Health Equity Group: Tanzania

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

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

PPROACH: The HEqG worked from the shared understanding
at equity in health and access to quality health services can
ly be achieved where underlying gender relations and
ructures of patriarchal power are challenged to enable social
stice. HEqG thus aimed to **promote awareness about
isting gender inequities in accessing healthcare** and
elfare rights, focusing on strengthening community-based
itiatives that allow women and young people to **demand
eir health-related rights**.

EqP also prioritised working in **partnership**, drawing
gether 4 likeminded NGOs to collaboratively tackling
ealthcare-related issues in Tanzania.

TERVENTION: HEqP was formed in 2004 by like-minded NGOs all working on healthcare-related issues. The group
rategy focuses on the situation of maternal and newborn health as an indicator of persistent inequities in health a
alth service delivery. Key aims included: increased public voice surrounding health and health equity; more effecti
rticipation of citizens and health workers in decision-making and accountability processes; and planning and budgeti
at focused specifically on addressing health inequalities, particularly in relation to reproductive, child and sexual healt
l findings from HEqP activities were then fed into a wider advocacy strategy to improve healthcare access and quality
omen and other marginalised groups.

2008, HEqP used the CSC to collect information on family planning in 4 communities in Magu and Missungwi Districts
wanza 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. Distri
level groundwork was carried out, which included conducting a workshop with local government officials, councillo
CSOs and community representatives, in order to gather support for the project. Staff then conducted workshops wi
community members, which covered both general health-related issues, particularly in relation to maternal health, a
on the CSC process. Finally, the input-tracking scorecard was developed, based on service-delivery policies a
information gathered from service users and providers.

Conducting the Scorecard with Community: The input-tracking scorecard was presented to community participan
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 a
other scale chosen by the group. Where low scores were awarded, groups were asked to suggest ways in which t
situation could be improved. Indicators included: availability of staff and health centres; equality of access to fam
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, loc
leaders and district health officials. All parties were prepared for the meeting in advance in order to ensure no

ABLING 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 activiti suffered as a result of delayed decision-making ar changing priorities among decision makers; ineffecti use of project resources; and a lack of commitment shared activities. High levels of HEqG staff turnov further compounded this issue.
- **Gender inequalities in participation**: A 2010 evaluatic revealed that the CSC failed to overcome gend inequalities amongst service users, as participan overwhelmingly male. As a result, men drove the majori of issues identified and responses given.
- **Lack of M&E**: One of the most consistently cite challenges of project implementation was the lack measurable outputs, targets or logical framework syste to guide implementation and monitor impact.
- **Continued challenges to interface dialogue**: Interfa meetings often suffered as a result of intimidation b service users of community members who raise negati comments about service delivery. In a number of cas this also resulted in services being withheld.

SUCCESSES:

- **Health awareness and positive health seekin behaviour:** CSCs raised awareness around matern health issues, particularly when implemented alongsic ongoing HEqP media activities. National health budgetir also increased, with the Ministry of Health and Soci Welfare allocating a specific budget line for matern health in 2006/7 and 2007/8; it is not clear whether th is causally linked to the efforts of HEqP.
- **Participation, engagement and communication:** Th CSC process in Mwanza increased community and civ society engagement in health planning, budgeting ar implementation. Users demonstrated willingness to tal responsibility for supporting service providers; fo example, by constructing doctors' housing in Mwagala combat the problem of staff availability.

EY LESSONS

Ensure sufficient time and budget allocation: The CSC is meant to be a gradual, iterative process, with multi scoring rounds and the ongoing and willing commitment of service users and providers. This must be consider during planning and budgeting, with time built into the process to allow for sufficient support gathering. It is al important that the CSC deliver at least some tangible changes, as result shows that participants are more likely 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 gaining community leaders' support for the CSC process. Where project implementation took place without sufficie leadership support, the overall reputation of the project was at risk. It is thus critical, particularly when tackling oft controversial issues such as maternal health, that the gaining of local leaders' support is prioritised at the preparati stage of project implementation.

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

NTACT: