Revitalizing the use of Community Based Distributors (CBDs) for improved Family Planning services in Bukiriro Village, Ngara District, Lake Zone – Tanzania

Second Community Meeting

Held at Bukiriro Health Centre
30th April 2014

Health Promotion Tanzania (HDT) and

Ifakara Health Institute Tanzania (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 Open Society Foundations

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Cite as: G.Mutashobya (HDT), J. Baraka (IHI), B. Kaim (TARSC) (2014). PRA Report: Revitalizing the Use of Community Based Distributors for Improved Family Planning Services in Bukiriro Village, Ngara District, Tanzania. Second Community Meeting: 30th April 2014. TARSC, EQUINET and COPASAH. Harare, Zimbabwe.

Acronyms

BHC	Bukiriro Health Centre
CBDs	Community Based Distributors
COPASAH	Community of Practitioners in Accountability and Social Action in Health
DHMT	District Health Management Team.
DMO	District Medical Officer
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
MSD	Medical Store Department
PHC	Primary Health Care
PRA	Participatory Reflection and Action
TARSC	Training and Research Support Centre
VEO	Village Executive Officer
VC	Village Chair
WEO	Ward Executive Officer

1.0 Background

This meeting is part of a larger programme in which the Training and Research Support Centre (TARSC), Zimbabwe is providing technical support to Health Promotion Tanzania (HDT) and Ifakara Health Institute (IHI) as a follow up to a PRA training on Social Accountability in Primary Health Care facilitated by TARSC in cooperation with Community of Practitioners in Accountability and Social Action in Health (COPASAH) and Regional Network for Equity in Health in East and Southern Africa (EQUINET).

On Wednesday April 30th 2014, Health Promotion Tanzania (HDT) and Ifakara Health Institute (IHI) held the Second Community Meeting as a continuation of efforts towards revitalizing the use of Community Based Distributors (CBDs) for improved Family Planning services in Bukiriro Village, Ngara District, Tanzania. The meeting brought together 12 participants from four groups; community leaders, health workers, community representatives (FP Service users), and community based distributers (CBDs). The Community Based Distribution Program is regarded as one of the best ways to strengthen primary health care through improved public involvement and health service accountability, especially in communities like Bukiriro where service users walk many kilometers to access health services including family planning. In bringing the service directly into clients' homes, the program also saves time in accessing family planning services and minimizes unnecessary congestion at the health facility.

The meeting aimed to:

- Review actions undertaken since the last meeting and implications for follow up work.
- Set progress markers that will be used to measure progress before the review meeting.
- Identify strategies for improved dialogue, action, and accountability between community representatives, CBDs and health workers for strengthening FP service delivery.
- Discuss future actions to ensure programme sustainability.

The meeting objectives mentioned above were developed based on a programme prepared and agreed upon by HDT, IHI, and TARSC (see Appendix 1). One meeting facilitator (Greysmo Mutashobya) came from HDT, in accordance with a work plan developed prior to actual implementation. With that existing work plan, availability of facilitator (s) from IHI and HDT-HQ was limited to the first Community meeting and review/third Community meeting. There were small significant changes on the participants' side whereby community representatives (FP service users) were invited. Also, Village Health Committee members attended this meeting to ensure continued strengthening of relations with the CBDs as a follow up to previous discussions that addressed CBDs motivational concerns.

2.0 Meeting Activities

2.1 Welcome and Introductions

Greysmo Mutashobya, from Health Promotion Tanzania (HDT) welcomed all participants to the meeting and allowed them to introduce themselves. Thereafter, the Village Executive Officer (VEO) officially opened the meeting. In connection with the meeting opening, the VEO acknowledged the efforts in improving FP services in Bukiriro Village. He concluded by encouraging all partners to be accountable in order to ensure programme progress and sustainability.

Figure 1: Participants during introduction session

2.2 Plenary Review of the First Community Meeting

All participants were required to stand in a circle and then a ball was thrown from one person to the next. Whoever received the ball had to mention an agenda of the first community meeting. From this exercise, participants managed to recall and mention agenda items and contents of the previous meeting. The exercise started slowly but gradually, participants recalled as much as possible and mentioned the contents of the first community meeting. Some participants mentioned FP needs which were identified in the previous meeting while others mentioned the strengths and challenges of the CBD Programme. Of most importance, participants mentioned the Community mapping exercise which aided them to know places where FP services users go when seeking the services. This kind of review/recap created a good base for the next activity which was to identify/review actions undertaken against identified FP problems since the last meeting and implications for follow up work.

2.3 Reviewing FP problems and actions taken

The session started by recalling the FP problems identified at the first community meeting. Because community representatives (FP service users) and Bukiriro Health Committee members had not participated in the first community meeting, they requested that the facilitator to allow the meeting to repeat the exercise of identifying, scoring, and ranking FP needs/problems so that their voice could be included. The facilitator accepted. The outcomes of this exercise were almost the same to those of the first meeting but the challenge arose when ranking the problems. From the community perspective, communication between FP service users and providers was considered a priority problem. Thus, they insisted that it should be ranked among the top three problems. To justify how communication was a big problem some reasons were given including; less information on stock outs, lack of close care and sometimes irresponsible responses from service providers. The chart below indicates prioritized FP problems in the first community meeting against those of the second community meeting;

No.	FP problems as identified and ranked in the First Community Meeting:	FP problems as identified and ranked in the Second Community Meeting:
1	Inadequate number of FP service providers.	Inadequate number of FP service providers.
2	Inadequate FP commodities to facilitate the provision of all FP methods.	Inadequate FP commodities to facilitate the provision of all FP methods.
3	Lack Mass education among community members on FP services and their benefits.	Poor communication between service users and providers

Figure 2: Identified FP problems during the first community meeting against those of the second meeting.

Despite the above changes, the meeting went on to look at the actions taken against each identified problem during the First Community Meeting. The top three ranked FP problems were reviewed and each responsible individual(s) or group had to indicate the action taken against each FP problem followed by the outcome:

This chart indicates the action(s) undertaken against each identified FP problem and the last two columns state the outcome(s) and responsible person/group. (Kiswahili version)

No.	FP problem	Action taken	Outcome (s)	Responsible
1	Inadequate number of FP service providers.	Re-training the CBDs in order to increase the workforce at the facility and during outreach services.	CBDs reinstated and currently carrying on with their responsibilities at the facility and in the community.	- BHC - HDT/IHI - CBDs
2	Inadequate FP commodities to facilitate the provision of all FP methods.	The facility properly and timely ordered all FP methods from the Medical Store Department (MSD).	FP service users accessed the methods of their choice at the right time. No alternative method has been provided to clients between March 15 and April 30, 2014.	- BHC - DHMT
3	Lack of mass education among community members on FP services and their benefits.	Pre-service sessions on FP benefits and side effects resumed at the facility.	Understanding of FP benefits gained for a positive change in the future.	- BHC

Figure 3: FP problem(s) against actions undertaken followed by Outcomes and responsible person or social group columns.

2.4 Setting progress markers

This session involved setting Progress Markers which will be used to measure the trend and quality of FP services in Bukiriro village from late April to mid June, 2014. All social groups came together in a plenary discussion to set the markers based on three levels, namely:

i. 'Expect to see' (usual situation).
ii. 'Like to see' (higher level or improved situation).
iii. 'Love to see' (more ideal situation).

However, with the changes in the ranking of FP problems due to the input of community members during the second community meeting, it was found wise to accommodate those changes and set the markers based on the revised FP problems. Thus, the markers were set as follows:

Problem 1: Inadequate number of FP service providers				
EXPECT To See Progress Markers		*Progress Monitoring		
		1	2	3
1	Two formally employed FP service providers joined by 4 CBDs to ease the work load at the facility and during outreach services.			
2	At least half of all FP clients using Oral pills and Condoms accessing their services 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 more staff in order to bring about the 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 their preferred FP method.			
LOVE To See Progress Markers				
1	The Number of FP service providers increasing adequately to serve users within 20-45 minutes.			
2	CBDs being trained and able to provide injectables which is the most preferred FP method.			

Problem 2: Inadequate FP commodities to facilitate the provision of all FP methods.				
EXPECT To See Progress Markers		*Progress Monitoring		
		1	2	3
1	Every FP user getting the FP method of her choice and not an alternative one.			
2	The number of FP service users increasing and 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				
EXPECT To See Progress Markers		*Progress Monitoring		
		1	2	3
1	The Village Health Committee sitting together for planning and reviewing the quality of FP services HOW OFTEN???			
2	FP service providers informing the 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. Increased level of respect – as subjectively measured - between FP services providers and users.			

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.			

2.5 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. Participants were grouped depending on their social groups and each group identified barriers towards improved dialogue and action. Thereafter, group members brainstormed on strategies for overcoming such barriers before proposing the implementation plan per a given strategy. This was followed by a plenary discussion and review of the work from each social group. The compilation of works from all groups brought about the strategies below:

Barriers to improved dialogue and action	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 level	- Both men and women asked to attend clinics and married women who come to the facility accompanied by their husband to be commended. - 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 Village Health priority plans.	- Village Health Committee
Lack of regular Community meetings	Holding regular community meetings	Hold community meetings at least quarterly for the purpose of discussing the trend and quality of FP services	- Community representatives - CBDs - Health Workers - Village leaders
Lack of commitment and FP Champions	Creating FP champions from each hamlet of Bukiriro Village for	Identifying champions from each Village hamlet during general Village meetings. (CBDs' recommendations very	All social groups.

	community sensitization	important).	
Poor communication	Ensuring good coordination and dissemination of all important information	The facility to disseminate information on notice boards, posters, e.t.c. on FP services schedule, 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	Setting internal plans at facility level and consulting other CSOs engaged in FP or Maternal health to train our 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	Holding a planning meeting between FP service users and providers so that the schedule does not compromise with other social-economic undertakings.	- BHC - Community representatives

3.0 General overview, Analysis and Findings

3.1 Accomplishments

- Meeting activities were conducted as per program and all invited participants attended and fully participated in the meeting.
- Participants seemed more active compared to the first community meeting and the inclusion of community representatives ensured that their perspective was included in the discussions.
- The inclusion of community representatives and gender considerations unveiled the kind of relationship shared between FP service providers and their clients.
- A good relationship between Village leaders and Health workers improves communication and subsequent action(s) leading to greater project success and sustainability. It is important to identify barriers between providers and users for the program to be successful.
- The Village Health Committee is an important organ in Village health decision-making processes

3.2 Challenges

- The program timeline is a great challenge since existing FP service delivery shortcomings require follow up beyond this program cycle.
- Family Planning education is still low among community members with many local beliefs and misleading rumours about contraceptives undermining successful uptake of these services.
- Low level of health education, and especially FP, in the community.

3.3 Lessons Learnt

- Community representation need to include all social groups otherwise the findings obtained may be irrelevant and/or biased.
- Reinstating the CBD programme is an important step in strengthening a community based and people centred health system – it will improve the ratio between service providers and clients, lessen dependence on government-enrolled health personnel, and give voice to community representatives at district level.
- Communities always have solutions to their problems, but they need guidance and facilitation to be able to articulate and implement the desired change.
- Due to gender inequalities existing in most of African communities, women participants are more able to express their feelings when grouped separately from men..

3.4 Next Steps

- Monitor the commitment made towards meeting the CBDs needs to have an incentive, especially the provision of 12.5 USD to each CBD on a monthly basis.
- Monitor the functioning of CBDs at community level after they have resumed their responsibilities and making a close follow up to ensure that all planned actions are fully implemented before the Review meeting.
- Identify and involve local Civil Society Organizations based in Ngara District to ensure sustainability of the program.
- Attend Bukiriro general Village meeting and support Health workers to sensitize community members on FP related issues.Plan and facilitate the Review/ community meeting with all target groups in early June, 2014.

3.5 Facilitators' Remarks

We facilitated well and meeting activities were covered as per program. The meeting ended on time and participants appreciated our facilitation skills. We are looking forward to the second community meeting.

Appendix 1: Meeting Programme

Wednesday April 30th, 2014

TIME	Session Content	Session Process	Role
9:00 am	Registration		All
9:30 am-10:00am	Opening the session	Welcome and introductions. Objectives of the meeting. Plenary Review of the First Community meeting.	*GM & All
10am-10:30am	Reviewing actions undertaken since the last meeting and implications for follow up work	Activity 1: Participants identify an action taken against each listed FP problem during the first 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
10:30am-11:00am	TEA BREAK		All
11:00am-12:15pm	Setting progress markers for measuring progress before the review meeting	Activity 2: all participants get involved in setting progress markers which will really show the level and quality of service being provided between April-June, 2014.	All
Sustainability Aspect:			
12:15am-1:45pm	Identifying/reviewing barriers and developing strategies for improved dialogue, action, and accountability between community representatives, CBDs and health workers for strengthening FP service delivery. Then, brainstorm on future actions to ensure programme sustainability	Activity 3: 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 3.1: By referring to the table drawn in activity 3, participants brainstorm on future actions for insuring program sustainability.	All
1:45pm-2:45pm	LUNCH AND RELAX		All
2:45pm-3:00pm	CLOSING		**VC

***Facilitator**

****Village Chairperson**

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 +255784483192	HDT-Transport and Logistics Officer
2	Greysmo Mutashobya *	Health Promotion Tanzania, P.O. Box 108, Ngara. gmutashobya@hdt.or.tz +255756279319.	HDT-Program Officer
3	Josephine Sinzimwe	Bukiriro Health Centre +255684162586	Matron at BHC
4	Revina Julius	Bukiriro Health Centre +255787884673	Nurse at BHC
5	Peter C. Muoji	Bukiriro Health Centre +255687983801	Clinical Officer
6	Mastidia Apianus	Bukiriro-Kati	CBD
7	Josepha Calist	Bukiriro-Rubanga	CBD
8	Suzana Maisha	Bukiriro-Rubanga	CBD
9	Adriana Philimon	Bukiriro-Mukibogeka	CBD
10	Bahati Byamungu	Bukiriro Village. +2556227872	Village Chair
11	Cosmas J. Ngoroye	Bukiriro Village. +255786410991	VEO- Bukiriro
12	Vaileth Peter	Bukiriro Village	Com. representative
13	Alexander N. Sendende	Bukiriro Village	Village Health Committee chair
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* Facilitators