

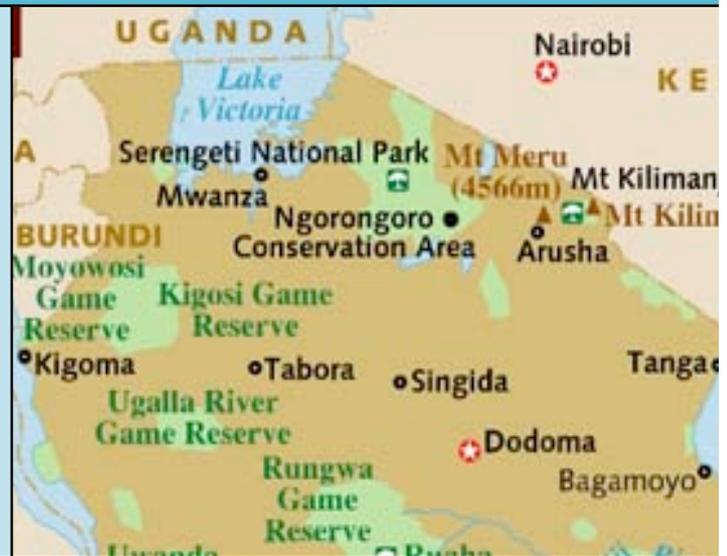
Health Equity Group: Tanzania

CONTEXT: Tanzania suffers significant challenges in providing equitable access to quality health services. While the Tanzanian Health Sector Reform process has been ongoing since the early 1990s, particular societal groups continue to suffer as a result of poor healthcare access; these groups include poor women, children and youth; people living in rural areas; people living in impoverished rural areas; and people with disabilities. Maternal health is particularly poor, with 57 maternal deaths per 100,000. Reforms have failed to either uniformly improve accountability in terms of health service provision, or to promote citizen and civil society participation in the health sector. In bringing together like-minded NGOs working on issues surrounding maternal health, the HEqG aimed to improve service delivery and awareness around health-related issues, and around maternal and infant health in particular.

OBJECTIVE: To create a popular health movement, which advocates for the right to health for all Tanzanians and generate commitment to equity in health as a visible strategy for citizens and their elected representatives.

APPROACH: The HEqG worked from the shared understanding that equity in health and access to quality health services can only be achieved where underlying gender relations and structures of patriarchal power are challenged to enable social justice. HEqG thus aimed to **promote awareness about existing gender inequities in accessing healthcare** and welfare rights, focusing on strengthening community-based initiatives that allow women and young people to **demand their health-related rights**.

HEqP also prioritised working in **partnership**, drawing together 4 likeminded NGOs to collaboratively tackling healthcare-related issues in Tanzania.



INTERVENTION: HEqP was formed in 2004 by like-minded NGOs all working on healthcare-related issues. 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. Key aims included: increased public voice surrounding health and health equity; more effective participation of citizens and health workers in decision-making and accountability processes; and planning and budgeting that focused specifically on addressing health inequalities, particularly in relation to reproductive, child and sexual health. Findings from HEqP activities were then fed into a wider advocacy strategy to improve healthcare access and quality for women and other marginalised groups.

In 2008, HEqP used the CSC to collect information on family planning in 4 communities in Magu and Missungwi Districts in Morogoro Region; it repeated the process in 4 further communities in 2010. The process took part in five stages:

Planning and Preparation: First, HEqP focused on building the capacity of CARE staff in CSC implementation. District-level groundwork was carried out, which included conducting a workshop with local government officials, councillors, CSOs and community representatives, in order to gather support for the project. Staff then conducted workshops with community members, which covered both general health-related issues, particularly in relation to maternal health, and on the CSC process. Finally, the input-tracking scorecard was developed, based on service-delivery policies and information gathered from service users and providers.

Conducting the Scorecard with Community: The input-tracking scorecard was presented to community participants who were then divided into interest-based user groups of between 5-8 participants. Each group developed 'performance criteria', after which each criteria, or indicator, was awarded a score of between 1-5, 0-10, 0-100 or another scale chosen by the group. Where low scores were awarded, groups were asked to suggest ways in which the situation could be improved. Indicators included: availability of staff and health centres; equality of access to family planning services by community members; sufficient counselling and advice on family planning-related issues.

Conducting the Scorecard with Service Providers: A similar scoring process was repeated with service providers.

Interface Meeting and Action Planning: This meeting brought together community members, service providers, local leaders and district health officials. All parties were prepared for the meeting in advance in order to ensure no

ENABLING FACTORS

Decentralisation and health reforms: Health Sector Reforms have provided an important framework in the promotion of more equitable and effective health service provision. While the reforms have fallen far short of expectations, the process of decentralisation through devolution, and the formation of such governance structures as local health facility management boards to enable citizen participation in health, provided foundations for local health management on which GAP could build.

Timing: HEqG made use of events in the political calendar to raise awareness and gather support for the improvement of maternal healthcare. For example, HEqG engaged in national-level political campaigns, re-ranking political candidates according to their commitments to maternal health.



- **Lack of coherent/cohesive leadership:** HEqG activities suffered as a result of delayed decision-making and changing priorities among decision makers; ineffective use of project resources; and a lack of commitment to shared activities. High levels of HEqG staff turnover further compounded this issue.
- **Gender inequalities in participation:** A 2010 evaluation revealed that the CSC failed to overcome gender inequalities amongst service users, as participation was overwhelmingly male. As a result, men drove the majority of issues identified and responses given.
- **Lack of M&E:** One of the most consistently cited challenges of project implementation was the lack of measurable outputs, targets or logical framework systems to guide implementation and monitor impact.
- **Continued challenges to interface dialogue:** Interface meetings often suffered as a result of intimidation by service users of community members who raise negative comments about service delivery. In a number of cases this also resulted in services being withheld.

SUCCESSES:

- **Health awareness and positive health seeking behaviour:** CSCs raised awareness around maternal health issues, particularly when implemented alongside ongoing HEqP media activities. National health budgeting also increased, with the Ministry of Health and Social Welfare allocating a specific budget line for maternal health in 2006/7 and 2007/8; it is not clear whether this is causally linked to the efforts of HEqP.
- **Participation, engagement and communication:** The CSC process in Mwanza increased community and civil society engagement in health planning, budgeting and implementation. Users demonstrated willingness to take responsibility for supporting service providers; for example, by constructing doctors' housing in Mwangala to combat the problem of staff availability.

KEY LESSONS

Ensure sufficient time and budget allocation: The CSC is meant to be a gradual, iterative process, with multiple scoring rounds and the ongoing and willing commitment of service users and providers. This must be considered during planning and budgeting, with time built into the process to allow for sufficient support gathering. It is also important that the CSC deliver at least some tangible changes, as results show that participants are more likely to support future scoring if they see direct outcomes from the process.

Importance of community level leadership: In a number of cases, the project suffered as a result of challenges in gaining community leaders' support for the CSC process. Where project implementation took place without sufficient leadership support, the overall reputation of the project was at risk. It is thus critical, particularly when tackling often controversial issues such as maternal health, that the gaining of local leaders' support is prioritised at the preparatory stage of project implementation.

Robust M&E system: Projects and CSC implementation processes should include a routine and systematic M&E system, with each activity given specific outcome indicators that are measurable and in line with the project's overall Theory of Change. This would also help in overcoming the issues of non-staff in some implementation areas due to budgeting/management constraints, which caused an issue in Mwanza in particular as local responsible partners lacked clear objectives and project targets.