Health Promotion Tanzania
PO Box 65147
Dar Es Salaam
Tel: +255 22 2772264/86
info@hdt.or.tz

Futures Group Headquarters
One Thomas Circle, NW, Suite 200
Washington, DC 20005 USA
Tel: +1.202.775.9680
Fax: +1.202.775.9694

HEALTH POLICY INITIATIVE

JULY 2013

Influencing Government Health Budgets in Tanzania

A Guide for Civil Society

Cover photo credit: Hendri Lombard

Suggested citation: Bujari, P., and E. McGinn. 2013 *Influencing Government Health Budgets in Tanzania: A Guide for Civil Society*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 5.

Table of Contents

ACKNOWLEDGMENTS 2

1. INTRODUCTION 3
   1.1 How to Use this Booklet 3
   1.2 Rationale for the Booklet 4

2. SUCCESSFUL TACTICS AND STRATEGIES FOR BUDGET ADVOCACY IN TANZANIA 7
   2.1 Introduction to Health Advocacy 7
   2.2 Successful Tactics and Strategies in Government Health Advocacy 7
      2.2.1 Advocacy planning 8
      2.2.2 Working with insiders 14
      2.2.3 Working with influencers 14
      2.2.4 Working with allies and champions 14
      2.2.5 Working with the media 15
      2.2.6 Monitoring commitments 16

3. THE BUDGET PROCESS IN TANZANIA 17
   3.1. Where Does the Money Come From? 17
   3.2. How Is the Budget Organised? 19
   3.3. How Is the Budget Developed? 20
   3.4. Entry Points for Health Sector Budget Advocacy 22
      3.4.1. The national level 22
      3.4.2. The district level 24

4. SUCCESSFUL CASE STUDIES IN BUDGET ADVOCACY 31
   4.1. District-Level Advocacy to Influence the Government Budget for Family Planning 31
   4.2 Improving Access to Medicine: Using Social Accountability Monitoring 34
   4.3. Cases to Influence the Budget System for Sustainability 37

ABBREVIATIONS 40

REFERENCES AND RESOURCES 42

ORGANISATIONS WORKING IN BUDGET ADVOCACY IN TANZANIA 44

Acknowledgments

The USAID | Health Policy Initiative, Task Order 5 would like to acknowledge the valuable contributions of the following individuals and organisations:

Thanks to Dr. Peter Bujari, Health Promotion Tanzania, and Erin K. McGinn, Futures Group, for their conceptualisation and authorship of the booklet; Mr. Simon Malanilo, Rev. James Mlali, and Ms. Jaliath Rangi for background research and input; and Molly and Jim Cameron, Lori Merritt, and Mary Brunnemer Brabble for careful editing and design.

We deeply appreciate the painstaking efforts of the review team, which included the following: Jasminka Milovanovic (Save the Children Tanzania Office); Edward Kinabo (Advance Family Planning/Johns Hopkins University); Dr. Conrad Mbuya (WAJIBIKA), Manka Kway (Deutsche Stiftung Weltbevoelkerung [DSW]), Petronella Mwasandule (TUNAJALI II), and Cristin Marona (Futures Group). The project would also like to thank the following individuals for their time and valuable contributions while researching this booklet: Dr. Msengi Mwendo, District Medical Officer for Kisarawe; Mustafa Sabuni, District Planning Officer for Kisarawe; Dr. Gunini Kamba, Municipal Medical Officer of Health for Kinondoni; Dr. Ezra Ngereza, Municipal Health Planning Coordinator for Kinondoni; Simon Moshy, Program Officer for Sikika; Elinami Mungure, DSW Tanzania; Anna Nswila, Ministry of Health and Social Welfare (MoHSW) Budget Focal Person; Jumanne Mwasamila, Head of Block Grant PMO-RALG (Prime Minister's Office, Regional Administrative and Local Government).

The authors would like to dedicate this booklet to the memory of Tim Manchester, USAID, who approved this activity, but did not get a chance to see its completion. He was tireless in his efforts to mobilise donors, government officials, and civil society to improve access to family planning in Tanzania.

USAID | Health Policy Initiative is implemented by the Futures Group. It is funded by USAID/Tanzania through the mission's Health and Population Office and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

The views expressed in this publication do not necessarily reflect the views of USAID or the U.S. government.

1 Introduction

1.1 How to Use this Booklet

The purpose of this booklet is to inform civil society organisations (CSOs) on how the health budget is developed in Tanzania, and to suggest entry points where advocates can seek to influence change. It is meant to be an introduction to and easy reference guide for health budget advocacy. Several extremely useful and comprehensive publications informed the development of this guide, and can be found in the references and resources section in an annex at the back of this booklet.

Section 1 provides information on the context of health as a right in Tanzania and current government allocations to health. It provides a brief overview of the roles of CSOs in the development of government budgets and the rationale for engaging in health sector budget advocacy.

Section 2 reviews some basic concepts and important steps in the advocacy process, and mentions a few tactics and strategies that are recommended for Tanzanian CSOs.

Who is an advocate?

An advocate is someone who speaks up (or writes) publically about how things are and how they should be. Advocates promote change, and in many cases, are fighting for a better situation for the disadvantaged. You can ***advocate for*** *a group (on their behalf),* ***or with*** *a group (building their capacity, or as a member of that group). An advocate can be anyone—young or old, rich or poor, educated or illiterate.*

Section 3 provides information on the health system in Tanzania and key structures to be aware of when wanting to influence change, particularly as they relate to budget allocations or monitoring. It also provides information on how the government health budget is structured and developed, and highlights entry points and timing at both the National and Local Government levels for successful health budget advocacy.

Section 4 provides three CSO case studies on government budget advocacy; two at the National level and one at the District level. These case studies provide information on how the advocacy agenda was framed, which advocacy strategies/approaches were used, and the results. Further information on the cases can be found by contacting the address provided.

The reader can find a list of abbreviations, references and resources, and information on organisations working on health budget advocacy in Tanzania towards the back of this booklet.

1.2 Rationale for the Booklet

Every human being has the right to health,[1] and governments have the responsibility of ensuring access to those things that safeguard our health, such as clean water, basic sanitation, essential medicines, and health services. In Tanzania, government commitments to safeguarding and improving the health of Tanzanians are laid out in the *National Health Policy of 1990* (revised in 2003), subsequent *Poverty Reduction Strategies* (referred to as MKUKUTA), and specific *Health Sector Strategic Plans* (I–III). Tanzania has also committed to international declarations and agreements on health, such as the *Alma Ata Declaration* (1978), *Health for All in the 21st Century* (1998), the *Abuja Declaration* (2001),[2] the *Kampala Declaration on Fair and Sustainable Health Financing* (2005),[3] and most recently, the *Rio Political Declaration on Social Determinants of Health* (2012).[4]

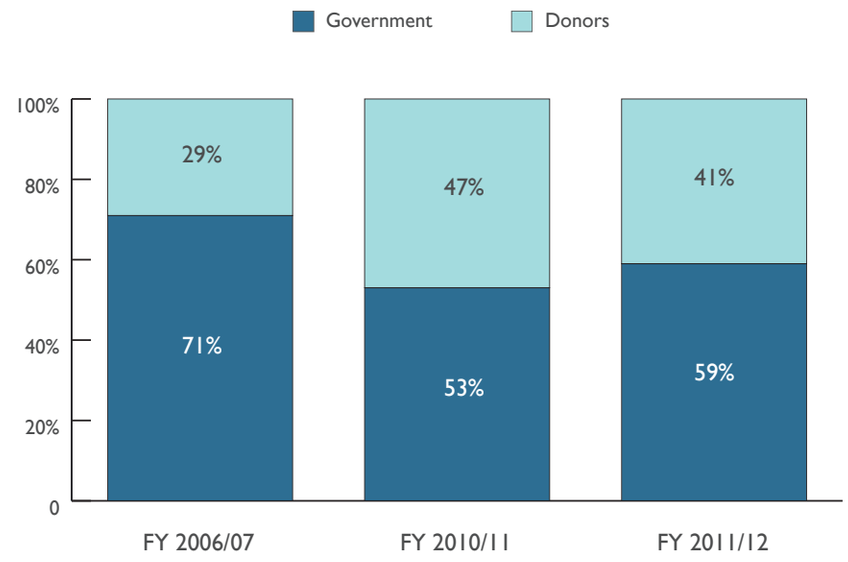
The government shows its commitment to health largely by allocating public funds to health-related activities and initiatives. Although public health sector financing more than doubled between 2006 and 2012, only about 10% of the government budget is dedicated to health, far below the 15% recommended under the Abuja Declaration. This translates to about $14.90[5] USD per person (in 2012), significantly below the World Health Organization's recommendation of $54 USD[6] and still short of Tanzania's goal of $15.75 USD found in the 2009–2015 *Health Sector Strategic Plan III.*

Public money is your money!

Government funds don't belong to government – they belong to the people. Government is responsible for collecting and disbursing public funds to benefit all citizens equally. Because government money is your money, you have a right to know how it is collected, allocated, disbursed, and spent.

Inadequate health funding has several implications, as health is central to sustainable development. In Tanzania, for every 220 babies born, a mother dies, and countless others suffer complications in childbirth.[7] One in 12 children die before celebrating their fifth birthday. It is estimated that one in four women of reproductive age have an unmet need for family planning, and frequent stock-outs of family planning impact both contraceptive access and choice. Tanzania has made significant progress on reversing the trend of HIV and increasing the rates of voluntary testing and counselling. However, one-third of women and half of men have never been tested for HIV. Overall, 5.1% of Tanzanians ages 15–49 are HIV positive, with HIV prevalence twice as high among women (6.2%) than men (3.8%).[8] Ownership of Insect Treated Nets (ITN) has increased under Tanzania's universal coverage campaign, but approximately one-third of the population still doesn't sleep under an ITN, and rapid diagnostic testing reveals that nine out of 100 children under the age of five have malaria.[9] Malaria prevalence increases with age, and is around 10% in rural areas and as low as 3% in urban areas.

Figure 1. Health Sector Budget Share between Government and Donors



Source: Data from 2012 MoHSW PER report.

The government of Tanzania clearly needs to devote more resources to health and use those resources more efficiently. Advocacy by CSOs and individuals is vital to make this happen, hence this guide. Civil society plays the increasingly important roles of monitoring governmental commitments and actions, and holding public officials accountable for resource allocations and utilisation. For example, the *Joint Assistance Strategy Tanzania 2006–2010*[10] specifically outlines the vital role civil society plays in holding both government and donors accountable. Over the past decade, CSOs have become more active in intervening in the budget process and monitoring and reporting on public expenditures in countries all over the world – and they can be successful. For example, a 2012 study of CSO budget advocacy in Uganda, Bangladesh, and the Philippines concluded that CSO involvement in budget advocacy positively influenced budget allocations for sexual and reproductive health.[11] Examples of successful health budget advocacy in Tanzania are also presented in this guide (see Sections 2 and 4). Yet, budget advocacy is often difficult for CSOs, due to a limited understanding of the budget cycle and limited transparency on behalf of government in budget preparation. Public guidelines on the government budget cycle (and thus where to intervene for maximum impact) are often lacking. **The purpose of this booklet is to describe as simply as possible how the health budget is developed in Tanzania, and to suggest entry points where advocates can seek to influence a change.**

Civil society in Tanzania plays a number of different roles in the budget process, though its formal role is limited to a consultative one through its participation in the Public Expenditure Review (PER) and related processes. Informal roles include analysing public budgets, producing simplified and popular versions of the budget and related documents, playing a watchdog role, tracking expenditures at the local level, and advocating for improvements in terms of specific requests and overall transparency and accountability. Civil society's informal roles are arguably more effective, particularly when combined with strategic use of media and citizen engagement.[12]

Table 1. Civil Society's Role in the Budget Process

Formal role	Informal role
Participation in the Public Expenditure Review (PER) and related processes	Analysing public budgets
	Producing simplified versions of the budget to increase public understanding
	Tracking expenditures

Endnotes

1. Article 12 of International Covenant on Economic and Social Rights.
2. Heads of 89 countries pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. At the same time, they urged donor countries to fulfill the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries.
3. It states that health is a fundamental human right, which must be supported by fair and sustainable health financing systems. In line with World Health Assembly (WHA) resolutions 58.31 and 58.33, it affirms that out-of-pocket spending should be minimised and prepayments expanded with a view to avoiding impoverishment of households and moving towards universal coverage.
4. WHA 65.8: Member states expressed their political will to improve public health, and reduce health inequities through action on the social determinants of health.
5. Public Expenditure Review (PER) report 2012.
6. PER report 2012.
7. Simplified from maternal mortality of 454 per 100,000 and under-five mortality rate of 81 per 1,000, according to the Tanzania Demographic and Health Survey (TDHS) 2010.
8. Tanzania HIV/AIDS and Malaria Indicator Survey (THIMS) 2011–12.
9. THIMS, 2012.
10. The framework for development co-operation between the Government of the United Republic of Tanzania and its development partners to achieve national development and poverty reduction goals. Available at: http://www.aideffectiveness.org/Country/Tanzania/Joint-Assistance-Strategy-Tanzania-2006.html
11. Dickinson, et al., 2012.
12. Policy Forum and Hakielimu, 2008.

2 Successful Tactics and Strategies for Budget Advocacy in Tanzania

2.1 Introduction to Health Advocacy

Advocacy is a *systematic* succession of actions designed to *persuade* those in power to bring a *change* to a specified issue of public concern. Advocacy is a deliberate process to deliver particular messages to decision-makers who develop laws or policies, or distribute resources that affect the lives of Tanzanians.

Advocacy is sometimes confused with other concepts, such as behaviour change communication (BCC) activities, fundraising efforts, raising issue awareness, or community and social mobilisation.[13] To differentiate between these concepts it can be helpful to consider the targets, objectives, and outcomes of each approach. Although raising awareness or mobilising specific communities can be steps in an advocacy campaign, the ultimate targets of advocacy are key decision-makers (politicians, government officials), and the objectives are usually to achieve changes to (or creation of) written documents (policies, strategies, budgets). Campaigning to create public pressure through mass action, public forums, and the media is often a strategy to meet these objectives, but equally important is direct advocacy (often called lobbying) of decision-makers; this frequently requires working with allies and insiders.

> *"Health budget advocacy is about lobbying and campaigning to change the way public resources are used to deliver health services. By analyzing how healthcare is funded and how budgets are drawn up, civil society groups will have more opportunity to influence how the government prioritizes health spending."*
>
> Health Sector Budget Advocacy, Save the Children, 2012, p. 2

2.2 Successful Tactics and Strategies in Government Health Advocacy

Key words in the definitions of advocacy above are *systematic* and *process*. A systematic approach to advocacy means clearly defining your goals and undertaking specific steps in the planning and execution of your advocacy campaign. A process also means successive interventions (not a one-time intervention). There are many excellent resources on advocacy (see page 42); however, this section provides a brief overview of the steps in advocacy planning and highlights some tactics that have been used successfully in Tanzania.

If undertaking advocacy for the first time, it is important for CSOs to reflect on the relationships they have with government. The roles of government and civil soci-

ety are different, but both exist to serve and build a better future for the individuals and communities of Tanzania. This vision should drive both government and CSOs, and both of these sectors need to understand that their roles are complementary and neither can one take the place of the other. In some cases, the relationship between government and civil society can become strained or adversarial because advocacy can sometimes be seen as merely criticising government. However, the aim of CSOs should be both to help the government do its job and remind it where improvements can be made. At all times, CSOs should offer solutions as part of their advocacy campaign, try to turn negatives into positives, and where possible, build bridges and common ground between civil society and government. See also helpful tips under step 6.

2.2.1 Advocacy planning

Step 1: Selecting an issue or problem to address

An advocacy problem must be identified, studied, quantified (determining who is affected and how much, what is the impact if not addressed), and assessed if it is in the public interest. The problem identified must be one that requires a change (by decision-makers) related to a policy, budget, strategy, or law. The advocacy objective should be very specific (so that you know what you are advocating for, and when you have achieved it), and your solution should have a public health impact and promote human rights.

Once the decision to embark on an advocacy campaign is made, the CSO should develop an advocacy strategy, informed by the following steps. However, CSOs should note that advocacy is not a linear process, and although these steps are listed in a sequence, their order and importance will depend on the situation and context. For example, one might find during implementation (step 6), that it is best to gather more data or analyse the external context more thoroughly (step 3) because some interventions are not working as expected.

Advocating for Safe Delivery Kits: The Public Health Concern

There are more than 1.6 million babies delivered in Tanzania each year, but only 50% of these are delivered at health facilities, despite a government policy of free clinical services for pregnant mothers, delivery, and child care. Delivering at good-quality and well-equipped health facilities reduces the likelihood of maternal mortality and morbidity. However, the government budget for medicines and supplies is less than half of what is required, and this lack of supplies within the health system demotivates women from delivering at a health facility. This compromises the health of both mother and child, and will prevent Tanzania from attaining its MKUKUTA targets of reducing the Maternal Mortality Ratio (MMR) from 454 to 265/100,000 by 2015.

Step 2: Developing a goal and objectives

Alongside identifying a health problem, advocates must also define a solution – the change they wish decision-makers to bring about. This change is the goal of the advocacy effort. Once the goal has been set, then intermediate achievements towards the main goal are set (objectives). For each objective, relevant activities and strategies need to be devised to meet those objectives.

Advocating for Safe Delivery Kits: Advocacy Goals and Objectives

Goal: Increased government allocation to maternal health budget for the purchase of safe delivery kits.

Objectives: (1) increased understanding of MoHSW and Parliamentarians of the need for delivery kits to reduce MMR, (2) signed commitment by Members of Parliament that ensures money is budgeted for delivery kits, and (3) increased understanding of the Medical Store Department (MSD) team on the need for constant supply of delivery kits.

A delivery kit is an all-inclusive package of essential items for a facility-based birth, and often includes such items as sterile gauze, clean cotton, a cord tie, ergometrine (a drug to prevent bleeding), syringes, gloves, a razor blade, etc. The benefit of creating a "kit" is so that all items are available when needed, rather than the facility running out of gloves or gauze, which are used for other procedures.

Step 3: Assessing the external and internal context

Planning for an advocacy campaign requires the CSO to assess the internal and external context in which it will operate. The organisation (or coalition/team) must analyse its strengths and weaknesses with respect to implementing the advocacy strategies. For instance, does it have adequate financial resources to implement an essential media campaign? Does it have a spokesperson who holds credibility with the target audience? Are there enough data to suggest that the proposed advocacy solution will work? Are there other programmatic activities that will affect the proper implementation and monitoring of the advocacy campaign?

Likewise, an external scan (often called an "environmental scan" or "landscape analysis") will help identify and determine whom else to work with (or avoid) and opportunities on which the advocacy campaign can be capitalised (for example, World AIDS Day events).

Advocates should map out their allies (supporters) and opponents (detractors), as well as brainstorm potential challenges and ways to overcome them. Although many advocacy efforts find support among other CSOs, don't forget to look at the business sector, among faith-based organisations, and for issue-driven politicians to find potential allies.

Advocating for Safe Delivery Kits: External Influences

Prior to embarking on a campaign to advocate for safe delivery kits, an external scan would require (1) collecting current local data on maternal health issues in Tanzania, including recent service delivery statistics; (2) identifying which other individuals and organisations consider maternal health as a core issue, such as the White Ribbon Alliance, the Wanawake na Maendeleo (WAMA) Foundation, Tanzania's Association of Gynecologists and Obstetricians (AGOTA), the Medical Women's Association of Tanzania, etc. While safe delivery is not generally a controversial issue (thus perhaps no formal detractors), it does need to compete with other public health issues. The advocacy campaign must be prepared to answer why the government should spend money on delivery kits, when half of women deliver at home.

Step 4: Creating an action plan

An advocacy campaign is similar to any work plan, in that you need to outline your objectives, design interventions to meet those objectives, and assign tasks to specific team members so as to establish clear accountability lines. If you are operating in a coalition and each member brings specific skill sets to the group, you may choose to divide the action plan according to objectives among the coalition partners (for example, a research group being in charge of generating and analysing data).

A pivotal component of budget advocacy is **timing**. Government budget advocacy requires good timing to make an impact. As shown in Section 3.4, there are multiple opportunities in time when you can effect a change because developing a national budget is a multi-step process involving several different actors at different government levels.

If you undertake government health budget advocacy in Tanzania, you can hope to have one of three impacts: (1) increase the share of the budget going towards health; (2) increase the funding allocation to a specific issue within the health budget; or (3) increase both the level of the overall health budget and allocations to specific budget lines within the health budget.

Step 5: Making strategic choices

It is essential to assess a target audience's receptiveness to your issue and identify how best to frame the issue in line with the audience's interests. Some issues are popular and non-controversial, while others can be contentious or simply gain little traction in the minds of decision-makers. Choices therefore have to be made on who is the target decision-maker and how to tailor the message. It is highly recommended that CSOs develop key messages and talking points prior to embarking on their advocacy campaign, particularly if they are working with several spokespeople and/or in a coalition. Advocacy messages and the political "ask" must be consistent throughout the campaign, and it is helpful to have a shared document among all the advocates to keep everyone on point. It is also good practice to brainstorm on possible difficult questions the campaign might be asked, and develop strong answers in advance that can support the advocacy objectives.

Choosing the right messenger is equally important. Some decision-makers will respond best to academic or medical authorities (e.g., head of a research institution or head of a medical association). Others might be moved by business, religious, or cultural leaders. Often advocacy has to use a mix to appeal to both the head and the heart. Often a decision-maker can hear data, but chooses to act based on personal experience or a moving personal account from others. The messenger must also understand the context in which he or she is delivering the message.

Advocates are advised to be resourceful when meeting decision-makers such as Members of Parliament, and should be able to give data that assess progress over time or between countries. Policy-makers prefer to compare Tanzania favourably with other East African countries, so it is important to contrast Tanzania's progress with neighbouring countries that are doing better. Likewise, it is important to present a human face to your message. For example, in the Tanzanian Parliament, percentages and ratios are rarely convincing. Statements such as "maternal mortality is high at 454 per 100,000" create no memorable feeling among parliamentarians. Consider re-packaging the data in a way many people can understand, such as: every year an estimated 7,559 women die from pregnancy-related causes; this translates to 629 mothers dying each month or 20 dying every day.

Finally, it is important that the arguments hinge on the Government's own commitments and that advocates also show the value of taking action (how the advocacy objectives will benefit the decision-makers and their constituents). Advocating for an increased budget for maternal health for example, can also be related to attaining "Kilimo kwanza" – *Agriculture first* because women provide a large proportion of the labor force in Tanzania. Without maternal health, there is no "*Maisha bora kwa kila Mtanzania"* (quality life for all Tanzania).

Examples of Advocacy Tactics & Tools:

Lobbying	Policy briefs
Petition	Position papers
Media campaign	Videos/multi-media
Public event/rally/sit-in	Testimonials
Public lectures/discussions	Social media (Jamii Forum, Twitter)

Helpful Tip:

In Tanzania, if you are addressing Members of Parliament sitting in a Committee, you must be SMARTLY dressed with no visible political identity (pins, colours), and you must address the Chair of the Committee. You must use the term *Honourable* – forgetting to do so may lead to their rejection of your agenda. Finally, you must speak and have your handouts (briefs, position papers, reference documents) written in Kiswahili.

Step 6: Implementing the activities

Successful advocacy hinges on steps 1–5, the careful planning and analysis. However, implementing the activities is where a CSO will spend most of its time and human and financial resources, as well as gauge progress and undertake course corrections. As such, it is equally important to implement the activities in line with strong project management principles and ensure that activities are guided by a well-developed work plan.

Implementing the activities involves all of the interim steps needed to accomplish major activities. For example, before you get to meet a group of decision-makers, you need to develop fact sheets or policy briefs for their easy reference. These will be based on the data you gathered and will outline the "solutions" you are proposing.

After each advocacy event, the advocacy team should meet and review how they performed, how their messages were received, what questions were raised, and what commitments were made (see also step 7). This will help identify ways to improve the next meeting and perhaps even add activities to the work plan, such as a specific follow-up activity.

Helpful Tip:

If you get an opportunity to meet a group of decision-makers to discuss your advocacy issue, a compelling presentation is essential. Your presentation should have a memorable and appealing title and should begin with the solution (your advocacy goal or objective) you are proposing. Your presentation should acknowledge and appreciate existing government policy commitments, and recognize any current programs, budget allocations, and disbursements making positive contributions to your issue. The presentation should also link current programs and trends in funding to major national development agendas such as "Kilimo kwanza" and highlight implications for these broader goals if your issue is not addressed. Finish by showing the trust/confidence you have in the decision-makers and reiterating the solutions you proposed at the beginning of your presentation. The advocacy team is advised to be resourceful and prepared to respond to questions and clarifications that may be needed. If you are not sure of the answer of a certain question, DO NOT LIE; instead, promise to look for the facts and come back to them.

Step 7: Measuring success

Measuring success is as important in advocacy as it is in service delivery, BCC, or other programs. It is particularly important to recognise the "quick wins," which are incremental achievements that can shed light on the advocacy campaign's progress towards attaining the overall goal. For instance, periodic review meetings are recommended after a major activity to debrief and assess how well the activity went, whether it contributed to reaching the goal, and whether the campaign is still on track. It is also helpful to assess whether any change of course or new activities are needed. Advocacy campaigns need to be responsive to changing circumstances and "serendipity."

For example, if a high-profile leader or celebrity gives birth to a new baby, a maternal or child health campaign could issue a press release of congratulations, but then use the opportunity to point out the health issues most Tanzanian pregnant mothers or newborns face. Tanzanian CSOs can also capitalise on events outside the country, such as a major UN conference on HIV or a statement made by the leader of another country, to write a commentary in the newspaper or hold a meeting with key groups to discuss the domestic perspective on the issue. These types of opportunities may not have been foreseen when the advocacy strategy was developed, but they often can help advance the advocacy agenda. Likewise, advocates are advised not to despair when one intervention doesn't succeed. Critical review on what they might have done wrong is required, and the team can brainstorm on how best to adjust the advocacy plan accordingly.

Helpful Tip:

Try to monitor what decision-makers say both in and outside of Tanzania and use public statements to support your advocacy objectives. If a decision-maker makes a statement that he/she will address a problem, advocates should (1) write a letter to thank him/her for that commitment and/or (2) hold a press conference thanking the decision-maker for such an action and elaborate on how it will benefit citizens. For example, President Kikwete was invited to co-chair WHO's Commission on Information and Accountability for Women's and Children's Health and subsequently authored an article about maternal health in Global Health and Diplomacy http://www.ghdnews.com/index.php/global-health-challenges/maternal-and-child-health/45-the-fight-for-maternal-and-child-health-in-sub-saharan-africa). Such public statements by a president can be used to support the need for safe delivery kits and other maternal health interventions.

2.2.2 Working with insiders

Insiders are people within the system who may be supportive of your cause and in a position to make decisions or influence others. Often, by virtue of their position or responsibilities, insiders cannot be public or outspoken advocates for issues that affect the public. However, insiders can be very useful sources of important information as well as a link between advocates and their target audiences. On the other hand, if they are taken for granted or treated inappropriately, insiders can be hindrances to advocacy initiatives. Therefore, advocates need to identify insiders and relate to them in ways that will make them feel respected and appreciated. They can be consulted for pertinent information without quoting them on such issues, an action that can threaten them or their positions, except when formally engaged as consultants due to their knowledge and skills. Also, insiders need to be assured of the benefits of advocacy activities and made aware of how such activities or initiatives support their objectives and goals.

For example, if you are advocating for an increased budget to support youth-friendly services at the District level, you will need the support from the Reproductive Health coordinator. This officer will give you local information on teenage pregnancy, youth-friendly services being provided, gaps to be addressed, funds currently allocated, etc.

2.2.3 Working with influencers

Influencers are people who are within the system and work closely with decision-makers (or have relationships with decision-makers, such as a high-profile relative or business person). These are, therefore, the people who know not only about the systems but also about the decision-makers individually. They can be the sources of the most useful information for targeting the audiences and can be helpful in knowing audiences' schedules, interests, and best ways to reach them. They can also, if properly informed and brought into agreement with your advocacy issues, provide the audiences with the necessary background information on advocacy issues and prepare them to support those issues.

Influencers, for that reason, need to be carefully identified, selected, and properly informed to lay the ground-work for the decision-makers' potential support. Influencers are key players in the success of advocacy issues, and like insiders, they should not be quoted.

2.2.4 Working with allies and champions

Advocacy initiatives need unified voices. Allies and champions provide an avenue for strengthening and unifying one voice from diverse constituents. While allies are usually peers and stakeholders from organisations with similar objectives, champions are usually high-profile individuals who are respected in society for various reasons and are supportive of the issues. Champions can also be those on the "front line" of the issue – like a health care provider, a young person advocating for sex education in schools, or a person living with HIV.

The selection of allies and champions has to be carried out carefully so that the support needed from them will be obtained. It is important to ensure that allies and champions clearly understand the issue, are supportive of your objectives, and are willing to commit their time and skills in moving the agenda forward as needed.

Working with Coalitions and Networks

Opportunities

- Strength in numbers/unified voices – this can counteract other powerful lobbies like business
- Common agenda/consensus solution – debates within the CSO community can be resolved behind closed doors
- Shared resources – such as finances, skilled people; some tactics are only affordable when costs are shared, like mass media campaigns
- More innovation – different experiences, connections, strategies are brought to the table

Challenges

- Managing a coalition takes time, human resources, a lot of internal communications
- Consensus takes time and compromise – CSOs may need to give up or alter the nature of the "ask" to accommodate everyone in the coalition
- Group decision-making can slow down responding to new opportunities
- Egos and self-promotion can get in the way (share credit and put the advocacy issue first in the news, before the names of individual or organizations)

2.2.5 Working with the media

The role of the media in supporting and moving advocacy forward cannot be overstated. The media has the potential to initiate and strengthen dialogue on an issue, quickly spread the agenda, and channel public support. In working with the media, advocates need to ensure that journalists and other media personnel clearly understand the issues at hand so they can communicate them clearly and correctly. Several organisations undertake journalist training which may consist of an intensive orientation to the issue (several days), followed by periodic orientations/refreshers. The key is to cultivate an ongoing relationship with the media, to sensitise and inform them of your issues, and encourage them to think of you as a reliable and trustworthy source of information on the subject.

In Tanzania, the profile level and accuracy of news stories are highly dependent on the understanding of the editor. If an editor is less informed on a subject (as it may be

with many health topics), news items related to the subject may be omitted, or diluted. Working with editors to ensure they understand the subject at hand is an effective way to work with the media in Tanzania. Editors and journalists have a different type of access to decision-makers. They can call government officials and get them "on the record" (a statement or response to an assertion made in the news article). The media can be perceived as "neutral" which invites decision-makers to offer "their side of the story." However, while budget increases or reallocations are not generally controversial issues, a news article on government spending can become political. Articles uncovering corruption are not often printed, and media houses can be owned by people with political affiliations and agendas. As such, advocates should be aware that politics can play a role in whether or not their news article is printed.

When dealing with new or controversial issues, it is necessary to be resilient and consistent until the media takes an interest. Keep your media contacts informed and updated on your issues; you may need to frame the topic in-line with current story trends for it to be "news worthy." During interviews with media, stick to your talking points and focus on the issues important to you. The interviewer can easily divert the path of discussion, which can end up diluting or undermining your messages.

2.2.6 Monitoring commitments

The work does not end after conducting an advocacy campaign/meeting and securing commitments. Decision-makers are often occupied with many demands and face multiple issues needing their attention. As such, securing a commitment doesn't guarantee follow-through. Decision-makers usually leave the responsibility of implementing their commitments to technocrats. Technocrats can themselves be overloaded with competing priorities, or may not relate to a particular issue themselves; this can result in technocrats forgetting or resisting implementing something agreed to by someone else.

Hence, advocates need to set aside time and resources for monitoring commitments until such commitments are fully implemented; or develop strategies for further advocacy if implementation does not take place (see also step 7 under Section 2.2.1).

Endnote

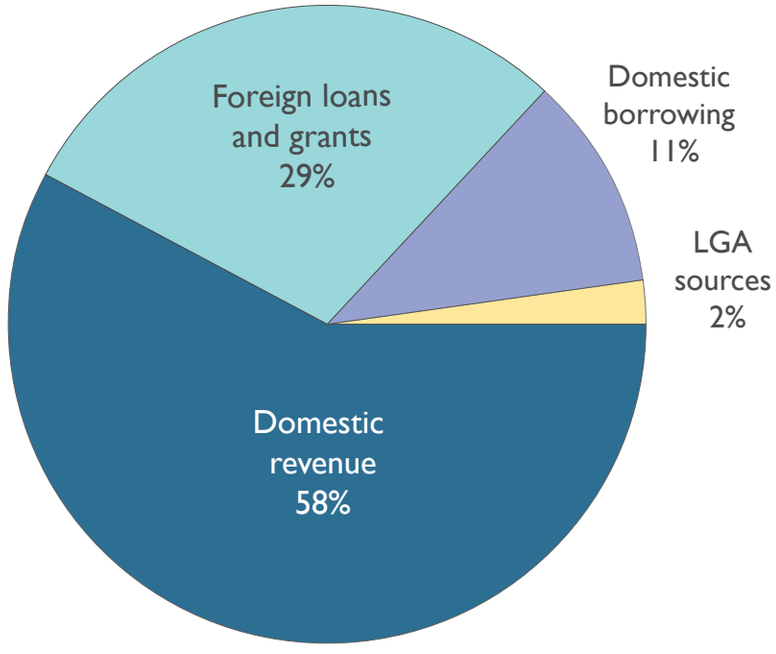
13. POLICY Project, 1999.

3 The Budget Process in Tanzania

3.1. Where Does the Money Come From?

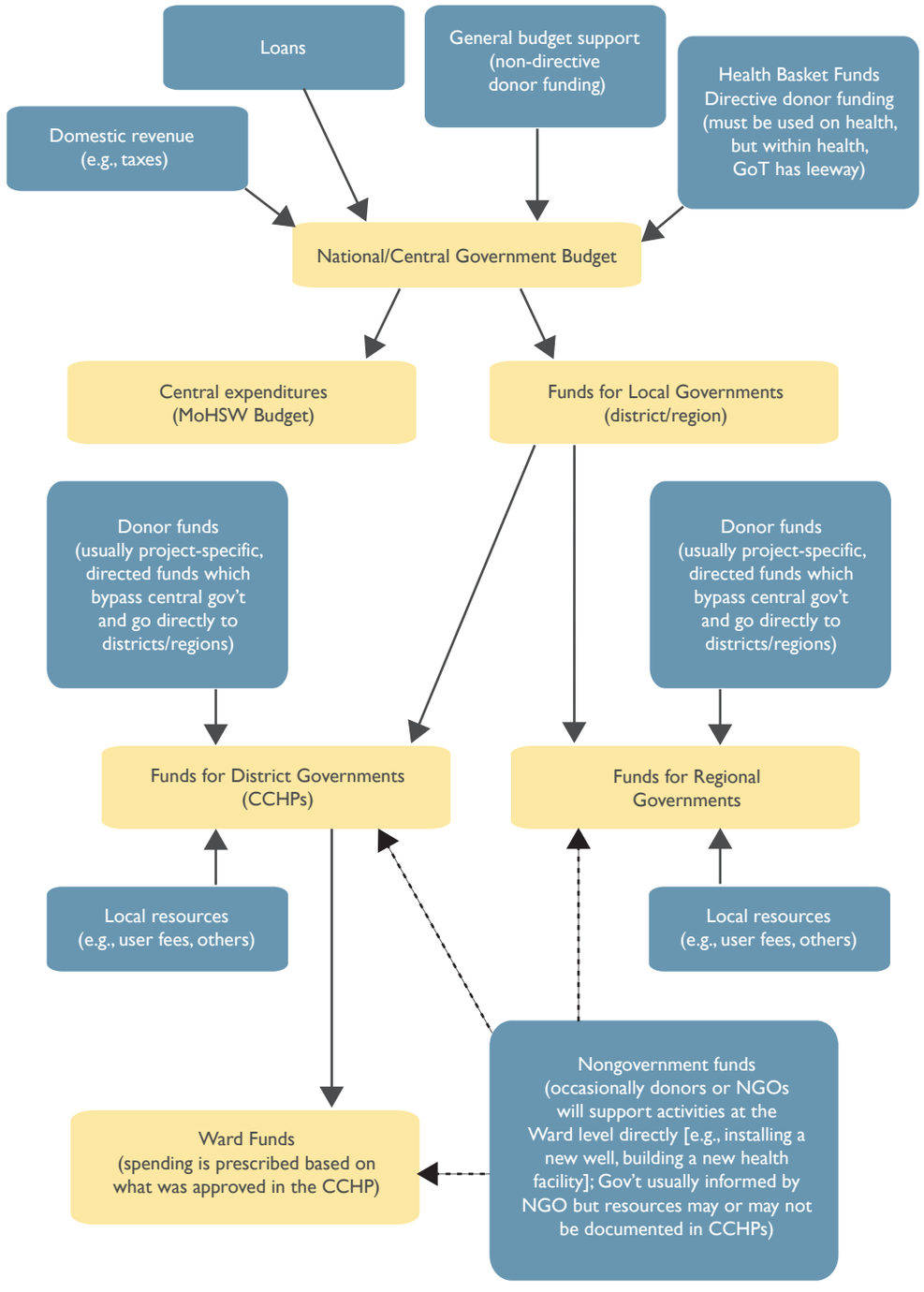
Government funds for health come from domestic revenue (e.g., taxes and non-tax revenues), borrowing from domestic markets, and grants or loans from development partners. Some of these funds are allocated for national-level health spending, such as the Ministry of Health and Social Welfare (MoHSW) budget. The government also uses its domestic and donor funds to form what is called a *Block Grant* to local government authorities (LGAs), and this money is allocated based on a specific formula.[14] Some international donors give money to the government of Tanzania (GoT) specifically for the health sector, referred to as *Health Sector Basket Funds* (HSBF). HSBF must be spent specifically on health, though within the area of health, there is a lot of GoT autonomy to allocate the funds among different health issues (e.g., malaria, HIV, family planning).

Figure 2. Sources of Funding in the Government Budget



Source: Data from MoF budget guidelines for 2012/13.

Figure 3. Source and Distribution of Government Budget Funds



At the local level, funding for the health sector comes from the central government and an LGA's own funds. Some donors also provide specific support to the District level that bypasses the National budget (called "off-budget support"). Furthermore, donors can also purchase medical supplies and commodities directly and donate those to the MoHSW (e.g., condoms). Thus, the total funding for the health sector can be found by analysing the MoHSW budget; specific donor support, especially procurement of medical supplies and pharmaceuticals; and, within the Prime Minister's Office, Regional Administration and Local Governments budget, which contains LGA budgets (including spending on health).

3.2. How Is the Budget Organised?

The national budget is composed of four "volumes." Volume I details the Government's expected revenue (this might outline taxes to be collected or the amount of promised donor funds; see Section 3.1. above). Volumes II and III are *"recurrent"* expenditures for Ministries, Departments, and Agencies (MDAs), and LGAs. Recurrent expenditures are regular and ongoing expenses needed to maintain operations, such as government worker salaries and benefits, general maintenance of government buildings, and ongoing supplies. Volume IV of the budget is for *"development"* expenditures for MDAs and LGAs. Development expenditures are investments in new services or programmes, significant scale-up of ongoing activities, or other spending of an investment nature (e.g., building a new health facility). Within each volume, there are "line items" (called "Votes") for each ministry and major departments; other agencies have line items (sub votes). For instance, the MoHSW's budget is called Vote 52.

As discussed in Section 3.1, it is important to understand that the MoHSW budget alone does not constitute the entire health budget. This is because money allocated to health is found in different places in the national budget. To assess and calculate the total amount of money government is allocating to health, one must look at a variety of line items (see Table 2).

Table 2. GoT Budget Votes for Health

Type of spending	Ministry/department	Where the line item can be found
Recurrent	MoHSW	Volume II, Vote 52
	Regional & LGA	Volume III, Votes 70 to 95
Development	MoHSW	Volume IV, Vote 52
	PMO-RALG local & foreign funds	Volume IV, Vote 56
	Regional local and foreign funds	Volume IV, Votes 70 to 95

When analysing the health sector budget, the MoHSW budget is found in Volumes II and IV, Vote 52. In Volume II, there are estimates for recurrent expenditures and in Volume IV there are development expenditures. Health funds for the regional and District/Council levels are found in Volumes III and IV. Both the recurrent and development expenditures for health at these levels are found in Volume III, Votes 70 through to 95. To calculate the total amount available for health spending, you must add up the amounts found in each of these Votes. A few Tanzanian nongovernmental organisations (NGOs) (e.g., Sikika, Health Promotion Tanzania [HDT]) routinely analyse health spending; CSOs can contact those organisations working on budget advocacy listed in the back of this booklet for more information.

3.3. How Is the Budget Developed?

The budget cycle of the Government of The United Republic of Tanzania runs from July 1–June 30 every year, with numerous opportunities for civil society engagement in the formulation and implementation processes. The budget process is managed by the Ministry of Finance (MoF).

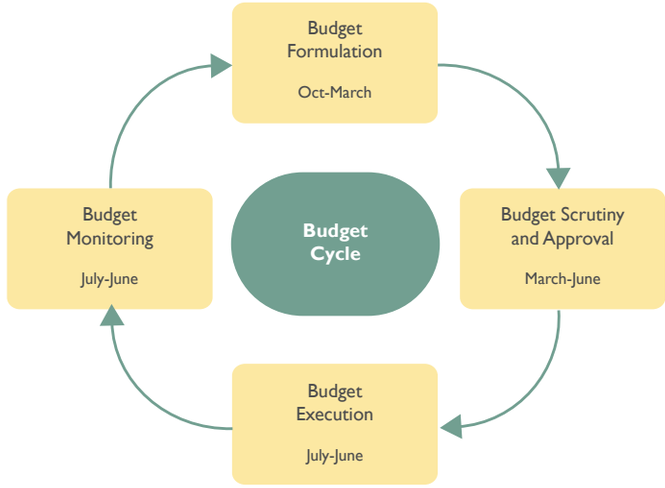
At the onset of the annual budgeting process, the MoF issues budget and planning guidelines. These guidelines outline government priorities for the planning period and can set ceiling amounts for each ministry. The Budget Guidelines contain:

- An overview of macroeconomic performance and projections
- Priority sector Medium-Term Expenditure Frameworks (MTEFs) (prepared by Sector Working Groups)
- Vote expenditure ceilings based on resource availability
- Procedures for preparation and submission of the draft budget to the MoF

Although issued by the MoF, the Budget Guidelines are developed by a committee comprising representatives from the MoF; the President's Office, Planning Commission (Mipango-POPC); the Prime Minister's Office; the President's Office, Public Service Management; and the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG). The Budget Guidelines are sent to the Department of Policy and Planning within each ministry; the ministry is then responsible for developing a three-year MTEF and the annual budget for that ministry. The MTEF projects government spending for the coming three years, and the annual budget is more detailed, with specific spending proposed for the current year under discussion.

The ministerial-proposed budgets are consolidated into a draft cabinet budget paper that covers the budget frame, the financial demands after dialogue with MDAs, the government priorities, and financial implications. This is tabled before the Inter-Ministerial Technical Committee (IMTC), composed of permanent secretaries from each ministry. The IMTC scrutinises budget proposals before they are finally approved by the Cabinet.

Figure 4. Annual Budget Cycle



of the Development Partners Group (DPG) could influence reallocation to specific issues within the health sector. This is an important entry point because donors have some influence on how HSBF are spent. Budget scrutiny and dialogue with the IMTC occurs in March, and the Permanent Secretary (or his/her staff) is a strategic target at this stage to influence sector allocation. Later that month, the Minister of MoHSW will request the Cabinet to approve the budget proposal. This is an opportunity for the Minister of Health to make a case for an increase in the overall health budget.

By late March or early April, Parliament begins, and so does budget scrutiny. This process begins with the PSSC reviewing the MoHSW budget, which it can approve as is or request for a reallocation of funds within the health budget for a specific issue (e.g., increase funds for HIV). At this stage, budget advocacy efforts should be targeting allies within the PSSC. At the same time, but separately, the Parliamentary Regional Administration and Local Governments (PRALG) Committee reviews the PMO-RALG consolidated health budgets, and budget advocacy efforts can also target allies within the PRALG Committee.

Parliamentary public debate follows, from April through June, where vocal and charismatic members of Parliament can be encouraged to speak out for more funding for health generally or for particular issues (e.g., maternal health). Mobilising like-minded Members of Parliament is crucial at this stage, and in some cases there are existing "clubs" of MPs devoted to specific issues (like a Family Planning Club or Maternal Health Club). This public debate can influence the Parliament to direct more money for health or demand an increase for a specific program area.

Once the health budget is approved by the Cabinet, the Minister of Health presents to the Parliamentary Social Services Committee (PSSC) for review. This committee may request the MoHSW to make adjustments within its budget to address a particular need. Once this committee approves the budget, the committee will most likely support it in the Parliament.

Figure 5 highlights different levels and their role in the Government health budget process.

3.4. Entry Points for Health Sector Budget Advocacy

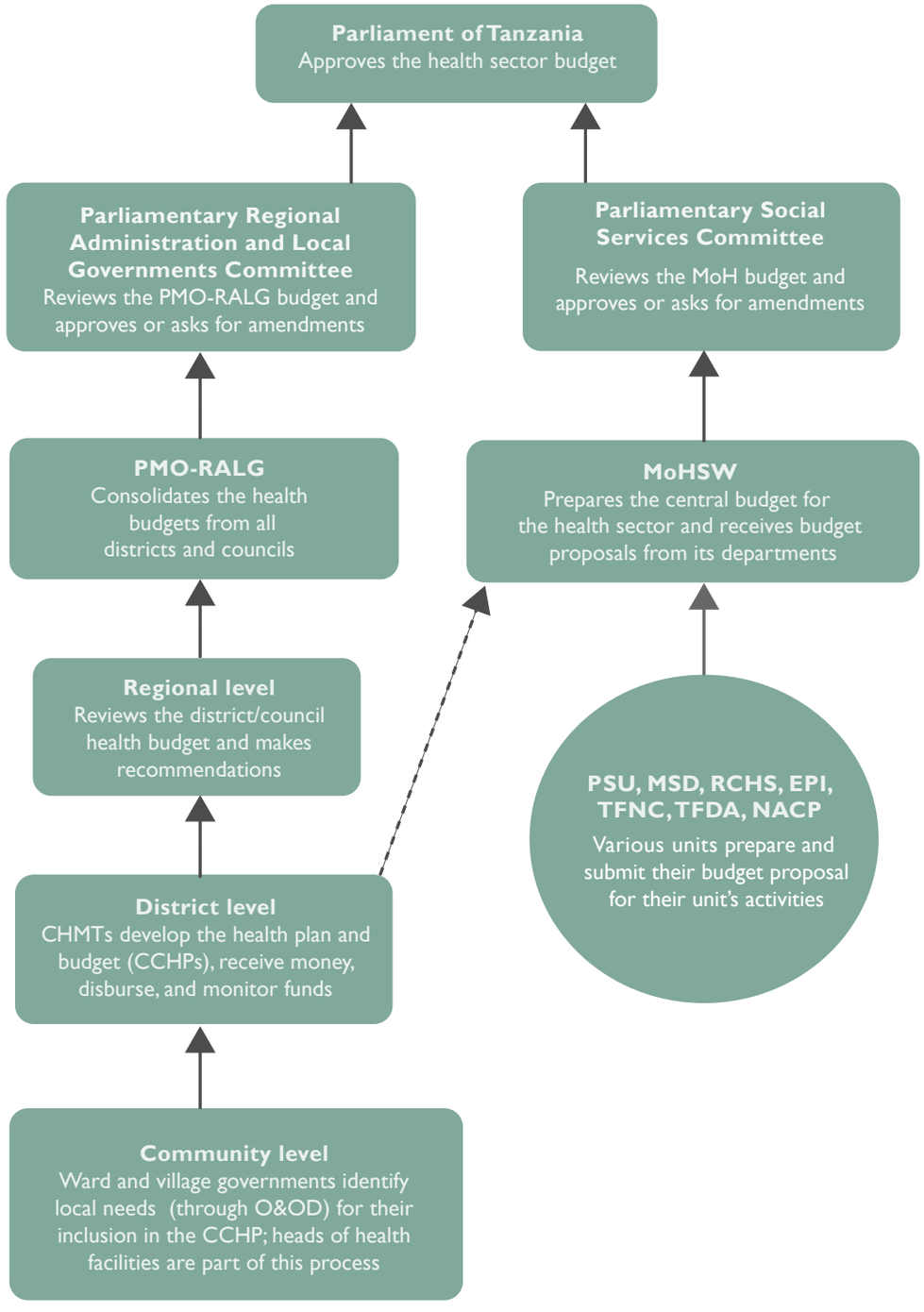
This section lays out the current budget development process in Tanzania at both the national and local levels and suggests specific "targets" for advocacy. These "targets" are the individuals who are likely the key decision-makers at that stage of the process and may be the primary people an advocacy campaign wishes to influence. However, CSOs should have undertaken a landscape analysis (see step 3, Section 2.2.1) to understand these advocacy targets, and in that process, may have identified secondary targets or influencers (Section 2.2.3) they also wish to reach. Furthermore, the timeline presented describes when certain activities happen within government. However, if advocates wish to influence a specific step in the budget process, they need to initiate their activities prior to the time presented below. For instance, if a specific meeting is being held in March, the advocates should start meeting with/lobbying their target audiences in February, if not earlier.

3.4.1. The national level

Throughout the annual budget process, there are numerous entry points for civil society to influence government spending on health, either by advocating for an increase in the total amount of money available for the health sector or advocating for a reallocation of the health budget to increase spending on specific health areas, such as maternal health, family planning, HIV/AIDS, or malaria.

The budget process begins in November, when the MoF circulates budget guidelines and expenditure limits to districts, regions, and ministries. If a CSO is successful in targeting the MoF budget commissioner, it can influence the expenditure limits set for health. This is an important entry point for CSOs wanting to encourage the government to reach the Abuja target of allocating 15% of government spending to health. In January, the MoHSW consolidates its budget and presents it to the MoF. During this time, targeting the budget head of the Department of Policy and Planning of the MoHSW for advocacy could influence allocations within the health budget (e.g., more funds to maternal health or family planning). In February, the MoF negotiates with the MoHSW on its budget proposal, and targeting the budget commissioner within the MoF could result in an increase to the overall health budget, a reallocation within the health sector to a specific issue, or both. Around the same time, GoT consultations with development partners occur. Targeting the Health Chair or members

Figure 5. Roles of Various Government Levels in Developing the Health Sector Budget



In July, once the budget is passed, disbursement of funds begins. Civil society plays a key role in monitoring government spending. CSOs can hold government accountable and assess "value for money" by generating and analysing data on the impact of certain types of spending (or lack thereof). CSOs can target or work with MoHSW staff within the units of interest (e.g., RCHS, EPI, MSD) to increase transparency on government spending on specific health areas. (See Figure 6.)

3.4.2. The district level

Decentralisation[15] reforms in Tanzania have created valuable new opportunities for community members and civil society to engage with the budget process and influence how health services are delivered. LGAs are playing an increasingly important role, particularly in the delivery of health and social services. The District or Municipal Council is made up of elected ward councillors and local parliamentarians who have a key role in reviewing and approving the proposed budget. Below the council there is the Ward Development Committee (WDC), which is a coordinating body linking the District/Municipal Council to the villages, streets, and hamlets. Members of the WDC include the ward councillor, village and street chairpersons, and the ward executive officer. Council directors (District Executive Directors or Municipal Directors) are responsible for overseeing budget formulation and implementation. At the health sector level/department, the District Medical Officer is in charge of developing and managing the health budget.

Health financing at the District level comes from local or central government resources, which are likewise classified as recurrent or development funds. These funds can be domestic or donor funds (see Section 3.2). Health services may get additional money from user fees, community health funds, the revolving drug fund, National Health Insurance Fund (NHIF) reimbursements to health facilities, NGO funding, or direct donor aid that bypasses the central government (see Figure 3). The health budget at the district level is captured in Comprehensive Council Health Plans (CCHPs).

As directed by the PMO-RALG (see footnote 18), the development of the CCHPs starts first at the village level, where village leaders meet with community members to identify local needs across sectors (in health, education, water, etc.). This is called the "Opportunities and Obstacles to Development" (O&OD) process[16] and includes the head of the health dispensary (if one is located in that village). These village needs are communicated upwards to the ward level, where WDCs, including the health committee, village leaders, and the head of the local health centre, make ward recommendations to the district. Since the O&OD process is participatory and involves community members, it is strategic for CSOs interested in budget advocacy at the local level to start with community engagement on these issues. Raising the community members' awareness of their rights and responsibilities in the government budget process will build their capacity to advocate for their own needs to their local leaders.

Ward plans filter up to the district level, where Council Health Management Teams develop the Council Comprehensive Health Plans, which are submitted to the Regional Administrative Secretaries (RAS; part of the PMO-RALG) for review, and then the plan and budget are returned to the district for amendment, if any. The plan and budget also are shared with the MoHSW, and District Medical Officers are called to defend their budget if needed. The CCHPs are finally consolidated into the PMO-RALG budget (see Figure 5, Section 3.3 on the budget process).

Civil society can play a role not only in influencing the budget development process at the local level, but can also contribute to government transparency and accountability with respect to how funds are subsequently spent. In Tanzania, the disbursement of funds is updated quarterly and posted on public notice boards. CSOs can monitor those notices, track whether the spending matches what was planned in the budget, and also assess the quality of what was done (e.g., the quality of repairs to a health facility). (See Figure 7.)

Figure 6. The Budget Development Process at the National Level

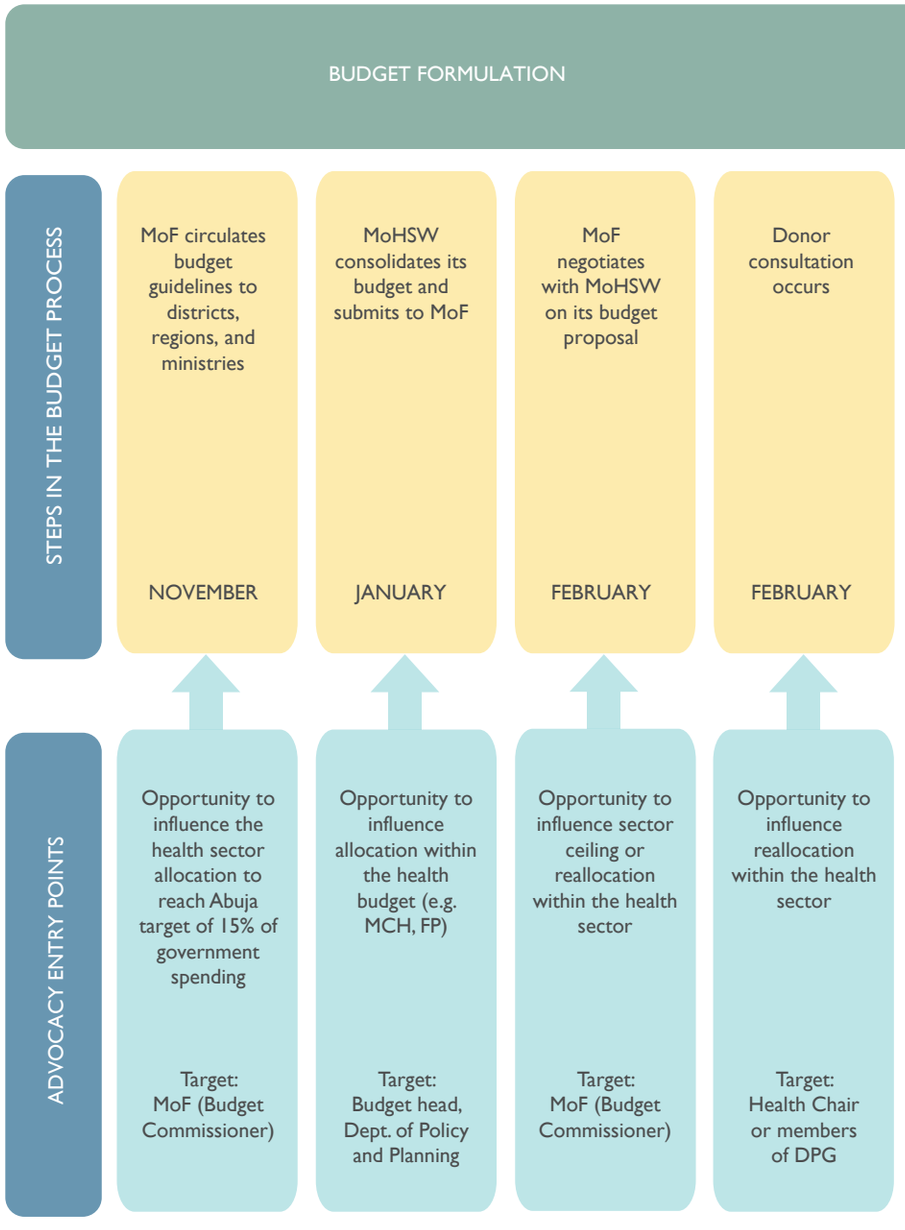


Figure 6. The Budget Development Process at the National Level *(continued)*

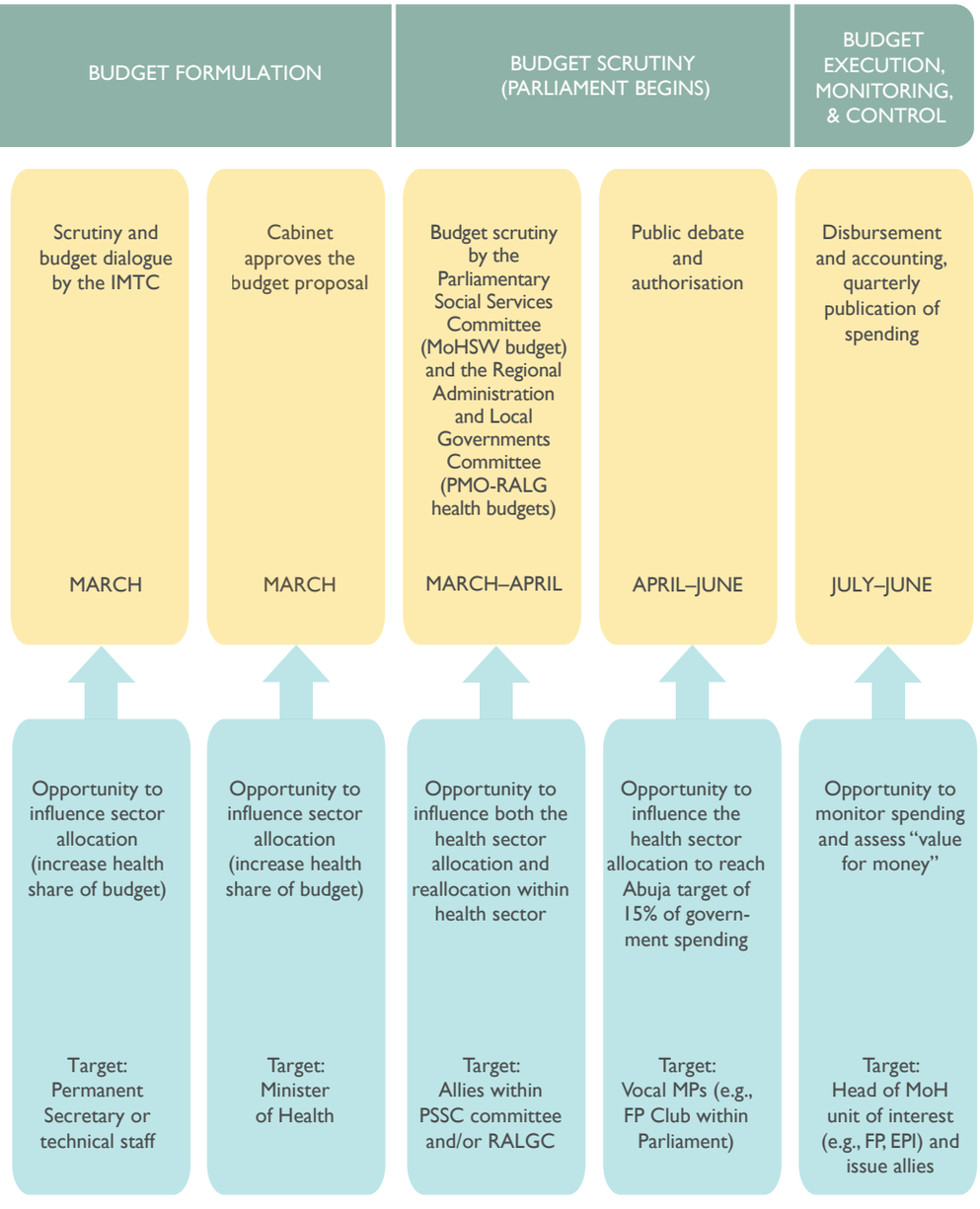


Figure 7. The Budget Development Process at the Local Level

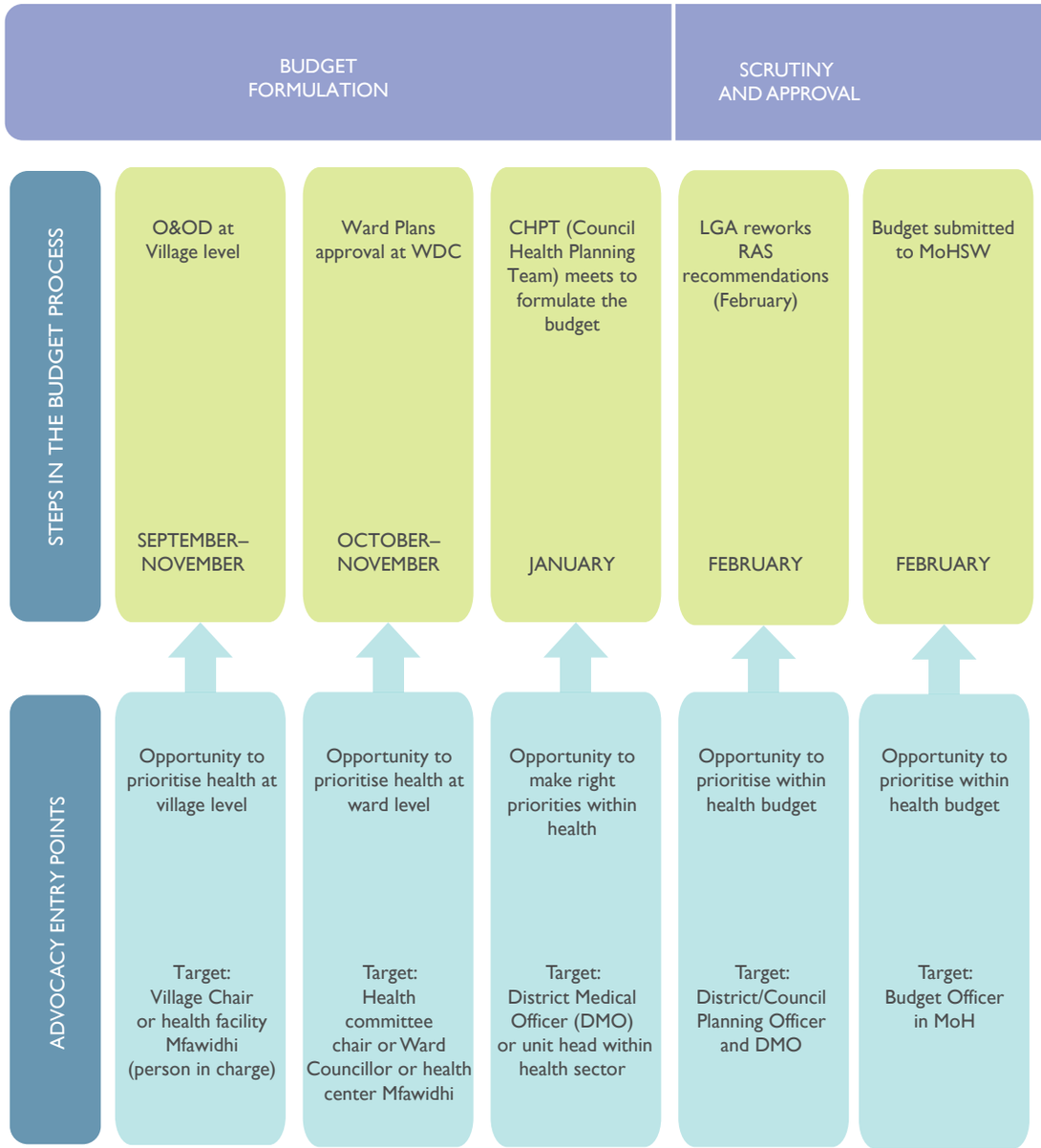
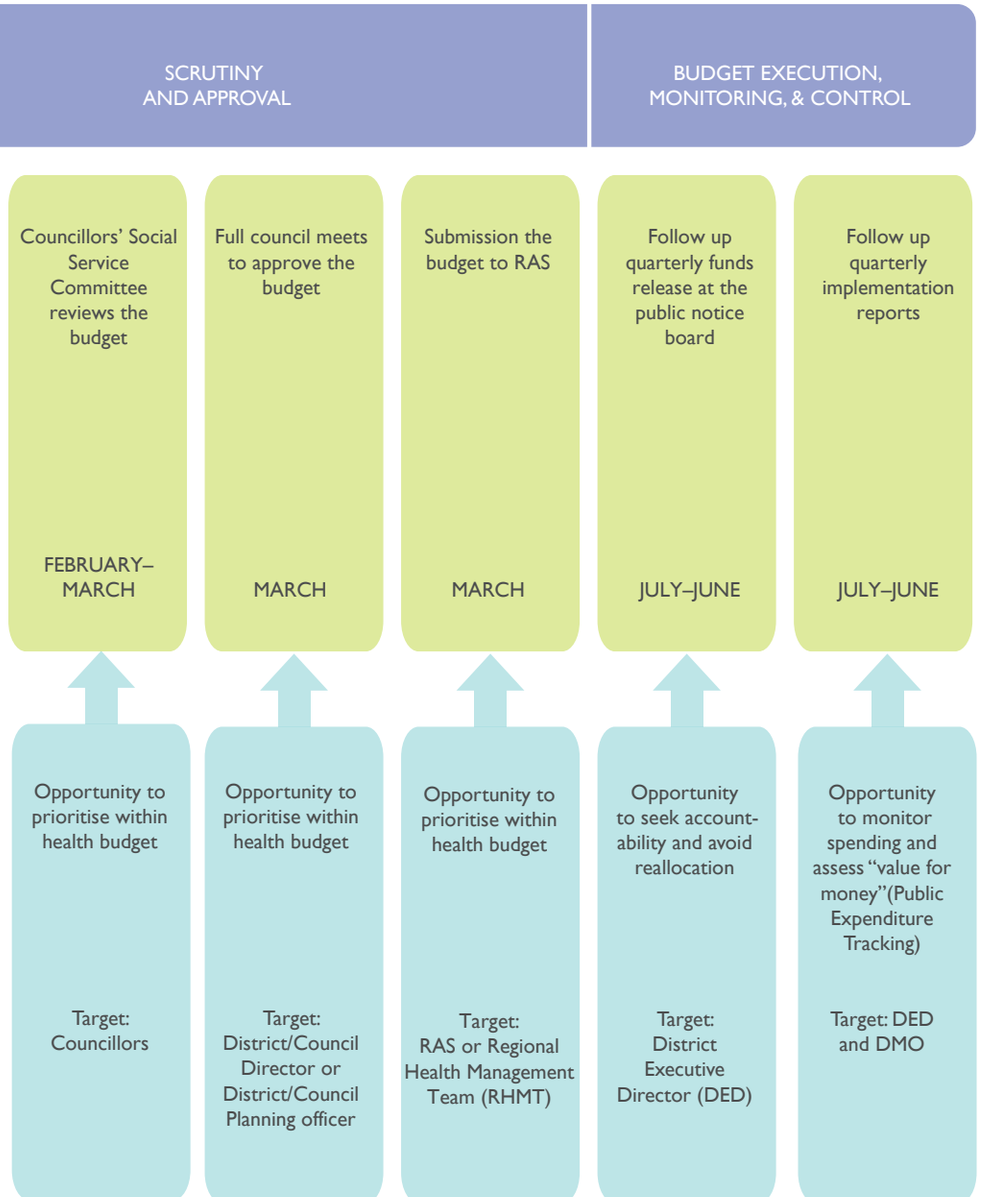


Figure 7. The Budget Development Process at the Local Level *(continued)*



Endnotes

14. Block grants are supposed to be allocated based on a district's population (70%), poverty count (10%), under-five mortality (10%), and the distance the district vehicle needs to travel for supervision (10%). District-level advocates may want to verify that the formula is being applied properly and the district is receiving the level of funding it should. For instance, a 2007 study found that under-five mortality was not related to the level of health grant received by LGAs; furthermore, the LGA's share of poor residents and the length of the route travelled by medical vehicles were only weakly related to the level of health grant received. See Allers, Maarten A. 2007. Do Formulas Reduce Political Influence on Intergovernmental Grants? Evidence from Tanzania. Available at http://www.rug.nl/staff/m.a.allers/politicalinfluenceongrants.pdf.
15. "Decentralisation" transfers power from the central government to lower levels of government, such that local government entities not only have administrative responsibilities, but also decision-making authority. In Tanzania, this is referred to as Decentralisation by Devolution, which was initiated in the government's 1998 Policy Paper on Local Government Reform.
16. In some areas, the O&OD process doesn't occur as it should. Communities can find more information on Tanzania's O&OD process, including Mchakato wa Kijijini and Mchakato wa Mjini, here: http://www.pmoralg.go.tz/menu-data/programmes/O-OD/; and can advocate with local leaders to implement the participatory process as required.
17. The quarterly disbursement and spending reports for the district are posted on the noticeboard at the office of the District Executive Director. Details on district health spending are posted at the office of the District Medical Officer.

4 Successful Case Studies in Budget Advocacy

Below are presented three CSO case studies on government budget advocacy; one at the District level and two at the National level. These case studies provide information on how the advocacy agenda was framed, which advocacy strategies/approaches were used, and the results. Further information on the cases can be found by contacting the address provided.

4.1 District-Level Advocacy to Influence the Government Budget for Family Planning

Introduction

Family planning (FP) services in Tanzania are chronically under-funded. An estimated one out of every four women of reproductive age has an unmet need for FP, and Tanzania experiences regular stock-outs of one or more types of modern contraceptives. Funding for the FP program is greatly dependent on donor funding. Central resources for FP are largely allocated to commodities, with some funds for supervision. Actual service delivery is largely the responsibility of the LGA. Although commodities are provided nationwide by the central government, other costs such as demand-creation, outreach services, and most supervision costs are borne by LGAs, or are largely off-budget contributions from international donors and NGOs. The following case study depicts HDT's experience advocating for increased resources at the LGA level with Kinondoni's Municipal Council (KMC), located within Dar es Salaam.

What was the advocacy problem?

LGAs did not allocate money for FP in their budget. Local leaders had a limited understanding of the link between FP, maternal and child health, and poverty reduction strategies. As such, there was no local interest in or commitment to allocating resources in the budget for FP.

Who were the advocates? What partnerships were formed?

HDT led a team of 11 advocates[18] from CSOs working in reproductive health and family planning in Tanzania. This project was supported by the Gates-funded Advance Family Planning project in Tanzania, and advocacy was conducted between April and August 2012.

Who were the decision-makers?

The decision-makers targeted for advocacy were the District Medical Officer (DMO) and the Municipal Council Chairperson (Honourable Mayor). The Honourable Mayor was the key decision-maker.

What advocacy methods and process were used?

A landscape analysis was undertaken to understand what the FP situation was in the district, which services were available, the level of funding for FP, and challenges clients might encounter when trying to access services. A two-page policy brief was then developed to showcase and present *"policy asks"* – the specific policy change the advocates wanted the policy-maker to undertake. Using a Smart Chart approach[19] to advocacy developed by the Spitfire Strategies consulting firm, a meeting was conducted with the Municipal Medical Officer over lunch (one on one) to familiarise him with the issues and explore what he cared most about and how it might link to FP. The advocates arranged a follow-up meeting with the District RCH Coordinator and likewise undertook site visits – joined by a few municipal councillors – to some local health facilities to assess the context of service delivery in the area. The advocates then requested a meeting with the mayor, to whom they presented the results of their analysis on access to FP services in KMC and the implications for health and development if the municipal councillors failed to act. These first targets of advocacy became local champions who started to speak out and persuade others about the need for FP funding.

A full council meeting was convened to highlight the problems caused by the lack of FP funding and discuss options on how best to address. A presentation was made on the national situation on access to FP services, with data specific to Kinondoni Municipal, the implications of the data, and recommended actions. The mayor and deputy were among the allies to support the motion for increased funding allocations to FP.

What were main advocacy messages?

The main messages were:

- Invest in FP to save the lives of mothers
- Invest in FP to reduce child mortality
- Invest in FP to increase girls' and women's life choices and productivity
- Invest in FP to reduce poverty in Tanzania
- FP contributes to development

What challenges were encountered during the advocacy process?

The main challenges encountered during this advocacy initiative were:

- The perception that malaria was the national priority and therefore there was no need to invest in FP.
- The misconceptions that FP was about controlling the population and that modern contraceptives had dangerous side effects.

How were the challenges overcome?

Malaria is a priority: We showed data that malaria cases were higher among pregnant women, many of whom had not planned to get pregnant; therefore, by providing FP services, we would both reduce unplanned pregnancy and the incidences of malaria. By reducing unwanted and mistimed pregnancies, we would also reduce the number of under-five children (who suffer most from malaria) who require free treatment by government. This would create a cost savings of government spending on health care. In the long run, reducing unwanted or mistimed pregnancies would also ease the education system, which has more pupils than it can afford.

FP is controlling the population: FP helps individuals and couples choose if, when, and how many children to have, and more than half of all women of reproductive age in Tanzania have a demand for FP. Spacing children at least two years (three to five is considered the healthiest birth spacing) reduces maternal and child mortality and is therefore beneficial to both fathers and mothers. Since the municipal government is in charge of providing health services, investing in FP will certainly result in cost savings in both education and health services. Furthermore, municipal leaders were shown data that clarified how little the central government is allocating to FP and, even if allocated, it is not often released for spending.

What were the results of advocacy?

The Municipal Council committed to increasing funds for FP. It agreed to allocate at least 1% of its own collections every year, starting in the 2012/2013 budget (up from 0.07% in 2011/12). When this resolution was passed, HDT drafted this commitment and requested that it be signed by the mayor and the Municipal Medical Officer. In absolute terms, this means that Local Government funding of FP increased from about $10,080 USD a year to $143,750 USD per year.[20] These funds will be used to increase the capacity of FP service providers in the KMC and expand access to youth-friendly services from 11 facilities to cover all 143 facilities in the municipality.

For more information, contact:

Rev. James Mlali
Health Promotion Tanzania
advocacy@hdt.or.tz

Dr. Gunini Kamba,
Municipal Medical Officer
guninik@yahoo.com

4.2. Improving Access to Medicine: Using Social Accountability Monitoring

Introduction

Access to medicine has become a growing concern in all public health facilities in Tanzania. There is evidence that medicine stock-outs are a barrier to service access and that services with poorer infrastructure may be more affected. Communities report several barriers to the uptake of health services, including shortfalls in medicines, medical supplies, and laboratory tests; households facing cost barriers reported borrowing from friends, family members, or money lenders and having to sell assets or delay care.[21] During 2006/07, only 21% of the population had access to affordable essential drugs on a sustainable basis.[22] In a 2007 survey, stock-outs were found to be associated with the following: poor physical storage conditions for medicines, inadequate management capacities for medicine procurement, a lack of buffer stocks, non-conformity of quantities delivered to orders, and constraints in the adequacy of the medicines budget.[23]

Sikika, a local Tanzanian NGO, conducts various advocacy initiatives to ensure quality health services for all. One of the approaches Sikika uses is ***Social Accountability Monitoring*** (SAM). In conducting SAM, Sikika works with citizens in various LGAs to empower them to demand high-quality services from their service providers and hold their leaders accountable for services provided.

What was the advocacy problem?

In its 2011 survey of District and primary-level facilities, Sikika found insufficient stock levels of medicines and supplies (for example, surgical gloves and syringes), which compromised the quality of care.

Who were the advocates? What partnerships were formed?

At the National level, Sikika worked in partnership with Members of Parliament and the national Technical Working Group (TWG) on health care financing.

Who were the decision-makers?

The advocates targeted the MoHSW and PMO-RALG officials at the National level; District Executive Director and Council Chairs were targeted as the key decision-makers at the LGA level.

What advocacy methods and process were used?

Between May and August 2011, Sikika did a rapid assessment of 100 health facilities and found that 29 suffered stock-outs of essential medicines and supplies. Sikika also conducted a budget analysis to determine allocations for medicines and compared these with some non-essential recurrent expenditures, such as allowances, travel, and hospitality. In the 2011/12 *Budget for Essential Medicines and Supplies*, the Pharmaceutical Supply Unit/Medical Store Department estimated that TSH 198 billion was needed to meet the demand for essential medicines in the public health sector. Yet in the MTEF, essential medicines were allocated only TSH 78 billion (about 40%). At the same time, non-essential expenditures (e.g., allowances, training, travels, hospitality and supplies, and acquisition of vehicles) rose from TSH 16.1 billion (2010/11) to 20.9 billion (2011/12), an increase of 29%.

With this analysis, Sikika presented to the PSSC a day before the MoHSW was scheduled to present its budget to the committee for scrutiny. During the presentation, Sikika recommended a reallocation of funds from non-essential expenditures to essential medicines. The committee was convinced and the next day urged the MoHSW to increase its budget for medicine. This resulted in a TSH 5 billion increase in the essential medicines line item (a 6.5% increase over the previous year).

To assess the quality of health services at the health facility level, given that the allocation for medical supplies and medicines was just 40% of the estimated need, Sikika partnered with citizen representatives from various constituencies (local CSOs, religious leaders, the District Executive Director's [DED's] Office, councillors, and the CHMT) in the districts of Kiteto, Mpwapwa, Kondoa, Iramba, and Singida Rural. Sikika conducted meetings with key decision-makers (Full Council, District Commissioners' Office, and DED's Office) to secure their support. Then they formed SAM teams[24] and trained them on monitoring the provision of health services in the districts. The SAM teams conducted service provision monitoring at all levels – district hospitals, health centers, and dispensaries. This monitoring revealed that spending on health services was lower than the amounts allocated in local-level budgets because of a lack of transparency on planning and expenditure. This resulted in a poor state of service provision due to low maintenance, inadequate medicines and medical supplies at the dispensaries, and inadequate human resources, with no retention mechanism in place. Thereafter, Sikika facilitated meetings between service providers, local leaders, and the SAM teams to share the findings from the monitoring exercise and make recommendations.

What were main advocacy messages?

At the National level: Allocating adequate funds for medicines is essential and saves lives.

At the Local level: If the transparency of public spending increases, the quality of services will improve.

What challenges were encountered during the advocacy process?

The main challenges encountered during this advocacy initiative were:

- Low levels of understanding among average citizens on their rights at the LGA level
- Difficulties in accessing information from government officials
- Misperceptions about advocates (i.e., government officials and civil servants perceived advocates as troublemakers)

How were the challenges overcome?

Citizens' low level of understanding: Sikika decided to develop a booklet called *Opportunities to Make Change in Tanzania: A Guide for Citizens to Improve Public Health Services* (forthcoming). Sikika district coordinators also participated in local community meetings to educate, empower, and support the community in its participation in the budgeting process.

Difficulties in accessing information: Since the implementation of this activity, a memorandum of agreement was put in place between the PMO and civil society organisations (Policy Forum), with a list of key documents that can be accessed by the districts. CSOs should familiarise themselves with this so they know their rights in accessing information. Nonetheless, obtaining these documents can still be a challenge for CSOs because of a lingering view of public servants that all government documents are confidential. To address misperceptions about advocates, CSOs are building relationships through positive interactions and dialogue, which enhance mutual understanding and minimise such tensions.

What were the results of advocacy?

The government increased the budget for medicines by TSH 5 billion in financial year 2012/13, an increase of about 6.5%.

Citizens in five districts were empowered to hold their leaders accountable and, as a result, they began to conduct monitoring of the provision of health services. Government accountability for medicine stocks and transparency of service providers and leaders increased. Sikika will continue to mentor the SAM team to increase their understanding of government budget documents and improve their analysis skills.

For more information, contact:

Josaphat Mshighati
Head of Programs for Sikika
0683021614
josaphat@sikika.or.tz

Simon Moshy
Program Officer
Healthcare Financing
simon@sikika.or.tz

4.3 Cases to Influence the Budget System for Sustainability

What was the advocacy problem?

HIV funds were being allocated only for National-level budgets (Ministries and Departments), which left districts with no resources to support direct service provision. The government budget system did not allow for budgeting for HIV at the district level. This meant that LGAs could not plan for or implement any HIV and AIDS activities beyond simply providing treatment, and for that, supplies came from the Medical Store Department directly. The 2005–2010 Poverty Reduction Strategy included HIV and AIDS as a development problem under its first cluster (economic growth) and second cluster (social well-being); this provided an opportunity to advocate for a change in the budgeting process that would enable district authorities to allocate funds for HIV and AIDS in their plans and budgets.

Who were the advocates? What partnerships were formed?

This issue was first raised in a meeting of a group of CSOs, that time known as the PER group of the Policy Forum. The members included Oxfam Ireland, Action Aid, the Tanzania Gender Network Program (TGNP), HDT, Concern Worldwide, Care International, Voluntary Services Overseas (VSO), and Policy Research for Development (REPOA).

Who were the decision-makers?

The target decision-maker was the budget commissioner within the MoF; this is the person who is in charge of the government's budget development process.

What advocacy methods and process were used?

A study was commissioned to evaluate the challenges that the Councils' Multi-Sectoral AIDS Committees were facing and how functional they were. The study provided information on which Councils had received funds from the Tanzania Commission for AIDS (TACAIDS) and which had not; it also provided information on how the funding limitation impacted their work. The results were compiled into a policy brief and were shared with the PER committee (made up of CSOs, government, and donors). A presentation was made on the HIV situation at the national level and focused on how those diagnosed with AIDS were migrating to rural areas and thus increasing the need to equip LGAs with resources to care for PLHIV and prevent new infections. The presentation also highlighted how the functionality of multi-sectoral committees was impacted by not receiving funds and future implications for the fight against HIV and AIDS in the country. The advocacy objective (policy ask) was for the GoT to introduce a specific objective/budget code for HIV and AIDS in all government agencies, which would allow government agencies to mainstream HIV issues within their own workplaces and beyond.

TACAIDS management agreed that this lack of a budget line item was a public concern and saw it as a mutual objective. Through the PER, it was re-affirmed that there was very little HIV funding to local government. The advocacy team made the same presentation to the Tanzania Parliamentary Committee on AIDS (TAPAC) and managed to build consensus among the various institutions and law makers responsible for HIV and AIDS within Government. TACAIDS was a valuable insider and organised successful meetings on the advocacy team's behalf with the MoF, and the proposal was accepted.

What were main advocacy messages?

The goal was to introduce a budget code in the government budget system for HIV and AIDS to best reach all those in need and contribute to poverty reduction and economic growth. The messages included: (1) allocate funds for local government to allow them to provide care to those infected, (2) allocate HIV funding to LGAs to allow them to prevent new HIV infections.

What challenges were encountered during the advocacy process?

Some technical people did not agree that HIV required that level of attention within government policy and budgets; this was most likely due to a misunderstanding of the link between HIV and poverty. They thus opposed the initiative. The other challenge was the competing priorities of government – when the advocacy team asked for the introduction of a budget code for HIV, technocrats asked how that might impact other priorities, like water, environment, and non-communicable diseases, which were on the increase.

How were the challenges overcome?

The challenges were overcome by presenting data and supporting them with a "human face" through case studies. The advocates always repeated the facts and highlighted the lives and productivity that will be lost as a result of not capacitating LGAs to plan and implement HIV and AIDS interventions.

What were the results of advocacy?

In 2007, the government budget system was changed to include Objective A, which is specific for HIV and AIDS; now it is a requirement that all government agencies allocate funds to this line item. It is a formula that takes into consideration parameters such as those used in Block Grants for the health sector: population 70%, disease burden 10%, district vehicle route 10%, and poverty head count 10%. As a result, funding that is allocated to LGAs for HIV and AIDS more than tripled, from less than TSH 4 billion to 12 billion by 2011/12.

For more information, contact:

Peter Bujari, MD
Health Promotion Tanzania
ed@hdt.or.tz

Beng'I Issa
Tanzania Commission for AIDS
bissa@tacaids.go.tz

Endnotes

18. These came from HDT, UMATI, TAMA, ANAT, AJAAT, TGNP, TAMWA, PAT, AGOTA, TAWLA, and MEWATA.
19. Spitfire Strategies' Smart Chart is a six-step strategic communications planning tool that is highly useful for advocacy planning. You can learn more at: http://www.smartchart.org.
20. Kinondoni Municipal Council collects about Tsh 23 billion a year, equivalent to approximately US$ 14.4 million.
21. Other reported barriers included distance from health facilities, transport costs, and a shortage of health workers. Macha, J., H.P. Mushi, and J. Borghi. 2011. *Examining the Links between Accountability, Trust and Performance in Health Service Delivery in Tanzania.* Ifakara Health Institute.
22. URT, 2008.
23. URT, 2008.
24. The 15 representatives were citizens, councillors, or religious leaders, or were from local CSOs, CHMT, the DED's office, Ward Executive Officers, and facility governing committees.

Abbreviations

AGOTA	Association of Gynecologists in Tanzania
AJAAT	Association of Journalists Against AIDS
ANAT	Advocacy Network Against AIDS in Tanzania
BCC	Behaviour Change Communication
CCHP	Comprehensive Council Health Plan
CHMT	Community Health Management Team
CHPT	Council Health Planning Team
CSO	Civil Society Organisation
DED	District Executive Director
DMO	District Medical Officer
DPLO	District Planning Officer
GoT	Government of Tanzania
HDT	Health Promotion Tanzania
HIV	Human Immunodeficiency Virus
HSBF	Health Sector Basket Fund
IMTC	Inter-Ministerial Technical Committee
KMC	Kinondoni's Municipal Council
LGA	Local Government Authority
MDAs	Ministries, Departments, Agencies
MEWATA	Medical Women's Association of Tanzania
MKUKUTA	Poverty Reduction Strategies
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Store Department
MTEF	Medium-Term Expenditure Framework
NGO	Nongovernmental Organisation
NHIF	National Health Insurance Fund
O&OD	Opportunities and Obstacles to Development
PAT	Pediatric Association of Tanzania
PER	Public Expenditure Review
PMO-RALG	Prime Minister's Office, Regional Administrative and Local Government
PSSC	Parliamentary Social Services Committee
RAS	Regional Administrative Secretary
REPOA	Policy Research for Development
RHMT	Regional Health Management Team
SAM	Social Accountability Monitoring
TACAIDS	Tanzania Commission for AIDS
TAMA	Tanzania Midwives Association
TAMWA	Tanzania Media Women's Association
TAPAC	Tanzania Parliamentary Committee on AIDS
TAWLA	Tanzania Women Lawyers Association
TGNP	Tanzania Gender Network Program
TWG	Technical Working Group
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
USAID	United States Agency for International Development
VSO	Voluntary Services Overseas
WDC	Ward Development Committee
WHA	World Health Assembly

References and Resources

Allers, Maarten A. 2007. "Do Formulas Reduce Political Influence on Intergovernmental Grants? Evidence from Tanzania." Retrieved from http://www.rug.nl/staff/m.a.allers/politicalinfluenceongrants.pdf.

BRIDGE Project. 2008. "Repositioning Family Planning: Guidelines for Advocacy Action." Geneva: WHO. Retrieved from http://www.who.int/reproductivehealth/publications/family_planning/fp_advocacy_tool/en/index.html.

Carlitz, Ruth. *Review of Impact and Effectiveness of Transparency and Accountability Initiatives*. Annex 2. 2010: Budget Processes. Institute of Development Studies (IDS).

Development Partners Group. 2006. "The Framework for Development Co-operation between the Government of the United Republic of Tanzania and its Development Partners to Achieve National Development and Poverty Reduction Goals." Retrieved from http://www.aideffectiveness.org/Country/Tanzania/Joint-Assistance-Strategy-Tanzania-2006.html.

Dewji, Ismat. 2006. "*All about the Health Budget! Dar es Salaam, Tanzania*." Retrieved from http://www.sikika.or.tz/en/cms/functions/files/publication122.pdf.

Dickinson, C., T. Collins, R. Loewenson, and S. Ghosh. Fall 2012. "Civil Society's Contribution to Budget Advocacy for Sexual and Reproductive Health: Findings and Lessons Learned from Three Country Studies in Bangladesh, The Philippines and Uganda." *Global Health Governance* VI(1).

Garza, Manuela. 2009. *Civil Society Budget Analysis and Advocacy as a Tool for Maternal Health Accountability*. Washington, DC: International Budget Partnership.

HakiKazi Catalyst. 2004. "Demystifying the Budget Process in Tanzania: A Seminar to Promote Civil Society Advocacy." Arusha, Tanzania: Tanzania Natural Resource Forum. Retrieved from http://www.hakikazi.org/papers/Budgeting-Seminar-Report.pdf.

HDT. 2010. *Advocacy Training Manual for Civil Society Organizations*. Dar Es Salaam, Tanzania.

International Planned Parenthood Federation. 2012. "International Budget Partnership: Handbook for Budget Analysis and Tracking in Advocacy Projects." New York: IPPF. Retrieved from http://www.ippfwhr.org/en/resource/handbook-budget-analysis.

Macha J., H.P. Mushi, and J. Borghi. 2011. *Examining the Links between Accountability, Trust and Performance in Health Service Delivery in Tanzania. Dar es Salaam, Tanzania*: Ifakara Health Institute.

Narton, Andy. 2002. *What's Behind the Budget?* London.

"Policy Forum. Strengthening Parliament's Budgetary Oversight Function: The Case for a Budget Office." Retrieved from http://www.policyforum-tz.org/files/Parliamentary%20Budget%20Office%20Brief.pdf.

Policy Forum and Hakielimu. 2008. *Understanding Budget Process in Tanzania, a Civil Society Guide.*

POLICY Project. October 1999. "Networking for Policy Change: An Advocacy Training Manual." Washington, DC: Futures Group, The POLICY Project. Volume IX. Retrieved from http://www.policyproject.com/pubs/AdvocacyManual.cfm.

Save the Children. 2012. "Health Sector BUDGET Advocacy: A Guide for Civil Society Organizations." London. Retrieved from http://www.savethechildren.org.uk/resources/online-library/health-sector-budget-advocacy-guide-civil-society-organisations.

Spitfire Strategies. n.d. "SMART CHART 3.0." Washington, DC. Retrieved from http://www.smartchart.org/content/smart_chart_3_0.pdf.

United Nations. 1976. *International Covenant on Economic, Social and Cultural Rights, Article 12 of International covenant on Economic and Social Rights.*

The United Republic of Tanzania. 2012. *The HIV and AIDS and Malaria Indicator Survey*. Dar es Salaam, Tanzania.

The United Republic of Tanzania. 2012. *Public Expenditure Review Report for Ministry of Health for Year 2011/12*. Dar es Salaam, Tanzania.

The United Republic of Tanzania. 2008. *Health Sector Performance Profile Report, Ministry of Social Welfare.* Dar es Salaam, Tanzania.

The United Republic of Tanzania. 2001. "Opportunities and Obstacles for Development." Retrieved from http://www.pmoralg.go.tz/menu-data/programmes/O-OD/.

World Health Organization. 2012. *The Rio Political Declaration on Social Determinants of Health (WHA 65.8)*. Geneva, Switzerland.

Organisations Working in Budget Advocacy in Tanzania

Health Promotion Tanzania
P.O. Box 65147
Dar es Salaam
Tel: +255 (22) 2772264/86
Email: advocacy@hdt.or.tz

Delloite
10th Floor, PPF Tower
Corner of Ohio Street & Garden Avenue
P.O. Box 1554
Dar es Salaam
Tel: +255 (22) 2 334 4455

DSW
(Deutsche Stiftung Weltbevoelkerung)
P.O. Box 1427
Arusha
Tel: +255 (27) 2555020
Mobile: +255 (0)764 990009
Fax: +255 27 255 5064
Email: peter.dsw-tz@habari.co.tz
www.dsw-tanzania.org

EngenderHealth
Plot No. 254
Mwai Kibaki Road/Kiko Avenue
P.O. Box 78167
Dar es Salaam
Tel: +255 (22) 2772425
Mobile: +255 (0)754 005070
Email: infotz@engenderhealth.org

Futures Group
P.O. Box 76724
Dar es Salaam
Tel: +255 (22) 2773023
policyinfo@futuresgroup.com

Pathfinder
Chato Street, Plot No. 260
Off New Bagamoyo Road Regent Estate
Dar es Salaam
Tel: +255 (22) 2700 726/729/753
Fax: +255 (22) 2700 731 or
+255 (22) 2700 815
Email: MKudrati@pathfinder.org

Policy Forum
P.O. Box 38486
Dar es Salaam
Tel: +255 (22) 2780200
Mobile: +255 (0)78 231 7434
Email: info@policyforum.or.tz

REPOA
157 Mgombani Street
Regent Estate
P.O. Box 33223
Dar es Salaam
Tel: +255 (22) 2700083 /
+255 (22) 2772556
Fax: +255 (22) 2775738
Mobile: +255 (0)78 455 5655
Email: repoa@repoa.or.tz

Save the Children
Plot 257, Kiko Avenue
Mikocheni A, Old Bagamoyo Rd.
P.O. Box 10414
Dar es Salaam
Tel: +255 (22) 2701725
Fax: +255 (22) 2701726

Sikika
P.O. Box 12183
Dar es Salaam
Tel: +255 (22) 26 663 55/57
Fax: +255 (22) 26 680 15
Email: info@sikika.or.tz