

# MATERNAL HEALTH IN TANZANIA: STUCK BETWEEN PUBLIC PROMISES AND BUDGETARY REALITIES

Case study (Full) | Peter Bofin<sup>1</sup> | December 2014

## INTRODUCTION

*Wajibika Mama Aishi* (Be Accountable so a Mother May Survive) is the name of White Ribbon Alliance (WRA) Tanzania’s campaign to hold the government accountable for the commitment it made in 2008 to improve maternal health in Tanzania. That commitment was to ensure that every ward in Tanzania would have a health center, and that 50 percent of those health centers would have facilities for Comprehensive Emergency Obstetric and Newborn Care (CEmONC).

This commitment was contained in *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania 2008 – 2015*, known as the One Plan. At the launch of the One Plan in May 2008, the President of Tanzania, Jakaya Mrisho Kikwete, emphasised that improving access to primary health care is a priority for Tanzania, as part of his commitment to advancing the UN Millennium Development Goals.

The WRA Tanzania campaign has a national reach, and aims to have a specified budget line for CEmONC that will ensure that 50 percent of health centers in the nation will be CEmONC ready. Within 15 months of the start of the campaign, WRA Tanzania recorded a significant victory. Speaking at a WRA Tanzania organized public event in March 2014, Prime Minister Mizengo Pinda made a commitment to prioritizing CEmONC in health budgets. He directed all 169 District Councils to develop a strategy for improving CEmONC, and to include a specific line for this service in their annual health plans. He said that the government would set aside a special “ring fenced budget” for

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CEmONC.<sup>2</sup> By July of the same year a follow-up directive was issued by the Prime Minister to all regional authorities, instructing that all district budgets include a line item for CEmONC.

However, this achievement was qualified. In spite of political commitment on the part of central and regional government, the complex process of budgeting and the fiscal crisis in Tanzania has compromised the extent to which a specific budget line at district level could be implemented for improving CEmONC in the 2014 – 2015 budget.

In this case study we look at how WRA Tanzania was able to achieve success in holding government accountable for its commitment to fund CEmONC facilities. In doing so, we will examine the context in which the ongoing campaign is taking place and the problem that it seeks to address. This will require that we review the state of maternal health in Tanzania and explore the complexity of the budgeting process (and specifically budgeting for health). We will then outline WRA Tanzania's past work in this area and assess the *Wajibika Mama Aishi* campaign itself. We will focus on the planning of the campaign and the relationships with stakeholders, and identify issues which may have affected the outcome of the campaign. Finally, we draw lessons from the WRA Tanzania experience and consider how the current economic and political context might affect future outcomes of the campaign.

## THE ISSUES THAT THE WRA TANZANIA CAMPAIGN WAS RESPONDING TO

The White Ribbon Alliance works in a number of different countries. It is an organization that focuses on the right of every woman to give birth safely. In Tanzania, WRA Tanzania's concern is how the public health system responds to women's pre- and neonatal health needs. This concern relates to staffing, supplies and financing through different arms of government at national and local levels. In this section we outline the scope of the challenge and the government systems through which it is addressed.

### THE PROBLEM

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Death in childbirth is a tragedy that can often be prevented without highly sophisticated interventions. Even so, maternal death remains at unacceptably high levels across Sub-Saharan Africa. In 2013 there were an estimated 179,000 maternal deaths in Sub-Saharan Africa, 7,900 of which occurred in Tanzania<sup>3</sup>. Table 1 shows that while some progress has been made in the past 23

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<sup>2</sup> White Ribbon Day Speech, March 15, 2014.

<sup>3</sup> World Health Organization. 2014 *Trends in Maternal Mortality*. Available at: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/>; Maternal mortality in 1990-2013: Tanzania, available at: [www.mamaye.org/en/evidence/maternal-mortality-1990-2013-tanzania](http://www.mamaye.org/en/evidence/maternal-mortality-1990-2013-tanzania)

years, the decline has not been dramatic. Annual changes for Tanzania range between 2 percent and 5.5 percent.

TABLE 1. ESTIMATES OF MATERNAL MORTALITY RATIO IN SUB SAHARAN AFRICA AND TANZANIA, 1990-2013

	1990	1995	2000	2005	2013	% change
<b>Sub-Saharan Africa</b>	990	930	830	680	510	49%
<b>Tanzania</b>	910	890	770	610	410	55%

Notes: Maternal mortality ratio (MMR) is the number maternal deaths per 100 000 live births.

Source: Trends in Maternal Mortality, World Health Organization, 2014.

CEmONC is one of the primary means of significantly reducing deaths in childbirth. Such care allows for surgical intervention, for example, when a caesarian delivery is required, when the placenta is retained and needs to be removed, or when the mother suffers eclampsia, which causes fits and unconsciousness. The requirements for CEmONC are relatively basic. A safe supply of blood and cold storage for the blood is needed. Basic medication, such as injectable antibiotics, is required for any surgical intervention, and magnesium sulfate is critical for treating eclampsia. A stable supply of water and electricity is also vital, along with skilled staff and an operating theatre.<sup>4</sup>

While reasonably basic, these services are unavailable to many women. According to WRA Tanzania's assessment of facilities in 2013 in Rukwa Region, where WRA Tanzania focused its campaign, not one health centre was CEmONC-ready. This meant that a woman experiencing any of these difficulties would need to be referred to a regional hospital. In WRA Tanzania's four target districts in Rukwa Region, the average distance from a health center to the referral hospital is 94.5 km, and in most cases transport is not available.<sup>5</sup>

Responding to this challenge involves complex planning when resources are limited and demands on resources are many. Part of the challenge is ensuring that statistics related to maternal mortality reflect reality. In the world of district health planning, this cannot be assumed. The standard maternal mortality rates in Table 1 are obtained from the *Demographic and Health Survey (DHS)*, conducted approximately every 10 years and based on a survey of a representative sample.

<sup>4</sup> Interview, Rose Mlay, December 4, 2014.

<sup>5</sup> White Ribbon Alliance, *Preliminary Findings of Assessment for Evidence Towards Advocacy Campaign for Improved Delivery of Maternal and Newborn Health*, unpublished report, 2013, Dar es Salaam, Tanzania.

However, the administrative data generated at the district level produce much lower mortality numbers, being based on incidents at public health facilities, along with a limited number of known deaths outside such facilities. These figures are typically much lower than DHS figures, and in Rukwa Region are less than 100 deaths per 100,000 births. When seeking to defend a budget allocation, these are the numbers that a district medical officer brings to the planning table. Thus it has been a priority of the safe motherhood movement to ensure that the more accurate mortality figures are accepted at policy and planning levels nationally, regionally, and at the district level.<sup>6</sup>

## THE GOVERNMENT'S RESPONSE TO THE PROBLEM

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The government's response to the high levels of death in child birth, was to produce *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008 – 2015*, known more simply as the One Plan. The One Plan was drawn up as Tanzania's commitment to the New Delhi Declaration of 2005, which called on countries to develop a single integrated plan to address maternal, new born, and child health through improved coordination and a better alignment of resources. The plan presented clear targets to be achieved across the spectrum of maternal and child health by 2015, including targets for the provision of CEmONC services.

The One Plan was drawn up under the leadership of the Reproductive and Child Health Section of the Ministry of Health and Social Welfare, but it included other ministries and a wide range of stakeholders, from multilateral and bilateral development partners to the private sector and the NGO community. Many of the NGOs are members of WRA Tanzania. The White Ribbon Alliance itself was involved in the early planning of the One Plan in 2008. One of its core members was on the drafting committee and is currently coordinating the drafting of a follow-up One Plan. This creates the unique situation where key NGOs working on safe motherhood, including WRA Tanzania, are involved in setting government priorities and targets. It should be noted that this is not the case for all NGOs, even in the health ministry. Where the work of NGOs is aligned with government priorities, levels of access and cooperation are quite good. Access and cooperation are less forthcoming, and relationships are more contentious, where NGOs are not in close alignment with government.<sup>7</sup>

The One Plan was deliberately inclusive and assigned responsibilities to each set of stakeholders involved in its development. For the NGO community, a key role is advocacy, targeting the Ministries of Health and Finance, the Office of the Prime Minister, and regional and local governments, particularly for increased budget allocations for the plan's priorities. WRA Tanzania is central to this advocacy effort. This places WRA Tanzania in a unique position. On the one hand it has been

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<sup>6</sup> Interview, Craig Ferla, December 4, 2014.

<sup>7</sup> Bofin, P. 2012 *Freeing Funds to Meet Priorities and Needs: Sikika's Campaign to Curb Unnecessary Expenditure in Tanzania*. IBP: Washington D.C. Available at: <http://internationalbudget.org/publications/freeing-funds-to-meet-priorities-and-needs-sikikas-campaign-to-curb-unnecessary-expenditure-in-tanzania/>

involved in developing targets and priorities for the health sector in partnership with government. And yet on the other hand, it has been assigned the task of holding the government to account for the commitments it has made, commitments that WRA Tanzania was involved in formulating.

Tanzania's public health system focuses on the 25 regions and 169 districts in mainland Tanzania, where up to 80 percent of expenditure takes place.<sup>8</sup> While policy is set at the Ministry of Health and Social Welfare, the development of the overall budget, the prioritization of needs, and the budget approval process is spread across a number of ministries and offices at national, regional, district, and sub-district levels. Understanding this planning and budgeting system is vital to understanding the challenge that WRA Tanzania faced in addressing emergency obstetric care as a budgetary issue, and highlights the complex bureaucratic structures through which public servants must work.

## THE BUREAUCRATIC ENVIRONMENT AND THE BUDGETING PROCESS

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It is important to have a picture of the bureaucratic structure that governs health financing, and to understand the guidelines under which officials operate, particularly at the district level.

The Ministry of Health and Social Welfare (MoHSW) determines policy, provides technical guidance, sets standards, and conducts budgeting in relation to public health. Policies, standards, and targets are determined by the Preventive Services Division and the Reproductive and Child Health Section, within which fall matters relating to maternal and newborn health. The Section has the responsibility for implementing and monitoring One Plan,<sup>9</sup> and works closely with safe motherhood NGOs. This responsibility is also shared with the Prime Minister's Office and with regional and local governments (see below).

Planning and budgeting within the ministry is the duty of the Policy and Planning Division, and within that, the Budget and Planning Department. In collaboration with other responsible ministries, these offices are responsible for determining the overall budget and for setting budget priorities within the public health sector.

The Ministry of Finance guides this process by setting the very broad guidelines indicating the timetable for budgeting processes and priorities. The current guidelines are the *Guidelines for the Preparation of Annual Plan and Budget for 2014/15 in the Implementation of the Five Year Development Plan, 2011/12-2015/16*. The only health priority mentioned in these guidelines is nutrition, whereby regional and district authorities are reminded to allocate resources in line with the National Nutrition Strategy.

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<sup>8</sup> Interview, Craig Ferla, December 4, 2014.

<sup>9</sup> The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015.

The Ministry of Finance determines the overall budget envelope for each ministry. However, this is communicated by a secret government circular and is not available to the NGO community. Therefore, those lobbying for particular budget allocations are denied access to a critical element of the process.

The Prime Minister's Office, Regional Administration, and Local Government (PMORALG) is maybe the most critical element in the bureaucracy, given the level of decentralization of health service planning and delivery. It is organized into different divisions covering different areas of service delivery. Health issues are under the leadership of a Deputy Permanent Secretary (Health).

Two further sets of budget guidelines are produced by the MoHSW and PMORALG. *Guidelines for the Preparation of Local Government Authorities Medium Term Plans and Budgets* is a PMORALG document that gives very broad guidelines for the preparation of the three-year Medium Term Expenditure Framework and annual budgets. It covers a wide range of areas, including livestock, agriculture, and education. Consequently, the attention given to health is sparse. The most recently available version of these budgeting guidelines, published in 2008, simply identifies five priority areas for consideration, without including maternal and newborn health.

The second key set of guidelines is the *Comprehensive Council Health Planning Guidelines*, produced jointly by the MoHSW and PMORALG. In practice, this is primarily a PMORALG document and serves as a template for health budgeting at the district level. Within these planning guidelines, emergency obstetric care is identified as an "intervention," within the priority area of maternal and newborn health. This is not a budget line as such, but a priority area, against which expenditure with a range of budget codes is to be allocated. These would include such things as medical supplies, salaries, per diems, and certain capital costs.

Regional and district budgets for health are approved and disbursed through PMORALG, not the MoHSW. Regions are headed by a regional commissioner, who is appointed directly by the President and reports to the President, and who is supported by the regional administrative secretary. Within health, these officials are responsible for approving budget submissions from districts within their region, monitoring expenditure, and ensuring adequate human resources.

The regional administration, and in particular the Regional Health Management Team (RHMT) under the regional medical officer, is responsible for, among other things:

- interpreting strategies, policies, regulations, and directives from both MoHSW and PMORALG;
- technical support to Council Health Management Teams on the preparation and monitoring of the Council Comprehensive Health Plan;
- budget review, which is a technical and administrative exercise to ensure that government policy and service delivery priorities are addressed, and that the plan is administratively sound and within budget; and

- technical coordination between MoHSW, PMORALG, donors, and other stakeholders.

In sum, the regional administration plays a critical role as the political channel with the authority and administrative power to make things happen on the ground.

At district level, the implementation of health policies and guidelines, budgeting for them, and management of health facilities are the responsibilities of the Council Health Management Team (CHMT). The CHMT consists of all medical officers at district level and is headed by the district medical officer. Along with the Council Health Planning Team (CHPT), the CHMT is responsible for drawing up the Comprehensive Council Health Plan – the basis of the health budget in the district. CHMT is representative. It is chaired by the district planning officer, but also includes NGO and private sector representatives, faith-based organizations, and representatives from the CHMT.

## PAST CAMPAIGNS FOR MOTHERS AND NEWBORNS

WRA Tanzania’s campaign on CEmONC as a budget issue was not an entirely new initiative. Since its foundation in 2004, WRA Tanzania has focused on maternal and newborn health. Since 2008, it has actively supported the government’s One Plan. Since 2009, WRA Tanzania has had a campaign strategy that has prioritized budget issues, and it sought to engage with members of parliament and other leaders, a key tactic in the One Plan’s own advocacy strategy. In this section, we examine WRA Tanzania’s previous campaigns for maternal and newborn health.

### PREVIOUS WRA TANZANIA CAMPAIGNS

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WRA Tanzania was launched in Tanzania in 2004 at the initiative of the current coordinator. Rose Mlay worked in midwifery in the country’s major referral hospital, and following her attendance at a WRA conference in India in that year, she decided to bring the White Ribbon Alliance to her own country. Early support for WRA Tanzania came from the USAID-funded Health Policy Project. By 2013, WRA Tanzania had grown into a broad alliance of local and international NGOs, bilateral and multi-lateral development agencies, and the Reproductive and Child Health Department (RCH) of Tanzania’s Ministry of Health and Social Welfare.

In total, WRA Tanzania has 3,000 individual members, with 108 member organizations. A leading Core Committee draws its members from key member NGOs, as well as civil servants who serve in their personal, not official, capacity. Up to 2013, the only full-time WRA Tanzania worker was its founder. WRA Tanzania considers itself a “national alliance” of all those interested in improving maternal and newborn health, and not as an NGO alliance as such. Accordingly, WRA Tanzania has had representation from the RCH and professional associations since its inception.<sup>10</sup>

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<sup>10</sup> Interview, Rose Mlay, January 30, 2015.

In 2006, White Ribbon Day was launched. This is an annual advocacy event that is unique within the global WRA network. Each year, a high-profile political leader is asked to officiate at a large public event and to speak on whichever aspect of the maternal and newborn health system WRA Tanzania is focusing on for that year.

In the early years, themes and approaches for the White Ribbon Day were chosen on a somewhat ad hoc basis by the Core Committee. In 2006, the theme was human resources; in 2007, the event was used to promote home-based life-saving skills. The 2008 event dealt broadly with safe motherhood, while White Ribbon Day events in 2009 and 2010 dealt explicitly with budgeting issues. In the 2006, 2009, and 2010 events we can see the emergence of key elements of WRA Tanzania's *Wajibike Mama Aishi* campaign.

The 2006 event was notable for three tactics that have been built into WRA Tanzania's current campaign: collection and use of evidence, buy-in from a high-profile figure, and follow-up with the authorities. It also highlighted a critical issue that would arise in 2014 - the challenge of implementing a commitment through multiple ministries that were uniformly under-resourced.

For evidence, WRA Tanzania was able to rely on its work in the previous year with regional medical officers to conduct a survey of actual health staffing levels at facilities in the Sumbawanga and Monduli districts, and compare those findings against the 1999 Establishment Order setting out the requirements for staffing. They found huge discrepancies, with facilities seriously lacking qualified staff. On the basis of this evidence, credible demands for the government to step up to meet its commitment could be made.

The headline figure that year – the first White Ribbon Day – was former President Ali Hassan Mwinyi, a popular and charismatic figure. He spoke to thousands, using evidence and testimony from WRA Tanzania. Later, follow-up with the Ministry of Health's Director of Planning and Budgets revealed that a request had been made for the recruitment of all public health graduates to the public health service. This request was granted and represented a gain in staffing for which WRA Tanzania can claim some credit. For 2007, the Ministry of Health and Social Welfare was instructed to employ 3,890 workers and deploy them to areas with critical shortages. This translated into a 33 percent increase in staffing levels within eight months at the 24 facilities surveyed by WRA Tanzania.

A less tangible element of the 2006 effort was WRA Tanzania's ability to leverage strong and high-level personal networks. The invitation extended to President Mwinyi was accepted, because he was the friend of a friend of WRA Tanzania's coordinator. The staffing survey conducted the previous year was facilitated by a senior staff member of a member NGO who could distribute the questionnaire to regional medical officers at an event unrelated to WRA Tanzania. She was also able to encourage commitment to WRA Tanzania's goals by leveraging relationships and networks that she had developed during her time as a senior civil servant.

But implementation of that directive to recruit more staff was, and still remains a challenge. Positions in public health services still need to be budgeted for, people need to apply to serve, and at times they must accept difficult postings (such as Rukwa). A key lesson for WRA Tanzania was that a positive response to the core demand is just the start of the next stage of work on an issue.

In 2009 and 2010, WRA Tanzania's focus was on budgets. From previous campaigns emerged the identification of the budget process as a critical element in improving maternal and newborn health; the need to engage with the different elements of the bureaucracy at national, regional, and district levels; and the need for focused follow-up activities.

In 2009, the theme for White Ribbon Day was "Clearly Identified Budget Line for Maternal New Born Health from National to Household Levels." The event itself was followed by a series of workshops with district medical and planning staff, regional medical officers, and reproductive child health coordinators. At these workshops, participants scrutinized a sample district budget, with an eye to identifying the budget for maternal and newborn health. They were not able to specify exactly what had been budgeted in this area by item, or even by total budget. Participants' recommendations were clear: the area of maternal and newborn health needed clear objectives and targets, along with a discrete budget code, to be attached to all related activities. The participants followed up on these recommendations with MoHSW, PMORALG, and the Ministry of Finance.

2009 was also the first year for WRA Tanzania to reach out to members of parliament and to catalyze the formation of the Parliamentarians Safe Motherhood Group, with an initial membership of nine. This group is an informal caucus, and though it has no formal status within parliament, provides an entry point to the legislature. Its members are committed to advocate for safe motherhood in their constituencies through their contributions in parliament, and through the Parliamentary Standing Committee on Social Services on which a number of the group's members sit. By identifying legislators as key allies, WRA Tanzania was effectively implementing the One Plan's advocacy strategy of identifying and working with a range of leaders who can exert influence in favor of safe motherhood initiatives.

The Parliamentarians' Safe Motherhood Group proved critical for the WRA Tanzania campaign in 2013 and 2014. One of its founding members was Stella Manyanya. She is still a sitting member of parliament and an active member of the group. By chance, she is also the presidentially appointed regional commissioner for Rukwa Region, which is the focus of the current campaign. Her personal commitment has helped the campaign get buy-in from regional and district officials.<sup>11</sup>

The 2010 theme was similar. It was an advocacy package that focused on the findings of the 2009 work with regional and district officials - that budgets for maternal and newborn health are actually unknown and to a large extent unknowable. The comprehensive advocacy package focused on the

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<sup>11</sup> Interviews, Rose Mlay, November 21, 2014; December 4, 2014; and January 30, 2015.

need for specific budget lines covering the health of mothers and newborns, investment in emergency obstetric care, and investment in human resources, particularly skilled birth attendants. These messages were reinforced by the White Ribbon Day 2010 guest of honor, Tanzania's First Lady, Salma Kikwete.

## THE WAJIBIKE MAMA AISHI CAMPAIGN

The current WRA Tanzania campaign, *Wajibike Mama Aishi* (Be Accountable so a Mother May Survive), has seen a change in the strategy and tactics of WRA Tanzania's campaign work for safe motherhood. From the beginning, the current campaign has been characterized by much improved planning and a more sophisticated strategy of engaging with those in power. WRA Tanzania's seven years' experience of the public health system has also laid the groundwork for understanding the formal structure and informal dynamics of the public health system.

### CAMPAIGN PLANNING.

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*Wajibike Mama Aishi* is part of a three-year, three-country project. It is managed by the White Ribbon Alliance Secretariat in Tanzania, Nigeria, and Uganda, and funded by the Bill and Melinda Gates Foundation to the amount of US\$5 million. This arrangement has had two key implications for the way the campaign has been managed. First, given the accountability relationship between the donor and the WRA Secretariat, there was closer engagement and support from the secretariat with the national alliances. Second, the multi-year funding meant that the campaign issue could be worked on beyond a single stand-alone White Ribbon Day event.

Initial planning for the campaign took place in January 2013. As usual, this involved Core Committee members, board members, and the secretariat, along with at least one representative from the Reproductive and Child Health Section of MoHSW. There were about twenty people in the room. But, in a break from the past, outside facilitators – one from the WRA Secretariat and a consultant contracted by the Secretariat – were brought in to help with the campaign planning.

Key national alliance stakeholders identified clear campaign goals and a change strategy (see below). But more importantly, they were encouraged to map out clearly what they wanted decision makers to do, what WRA Tanzania itself could do, and which individuals could help make these things happen. When combined with an analysis of basic strengths and weaknesses, this level of planning provided WRA Tanzania with a detailed power analysis that considerably broadened WRA Tanzania's engagement with government. It therefore shifted from a focus exclusively on the health ministry, with occasional follow-up with PMORALG, to a broader and consistent engagement with PMORALG and MoHSW, with regional leadership in Rukwa, and with CHMT and CHPT in the four target districts

in Rukwa. Engagement with national champions of the cause – members of parliament and White Ribbon Day guests of honour – remained a constant.<sup>12</sup>

The wider focus on the bureaucracy was complemented by a sharper focus on encouraging community engagement and demanding accountability from government. This emphasis on community engagement reflected the new strategic direction of the alliance globally, whose strategic plan for 2013-16 places much greater emphasis on community engagement and reflects a greater concern across civil society globally to ensure that citizens are given a voice.

The principal product of the planning was the campaign grid, which mapped out the campaign, week by week and month by month. It helped the campaign to focus attention, and made an ambitious workload realistic. As the WRA Tanzania Coordinator explained, it led them to “very clearly identify who to meet, how to reach them, when they should be met, and what the ask should be.”<sup>13</sup>

Hands-on support from the global secretariat allowed WRA Tanzania to build on key elements of its experience in previous campaigns, while at the same time bringing critical analysis and planning tools to what would be a more sustained period of campaigning.

#### CAMPAIGN OBJECTIVES AND A THEORY OF CHANGE.

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The campaign planning sessions were used to arrive at the goals and objectives for the campaign, and to agree on a common change strategy. The identified goal was clear and was taken directly from the government’s One Plan: *Tanzania upholds its commitment that 50% of health centres provide CEmONC by 2015.*

The choice of emergency obstetric care as the focus of the campaign was, for the national alliance, an obvious one. In the words of the alliance’s coordinator, “Women die in childbirth, and it’s not because of men, and it’s not a behavior change issue. It’s due to inadequate facilities. Targeting emergency obstetric care is targeting the bullseye.”<sup>14</sup>

To reach this goal, WRA Tanzania identified four clear objectives:

- 1) Increase the number of health centers in Rukwa that provide CEmONC to one health center per district by 2015, and to 50 percent of health centers in the region by 2016.<sup>15</sup>
- 2) Establish a specific budget line for CEmONC in the budgets of these four districts.

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<sup>12</sup> WRA Tanzania, *Wajibika Mama Aishi Campaign Grid*, Dar es Salaam, 2013.

<sup>13</sup> Interview, Rose Mlay, November 21, 2014.

<sup>14</sup> Interview, Rose Mlay, December 4, 2014.

<sup>15</sup> This objective refers to the Government of Tanzania’s commitment to ensure CEmONC is available at 50 percent of health centers as detailed in *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 – One Plan (April, 2008)*.

- 3) Employ citizen action to influence Council Management Teams (CMTs) to ensure provision of CEmONC services at health centers in Rukwa region by 2014.
- 4) Motivate PMORALG and MoHSW to allocate funds on a specific budget line item for CEmONC.<sup>16</sup>

The objectives identified the provision of emergency obstetric care as a budget issue that needed to be addressed at both national and local levels. As a budget issue, WRA Tanzania explains that CEmONC is “something that can be monitored easily. Maternal and newborn health is too broad, but a focus on one line for one course of action is easier to call for, easier to monitor. You can question the size and track it over time.”

A key issue to bear in mind is that no single health intervention can be addressed through a single budget line. The CCHP Guidelines in their instructions to district level planners make it clear that priority interventions must be supported through a number of budget sources and codes. The budgeting process is complex, with officials having to respond to competing priorities from different authorities, even within a single sector such as health.

A key element of the *Wajibike Mama Aishi* campaign was to see how to ensure that a key priority is addressed through the budgeting process, with a readily comprehensible policy request. As we shall see below, the actual practice of WRA Tanzania in Rukwa, and Prime Minister Pinda’s substantive directive to regional authorities, were clearly understood, both within WRA Tanzania and within government. The call for a single budget line, in reality, seeks to build on, and reinforce the theme of the 2009 White Ribbon Day: “a clearly identifiable budget for MNH.” To monitor how that works, a tight focus on the bullseye of emergency obstetric care was needed.

The campaign’s theory of change is explicitly stated in the campaign’s project document, and is worth quoting in full:

Engage citizens of Rukwa to demand Comprehensive Emergency Obstetric and Newborn Care (CEmONC) so that District Authorities have CEmONC as a policy priority in their council planning and budgeting so that they allocate budget line items and allocate funds for CEmONC so that CEmONC services are available at least in one health centre in each of the Rukwa Districts, namely Kalambo, Sumbawanga Rural and Urban, and Nkasi so that pregnant women are assured of CEmONC near their homes in case of obstetric emergencies so that they develop confidence and give birth at dispensaries knowing CEmONC can be accessed nearby so that many pregnant women avoid giving birth at home with unskilled persons so

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<sup>16</sup> White Ribbon Alliance, *Wajibika Mama Aishi CEmONC Stakeholders’ Meeting*, unpublished presentation, August 2014.

that the Government can be influenced to establish CEmONC in 50% of all health centres so that maternal and newborn deaths can be reduced.<sup>17</sup>

The theory of change is silent on two important things that relate to the strategy adopted by the campaign. Firstly, it does not refer to the use and importance of evidence in the proposed campaign. Secondly, it omits entirely the considerable work to be undertaken at national level with the MoHSW and PMORALG, as well as the technical engagement at district level that was envisaged. All of this was reflected in the Campaign Grid. Community engagement as a strategy was emerging within the international alliance as a critical element of campaigning for the immediate future, and it is little surprise that it dominates a theory of change that had considerable input from the global secretariat. But this didn't overwhelm the campaign's foundations, which were built on WRA Tanzania's experience over the previous seven years.

In looking at the campaign's work toward the four objectives, we will examine the value of its evidence-based advocacy, how it engaged with national and regional government and sought to work within the system, and how it networked and engaged with influential role players in parliament, as well as local religious leaders, community members and health workers.

## EVIDENCE-BASED ADVOCACY

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The basis of WRA Tanzania's influence and its credibility with planners was its assessment of CEmONC in Rukwa Region. This involved an assessment of ten health centres in four districts, and occupied most of the first seven months of the campaign, up to August 2013. This assessment was undertaken directly by the WRA Tanzania Coordinator, a member of the Regional Health Management Team, and a district medical officer, who was WRA Tanzania's focal person in Rukwa.<sup>18</sup>

The assessment was simple and based on a World Health Organization toolkit for assessing health centers. It assessed whether the health centers had the capacity to deliver all nine "signal functions" required to provide CEmONC. These cover a range of specified emergency obstetric interventions ranging from "basic" functions, such as the ability to remove placenta or administer treatment for eclampsia, to being able to perform surgery, usually for caesarian section delivery. The reasons that certain functions were not available were also noted, for example the absence of equipment necessary for removing placenta or for storing blood.

After mapping functions across the health centers, the WRA Tanzania assessment also reviewed the availability of personnel and the existence, or lack, of the necessary infrastructure. Staffing was

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<sup>17</sup> WRA Tanzania *Current Advocacy Strategy*, Dar es Salaam, 2013.

<sup>18</sup> WRA Tanzania has focal persons in a number of regions drawn from its membership.

assessed against the 1999 Establishment Order's standards for health centers, along with the infrastructure necessary for CEmONC, such as running water, an operating theatre, and electricity.

In this way, the assessment gathered evidence relevant to the campaign goal and identified the gap between the reality of available services and the commitment made in the One Plan. This allowed later gap analysis to be undertaken by CHMTs and CHPTs in order to see where resources needed to be allocated to move toward the objective of having at least half of the health centers in a district able to deliver on the commitment. It is notable that this information was not previously available to officials at any level, which explains the strong impression that the data made on senior officials.

In addition to being a planning tool, the assessment also sought to be a powerful advocacy tool, capturing the voices of women and health workers on five critical elements of obstetric care: reasons for home delivery; reasons for delivery at health centers; who makes that choice; barriers to health centers providing CEmONC; and reasons for maternal deaths.

## INFLUENCING NATIONAL DECISION-MAKERS

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With the evidence from the assessment and the Campaign Grid as a guide, an intense series of lobbying meetings were held. On the supply side, these focused on meetings with ministerial officials in the ministries of health and finance, and with local and regional leadership. These were the "decision makers" of the Campaign Grid. Influential role players were also targeted. Members of parliament were a priority, while at regional level religious leaders were targeted. In terms of community engagement, a series of events sought to motivate and engage community members and health workers. A concerted media campaign backed up these efforts.

The original plan had been ambitious. It envisaged a series of meetings with senior government officials in September 2013, advocating for a special budget line for CEmONC to be included in district budgets. It was planned that a series of meetings with officials would culminate in a meeting with the Prime Minister himself, who would make a commitment to WRA Tanzania's demand.

Things didn't go quite so smoothly. Prime Minister Pinda did not meet with WRA Tanzania until early the following year. But WRA Tanzania did gain access to significant decision makers at the ministerial level. The first meeting was with the Commissioner for Budgets from the Ministry of Finance. WRA Tanzania presented national data, data about the situation in Rukwa, and an indication of the funds needed to achieve the national goal. The commissioner's advice was to meet with the Deputy Permanent Secretary (Health) in PMORALG. As district health budgets go through PMORALG, it would be for them to justify any increase.

The Deputy Permanent Secretary was more enthusiastic, expressing his strong support for WRA Tanzania's campaign goals. He suggested that CEmONC funds be "ring-fenced" to ensure that they are not channeled elsewhere, and that WRA Tanzania sit with the Ministry of Health's Coordinator of District Health Services and Health Systems Strengthening to plan the exact line items that should

appear in Comprehensive Council Health Plans. These line items would also need to be agreed to by the Permanent Secretary and the Chief Medical Officer. He furthermore recommended that WRA Tanzania make a request to the Medical Stores Department to earmark a certain percentage of budget for CEmONC equipment and supplies.

The response from the District Health Services Coordinator was heartfelt and supportive, telling WRA Tanzania that “I don’t see why a single woman should die because of lack of CEmONC near her home. The Health centers can offer CEmONC, and we can start slowly. In, say five years, we will be there.” She further stated that it was possible to have a special budget for CEmONC at health centers and that she should work with the team to ensure the districts have a special budget item in their plans.<sup>19</sup>

Another meeting in the health ministry took place with the Assistant Director of Reproductive and Child Health Services, where it was again suggested that a “special budget” be established with the possibility of it being “ring-fenced.”

The final ministerial meeting was with the health ministry’s Permanent Secretary. This meeting had three objectives. First, it was to push the demand for a specific budget line for CEmONC; second, a supplementary request was made for the establishment of a training theatre in each district in order to develop staff skills; and finally, the meeting sought the backing of the ministry in inviting Prime Minister Pinda to the White Ribbon Day celebrations in Rukwa, in March 2014. Full support was given for Prime Minister Pinda’s appearance and the other issues were to be the subject of future discussions with PMORALG.

In the Campaign Grid, the meeting with the Prime Minister had originally been scheduled for September 2013. However, it was not until February 2014 that the WRA Tanzania secretariat and board members were able to meet with him. A meeting with the Prime Minister is not unusual. Press coverage suggests that a large part of his diary is taken up with meetings with various interest groups or prominent individuals. But getting such a meeting is still not easy, and WRA Tanzania had not considered doing so before planning the campaign in January 2013.

WRA Tanzania achieved the meeting through a combination of support from the health ministry and personal connections. A mutual friend of the Prime Minister and the WRA Tanzania Coordinator assisted in organizing the meeting, and with the health ministry’s support WRA Tanzania was able to follow the necessary protocol to put forward a formal request. The meeting was an opportunity for

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<sup>19</sup> WRA Tanzania, (2013) *Quarterly Report, July to September 2013*, Dar es Salaam, 2013.

the national alliance to present the situation in Rukwa and to communicate the campaign's key demands.

## INFLUENCING REGIONAL AND LOCAL DECISION MAKERS

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The meetings with national leaders were complemented with engagement with government officials at the regional level. In October 2013, a major meeting was held in Sumbawanga to introduce the campaign to regional department heads, religious leaders, and NGO leaders in Rukwa.

The meeting had high level buy-in, being organized by the regional administrative secretary and the regional medical officer. The regional medical officer gave a presentation on the state of maternal and newborn health in Rukwa, in which he stressed the importance of CEmONC as an intervention. He told the meeting that providing emergency obstetric services locally is the only way to save the lives of mothers and newborns. "The deaths that occur at the regional hospital," he continued, "are mainly because they arrive at the hospital too late due to delays. Thus the campaign *Wajibika Mama Aishi* is timely and crucial. Each district should have at least one [operating] theatre" for obstetric emergencies.<sup>20</sup>

This meeting was an opportunity for WRA Tanzania to present its assessment of CEmONC in Rukwa, as well as budget proposals to regional officials for the establishment of a theatre capable of providing CEmONC, training for three staff members, and provision of medicines and other supplies.

The meetings were followed up by detailed technical sessions with the CHMTs in the four target districts in the region. This was a critical opportunity as these sessions were the first opportunity for the CHMTs to identify priorities, set plans, and consider budget allocation. Given the findings of the Rukwa CEmONC assessment, CHMTs were convinced to prioritize this in the budget for 2014-15.

It should be noted that there continues to be considerable political backing for the campaign from Regional Commissioner Stella Manyanya. She is not only the RC for Rukwa Region, but also a member of parliament, where she holds one of the Women's Special Seats. She has also been a member of the Parliamentarians Safe Motherhood Group since its inception. Her involvement in so many influential organizations has been critical to the successes of the campaign.<sup>21</sup>

## TARGETING OTHER INFLUENTIAL ROLE PLAYERS

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Other key influential role players that the campaign sought to engage were members of parliament, religious leaders in Rukwa, community members and health workers in Rukwa, and the media.

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<sup>20</sup> WRA Tanzania, *Quarterly Report, October to December 2013*, Dar es Salaam, 2013.

<sup>21</sup> Interview, Rose Mlay, November 21, 2014.

Members of parliament are longstanding allies of WRA Tanzania through the Parliamentarians Safe Motherhood Group, established in 2009. Work with MPs was built around a petition, calling on the government to provide “specific funds for CEmONC in the 2014-15 budget.” This issue was first raised in October 2013, when the WRA Tanzania Coordinator presented the findings of the Rukwa assessment to the group. It was agreed that the group would launch the petition formally in January 2014, with a view to presenting it to Prime Minister Pinda on White Ribbon Day in March 2014.

By May 2014, 81 MPs had signed the petition. More importantly, WRA Tanzania was able to organize a seminar for MPs on the state of maternal and newborn health in Tanzania and the importance of CEmONC as part of the response. This took place in May 2014, just one month before what would turn out to be a heated debate on the budget of the health ministry.

While 70 percent of the Parliamentarians Safe Motherhood Group are members of the Social Services Committee, the campaign did not engage directly with that committee. The Social Services Committee reviews the health ministry’s proposed budget before it is presented to parliament, and also reviews the previous year’s performance. WRA Tanzania failed to engage with this committee because it was not aware of the role of the committee, or of the intricacies of the budget development process.<sup>22</sup> WRA Tanzania lacked knowledge on this front because its earlier campaigns had been based on an understanding of the administrative aspects from district-level up to the political leadership of the minister.

Community engagement was also a departure for WRA Tanzania in this campaign. The objective was to catalyze citizen action to demand CEmONC services at district level. This turned out to be one of the most challenging parts of the campaign. The international secretariat of the White Ribbon Alliance explained that they had underestimated the effort required to conduct such work. The WRA Tanzania network, with just one volunteer coordinator per region, was not well positioned to engage with communities and community leaders in the depth that was required. The national secretariat saw the importance of engagement not so much in making the campaign demands, but in ensuring that commitments were adhered to in the next stage of the campaign.

Activities designed to engage communities included meetings with community members and village health workers where they signed petitions, an activity that was particularly intense during the week of White Ribbon Day. Religious leaders were also targeted due to their significant influence on the community and its leaders and officials.

A concerted media campaign was undertaken throughout the year. The of this was a strategic partnership with IPP Media’s ITV and Radio One, the country’s most popular private television and radio broadcaster with a national reach. This effort led to the broadcast of a series of TV and radio

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<sup>22</sup> Interview Craig Ferla December 4, 2014.

spots that encouraged the involvement of mothers, family members, and health workers in ensuring safe and healthy child delivery, as well as specific demands for adequate budgeting for CEmONC.

Media coverage peaked around White Ribbon Day, and before the presentation of the health ministry's budget in June 2014.

## GOVERNMENT RESPONSE

From the government there were a number of responses at different levels. This was to be expected because of the varying levels of responsibility for health budgeting, and, arguably, varying levels of understanding of the budget development process within government itself. The wider context in which this took place was one of dramatically declining actual expenditures in the health budget. This element makes Prime Minister Pinda's commitment all the more impressive, but also all the more challenging with regard to implementation.

### CENTRAL GOVERNMENT AND THE PRIME MINISTER

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The headline government response came on White Ribbon Day on March 15, 2014 in Sumbawanga District. In a speech read by the Minister for Health and Social Welfare, Dr. Seif Rashid, Prime Minister Pinda made repeated commitments to improved budgeting for CEmONC. Addressing the core campaign ask, he stated that "as the government, we have to ensure that there is a special budget that will enable the majority of poor women to access comprehensive emergency obstetric and newborn care near their homes at health centers." He concluded by saying that "our government will set aside adequate budget ring-fenced so that at least each district has one health center that can provide CEmONC services, including caesarean section, safe blood transfusion in an environment with reliable electricity, water, equipment, and medicines without forgetting qualified health workers for the task."<sup>23</sup>

With this commitment, he echoed the initial responses of senior bureaucrats in MoHSW and PMORALG back in September 2013 – the promise of a "special budget" or a "ring fenced" budget for CEmONC.

Unfortunately, such a commitment wasn't possible without a radical revision of the government's health budget, something not possible three months before the end of the financial year, and very near the end of the planning process. Central government can only make specific budget commitments if they are reflected in the Medium-Term Expenditure Framework (MTEF), which has a three-year time frame. In this case, if funding turned out to be available, MoHSW could have

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<sup>23</sup> It is worth noting that Doctor Rashid also described in detail the story presented in a program broadcast by ITV as part of the campaign. Whoever wrote his speech had paid close attention, for his words mirrored the TV program. White Ribbon Day Speech, March 15, 2014.

earmarked the expenditure. In the current budget, for example, funds for the rehabilitation of health facilities in the Tabora, Mtwara, and Mara Regions were earmarked as “Support to Maternal Mortality Reduction.” As this is in the MTEF, it can be reflected in the ministry’s plans. Furthermore, health expenditure for the regions is allocated annually per region under very broad headings, which are then fleshed out through the bottom-up budget planning which, in the health sector, starts with the CCHP.<sup>24</sup>

Of course, the Prime Minister and his administrative staff knew this. Ten days after the White Ribbon Day speech, his office issued a directive to all regions that was considerably more nuanced and reflected the primacy of local planning processes. His 12-point memo made no mention of special or ring-fenced budgets. It gave no specific targets. Yet the directive gave political weight to the importance of addressing maternal mortality and called on district authorities “to allocate an adequate budget for comprehensive emergency obstetric care, including operating facilities, a safe blood supply, and adequate equipment and human resources.”<sup>25</sup>

It is worth remembering that the initial and confident responses of officials in MoHSW and PMORALG to WRA Tanzania’s request for a specific budget line for CEmONC, along with recommendations for a “special budget” or a “ring-fenced budget,” were echoed in Prime Minister Pinda’s speech. But critically, they were not echoed in his office’s actual directive on budgeting for CEmONC.

#### WRA TANZANIA ENGAGEMENT WITH THE DISTRICTS IN RUKWA REGION

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Given their familiarity with the CCHP Guidelines, the CHMTs and CHPTs must have understood the difficulties involved in making changes in budget lines from the start. WRA Tanzania also understood that the task could not be done by the stroke of a single administrator’s, or even the Prime Minister’s pen. Even before the Prime Minister’s declaration, WRA Tanzania was working with the four districts in Rukwa Region to see how CEmONC could be prioritized and resourced from the start of the annual planning process. Since the beginning of the current financial year, they had met with district planning officers and district medical officers to examine final approved budgets, and to compare them with the gaps identified in the original CEmONC readiness assessment. This is an exercise expected to be conducted on a quarterly basis.

Filling these gaps is not a straightforward exercise. Budgeting remains a process of bargaining between departments, rather than a simple allocation of scarce resources to objectively defined priorities. This issue affects health budgeting across the board, not just for CEmONC or for maternal and newborn health more broadly. There can however, still be positive outcomes that may not be

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<sup>24</sup> Interview, Hope Lyimo, December 11, 2014.

<sup>25</sup> United Republic of Tanzania, *Maelekezo ya Mh. Waziri Mkuu Kwenye Maadhimisho ya Siku ya Utepe Mweupe Kitaifa Mkoani Rukwa*, Letter from Rukwa Regional Administration to District authorities containing the Prime Minister’s directives on budgeting for CEmONC, March 2014.

obvious. For instance, Nkasi District allocated less to CEmONC activities in 2014-15 than in the previous year, but it was careful to ensure that the identified gaps were addressed.<sup>26</sup>

## THE 2014-15 BUDGET AND THE FISCAL CRISIS

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The parliamentary budget sessions are the high point of lobbying for many NGOs. WRA Tanzania, too, had targeted this as a critical time during which to leverage the concern and influence of the Parliamentarians Safe Motherhood Group and other sympathetic MPs. With over 100 MPs attending WRA Tanzania's parliamentary lobbying event, there was clear concern over maternal mortality. There were also other plans in place. In a symbolic gesture, the MPs agreed to caress their navels as they entered the chamber on the day of the health budget debate in recognition of the legacy of all our mothers.<sup>27</sup> More hardheadedly, they kept open the option of not passing the budget if CEmONC was not adequately budgeted for.

The health budget debate was one of the most heated of 2014-15. This is hardly surprising, given that the overall budget of TZS622 billion (US\$365 million) was considerably less than the previous year's allocation of TZS753 billion (US\$450 million). Though the overall government allocation had been increased, the decline in funding was blamed on lower donor funding. There was no mention of funding for CEmONC by Minister Seif Rashid in his budget speech.<sup>28</sup>

This decline was the focus of the debate, as was the very low actual expenditure incurred in 2013-14 of just under TZS387 billion (c. US\$230 million). Reflecting concerns seen at WRA Tanzania's meetings with MPs, many focused on the impact of this level of funding on maternal mortality. "We are not ready to see women die while President Jakaya Kikwete says maternal mortality is decreasing," said ruling party CCM MP Zaynabu Vullu. "We have yet to implement the Abuja Declaration. Are you saying this is optional?" she concluded rhetorically.<sup>29</sup>

Nevertheless, the budget was passed, with an extra TZS82 billion (US\$48 million) allocated for medical supplies, in response to a demand from Margaret Sitta, chair of the Social Services Committee and a stalwart of the Parliamentarians Safe Motherhood Group. This addition was made partly in response to threats by MPs to not approve the ministry's budget. Yet in the light of actual

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<sup>26</sup> Interview, Craig Ferla, December 4, 2014.

<sup>27</sup> Craig Ferla, "Mothers and Babies Survival Unites Tanzania's Parliamentarians," Mama Ye! blog, June 2, 2014, available at: <http://www.mamaye.or.tz/en/blog/mothers-and-babies-survival-unites-tanzanias-parliamentarians>

<sup>28</sup> United Republic of Tanzania, *Hotuba ya Waziri wa Afya na Ustawi na Jamii Mhe. Dkt. Seif Selemani Rashid (MB), Kuhusu Makidirio ya Mapato na Matumizi ya Fedha kwa Mwaka 2014-15*, Dar es Salaam, Ministry of Health and Social Welfare, 2014.

<sup>29</sup> F. Butahe and S. Sauwa, *Wampigisha kwata Waziri wa Afya*, Mwananchi Newspaper, June 5 2014.

expenditure the previous year, and a fiscal crisis that was to emerge just five months later, such a last minute commitment can be seen as being largely for show.

## LESSONS LEARNED FROM THE CAMPAIGN

*Wajibike Mama Aishi* is a campaign in process. Positive results have been achieved in the four target districts, where WRA Tanzania understands that CHMTs and CHPTs are on track to reach the One Plan's commitment in their budgets. Ongoing support from WRA Tanzania will help with this effort and will further improve planning for 2015-16. From the campaign so far, it is possible to draw some interim lessons.

### THE IMPACT OF PLANNING

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Careful planning based on what was essentially a power analysis of the sector and those who can influence WRA Tanzania's demands was an important aspect of the campaign. It broadened the range of decision makers to be targeted, and sought to build on and expand the formal and informal networks that WRA Tanzania has developed over the years. The use of outside facilitators was identified as key to this effort. Core Committee members were encouraged to identify what decisions needed to be made, who would make them, and how WRA Tanzania could influence those decision makers. This led to consistent engagement with PMORALG and a much closer relationship with the CHMTs and CHPTs in the districts. This was a hugely positive element of the campaign. Given the national alliance's obviously positive view of the impact of such planning, this is likely to continue to be a feature of WRA Tanzania's work. It is an important lesson for other NGOs working for social change that can appear to be simple, but that are lodged in a complex and often opaque system of government and budgeting. Learning the lay of the land and planning accordingly is crucial.

### THE USE OF EVIDENCE IN CAMPAIGN ADVOCACY

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Evidence gathered in the assessment of CEmONC readiness in the ten health centers surveyed in Rukwa was the basis of the campaign, and the basis of presentations and petitions at all levels, from meetings with village health workers to meeting Prime Minister Pinda. Indeed, some of the findings made their way into the Prime Minister's speech on White Ribbon Day. Beyond being a powerful advocacy tool, the assessment was designed in such a way that it could act as an effective baseline and thereby a planning tool for district-level planning teams. Gathering and using evidence was not new to WRA Tanzania, but the way in which this assessment has been used gave it greater impact.

### RELATIONSHIPS AND NETWORKS

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The level of access to government enjoyed by the WRA Tanzania is notable. It goes back to its involvement in the formulation of Tanzania's One Plan, which reflects the Tanzanian government's

genuine efforts to encourage multi-stakeholder involvement in the health sector. It also reflects the personal and professional networks developed by the secretariat, by individual members, and by member NGOs over years. Some of these connections go back to before the establishment of WRA Tanzania. The health profession in Tanzania is small, and senior professionals move in similar professional networks. Many have studied together and are members of the same professional associations.

There is also considerable shifting between government and NGO roles. For instance, one of the longest-serving Core Committee members for WRA Tanzania works for one of the biggest NGOs in the health sector, and formerly worked with the Reproductive and Child Health Division in the ministry. The planning for the campaign built on these relationships in the health sector, and this may have given the national alliance the confidence to move beyond the health ministry and reach out to other relevant ministries. Doing so also facilitated high level access and helped smooth a path to the Prime Minister's office.

WRA Tanzania is something of an outlier among civil society coalitions in Tanzania in that it has a government department among its members - the Reproductive and Child Health Section of the Ministry of Health. Individual civil servants are also members. In this sense, WRA Tanzania can be seen as a network of professionals, members of civil society, and government officials who share an interest in, and concern for maternal and child health. This is the context in which the campaign is situated. It is advocating for one element of the One Plan. As noted, the One Plan itself contains an advocacy strategy with a clearly defined role for NGOs.

#### UNEVEN UNDERSTANDING OF THE BUDGET PROCESS

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Perhaps the most important lesson that has emerged from the campaign so far, is that an understanding of budget processes is not uniform within government. MoHSW and PMORALG were enthusiastic in their responses to WRA Tanzania's demand in September 2013 for a specific budget line for CEmONC. They were also confident of their ability to deliver it. Yet as the Prime Minister's final directive of March 2014 suggested, a specific budget line was not feasible in the Tanzanian budgeting system. His directive spoke to the devolved powers that councils have to set budgets using a range of budget sources and codes, as reflected in the CCHP Guidelines. It may have been possible to "ring fence" a certain budget if it was the ministry's budget to do so. For example, the African Development Bank funded support to renovating operating theatres in referral hospitals in three regions. At this level, officials in the Ministry of Health can plan, allocate, and "ring fence." However, below that regional level, they can't, because budgeting at the district level is a bottom-up process controlled by regional and district administrations.

We should also acknowledge that WRA Tanzania's own understanding of the budget process was not complete. For example, recognizing the importance of the MPs at the budget approval stage, WRA Tanzania sought to make an impact during the debate on the health ministry's budget in 2014.

However, budget appraisal is the responsibility of the relevant standing committee, in this case the Social Services Committee. WRA Tanzania did not engage that committee or the Local Authorities Accounts Committee, which is responsible for overseeing expenditures.

## STATEMENTS OF POLITICAL COMMITMENT

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What is significant is that Prime Minister Pinda was comfortable to make very specific commitments in public that Tanzania's public finance system could not necessarily accommodate. Nevertheless, we can conclude that his commitment was genuine, as reflected in his subsequent memorandum.

Similar commitments were made in WRA Tanzania's initial round of meeting with officials in MoHSW and PMORALG. These included the "ring fencing" idea and the acceptance of the notion of a "clearly identifiable budget line" for CEmONC. We could not assess why such commitments were made because we could not get interviews with government officials. However, a tentative lesson to be learned is the importance of clearly identifying incentives and the various levels of authority of advocacy targets. The high-profile political incentives of a prime minister or departmental minister were critical in persuading them to offer a strong political statements of support. At the regional level, the personal commitment of the regional commissioner, achieved through the parliamentarians group, was critical in gaining the support and cooperation of technical staff at regional and district levels.

## FISCAL CONTEXT

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Funding for health in Tanzania is in crisis. Budgets are falling, and actual expenditure is just a fraction of what is budgeted. This will not change soon. In December 2014, Tanzania had seen over US\$500 million withheld by general budget support donors in response to inaction by the government over a grand corruption case at the central bank. A similar amount of funding from the US government, earmarked for electricity and infrastructure, may be delayed if action on the same case is not taken.

Aside from the corruption case, there was already worry over the size of the fiscal deficit: the difference between what the government raises in taxation and donor support, and what it spends. Currently, tax revenues are consistently below target, while since October 2014, over US\$500 million was withheld in the wake of the corruption scandal. With tax revenues consistently below target and donor funds under threat, pressure on all government expenditures will increase. While these issues are not directly related to health issues, the fiscal context is all important and should not be overlooked.

## CONCLUSION

WRA Tanzania began the *Wajibika Mama Aishi* campaign with significant strengths. It had a history of working in the area of maternal and infant health, which also gave it a powerful and well-connected network of supporters, who, if not actually members of WRA Tanzania, were familiar with

its work. Networks and relationships are critical to making social change. WRA Tanzania was also different from other NGOs in that it had a quasi-governmental role that had made it influential in creating the government's own One Plan policy. This improved WRA Tanzania's knowledge of the workings of the government, access to state officials at all levels, and allowed it to get its issues on the national agenda.

At the same time, hard evidence was most persuasive with policymakers. In the early months of its campaign WRA Tanzania had undertaken an assessment of health centers in Rukwa Region, and the evidence of the poor quality of service and its connection to maternal and infant mortality, carried much weight with those who needed to be brought on board.

While it is important for a civil society organization to draw on its strengths, it can be equally valuable to analyze weaknesses. In this campaign, WRA Tanzania was not alone in failing to take account of the complexity of the budget system in Tanzania. Even members of the national government did not initially consider how difficult it would be to achieve some of the goals of the WRA Tanzania campaign. But WRA Tanzania is persisting in its efforts to work its way through the mazes of budgeting, appropriations, and oversight. Despite the fiscal crisis that besets the country, WRA Tanzania remains determined to succeed in its effort to save the lives of mothers and infants.

## ANNEX 1: INTERVIEWEES

Rose Mlay, Country Coordinator White Ribbon Alliance Tanzania; 21 November, and 4 December 2014, White Ribbon Alliance Tanzania office, Dar es Salaam.

Craig Ferla, Country Director, Mama Ye! Tanzania, Chairperson, WRA TanzaniaZ, 4 December 2014, Mama Ye! Tanzania office, Dar es Salaam

David Lyamuya, Project Manager, White Ribbon Alliance, Tanzania; November 28 2104, WRA TanzaniaZ office, Dar es Salaam

Hope Lyimo, Programme Officer, Sikika; December 11 2014, Sikika office, Dar es Salaam

Kristin Savard, White Ribbon Alliance, December 5 2014, by Skype.

Gaudiosa Tibaijuka, Senior Technical Manager JHPIEGO and Core Committee member, WRA Tanzania, November 28 2014, Dar es Salaam, JHPIEGO office.