenge is the long time frame required for changes to occur and that often funding cycles for advocacy work may not realistically match the timeframe required to achieve high level policy change and longer term advocacy goals.

As a result, standard social science methods that identify an independent variable and a specific set of dependent variables likely to affect change are not always well-suited for measurement of advocacy and policy work (Reisman, 2007). There are no commonly agreed upon outcome categories for advocacy and policy work (Reisman, 2007). So what are we left with then?

To begin, an advocacy project must determine whether it is working on a specific short-term change achievable within a typical project funding cycle, or whether the project is a longer term process of policy or social change (Reisman, 2007). Needless to say,

achieving longer term change requires a longer term commitment. Once that is decided, short- and intermediate-term outcomes can be defined and measured as a pathway to achieving longer term change.

The pathway to achieving longer term change should be guided by a theory of change. The theory of change will provide essential clarity for developing a monitoring and evaluation design, by clearly articulating how, what, and why advocacy processes are taking place by defining the strategies and outcomes that lead to an ultimate impact, or change (Reisman, 2007). Once the theory of change has been clearly articulated to all stakeholders, key evaluation design questions can be answered including: what specific strategies and outcomes should be measured (indicators)? How should M&E processes be structured and how often should evaluation data be collected (type of data required)? And how will results be communicated? It is crucial to carefully consider what type of data you should collect through an on-going M&E system, so that the data can be useful for monitoring your progress, outcomes and impact (Constella Futures).

M&E should be planned for from the very onset of advocacy project initiation, including the development of indicators in line with the theory of change. Indicators are predetermined milestones, or check-in points, to monitor progress, outcomes and impact of specific activities, or outputs (Constella Futures). For example, output indicators may include the number of newspaper articles printed or PSAs aired that capture the reach of a particular campaign or public awareness initiative (Reisman, 2007). Output indicators are a step to demonstrating progress towards your longer term impact indicators, which ultimately demonstrate a positive change in beneficiaries lives as a result of your advocacy efforts, for example, passage of new legislation. When considering evaluation methodologies and deciding upon indicators, it is important that to remember that it is not necessary to create special equity indicators of health outcomes, rather the M&E system can be designed to collect standard health outcome indicators such as skilled attendance at birth and this information can then be disaggregated according to target beneficiaries (USAID, 2010).

Given the inherent complexities of advocacy processes, it is often more credible to show how your efforts *contributed to* specific impact, rather than *resulted in* such an impact. By monitoring progress and outcomes during project implementation, and documenting the impact of your advocacy efforts, you are in a better position to determine that you have contributed to the impact you observe.

## *4.2 Health Equity Project*

The findings related to the HEqP emerged from the KI interviews with 10 participants involved in HEqP implementation. These KI interviews were conducted to gather

primary source data to fill gaps in project documentation and to assess KI perceptions on the impacts and successes of the project, challenges encountered during project implementation, lessons learned, and recommendations for future programming.

### 4.2.1 Project Design and Framework

Under the HEqP, the concept of health equity was centered around the idea of "Usawa kwa wote," or rather, equality for all. The specific definition of health equity adopted for this project is quality access to health services for all regardless of geographic location, education level, socio-economic status, and gender. In this case, the situation of maternal health was prioritized as a lens to address health inequity. Project efforts were concentrated on addressing that situation in order to improve quality access to health services for all.

The criteria used to decide where project activities would be implemented were agreed upon by the collective HEqG, based upon identification of key advocacy gaps. The annual planning process was flexible; in theory, needs analyses and compelling issues on a year-to-year basis directed the selection of target geographical areas for project interventions. Namely, differences in budgetary allocations, health care access and awareness were analyzed to determine priority target groups and geographic focus areas.

However, within this process, each organization used this collective effort as a platform to continue to build upon their past and on-going programming in different areas of Tanzania. For CARE, this project was used to strengthen community-based maternal health and equity programming in the Mwanza region, including Magu and Misungwi districts. Based upon a review of project documentation and KI interviews, it is not clear that criteria to decide where project activities would be implemented were based on a rigorous baseline analyses, involving communities and disadvantaged groups themselves, to quantify the magnitude of the problem, identify groups most affected by these inequities, and the underlying socioeconomic issues and barriers in a specific area that lead to that situation of inequity.

Recognizing that resources and time for project implementation are limited and that key relationships with relevant stakeholders help lead to successful outcomes, it seems appropriate to build off of and strengthen on-going programming efforts of each organization in order to realize improved health equity outcomes through advocacy. However, what appears to be missing is a presentation of relevant regional and district level statistics to substantiate decisions to work in certain areas over others. Below is an illustrative example of information related to regional differences in budgetary allocations, health care access, awareness and outcomes that could highlighted to further substantiate priority target groups and geographic focus areas, especially for interventions implemented on the local level under this project.

| Tanzanian Ministry of Health Resource Allocation | |
|---|---|
| Region | District #1 |
| | District #2, etc |
| Population | Total # of persons |
| Annual Health Resources | Overall # |
| Resources Per Capita | Proportion of Resources received per total population |
| Situation of Health Inequity | Key MH DHS outcomes according to disaggregated groups |

### 4.2.2 Project Outcomes and Impacts

The below set of specific outcomes and impacts have been attributed to this project.

As we learned through the literature review findings, one of the main challenges related to advocacy work is that when organizations work in partnerships or coalitions towards shared advocacy aims, it often becomes difficult to attribute any changes or results witnessed directly to your specific set of actions. Bearing that in mind, some of the outcomes and impacts reported as a result of this project may be difficult to attribute to CARE's portfolio of activities alone, instead these outcomes and impacts could be result of the overall HEqG working in coordination towards a shared advocacy aim or these outcomes and impacts could be the result of other external factors, as is often the case in advocacy work. Where possible, changes that can be directly attributed to CARE's specific portfolio of activities and actions have been noted. On the whole, however, it is important to bear in mind that advocacy is an incremental and often long term process and changes should be celebrated as shared victories towards the achievement of a long term goal towards improved health equity in Tanzania.

#### 4.2.2.1 Resource Allocation for Maternal Health

Through CARE's advocacy efforts and the collective efforts of the HEqP around ensuring a 15% allocation national budget to health, public leaders and government representatives have realized the importance of putting priority in budgeting for health, which has been demonstrated through notable, if unpredictable, increases in the overall proportion of Tanzania's national budget allocated to the health sector. The most notable outcomes of the HEqP have been resource allocations in the Ministry of Health and Social Welfare (MoHSW) budget for maternal health. For example, the MoHSW budgets for 2006/07 and 2007/08 included a budget line for maternal health. Moreover, the Government of Tanzania has recently allocated resources for the procurement of 400 tricycles for helping pregnant mothers in the rural areas, which has been a key advocacy focus area for CARE under the HEqP. In addition, HEqP advocacy on delivery kits resulted in the government budgeting for these supplies in the national budget, however

this cannot be attributed to the HEqP 100% outright. Budget priority has also been given to ensuring availability of skilled birth attendants.

#### 4.2.2.2 Increased Awareness on Maternal Health

The national level dialogue on maternal health and health issues in general has gained intensity. Prior to the HEqP, policy-makers originally were generally not aware of equity issues in health. Following the advocacy interventions there has been a notable increase in the level of awareness of Members of Parliament on equity and maternal health issues. The HEqG can claim a role in this through through their involvement in the Technical Working Group on the Basket Fund and the Safe Motherhood working groups of the MoHSW, as well as through their dissemination of 2008 budget analysis findings to members of Parliament.

Overall, the HEqP was well known among governmental and non-governmental actors in the Tanzanian health sector and managed to draw people's attention to the issue of maternal health. A high level of awareness was raised through the CSC process, media campaigns, print materials, the campaign launch, GDSS, GF, and PT.

#### 4.2.2.3 Evidence-based Decision-Making

The HEqG was involved in supporting increased capacity for evidence-based planning, resource allocation and utilization at the LGA and national levels. For example, after the budget analysis was conducted in 2008, the findings were disseminated to 15 Members of Parliament from the social service and finance committee. This sparked a lively debate and helped MPs realize gaps in the current budgeting processes and levels of resource allocations to health in general and maternal health specifically.

#### 4.2.2.4 Linkages to National & International Advocacy Movements

CARE, through the HEqG, has provided support to the White Ribbon Alliance - Tanzania, which is a member of the global advocacy alliance for maternal health. Moreover, the HEqG has used forums like the Gender Festival, GDSS, PT to establish linkages to national level advocacy movements to advance the cause of maternal health.

#### 4.2.2.5 Improved Maternal Health Outcomes

Research has demonstrated that the CSC process CARE facilitated in Mwanza was successful in improving health outcomes, including maternal health. Increased positive health seeking behaviors have been reported in the communities where the CSC was implemented as a result of engaged dialogue between service users and service providers and monitoring of key dimensions of health service provision by those involved in the process.

#### 4.2.2.6 Development of Effective Community Empowerment Tools

Research has demonstrated that the CSC process CARE facilitated in Mwanza was successful in improving community and civil society participation and engagement in planning and budgeting for health and improving the relationship between health service providers and service users. This CSC process resulted in increased accountability of health service providers and several tangible outcomes, including the DMO's commitment and follow through on the provision of a midwife in N'gombe community following his participation in the interface meeting phase of the CSC implementation process. Overall, the CSC process has been effective in empowering communities to demand their health rights. Given this success, the CSC process holds potential for meaningful applications in different thematic areas and scale up into different target geographical areas.

### 4.2.3 Challenges Encountered

As discussed previously, advocacy for policy change and improved health equity outcomes is a complex process that takes place in a dynamic and changing environment. Advocacy processes are often wrought with challenges both internal and external that can affect progress towards the advocacy goal and objectives. In this case, the HEqP faced several challenges that did not take away from the outcomes and impacts realized, but are worthy of note to understand how to mitigate foreseeable challenges in future programming and to help assess the most cost effective and efficient use of project resources.

#### 4.2.3.1 Delayed Decision Making Among HEqG Members

Very few activities planned under the HEqP were actually implemented within the year they were scheduled on account of several delays related to the decision-making processes among HEqG members. Each partner within the HEqG lacked a dedicated person to serve as the organization's representative or liaison between the group and his or her respective organization. This challenge created a lack of strong institutional memory within each member organization, which served to slow group decision-making processes, delay work plan implementation, and create difficulties in following up and moving forward on commitments and agreements made from one meeting to the next. The decision to hire a coordinator in part abated some of these coordination and decision-making challenges, however the coordinator was not in a position to make decisions on behalf of any one organization.

Moving forward, it should be acknowledged that the presence of the coordinator cannot supplant the need for organizational commitment and dedication to stand strong on fulfilling the annual work plan. Each organization needs to ensure that HEqP

management structures are incorporated in their internal management and decision making processes. This could be streamlined by ensuring that each organization has a HEq focal person that serves as a dedicated representative and liaison to each respective organization.

#### 4.2.3.2 Lack of Follow Through on Shared Activities

The lack of dedicated staff members from each organization functioning as representatives and liaisons to the HEqG at times weakened follow through on shared activities, especially as there was a general lack of ownership by specifically assigned personnel to coordinate shared activities. One such example is the "campaign." Excitement and energy about the campaign seemed to dissipate immediately following its launch. In this case, the guest of honor was not assigned with a specific task or area of responsibility to accelerate the momentum or spread the reach of the campaign launch. Moreover, there was no action plan set in place for scaling up the campaign launch and systematically moving it beyond Kisarawe and the Gender Festival. This raises important issues around the cost effective use of project resources.

#### 4.2.3.3 Cost Effective Uses of Project Resources

Interviews with some KIs revealed how certain project activities were more successful, but more importantly, more cost effective than others. For example, engagement with members of Parliament, while effective, was perhaps not the best use of project resources in light of other more cost effective approaches that could have been adopted to achieve a similar effect with wider reach. Direct engagement with members of Parliament was a very expensive project approach, when the use of the policy packs could have been disseminated to them to grab their attention on important inequities in budget allocation for health and the resulting differences in health outcomes among various disadvantaged groups as a result of inequitable resource allocation. The resource savings could have been used to reach an even wider audience with the same message throughout different levels of the Tanzanian health system and sector.

Moreover, significant resources need to be allocated to effectively implement the CSC process. It is designed to be a gradual process with several iterative rounds of scoring of services among service users and service providers. Sufficient time and resources are needed to facilitate engaged dialogue about the resulting scores and follow up on the plan of action resulting from the two-way dialogue. People need to understand the benefits of such a process and research demonstrates that people are more inclined to hold a favorable view of the CSC process when they witness direct and tangible benefits from the implementation of the process. The richness of this process cannot be cheapened by failure to lay the appropriate groundwork, secure buy-in from local leaders, service providers and community representatives, and ensure follow up on commitments made within this process.

#### 4.2.3.4 Shifting Focuses and Priorities of HEqG Members

Beyond delayed decision-making processes of individual HEqG member organizations, another challenge cited in this evaluation process is the feeling among HEqG members that the group has lost its focus and passion on policy change and the use of information from the community to feed advocacy approaches, which was the primary focus of the HEqG's original proposal. In part, this is explained by the fact that the original justification for a focus on maternal health and its connection to improving health equity and outcomes writ large was weakly defined and perhaps not explicitly address across all project documentation.

The lack of a memorandum of understanding or a cohesive and overarching management document for all members of group presented a huge challenge in binding the group together and ensuring consensus on the most appropriate areas for programming emphasis and focus. Such documentation would prove critical in serving as reference material embodying previous commitments and agreements in the face of project implementation challenges and changing vision of group members. The role of the HEqG coordinator should not be confined to arbitrating group disputes, and accordingly, the presence of the HEqG coordinator cannot supplant the need for such guiding documentation to bind the group to a specific, well-defined set of agreements to guide the direction of overall advocacy aims and the focus of project activity implementation.

#### 4.2.3.5 Staffing

Specific to CARE, a high level of HEq staff turnover hindered project momentum. It was noted that high levels of staff turnover was one of the most challenging aspects of project implementation, especially as over a period of three years there were three different HEq managers. Each manager applied a new set of thinking and approaches. Against that reality, the project direction changed according to the vision of each new manager, which resulted in inconsistent project planning and implementation.

Also specific to CARE, significant challenges related to staffing were noted in the implementation of community-based activities. There was no dedicated HEq project officer located in Mwanza where CARE's community-based activities were focused, rather the HEq project manager was located in Dar es Salaam which created a big set of logistical challenges in terms of effective and cost efficient project activity management. The HEqP relied on WAGE staff located in Mwanza to implement HEqP activities. The use of staff from other projects prevents full dedication and focus to the activities at hand, but more importantly, hampers the commitment to monitoring progress of activities. This is especially true because in this case there was no proper planning of human resource management of activities between HEq staff in Dar es Salaam and WAGE staff in Mwanza.

It was also noted that reliance on consultants to implement technical aspects of the project did not serve to build the capacity of the internal group and staff members in key technical areas of program implementation. This model weakens the ability to build capacity of internal staff and in turn holds sustainability and cost effectiveness issues in future activity implementation.

#### 4.2.3.6 Lack of a Monitoring and Evaluation Plan

One of the most consistently cited challenges of project implementation was the lack of measurable outputs, targets, and a logical framework to guide activity implementation. The lack of an M&E plan greatly weakened the ability of the project to demonstrate measurable progress and evidence towards achieving the advocacy goal of improved health equity.

#### 4.2.3.7 Missed Opportunities

Budget analyses were only done on the national level. This represented a missed opportunity to measure and assess impact of the HEqP advocacy and community engagement activities on the district level. While the CSC process anecdotally indicates that the project was successful in achieving some of its intended equity aims on the district level, there have been no formal analyses to substantiate these claims and preliminary indications. Such an analysis would also serve to create stronger and more compelling feedback loops between community level advocacy and equity activities and national level advocacy and equity activities. This should be included as part of the M&E plan for the next round of project implementation. The Tanzanian Ministry of Health Resource Allocation table provided in Section 4.2.1 provides an illustrative structure for such an analysis.

#### 4.2.3.8 Community Level Leadership

In terms of project activity implementation on the local level, community readiness is essential to realize success. Varying levels of community "readiness" can negatively impact uniform realization of outcomes and impacts across all communities. Weak political leadership and buy-in impedes progress, especially with respect to such difficult and challenging issues as improved maternal health outcomes and improved health equity. In some areas where the CSC process was implemented, engaged commitment of local leaders proved challenging. Implementing project activities prior to securing engaged and committed leadership from local leaders can hold the unintended consequence of harming the project's reputation within the intended impact area.

#### 4.2.3.9 A lot of Talk, Little Action

As noted earlier, advocacy is a long and often times challenging process. Some project stakeholders pointed out their sense of frustration with the fact that Tanzania has not yet

hit the political will to realize the changes envisioned by the collective HEqG. This project was successful in generating a lot of engaged dialogue and meaningful talk about health and maternal health issues, but less successful in realizing concrete actions, political commitments, and improved health outcomes as a direct result of this project. This is an important lesson to bear in mind as the project moves forward. An M&E plan with tightly defined outcome and impact indicators would provide project staff with an opportunity to celebrate incremental achievements towards the overall project goal by seeing how their collective actions are bearing fruit towards the intended outcomes and overall goal.

# 5. Recommendations & Way forward

These findings help us to understand which activities and approaches are more successful than others in project implementation. These findings have been used to develop a set of recommendations for the way forward for future HEqG programming.

## *5.1 Establish Routine and Systematic M&E systems*

Now that the lack of an M&E system for this project has been widely recognized as a problem, the next iteration of the project presents a formidable opportunity for the group to address this weak point. Moving forward, tools to measure progress should be agreed upon, adopted and utilized by all consortium members. Each activity should have outcome indictors which are measurable and in line with the project's theory of change. For CARE, these indicators should be aligned with the Country Office 10 year Strategic Plan and its associated theory of change.

We know that advocacy is a complex, long term process that often involves many players, making it difficult to demonstrate how impacts and achievements are a direct result of your advocacy efforts, but it possible to show how your efforts have contributed to that impact. Also, through this process, we learned that some "investments" of the HEqP were not as effective as they could have been, it is only through on-going M&E processes that this determination would otherwise be possible. By monitoring progress and outcomes along the way and documenting the impact that your advocacy efforts, you are not only in a strong position to determine that your actions have contributed to the impact you observe, but also improve your project approaches according to your findings.

Routine M&E systems will allow you to understand which activities are working and which ones are less successful in contributing to your goal. Information gleaned from on-going monitoring processes should be used on a continuous basis to inform project approaches and activity implementation. Monitoring and evaluating advocacy should be a dynamic process, whereby it should be flexible enough to accommodate changing objectives and tactics. Moreover, monitoring and evaluating advocacy should rely on

simple, common-sense indicators over the adoption of complex tools and techniques (O'Flynn 2009).

If possible, it is even recommendable to hire a M&E person for the HEqG who would be dedicated on a full time basis to develop a set of specific outcome and impact indicators for the project and track the outcomes of each organization's activities to ensure the project is on target to meet its advocacy and social change goals and objectives.

## *5.2 Develop a Memorandum of Understanding Among Group Members*

On the whole the HEqG needs to be more explicit about their collective advocacy and social change aims. This could involve reaffirming and reinforcing a collective focus on maternal health or refining the group's focus to include other health focus areas and outcomes. Either way, the group consensus about this decision needs to be captured in writing and all members of the group need to be understand the implications of this stated commitment and ensure the resources necessary to fulfill this stated commitment.

## *5.3 Harmonize Management of Activities*

High levels of staff turnover are likely to be an ever present reality, especially within the NGO sector. Since this reality is difficult to change, CARE and the HEqG can instead change their approach to mitigating the impacts and consequences of this reality. Hiring a group coordinator was a necessary first step towards overcoming some key management and institutional knowledge challenges the group has contended with in the past. Adopting the set of recommendations provided below will help to overcome remaining challenges.

CARE should place a HEq project officer in areas where community-based activities are being implemented to oversee the project progress. If this is not possible due to limited funding or other management constraints, an annual work plan needs to be developed with clearly identified persons responsible for each activity to be implemented, and adequate resources need to be budgeted to support proposed activities, including vehicles and support staff. The system of communicating plans and making requests of field-based staff on an as-needed basis is simply not functional, worse yet, it compromises the successfulness of project activities in achieving intended outcomes and impacts.

As relates to the group, dedicated and responsible persons need to be assigned for each shared group activity. This will help to create a sense of "ownership" over joint activities and will help to ensure follow through on commitments made to joint programming and activity implementation.

## *5.4 Reinvent the Health Equity Group "Brand"*

One the most exciting aspects of project implementation was cited to be the original ease with which the group worked together and were guided by a firm belief in the importance of what they were together working towards. Moving forward, a commitment from all parties involved will be crucial to the continued successes and collective achievements of the group.

One recommendation to reinsert positive energy and reinforce the collective commitment to the advocacy aims and intended outcomes of the group is to more proactively share key HEqG findings, successes and outcomes with relevant stakeholders. Findings should be regularly and systematically communicated with international and country level groups, including universities, donors, country ministries of health, non governmental organizations, and other organizations implementing country level activities. This would help the HEqG fulfill its stated goal of reaching one its three target groups – the donor community – and ensuring the priorities, plans, budgets, and guidelines are working towards health equity and that governments and donor agencies are held accountable for these.

One interesting, and perhaps fun, form this could take could be a HEqG open house and reception, where project stakeholders are invited to come and learn more about the key achievements of the group's collective work. Each organization could either present their work individually or the group's work as a whole could be presented.

These "marketing" and "public relations" functions could be enveloped into the HEgG coordinator's role and position description. An indirect benefit of such an approach would be increased knowledge management processes and procedures across the group in the documentation and sharing of key findings, successes, outcomes, and impacts of the group's collective work, in addition to increased motivation of staff involved in the project implementation through regular feedback from stakeholders and celebrations of successes achieved when merited. Further, this could serve to propel the momentum of this advocacy movement by broadening the reach and building formative partnerships to sustain and scale up results.

## Sources Referenced

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Reisman, Jane, Anne Gienapp, and Sarah Stachowiak. 2007. A Guide to Measuring Advocacy and Policy. Prepared for Annie E. Casey Foundation by Organizational Research Services.

United States Agency for International Development (USAID). 15 December 2010. Considerations for Incorporating Health Equity into Project Designs: A Guide for Community-Oriented Maternal, Neonatal, and Child Health Projects. Draft.

## Recommended Resources

1.
A Handbook of Data Collection Tools: Companion to A Guide to Measuring Advocacy and Policy is available at www.organizationalresearch.com and www.aecf.org. It is also available as an online resource at www.innonet.org.

This interactive compendium allows users to review specific data collection approaches and examples of measurement tools that correspond to a menu of outcome categories. Users can easily adapt data collection tools to match their own evaluation efforts.

2.
KPC is a tool that can be used to measure equity for both evaluation and monitoring. For more information about the KPC tool, see KPC Resources at the following link on the MCHIP website: http://www.mchipngo.net/controllers/link.cfc?method=tools_mande.