Revitalizing the Use of Community Based Distributors (CBDs) for Improved Family Planning Services in Bukiriro Village, Ngara District, Lake Zone, Tanzania

THIRD COMMUNITY MEETING: REVIEW AND WAY FORWARD

Held at Bukiriro Health Centre
13th June, 2014

Health Promotion Tanzania (HDT) and Ifakara Health Institute (IHI)

together with

The Training and Research Support Centre (TARSC),

Community of Practitioners in Accountability and Social Action in Health (COPASAH)

and

The Regional Network for Equity in Health in East and Southern Africa (EQUINET)

with support from the Open Society Foundations

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Cite as: G.Mutashobya (HDT), J. Baraka (IHI), B. Kaim (TARSC) (2014). Revitalizing the Use of Community Based Distributors for Improved Family Planning Services in Bukiriro Village, Ngara District, Tanzania. Third Community Meeting: Review and Way Forward. June 2014. TARSC, COPASAH and EQUINET Harare, Zimbabwe.

Acknowledgements: HDT and IHI are pleased to express our profound gratitude to COPASAH, EQUINET and TARSC–Zimbabwe for organizing the PRA Training in October 2013 which gave birth to Revitalizing the CBDs Programme in Bukiriro Village in Ngara District Tanzania. We also want, especially, to extend our heartfelt thanks and appreciation to Barbara Kaim and the rest of the TARSC staff for their on-going technical support, done quietly in the background and yet consistently providing us with the strength and knowledge needed to implement the PRA work in Bukiriro Village. In addition, we recognize the role and efforts of Bukiriro Health Centre Officer-in-Charge Mr. Mayamba in making this work come true so that it could reach this particular milestone; the DMO for Ngara District for his authoritative support which allowed the implementation of this work in Bukiriro Village; Mecktrida Byambwenu's (DRCHCo) for her technical support and cooperation; and the local leaders in Bukiriro village for giving the CBDs a morale boost by facilitating the process which resolved their concerns on incentives. Nothing would have been possible without the financial support from the Open Society Foundations and, thus, we collectively appreciate their support.

Finally, we are pleased to thank the CBDs for accepting to resume their responsibilities, and the Bukiriro health workers and community members who participated in the implementation process. Thanks also go to all the other people at Bukiriro village who took part, either directly or indirectly, in this programme.

1. Background

This report documents the proceedings of the third community meeting in Bukiriro Village in Ngara District, Lake Zone in Tanzania which aimed to review progress in revitalising the work of Community Based Distributers in the area. The report is the final document in a programme undertaken with support from the Training and Research Support Centre Zimbabwe in cooperation with the Community of Practitioners in Accountability and Social Action in Health (COPASAH) and the Regional Network for Equity in Health in East and Southern Africa (EQUINET) which set out to explore how participatory approaches can raise community voice in strengthening the resourcing and functioning of primary health care (PHC) systems. This report thus also reflects on accomplishments, challenges and lessons learnt since the start of this programme in February 2014 and documents plans for the way forward.

1.1 Setting the context

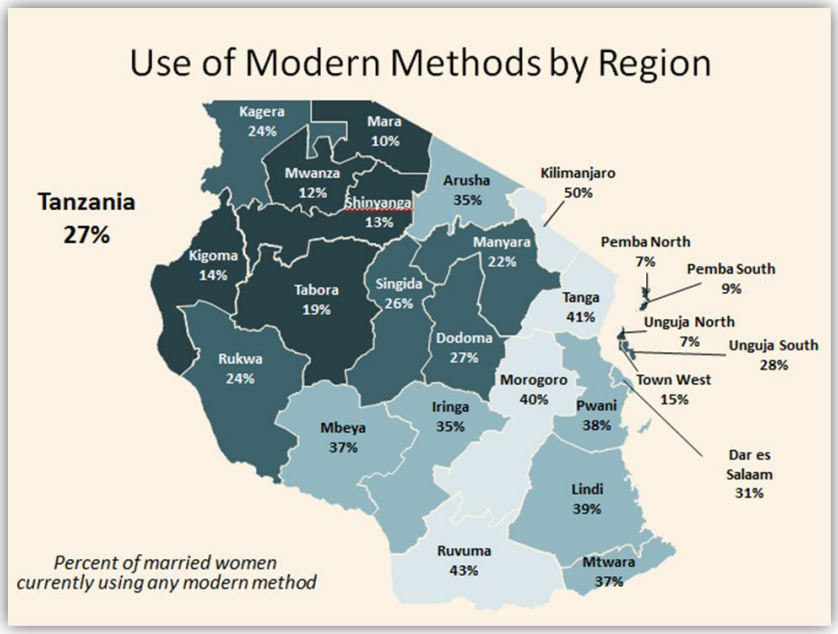
Tanzania, like many other Sub-Saharan countries, has been facing a series of challenges in the health sector due to a shortage of financial and other resources. At PHC level, there is a shortage of health facilities which results in clients having to walk long distances to visit a health centre and, upon arrival, are met with a number of challenges in terms of the quality of service provision, including shortages of staff, medicines and a breakdown of communication with their service providers.

Tanzania is also one of the developing countries in Sub-Saharan Africa which is lagging behind in attaining the Millennium Development Goal (MDG) on maternal health. The country's population is growing at an annual rate of 2.9% with a total population of 44.9 million people (2012 census). The fertility rate in the country is high - at 5.4 children per woman of reproductive age (6.1 for rural women and 3.7 for those in urban areas). Women have their first births at a median age of 19 years. Around 23% of teenagers have already begun childbearing, and maternal mortality rate (MMR) is high at 454 deaths per 100,000 live births. Contraceptive use is 34% for all methods and 27% for modern methods, while unmet needs are at 25%.

Within this context, Tanzania aims to increase the Contraceptive Prevalence Rate (CPR) to 60% by 2015 and reduce the MMR to 193/100,000[1]. To achieve this, the country would have to double the number of family planning users from 2.1 million recorded in 2010 to about 4.2 million by 2015 and ensure the provision of family planning and maternal health services to all men and women of reproductive age who need them.

The Lake and Western Zones of Tanzania (Mara, Mwanza, Geita, Simiyu, Shinyanga, Kigoma, Tabora, and Kagera) **(**see map of Tanzania below**)** are the areas with the highest fertility rates (6.3 in the Lake Zone and 7.1 in the Western Zone), lowest contraceptive use (CPR with percentages of between 10 – 24 %) as well as the highest proportion of teenager childbearing trends (29% in the Lake Zone and 30% in the Western Zone). These indicators are notable contributors to MMR, resulting in gender inequalities in access to education and other social services, and greatly contribute to the viscous cycle of poverty which affects the majority of women and children.

[1] United Republic of Tanzania. (2008). The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008 – 2015).



Map of Tanzania showing regional use of contraceptives
Source: United Republic of Tanzania. (2010). Tanzania Demographic and Health Survey (TDHS) 2010.

The area of this programme - Bukiriro village (with a population of 4 000) in Ngara District located in the western part of Kagera Region close to the Rwandan border - records a CPR of 10%, far below the national average of 27% and lagging far below the national target of 60% CPR by 2015. The MMR in the district was recorded at 59/100,000 in 2011. Teenage pregnancies and pregnancies among women over 35 years constituted 52% of all 14,937 pregnancies recorded in 2012[2]. The nearest health facility is 15 kms away[3]

1.2 The CBD Programme in Bukiriro Village, Ngara District

Community Based Distribution is recognized as one of the most effective strategies for increasing contraceptive use[4], aimed at reaching populations with inadequate health facility-based distribution, and hence with limited access to family planning services. It is a strategy for strengthening primary health care provision of family planning services using community structures that include home visits by trained agents with the aim of promoting the use of safe contraceptive methods[5]. Community Based Distributers (CBDs) have been reported to increase modern contraceptive use 3 to 10 fold[6].

[2] DED. (2012). Plan and Budget for 2012/2013 within the Five Year Development Plan Framework (2011/12-2015/16). Ngara District Council.
[3] AFP: (2012). Lake Zone Mission Report. The Advance Family Planning (AFP) Project, Tanzania
[4] Jahanfar, Et Al., (2005). Community-Based Distribution and Contraception Usage in Iran.
[5] Routh, Et Al., (1997). Developing Alternative Service Delivery Strategies for Mch-Fp Services in Urban Areas: Findings From An Experiment. Dhaka.
[6] Routh, Et Al., (2001). Coping With Changing Conditions: Alternative Strategies for the Delivery Of Maternal And Child Health And Family Planning Services In Dhaka, Bangladesh.

In Tanzania, CBDs are referred to as community health workers. They are trained in family planning-related issues by the District Health Department with their major role being distribution of oral pills and condoms, as well as educating FP service users on the benefits and side effects of contraceptives and ways to manage them. Since its inception, there have been some important successes. For example, CPR reached 56% in Muheza District, Tanga region in the Eastern Zone of Tanzania in 2011 due to the use of CBDs.[7]

In 2010, a group of community service providers from Bukirira Village was recruited by Ngara District Health Department and trained in the provision of oral pills and condoms. However, like elsewhere in Tanzania, the program was dependent on donors and the Local Government Authorities (LGA) for its survival. As a result, due to dependence on external resources and insignificant community support, the CBD programme faltered – the CBDs started withdrawing one by one until only 3 remained. These 3, however, are not providing FP services, but have focused on other services such as supplying treated mosquito nets and helping health centre workers during immunization programmes. Despite these difficulties, community based distributers in Bukiriro Village have expressed their readiness to resume their responsibilities.

In 2013, following a PRA training on Social Accountability in Primary Health Care facilitated by TARSC Zimbabwe in cooperation with COPASAH and EQUINET [8], Health Promotion Tanzania (HDT) and Ifakara Health Institute (IHI) sourced a small grant from COPASAH to work in Bukiriro Village. The aim of the programme was to assist in revitalizing the work of the CBDs in Bukiriro Village while also identifying strategies for improved dialogue, action and accountability between community representatives, CBDs and health workers. Both organisations have experience working at national and district levels to ensure increased resources for Family Planning (FP), improved policy environment and publicity of FP services.

The programme focused on the facilitation of three community meetings to identify and prioritize, from a community perspective, the key FP health needs in Bukiriro, and the skills, resources, and actions needed to reinstate the CBD programme. By the end of the First Community Meeting, held in February 2014, the CBDs had identified short term actions and key people who could implement those actions. This included a refresher training for the CBDs and successful negotiations with local authorities on incentives (in the form of USD12.50 per month) to be given to the CBDs. The second community meeting was held in April 2014 in which participants reviewed actions undertaken since the first meeting, set progress markers and identified strategies for improved interaction between community representatives, CBDs and health workers for strengthening FP service delivery[9]. This third community meeting, held on 13th June 2014, is the last under the COPASAH-funded programme and was, therefore, structured to review progress to date and to plan for future actions to ensure programme sustainability.

Specifically, this third community meeting aimed to:

[7] Tanzania Journal of Health Research - Volume 13, Number1, January 2011.
[8] See TARSC, COPASAH, EQUINET (2013). Training Workshop on Participatory Methods for a People-Centred Health System: Strengthening community-focused, primary health care oriented approaches to social accountability and action. Meeting report. October 2013. TARSC, Harare, Zimbabwe.
[9] The first two community meeting reports are available on both the EQUINET and COPASAH websites (see www.equinetafrica.org and www.copasah.net)

- Review and reflect on actions undertaken since the last meeting
- Give an update on CBDs work in progress, implementation challenges, and to develop plausible plans to overcome such challenges
- Review progress markers
- Develop strategies for improved dialogue, action and accountability.

The meeting objectives mentioned above were developed based on a programme prepared and agreed to by HDT, IHI, and TARSC (see Appendix 1).

Since the start of this programme, community meetings have attracted participants from four groups - community leaders, health workers, community representatives (FP service users and non-users), and Community Based Distributers (CBDs). In contrast to the first and second community meetings, this third meeting included FP users and non-users, one male and one female representative for ensuring gender balance. It was hoped that, by including both users and non-users at this meeting, it would bring to light a wider range of community perspectives on issues related to FP.

2. Meeting Activities

2.1 Welcome and introductions

The meeting started with a welcoming note by Greysmo Mutashobya from HDT. After participant introductions, the Village Chairperson (VC) officially opened the meeting. This was followed by a speech from Stella Dario, Assistant District Reproductive and Child Health Coordinator (DRCHCo), who noted that she greatly appreciated the PRA work being undertaken in Bukiriro Village and promised to fully support the implementation of the program for sustaining its outcomes. She concluded by requesting all social groups to provide any required support to the CBDs in order to facilitate the fulfillment of their responsibilities.

Introduction Session led by the Village Chairperson

2.2 Plenary review of the Second Community Meeting

All participants were requested to stand in a circle and a ball was thrown from one person to the next. Whoever received the ball had to mention one agenda item from the Second Community Meeting. From this exercise, participants managed to recall all agenda items and the content of the previous meeting. Furthermore, participants remembered the progress markers' setting exercise and perfectly recalled FP issues prioritized. The participants' responses showed how they had internalized their understanding of the Reflection-Action-Reflection process. Thus, entry into the Third Community Meeting agenda was easy in that some participants were able to mention what should be done in the Third Community Meeting. The Third Community Meeting agenda items proposed by the participants included reviewing of progress markers and reflecting on new challenges which might have arisen between the previous and current meeting.

2.3 Review actions to deal with barriers to improved dialogue and action

This session was meant for the purpose of reviewing barriers to improved dialogue and actions undertaken against each barrier. Participants were again able to recall the barriers as they were identified in the Second Community Meeting. They then went on to describe the actions undertaken against each barrier, further identifying what had worked and what had not. The reviews began at social group level because each one had its own actions to implement, and later all groups were brought together for a collective review. This identified deviations and plans to address them. The following table shows what actions were taken since the last meeting in dealing with FP barriers:

Table 1: Actions undertaken to deal with FP barriers since the last community meeting

Barriers	Action (s) undertaken	Outcome (s)	Responsible person/group
Gender inequalities	▪ FP sensitization meetings done by CBDs at hamlet level involving both genders ▪ Pre-FP service sessions at BHC addressing both genders. ▪ Both men and women invited to attend the Third Community Meeting, including both FP users and non-users.	▪ Involvement of both genders in reproductive and health issues increased at the facility since April 2014 as a result of the PRA work being conducted in the area. ▪ Improvement in gender equality noted at the third community meeting through gender representation.	BHC, HDT & IHI, CBDs
Traditional and religious beliefs	▪ Barriers arising from traditional and religious beliefs in relation to use of FP services addressed through Pre-FP service sessions at BHC ▪ CBDs talked to clients on the importance of FP with the aim of addressing myths and misconceptions.	▪ Myths and misconceptions addressed and the number of FP clients gradually increasing.	BHC CBDs
No FP component in the Village	▪ An official letter from HDT/IHI was sent to the Village Health Committee Chair reminding him of	▪ Proposal accepted and waits for an upcoming Health Committee meeting to be held at the end of	HDT/IHI Village Health

Barriers	Action (s) undertaken	Outcome (s)	Responsible person/group
health plans	the importance of including FP as a component in the Village Health plans.	June 2014.	Committee
Lack of regular FP sensitization meetings	▪ CBDs have organized sensitization meetings among small groups of FP clients but large meetings have not been held.	▪ Increased FP services uptake in the village (confirmed by the facility Matron as per May 2014 report)	Community reps CBDs Village leaders
Lack of commitment and FP Champions	▪ All social groups approached to commit resources, such as money and time, for facilitating FP services in the Village and fully participate in FP related events	▪ Increased commitment, especially among Village Leaders and Health Committee members. FP champions will not be identified until the General Village meeting is held.	Village leaders CBDs Community reps
Poor communication between FP clients and health facility.	▪ FP clients informed on schedule of services so clients do not waste time coming to the facility for unavailable FP services.	▪ The level of communication, especially in terms of information dissemination, is better compared before. The clinic timetable and availability or lack of FP methods has been pinned to the notice board. ▪ Most of the information pertinent to FP services disseminated through CBDs.	BHC CBD
Lack of regular CBD training on FP service provision	▪ Mentorship conducted to build CBDs' capacity in FP service provision especially in client counseling, reporting, and side effects of FP methods.	▪ CBDs' capacity to provide FP services strengthened and their work has improved.	BHC
Poor and one sided planning	▪ No planning meeting has been held.	NIL	BHC Community Reps (FP clients)

As the table shows above, there have been some important successes in overcoming the challenges identified during previous meetings, and especially in relation to improving relations and a sense of accountability between users, CBDs and the Bukiriro Health Centre. Actions have been taken up by a wide range of players including the BHC, CBDs, community representatives, village leaders and both HDT/IHI. The meeting agreed that the level of change attained to date is exciting and highly encouraging.

2.4 CBDs' work in progress, challenges and proposed solutions

This session was meant for the purpose of getting feedback on the CBDs work in progress, their implementation challenges, and to encourage collective brainstorming on possible solutions. Health workers at Bukiriro Health Centre were also encouraged to give feedback since they closely monitor the functions of the CBDs.

The CBDs reported that their work was going well and that they were encouraged by how accepted they were by their clients. They appreciated the level of recognition they were getting from the community. In turn, the health workers praised HDT/IHI for the revitalization of the CBD programme since their workload had significantly decreased since April 2014 when CBDs resumed their responsibilities. Apart from these kind words of appreciation, the CBDs and health workers also mentioned some implementation challenges which need immediate attention as can be seen from the table below:

Table 2: Challenges faced by CBDs and proposed actions

Implementation Challenge (s)	Proposed action (s)	Responsible person/group
▪ Daily submission of reports to the facility by CBDs.	▪ BHC and CBDs to meet and agree on the best way and time interval for report submission.	BHC CBDs
▪ Easy access to oral pills and condoms at FP clients' homes through the CBD programme has led to more users requesting use of these two methods, specifically oral pills, and abandoning other methods.	▪ CBDs should only serve users who are registered for oral pills and condoms while new clients and those registered for other FP methods are required to go to the facility for consultations before opting for oral pills or condoms.	CBDs BHC Community representatives
▪ Long distances between FP users' residences across the village is a source of stress among CBDs	▪ Encourage clients to visit CBDs' homes for the services and CBDs to visit clients no more than three times a week.	CBDs Community Representatives BHC

The above proposed actions to problems identified are practical and easy to achieve.

2.5 Reviewing Progress Markers

Participants in group discussion

This session involved reviewing Progress Markers which were developed during the Second Community Meeting for the purpose of measuring the trend and quality of FP services in Bukiriro Village from April to June 2014. All participants from all social groups came together in a plenary discussion in which an individual or group had to state the extent of implementation reached in the time period under discussion. In this respect, participants stated whether implementation had been DONE, had STARTED, was ONGOING or NOT DONE. Table 3 below are the progress markers after being reviewed by all participants:

Table 3: Assessment of progress made in meeting Progress Marker goals

PROBLEM 1: Inadequate number of FP service providers		Not Done	Started	On going	Done
EXPECT To See Progress Markers					
1	Two formally employed FP service providers joined by 4 CBDs to ease the workload at the facility and during outreach services.				
2	At least half of the number of all FP clients using oral pills and condoms accessed around their homes.				
3	The District Health Management Team sharing information with Village leaders, Village Health Committee, and Facility Management on recruitment of new staff.				
4	Bukiriro Facility Officer-in-Charge to approach the DMO and request for more staff in order to bring about a balance between providers and clients.				
LIKE To See Progress Markers					
1	More than 2 FP service providers in the FP room				
2	A decrease in time (4 hrs to 1 hr) spent to access FP services at the facility.				
3	FP service users directed to the correct FP service provider depending on one's preferred FP method.				
LOVE To See Progress Markers					
1	Number of FP service providers increasing adequately to serve users within only 20-45 minutes.				
2	CBDs being trained and able to provide injectable which is the most preferred FP method.				

PROBLEM 2: Inadequate FP commodities to facilitate the provision of all FP methods		Not Done	Started	On going	Done
EXPECT To See Progress Markers					
1	Every FP user getting the FP method of her choice and not an alternative.				

2	Increasing number of FP service users with many more people adhering to the services.				
LIKE To See Progress Markers					
1	Reducing the impact of side effects caused by providing alternative FP methods to the clients				
2	Providers informing their clients on commodity stock levels so they do not waste time coming to the facility for unavailable FP services.				
LOVE To See Progress Markers					
1	All FP methods (short, long term and permanent methods) being provided at all times at the facility by well-trained providers.				

PROBLEM 3: Poor communication between service users and providers		**Not Done**	**Started**	**On going**	**Done**
EXPECT To See Progress Markers					
1	The Village Health Committee meeting at least once per quarter for planning and reviewing the quality of FP services.				
2	FP service providers informing clients on commodity stock levels and other important information.				
LIKE To See Progress Markers					
1	Both FP service providers and users engage in annual planning meetings aimed at developing service delivery improvement plans.				
2	FP service users fairly treated and valued by service providers at all times of service delivery.				
3	FP service users involved in scheduling Outreach services and the particular schedule to appear on Notice Boards.				
LOVE To See Progress Markers					
1	90% of FP service users satisfied with providers' response and vice versa.				

The shaded areas in the table above identify the status of implementation of the progress markers. From this we note that this program has made good headway in almost all progress markers, except for the implementation of markers in the "Love to See" section. This was predicted since not enough time has passed to see progress in these more long-term goals.

2.6 Strategies for Improved Dialogue, Action and Accountability

This session was meant for the purpose of identifying strategies for improved dialogue, action and accountability between community representatives, community leaders, CBDs, and health workers for strengthening FP service delivery. However, after participants were clustered into their social groups for the exercise they insisted that barriers and proposed strategies to overcome challenges as developed during the Second Community Meeting still needed further action. They, therefore, proposed that these should be kept in place for close monitoring and action. The chart below summarizes the information explained:

Table 4: Proposed Strategies to Overcome Barriers to Improved Dialogue and Action

Barriers	Proposed Strategy for Overcoming barrier(s)	How to implement the proposed strategy	Responsible person/social group
Gender inequalities	▪ Involvement of both genders in FP related issues at Village and Facility levels	▪ Both men and women to attend clinics; women encouraged to go to the facility with partners. ▪ Both men and women to be invited to FP sensitization meetings.	BHC HDT/IHI Village leaders
Traditional and religious beliefs	▪ Meeting with religious leaders within the area	▪ Conduct one on one meetings with religious leaders to advocate for FP adherence and inclusion in their church teachings.	BHC Village leaders HDT/IHI
Lack of FP component in the Village Health Plans	▪ Inclusion of FP agenda in each Village Health Committee meeting	▪ Every Village Health Committee meeting to include a FP component and later make it a part of the Village Health priority plans.	Village Health Committee
Lack of regular Community meetings	▪ Holding regular community meetings	▪ Hold community meetings at least quarterly to discussing the trend and quality of FP services	Community reps Health Workers Village leaders
Lack of commitment and FP Champions	▪ Creating FP champions from each hamlet of Bukiriro Village for community sensitization	▪ Identify champions from each hamlet during General Village meetings.	All social groups
Poor communication	▪ Ensuring good coordination and dissemination of all important information	▪ The facility to disseminate information on notice boards, posters, etc. on FP services schedules, trends, and stock levels so that clients are aware.	BHC
Lack of regular training on FP services provision	▪ Organizing regular FP trainings and mentorship sessions for service providers	▪ Set internal plans at facility level and consult other CSOs engaged in FP or Maternal health to train service providers.	HDT/IHI BHC DHMT
Poor and one sided planning	▪ Proper and collective planning for outreach and mobile services between service users and providers	▪ Hold a planning meeting between FP service users and providers so that the schedule does not compromise other social-economic undertakings.	BHC Community reps

3. General Overview, Analysis and Findings

This general overview reflects on accomplishments, challenges and lessons learnt since the start of this programme in February 2014. Reflections relate to both the use of PRA as a tool for social transformation and for strengthening relations between providers and users of FP services (process), as well as providing an overview in terms of programmatic successes, challenges and lessons learnt (content).

3.1 Accomplishments

Outputs:
During the period of this programme, HDT and IHI with the active participation of the CBDs, the BHC and other stakeholders have successfully:

- held 3 community meetings between February and June, 2014
- with technical support from the District Management Team, and especially the DRCHCo and BHC, held a one day CBDs Refresher Training in which all four CBDs attended
- through negotiations with Bukiriro Village leaders and health workers, resolved the issue of incentives for CBDs, thus boosting their working morale.
- as part of the implementation of actions arising from the Second Community Meeting, the District Health Management Team has directed two full time health workers to Bukiriro Health Centre. One will be added to the Reproductive and Child Health (RCH) unit to support the role of the CBDs.

This has resulted in the successful revitalization of the CBDs programme, with outcomes listed below.

Outcomes:
- Relations between community representatives, CBDs and health workers have improved considerably, resulting in greater trust in the health system at community level, greater accountability on the part of the health workers, and improved access to and quality of health services.
- According to the BHC Matron, the number of FP service users has significantly increased in the past two months as a result of the revitalized CBD programme in Bukiriro Village. This is evident when comparing statistics for this quarter compared to the first quarter, January to March, 2014.
- There has also been a change of roles within the BHC. As noted by the BHC Matron, health workers at BHC are excited by the significant fall in the amount of time they spend on family planning counselling and a decline in congestion at the facility especially at the Reproductive and Child Health Unit (RCH). They attribute this to the increased number of users accessing FP through the CBDs.
- The broadening of community representation at the community meetings to include both male and female FP service users and non-users has increased the confidence of community representatives in articulating each group's needs and misgivings when it comes to using different family planning methods.

- The involvement of the District Health Management Team in the program has facilitated BHC's request for more staff and drugs - especially FP commodities - hence addressing the problem of stock outs and workload to a great extent.
- Meeting activities were conducted as per the agreed program and all invited participants attended and fully participated in all 3 meetings. Those who could not attend in person, such as the DMO and DRCHCo, sent representatives to act on their behalf. The number of participants increased from 16 in the first community meeting to 28 in the third community meeting, with improved gender balance and representation of FP users and non-users over time.
- Participants' understanding of the use of PRA, especially in relation to the Action-Reflection cycle, increased over time thus deepening the process. In particular, it gave participants a good grounding for ensuring that what they discussed during the meetings was followed up between meetings at community level.

3.2 Challenges

- The program timeline has been a great challenge since existing FP service delivery shortcomings require follow up beyond this program cycle. For example, 'Love to see' progress markers could not be achieved within the project timeline. However, the strengthening of the CBD programme and increased role of the BHC and DHM bodes well for ensuring continuation of this work beyond the COPASAH-funded cycle.
- Ease of and adequate access to oral pills and condoms at FP clients' homes has attracted more users to ask for these methods, specifically oral pills, and abandon other methods. This is dangerous because clients who do not qualify for oral pills for health reasons may persuade providers to register them nevertheless.
- Logistical issues remain a challenge, especially the distance between residences of FP users across the village. This puts a lot of stress on CBDs to ensure adequate follow up.
- Daily submission of CBD reports to the facility is overly demanding for CBDs.
- PRA approaches need time to implement, in part because they are by definition time consuming, but also because they are initially not easy to use. From our experience, both facilitators and community members need a period of time to orient themselves on how to implement a PRA process before this process begins to show its full potential.

3.3 Lessons Learnt

In terms of the CBD programme:

- Clients want to use any FP method which is easily available and does not require them to walk long distances. This is regardless of likely side effects. Oral pills and condoms should be provided to eligible users only after consultation with health workers at the facility to ensure correct diagnosis.
- FP non users are driven by the fear of side effects when using any FP method. This fear is triggered by rumours, incorrect traditional and religious beliefs, and sometimes negligence.
- CBDs are an essential part of any FP programme in Tanzania. For Tanzania to reach a CPR target rate of 60% by 2015, CBDs should be trained throughout the country in counselling and distribution

of FP methods. This includes not only oral pills and condoms, but also other methods of contraception so as to reach a greater number of clients.
- For the sake of program sustainability, a sense of ownership among community members and their local leaders remains vital and of great importance.

And, in terms of process:
- PRA processes are an effective way of bringing together community members, health service providers, and the district level health management and this helps in addressing some of the problems which hinder effective service provision. This results in greater social accountability and trust.
- The involvement of men and women, users and non-users, as well as various community groups, local and district health structures and external agencies providing technical support remains the best way to strengthen community participation and the development of a people-centred, primary healthcare focused health system.
- Communities always have solutions to their problems, but they need guidance and facilitation to be able to articulate and implement the desired change.
- PRA builds community will and commitment in addressing their problems rather depending on external support.

4. Next Steps

Following the end of the COPASAH funding of this programme, HDT and IHI, in collaboration with relevant stakeholders, will continue to undertake the following responsibilities:

- Monitor the functioning of CBDs at community level to ensure all planned actions are fully implemented
- Support health workers from BHC in mentoring and improving the skills of the CBDs
- Monitor the commitment made towards the Resolution on CBDs' Incentives Concerns especially the provision of 12.5 USD to each CBD on a monthly basis.
- Attend the Bukiriro General Village Meeting and Health Committee Meetings for the purpose of supporting health workers in sensitizing community members on FP issues.
- Hold discussions with Bukiriro ward leaders to expand the scope of the project to cover the remaining three villages in the ward.
- Approach other local Civil Society Organizations (CSOs) operating in Bukiriro Village or neighboring areas to persuade them to join efforts in strengthening the CBD programme in their area.
- With technical assistance from TARSC, prepare and submit proposals to different donors for funding the PRA work in the remaining three villages of Bukiriro ward.
- Monitor use of PRA and its outcomes along with other HDT field activities in Bukiriro village.

Appendix 1: Meeting Programme

TIME	Session Content	Session Process	Role
9:00 am	Registration		All
9:15 am-9:30am	Opening the session	Welcome and introductions. Objectives of the meeting. Plenary Review of the Second Community meeting.	DMO & All
9:30am-10:00am	To review and reflect on actions undertaken since the last meeting	Activity 1: Participants identify an action taken against each listed challenge during the second meeting and analyze the outcomes of each action (who was involved in implementation; doing what; what worked, what didn't and why; next steps)	All
Review of CBD programme			
10:00am-10:45am	Debriefing on CBDs work in progress, implementation challenges and developing viable solutions	Activity 2: CBDs and Health workers update the rest of participants on the work and challenges, and then all participants develop viable solutions for identified problems	CBDs & H/Ws
10:45am-11:15am	**TEA BREAK**		**All**
11:15am-12:00pm	To review progress markers	Activity 3: All participants engage in reviewing progress markers (Each social group give relevant response depending on implementation status)	All
Strategies for improved dialogue, action and accountability			
12:00pm-12:45pm	To discuss future actions to ensure sustainability	Activity 4: Participants in groups of 6-8 people (depending on their social groups) draw a table of about five columns indicating the barrier, strategy to overcome barriers, how to implement/action and progress indicator. Activity 5: By referring to the table drawn in activity 3, participants brainstorm on future actions for insuring program sustainability.	All
12:45pm-1:45pm	**LUNCH AND RELAX**		**All**
1:45pm-2:00pm	CLOSING		DMO

Appendix 2: List of Participants

No.	Name	Village/CSO, Contact address and phone number	Title
1	Paschal Kamugisha	Health Promotion Tanzania, P.O. Box 108, Ngara. pkamugisha@hdt.or.tz +255 784 483192	Program Assistant, HDT
2	Greysmo Mutashobya	Health Promotion Tanzania, P.O. Box 108, Ngara. gmutashobya@hdt.or.tz +255 756 279319	Program Officer – Advocacy, HDT
3	Josephine Sinzimwe	Bukiriro Health Centre +255684162586	Matron at BHC
4	Revina Julius	Bukiriro Health Centre +255 787 884673	Nurse at BHC
5	Stella Dario	Ngara District Council, P.O.BOX 30, Ngara. Tel: +255 788 205984	Assistant DRCHCo
6	Mastidia Apianus	Central Bukiriro Hamlet	CBD
7	Josepha Calist	Rubanga Hamlet, Bukiriro	CBD
8	Suzana Maisha	Rubanga Hamlet, Bukiriro	CBD
9	Adriana Philimon	Mukibogeka Hamlet, Bukiriro	CBD
10	Domisian Havyalimana	Bukiriro Village +255 68227872	Village Chair
11	Cosmas J. Ngoroye	Bukiriro Village. +255 786 410991	VEO- Bukiriro
12	Vaileth Peter	Bukiriro Village	Community Representative
13	Alexander N. Sendende	Bukiriro Village	Village Health Committee Chair
14	Apianus Semyonga	Bukiriro-Kati	Community Representative
15	Cosmas A. Bakobishiga	Bukiriro-Rubanga	Community Representative
16	Laurecia Mdogo	Bukiriro-Mukibogeka	Community Representative
17	Anizia R. Laurent	Bukiriro-Rubanga	Community Representative
18	Filotea F. Magabili	Bukiriro Ward	WEO
19	Hassan Runahi	Ngara District Council, P.O.BOX 30, Ngara. Tel: +255 782 492529	DMO's Representative
20	Peter Sekishahu	Bukiriro-Kati	Hamlet Leader

Appendix 3: Acronyms

BHC	Bukiriro Health Centre
CBDs	Community Based Distributors
CPR	Contraceptive Prevalence Rate
COPASAH	Community of Practitioners in Accountability and Social Action in Health
DHMT	District Health Management Team
DMO	District Medical Officer
DRCHCo	District Reproductive and Child Health Coordinator
EQUINET	Regional Network for Equity in Health in east and southern Africa
FP	Family Planning
HDT	Health Promotion Tanzania
IHI	Ifakara Health Institute
HQ	Head Quarters
LGA	Local Government Authority
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MSD	Medical Store Department
PHC	Primary Health Care
PRA	Participatory Reflection and Action
RCH	Reproductive and Child Health
TARSC	Training and Research Support Centre
VEO	Village Executive Officer
VC	Village Chair
WEO	Ward Executive Officer