COMMUNITY BASED ORGANISATIONS WORKING ON REPRODUCTIVE HEALTH IN DODOMA URBAN AND KONDOA DISTRICTS: SUCCESS AND CHALLENGES.

By

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance of dissertation entitled ***Community Based Organizations Working on Reproductive Health in Dodoma Urban and Kondoa Districts: Successes and Challenges*** in fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

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I, Nora J. Mkenda, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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DEDICATION

This work is dedicated to my family; especially my husband Jerome who gave me financial, emotional as well as prayer support throughout my studies.

ABSTRACT

Morbidity and mortality resulting from poor reproductive health cause major losses and harmful effects on the Tanzanian community. Community-Based Health Initiative (CBHI) Project, aims at supporting the government of Tanzania in order to include a larger group of people in Tanzania's process of Health Sector Reform. CBHI supports community based organizations (CBOs) with their self identified health problems, supporting them with technical assistance and tsh 2,500,000.00 for one year. The purpose of this study was to evaluate the performance of seven CBOs in Kondoa and Dodoma Urban with regard to appropriateness, effectiveness and sustainable implementation of their plan which involved health promotion in reproductive health..Focus group discussions, in-depth interviews, group interviews and document review methods were employed. The 106 sample included: local government officials; health representatives including District Medical Officers; direct and indirect beneficiaries and CBO members and leaders. The study found that all CBOs' intervention plans were appropriate and that their effectiveness and sustainability depended on availability of external technical and financial support, also the availability or adequacy of advocated health services. This research concludes involving CBOs in health promotion activities in Dodoma Region has been successful and is the unsurpassed approach to facilitate behavior change. CBOs in health promotion can not sustain themselves financially so continuous external funding should be incorporated in their original planning stages. It is being recommended that more resources should be located in increasing the capacity of established CBOs that have been accepted by all the stakeholders in the community.

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LIST OF ACRONYMS

CBHI	Community Based Health Initiative
CBO	Community Based Organization
CBPR	Community Based Participatory Research
DMO	District Medical Officer
DPC	District Project Coordinator
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GTZ	German Technical Cooperation
HSR	Health Sector Reforms
HSSP	Health Sector Strategic Plan
MCH	Mother and Child Health
MDG	Millennium Development Goals
MKUKUTA	Mpango wa Kukuza Uchumi na Kupunguza Umasikini Tanzania
MMR	Maternal Mortality Ratio
MoHSW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University of Health Sciences and Allied Sciences
NHP	National Health Policy
NSGRP	National Strategy for Growth and Poverty Reduction
RCH	Reproductive and Child Health
RH	Reproductive Health
SDC	Swiss Development Cooperation
SRH	Sexual and Reproductive Health
STD	Sexual Transmitted diseases
STI	Sexually Transmitted Infections
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION

1.1. BACKGROUND

1.1.1. Reproductive Health

Tanzania has a very poor reproductive health status, with total fertility of 5.7, maternal mortality ratio of 578/100,000 live births and an estimated 45,000 newborns deaths each year in Tanzania. (URTb, 2005) Pregnant women who deliver in health facilities are only 47% and the rest deliver at home, assisted by traditional birth attendants or unassisted. (URT-MoHSWc, 2008; URTb, 2005)

More than half of the population receives poor antenatal care, poor care during child birth, poor care of obstetric emergencies, poor postpartum care, poor post abortion care, poor family planning service, poor HIV/AIDS and STD diagnosis and management, poor prevention and appropriate treatment of infertility, poor prevention and management of cancers, and the majority of them have poor nutrition status, practice harmful practices such as female genital mutilations, etc. (URT, 2005b; URT-MoHSWc,2008; DHS, 2007; UNFPA, 2004)

The situation is being complicated by household economic factors, inadequate maternal and child care, insufficient and inaccessible health services as well as unhealthy environment community culture, health education, adolescent and women status in the communities etc. (URTb, 2005)

The government has made many attempts to address Reproductive Health challenges including through the National Health Policy of 2007, the Health Sector Reforms and the Health Sector Strategic Plan of 2003-2007 (URTa, 2004). Improving the Reproductive Health is also a priority area in National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA) of 2005-2010 (URTa, 2004), as seen in their operational targets that relates to maternal, child and vulnerable groups in cluster two. Health Sector Support Program III 2008-2012 also incorporates and addresses Reproductive Health issues in alignment with government policies, resource mobilization and donor harmonization to ensure equitable and quality services to communities. (URTb, 2005)

1.1.2. Community Based Organizations in Health Promotion

Community based organizations are formed by the local community. They share physical boundaries and culture. It has been suggested by many studies before that involving the members of the community in planning, designing, implementation, monitoring and evaluation of their own problem solving community-based interventions increase the chance and magnitude of the expected successes. They minimize cost of intervention and they increase the community's participation.

Despite of the advantage and significance of the Community Based Organizations (CBO) in community health interventions, they are being faced by many challenges, e.g. lack of funding, technical capacity, inability to volunteer for long time, coverage and sustainability of the initiatives after donor support has ceased. (Bell et al., 2007)

1.1.3. Community Based Health Initiatives Project

In response to the need of having CBOs in health promotion, the Community-Based Health Initiatives Project (CBHI) was agreed upon in October 2004 between Tanzania and Switzerland, as part of Swiss Development Cooperation (SDC) with the aim of reducing communities' exposure to health risks by equitable access to existing health resources and by gaining control over their environment. The project is being implemented through GTZ-International Services. It is operating in line with the National Strategy for Growth and Reduction of Poverty (NGRP) to attain Millennium Development Goals (MDG). CBHI also operates under their country program domain of 'social and physical well being' which entails aspects of health, education, access to and quality of services, water and sanitation and safety nets (Evaplan, 2005; GTZ 2006).

CBHI works with CBOs in order to achieve participation of a larger group of people (WHO, 1978) in Tanzania's process of Health Sector Reform. The CBHI is committed to tackle self-identified community health problems by supporting selected CBOs with TSh 2,500,000 and technical assistance for one year only, after which these CBOs are left to sustain their initiatives using local and other resources.

At the moment, CBHI intervenes in 3 districts of Dodoma Region: Kondoa, Kongwa and Dodoma Urban. About half of the pregnant women there give birth in health care institutions about the same as the national average of 47%. A great number of women become pregnant involuntarily as a result of not using contraceptives (only every fifth pair uses contraceptives), youths are hardly informed at all about how they can protect themselves against unwanted

pregnancies, HIV infections or sexual violence also the fact that Dodoma culture promotes female circumcision. These reasons which contribute highly to the high levels of mortality and morbidity are the reasons which made CBHI in Dodoma put intervention on Reproductive health among its priority themes. Refer to (table 1) below. It is being assumed that because these CBOs are being formulated, on the community's own self driven initiative, they are in position, when assisted financially and technically to attain the objectives which are in line with the CBHI Project. (URT-MoHSWc, 2008; DHS, 2007)

Table 1; CBO in RH supported by CBHI in 2005-2007

Name of Group	District	Location	Activity/Objective	Members	When Established
UMOJA NI NGUVU	DODOMA URBAN	IPALA	EDUCATION TO WOMEN ON RH, EDUCATION FEMALE STUDENTS ON RH	3 FEMALE 2 MALE	2006
MEENA WOMEN	DODOMA URBAN	KIZOTA	EDUCATION OF WOMEN ON MCH, HOME VISITS	9 FEMALE	1995
UPENDO	DODOMA URBAN	MIYUJI	EDUCATION ON SRH, ENROLLINGADOLESCENTS IN VOCATIONAL TRAINING SCHOOLS	12 WOMEN	1998
MT AUGUSTINO	DODOMA URBAN	NKUHUNGU	EDUCATION ON SRH	24 FEMALE	1999
MT GABRIEL	KONDOA	KURIO	SINGING AND EDUCATION ON MCH AND NUTRITION	8 FEMALE 10 MALE	2003
WAKUNGA WA JADI	KONDOA	LOO	EDUCATION & SENSITIZATION ON MCH	12 FEMALE	2003
UHAI WOMEN GROUP	KONDOA	LOO	EDUCATION, SENSITATION ON RCH	10 FEMALE	2006

1.2. PROBLEM STATEMENT

Reproductive Health continues to be a big challenge to the whole world and Tanzania being among poorest countries fairs worse off. Complications resulting from child bearing are the highest cause of mortality among women between 15 and 45 years. It is estimated that 21,000 women die each year as a result of pregnancy related complications and about 420,000 more develop short and long term disabilities as result of pregnancies alone. (URTc, 2008) Focus on Sexual and Reproductive Health issues is crucial when addressing both the sources of human capital and implications on its growth and achieving development. Equity and accessibility to SRH care are major contributors to achievement of the gender and health-related Millennium Development Goals whereby the most significant preventive interventions are provisions of family planning and STI/HIV/AIDS education and services to the sexually active population. (URTb, 2005)

Since 2004, Tanzania through the Ministry of Health and Social Welfare together with her development partners GTZ Tanzania and SDC embarked on the Community-Based Health Initiatives Project with the aim of reducing communities' exposure to health risks by equitable access to existing health resources and by gaining control over their environment. In Dodoma region, Community Based Organizations were supported in order to achieve larger participation of communities in self initiated health interventions.

The CBHI has completed 2 phases of its one year support to seven CBOs operating in Dodoma region focusing on providing women, adolescents and in and out of school youth

with comprehensive information on sexual reproductive health and HIV/AIDS and reproductive and child health. These CBOs have been given financial and management training and supervision for a period of one year.

Although studies done in other developing countries and Tanzania shows that when communities are enabled, they can identify, plan and implement health initiatives to improve their own well being there is no evaluation which has been done to understand the inputs and outputs, the processes, the efficiency, appropriateness and relevance of the CBOs in relation to the CBHI and National health objectives. This study concentrates on studying the successes, challenges and factors leading to success and or failure in the CBOs when planning and implementing their objectives especially after the CBHI funding has ceased.

1.3. RATIONALE FOR THE STUDY

The purpose of evaluation is to study actionable and measurable indicators in order for the planners to collect evidence on a program's appropriateness, efficiency and effectiveness to be accountable to funding organizations; to identify ways to improve the project, to improve its usefulness, to determine what works and what doesn't and why; to clarify project plans and to improve communication among those involved in the project.

This study aims at conducting an evaluation of the seven CBOs dealing with Reproductive Health in Dodoma Region and will take place in the CBOs' social settings. The evaluation is intended to identify major aspects that affect the program services and the quality of implementation.

Up to now there is no study which has been done to study the CBOs supported by CBHI in Reproductive Health if they are in line and on track of meeting their own objectives, the CBHI Project objectives and the Health Sector Reforms objectives. This study aims at studying the CBOs to document from their own perspective, filling the gap and answering the question; "what are challenges and success stories and the factors behind those stories of the CBOs in Dodoma?"

The results of this study will assist in increasing knowledge to CBHI and assist in modifying the current plan for a more effective and more appropriate health promotion initiative.

1.4. STUDY OBJECTIVES

1.4.1. Broad Objective

To evaluate the performance of CBOs based interventions on sexual and reproductive health under the CBHI with regards to plan appropriateness and effective and sustainable implementation.

1.4.2. Specific Objectives

1. To assess the factors that enabled or hindered the Community Based organizations to realizing success during the planning process, supervision, implementation, management and of selected reproductive health initiatives supported by CBHI in Dodoma region.

2. To assess the effectiveness of the CBOs once supported by the CBHI in Dodoma region.

3. To assess the plan appropriateness of the CBOs once supported by the CBHI in Dodoma region.

4. To assess the sustainability prospects of the CBO interventions in their settings.

CHAPTER TWO: LITERATURE REVIEW

2.1. DETERMINANTS AND EFFECTS OF POOR REPRODUCTIVE HEALTH

Many of the inequalities in health, both within and between countries, are due to inequalities in the social conditions in which people live and work. These social determinants have an important effect on health status and general wellbeing of people. Tackling these underlying causes of poor health can contribute to improving health and health equity (Assai, *et al.,* 2006). It was noted by the Alma Ata conference which mainly advocated for community participation in order to tackle these health determinants through affordable primary preventive care strategies (Gillam, 2008). However, until now the goal of achieving 'health for all' by 2000 has not yet been achieved. Among other reasons, poverty and illiteracy are the leading determinants of poor reproductive health; (Assai, *et al.,* 2006) they are on the top of the health pages as the factors hindering the achievement of optimal Reproductive Health.

2.2. COMMUNITY INVOLVEMENT IN HEALTHCARE

Healthcare requires integrated intensive approaches that will address both the individual and his/her local environment using various simultaneous forms of interventions. It has been noted that community-based solution approach can be more effective in solving the healthcare needs of a community. (GTZ, 1998)

A community, as a unit of identity, is defined by a sense of identification with and emotional connection to other members, through common values, norms and symbol systems, and shared

interests and needs and commitment to meeting them (Steuart, 1993). Communities of identity may be geographically bounded, for example, a neighborhood, or may be geographically dispersed, sharing a common identity (e.g., ethnic group) with a special way of communicating. In order to set grounds for appropriate, effective, efficient and sustainable healthcare solution, the study of these modes with regard to particular communities is important. The rising burden of diseases in developing countries makes it imperative to formulate community-based interventions with effective communication strategies. (Gaziano, *et al.*, 2000) The success of these interventions will depend on the felt needs of the community.

Incorporating education and partnerships in the community-based actions, therefore, brings more success in their sustainability and importantly in reducing resistance and the likelihood of short-lived results. As some experts put it, people are likely to resist changes and innovations that: are not clearly understood, those that they have had no partnership in bringing about, changes that threaten their interest and security, changes advocated by those they do not like or trust especially due to past experiences, and, changes that did not fit into their cultural values of the community. (GTZ, 1998; Seifer, 2006)

2.3 COMMUNITY BASED ORGANIZATIONS

Previous studies claim that CBO interventions need longer time to establish in order to manage to put all the playing factors into place so that the intervention can still remain with the communities even after its period is over. (Bell *et al*, 2007)

In a study to evaluate CBOs, Cookie, (2005) established that the CBOs could reach populations that the Ministry of Health could not reach and at a lower cost. The CBOs could also contribute more volunteering time at a lower cost that health workers would have demanded. Given the fact that these interventions are self initiated, the impact on health is greater than when the government acts directly.

2.4. ASSESSMENT OF CBO IN HEALTH PROMOTION PROGRAMS

The selection of appropriate community-based interventions often comes with challenges of fitting the capacities, resources, community's perception and readiness, as well as which relevant stakeholders to involve. Social needs and resources assessment should help to profile the problem, population, strategies and make a comprehensive plan of what and who should be selected, and how to evaluate the success at some point Questions to be asked in the selection of the intervention itself, the beneficiaries and the means include: Is the intervention appropriate? Is the intervention effective? How sustainable is the intervention? (Marek and Mancini, undated)

Community based development projects have a potential to create effective community infrastructure for health promotion, they however require enabling institutional environment, which requires government commitment, and on accountability of leaders to their community to avoid "supply-driven demand-driven" development. External agents strongly influence project success, but facilitators are often poorly trained, particularly in rapidly scaled-up programs. The naive application of complex contextual concepts like participation, social capital, and empowerment is endemic among project implementers and contributes to poor design and implementation. The evidence suggests that community-based and -driven development projects are best undertaken in a context-specific manner, with a long time horizon and with careful and well-designed monitoring and evaluation systems. (Mansuri and Rao, 2004)

Kathrin Schmitz (2008) in her thesis looked at the success of CBO run interventions as categorized into two parts: those relating to the approach used and those relating to the implementing CBO itself. Factors which related to the approach also relate to the effectiveness of the project, they were: how the message is being delivered to the target group, accessibility of the health services which are being advocated and how the community members and leaders are being involved. She also listed the factors which relate to the CBO itself as the attitudes of the CBO members, their capacity and the structures o the CBO and community. These factors also determine the appropriateness of the implementation.

2.4.1. Appropriateness and relevancy of interventions

Appropriateness of public health interventions has shifted its focus from the macro-levels to utilization of the opportunities found at the community levels. Appropriateness and relevance of interventions are closely related, but community demands and needs, and the assessment of the intended results of an intervention marks their slim difference. This difference has been shown by researches that some community-based interventions approaches when based on Western models may produce adverse effects when applied in the developing countries. Barrio (2000), argues in his paper that although some solutions may be relevant enough as health solutions in general but may not be appropriate with limited resources and capacities as exhibited in developing nations (Barrio, 2000; Gaziano, *et al*, 2007).

2.4.2. Effectiveness of interventions

Effectiveness is a measure of benefit resulting from an intervention under which problems are tackled within the milieu and resources capacity of the target population. It is the extent to which an intervention works under local circumstances and not in ideal situation. It means tailoring the ideal strategies to fit the local feasibility and consumption. If intervention approaches can be intertwined within the community's system then the outcome is more likely to be fruitful. Douthwaite and Schulz (2001), assert that, "Use by the intended beneficiaries is a more important validation of the results produced by research than publication in a peer-reviewed journal".

Effectiveness goes hand in hand with the community's culture and other components building the unit of a community. For reproductive health programs to be effective, the way of living of a particular community has to be taken into consideration. For example Reproductive Health interventions in male dominated societies will be more effective if you also target men as the propagators; not only women and children (Haddad, 1999). Reproductive Health programs targeting adolescents are expected to be more effective when parents and caretakers are also included.

2.4.3. Sustainability of interventions

Sustainability of health programs is also defined as the capacity of programs to continuously respond to community issues. A sustained program maintains a focus consonant with its original goals and objectives, including the individuals, families, and communities it was originally intended to serve. (LaFond, 1995; Shediac-Rizkallah and Bone, 1998, Scheirer, 2005)

Certain health programs offer the same prevention activities for years, and others introduce different activities that remain focused on their general goals and objectives. The key element of sustainability is providing continued benefits, regardless of particular activities delivered or the format (institutionalization versus independence) in which they are delivered.

Sustainability of health interventions can be assessed through elements like; Leadership competence, Effective collaboration, Understanding the community, Demonstrating program results, Strategic funding, Staff involvement and integration, and Program responsivity.

However, Swerissen and Crisp (2004) in their study in analyzing sustainability of health promotions, argued that there was a necessity of decision makers to be able to note the level of the organization which is the focus of change, the means and programs uses to bring change, the outcomes and effects achieved, and funding characteristics.

2.5. EVALUATING CBOs

Recognizing that many of the key determinants of health were socioeconomic rather than directly related to health care, the success of community healthcare programs might not be self-evident. Particularly due to an attribution gap and lack of outcome evidence, many community-based preventive and health promotion programs cannot vividly associate their inputs directly to the reduction or elimination of the health problem in the population. (World Bank, 2002)

Among the methods in participatory evaluations for CBOs, Focus Group Discussions (FGDs) and group interviews have been seen as an effective method that uses group interactions to explore people's knowledge, experiences and how they come to assert their assessment conclusions. The FGDs remove confirmation bias by generating theories or hypothesis instead of formulating and testing them; since testing of the already formulated hypothesis might miss the real occurring phenomena on the ground (Burke and Onuwegbuzle, 2004). In the article, Qualitative Research: Introducing focus groups, Kitzinger (1995) asserts that, when FGDs are used to study community based groups, "they touch interpersonal communication which is relevant in highlighting the cultural values or the norms found in a particular community or group thus reaching the parts that other methods cannot reach, revealing dimensions of

understanding that often remain untapped by more conventional data collection techniques". (Kitzinger, 1995; Koepsell, *et al.*, 1992)

Sobo, *et al.*, (2003) outlined the importance of studying different stakeholders, that they identified different issues, which would not be raised, by the other stakeholder.

CHAPTER THREE: METHODOLOGY

3.1. RESEARCH DESIGN

This research was a process evaluation where qualitative approach was employed. Qualitative methods were combined in order to acquire rich data and also increase the overall validity of the study. Interventional CBO activities were studied to determine why and how some are successful and sustainable, and some not.

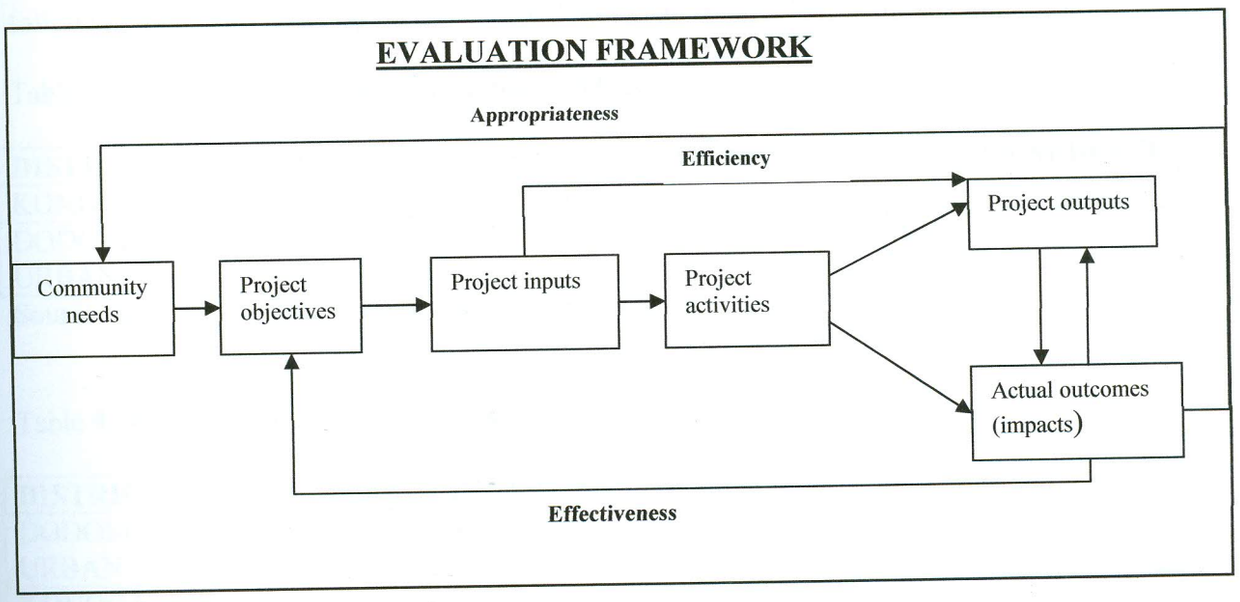
Data was collected by group or in-depth interviews, document review and focus group discussions. The questions were designed to assess the perception of stakeholders regarding the success ability, challenges and sustainability of the CBOs according to the timetable of activities, existing resources (including human resources, budget and various facilities), obstacles confronted by project managers and the extent of integration of projects into the existing systems (see table 2).

All input information (ESCAP 2003), (types of interventions, human resources, and the amount of the budget spent) and output information (number of intervention venues, number of trained individuals, number of approved legislations, the CBO's impression of the success of interventions, feasibility of integrating the projects into the existing system, impediments and facilities) were collected. (Sobo, et al., 2003) (See figure 1)

Table 2. Input and Output indicators

INPUT INDICATORS	OUTPUT INDICATORS
Human resource Budget spent Educational activities Time	Educational activities conducted Number of Human Resource trained Number of reached people Number of changes legislations Number of assets/ facilities obtained Continuity impressions from the CBO members Other sources of finances Capacity building Feasibility of the interventions Partnerships made

Figure 1. Evaluation Framework



3.2. AREA OF THE STUDY

The study was conducted in Kondoa, a rural district and Dodoma Urban an urban district in Dodoma Region in Tanzania. The communities in Kondoa live in semi arid conditions and have water shortage. Kondoa has a total population of 428,000; while the Dodoma Urban district has a population of 323,000 people. (URT, 2004)

3.3. THE TARGET POPULATION

Dodoma is a region centrally positioned in Tanzania. It is comprised of the following districts: Dodoma-Rural, Kondoa, Mpwapwa, Kongwa and Dodoma Urban. The first four districts are rural while the last one is an urban district. The whole population is about 1.7 million. The following table shows the population of Dodoma districts involved in this study.

Table 3: Population Distribution in Kondoa and Dodoma Urban

DISTRICT	MALE	FEMALE	TOTAL	PPL/HOUSEHOLD
KONDOA	213,724	216,100	429,824	4.8
DODOMA URBAN	157,469	166,878	324,347	4.3

Source: adapted from Tanzania Census report 2002

Table 4: Ward Distribution in the 3 districts is as summarized by the table below

DISTRICT	AREA SQ.KM	DIVISIONS	WARDS	VILLAGES
DODOMA URBAN	2,576	4	30	42
KONDOA	13,210	8	35	160

Source: adapted from Dodoma Profile report – RC Dodoma office 2002

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As shown by table 3 above the female population is slightly higher in all the districts as compared to the male population. Majority of these women, especially in rural areas, are engaged in agricultural activities. The overall sex ratio is 94 males for 100 females.

3.4. BACKGROUND OF THE SEVEN COMMUNITIES UNDER STUDY

Five of the studied populations were in rural areas while the other two were in peri-urban centers. The CBOs studied in Kondoa district were all rural, and all three were not less than ten km from a health centre. The villages have scattered households which could take more than two days for a person to pay a door to door service.

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Kurio-Kwa-Mtoro area lies over 70KM from Kondoa town and has semi-arid climatic conditions with scattered population. The other communities under study were in Loo about 10 km from Kondoa town. Due to its large size, the district authority has made a decision to split into two villages in the next financial year.

In Dodoma Urban district, four CBOs were studied in Miyuji and Ipala wards are rural communities. Miyuji is located at the periphery of Dodoma town (about 5KM north of Dodoma centre while Ipala is located about 40km from Dodoma centre. Others are Nkuhungu and Kizota wards which are located in the periphery of the town and about 3KM west of Dodoma centre.

3.5 SAMPLING PROCEDURES

Dodoma is a region centrally positioned in Tanzania. It is comprised of the following districts: Dodoma-Rural, Kondoa, Mpwapwa, Kongwa and Dodoma Urban. The first four districts are rural while the last one is an urban district, just as its name indicates. The whole population is about 1.7 million. The following table shows the population of Dodoma districts involved in this study.

Selection of the Community-based Groups

Within Dodoma Urban and Kondoa all 7 CBOs dealing with sexual and reproductive health issues (RCH, MCH and SRH) which were supported by the CBHI in its 1st and 2nd phases were chosen. These CBOs has very different approaches of implementation. It was assumed that by evaluating all the CBOs in Reproductive Health there will be a chance of comparison of the different methods and approaches in interventions and some possible differences that will be reflected in the effectiveness, appropriateness and sustainability of the CBOs.

Selection of the beneficiaries

A beneficiary was considered to be any person who directly or indirectly benefited from the CBOs services. The indirect benefits could be traced directly to the services of the CBOs. Selection of the direct and indirect beneficiaries was also done purposefully. The beneficiaries were selected during the field study. Based on the information gathered from members' interviews, the community members to be included were selected without prior notification.

Selection of the Community Leaders

The leaders were members of the communities in focus who held an official position elected by the communities through the voting process. The leaders came from the areas of operation of the CBOs. Community leaders representing each local area of the CBOs were also purposefully selected using the following criteria, that the leader was directly involved with the CBOs either by the reason that the CBOs area of operation is under his/her area of jurisdiction (village) or his participation in CBOs activities of any kind.

Selection of the Health Facility Workers

First line health facilities that were found in the operational areas of CBOs or are involved with the CBOs in any way were sampled. The doctor, clinician or a nurse in-charge of the facility or other health workers were included for individual or pair interviews in order to provide insight of the health impacts observed in the health facility as a result of the CBO.

Selection of the CBO members

CBO Members are the bona fide members of the community based organization which once received funding support from CBHI and who were present during the funding period. All CBO members were included in the study. Leaders were interviewed separately.

Due to the qualitative nature of this study as explained above, the sampling followed purposive sampling. Sometimes convenient sampling was employed guided by a couple of

factors like recommendation from the project management office – CBHI, researcher's preference, resources and the time constraints.

3.6. DATA COLLECTION METHODS

Data was collected using observation methods, in-depth interviews, group interviews and focus group discussion (FGD). These methods were chosen because divergent findings are expected from different groups and individuals that would assist in drawing more credible conclusions from a synthesis of results. At the field, Kiswahili was used the language to collect the data.

Interviews: Group interviews and in-depth interviews were used as the primary strategy for data collection on the CBO members, CBO leaders, community leaders and the health workers. The interviews were be semi-structured and were free to probe and explore within predetermined inquiry areas. (Bogdan and Biklen, 1982) Interview guides were prepared to cover participants' knowledge of the respective CBO. Furthermore, interview guides ensured good use of limited interview time; making interviewing multiple subjects more systematic and comprehensive; and kept interactions focused. For all interviews, tape recording was done after a verbal agreement form the interviewee so as to capture information more faithfully and make it easier for the researcher to focus on the interview.

FGD: Each focus group discussion consisted of about twelve informants and the three person research team. For the sake of getting rich information, FGDs were conducted separately for each district. These were conducted in a quiet, comfortable and independent place (i.e. not a property of the CBO member or any beneficiary) in order to avoid any influential bias of the choice of place and interruptions when the discussions were going on. Three members from

the research team (the moderator, the research assistant and the observer) and the interviewees were all seated in a circle to create a sense of an atmosphere of equality in participation during the discussion. Besides taking notes, a recorder was used to record the discussions.

An interview guide for the discussions was used in order to maintain a systematic collection of the data. Before the actual interviews about seven minutes was spent to familiarize with each other and relieve any tensions while at the same time obtaining their consent of voluntary participation.

Observations: Observations were conducted all the time within the locality of the CBO coverage area. Documental evidence was collected whenever possible with or without the knowledge of the CBO members. Body language, local gestures, use of tone and language, were among the things which were observed during the discussions and interviews in order to read and associate more meaning to what was being discussed.

3.7. DATA QUALITY

To ensure that the quality of the data collected was of high standard, and to improve the validity the following issues were taken into consideration during the designing of the study, data collection and during data processing.

The research Team

The research team consisted of three team members: the principal investigator and two research assistants. The principal investigator was responsible for guiding all the discussions

and conducting all the interviews. The objective was to maintain consistency and easy recognition of where to adjust or modify during the data collection procedure. After every interview or discussion, meetings were conducted to discuss in order verify the information collected and other observations. Every team member was allowed to give their independent observations before discussing it and coming into a unanimous conclusion after which the conclusions would be noted down.

The training of the research assistants took one day. They were trained on: i) The study and its objectives ii) How to collect the data ii) How to take notes and use of auxiliary electronic apparatus iii) How to do the transcribing and transferring the data into the computer, iv) The ethical aspects surrounding the study.

Pilot-test

Out of the already-selected CBOs, one was randomly picked for the pilot test. The intention was to see if the results from this test would have an effect in the amendment of the study approach by a greater degree. Minor amendments were made to the research tool after the pilot test. This CBO however was not included in the actual study.

Use of multiple qualitative methods

Owing to the quality of data, various qualitative methods were applied in this study. Focus Group Discussions, in-depth individual interviews as well as group interviews and observations were used as complementary methods of data collection. Information was considered to be true when it was verified by different stakeholders at separate occasions.

Use of the local language and electronic equipment auxiliaries

In order to ensure that data migration is safe, the recruitment of the research assistants followed one strong criterion among other criteria that the research assistants had to be bilingual, that is, having a good command of English and Kiswahili languages is an obligatory pre-requisite. Electronic recorder was also used in each conversation.

Data Migration

The data collected was immediately transferred into the computer on the same day to ensure that while the minds were still fresh, there was no loss of some information due to some recall bias. The data entered in the computer was verified by all the three research team members to maintain the data originality and check any inconsistencies in order to rectify them. Data processing and analysis was done by the principal investigator.

3.8. DATA PROCESSING AND ANALYSIS

Data was be analyzed qualitatively. It involved organizing data, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what was to be learned. (Bogdan and Biklen, 1982)

Data was managed by the assistance of the Microsoft Word and Excel software. This involved transcribing the data from Kiswahili language to English language before coding it. The responses to a particular guiding question were combined into one category; then each response from every respondent was reviewed and compared with the other responses. Each

team member coded the data separately after which they compiled together and be compared. The last stage of data analysis was done by the principal investigator alone. It followed sub-coding to give a broader meaning from the views of the respondents. All these processes were done in a separate Microsoft Word files in order to keep on maintaining the original themes of the respondents.

3.9. ETHICAL CONSIDERATIONS

Research ethics covers a number of concerns including ensuring the welfare of those who participate in the research, maintaining honesty in conducting research and treating information given by participants with utmost anonymity and confidentiality if they request it (Field, 2004). In the process of adhering with ethical issues, ethical clearance was sought and obtained from Muhimbili University of Health and Allied Sciences (MUHAS) prior to the study. Research authorization was also sought and obtained from the Dodoma region and Dodoma Urban district authorities. Furthermore, informed consent was sought and obtained from participants before they participate in the study. Specifically, participants were informed about the objectives of the study and that their participation was voluntary. Furthermore, participants were free to decline or withdraw at any time in the course of the study without any repercussion. It was clearly clarified that the information to be provided whether orally or in writing will be for research purposes and would therefore be strictly anonymous and dealt with confidentially. Furthermore, at the field sites, the researcher ensured that verbal consent from the participants was also obtained before and during the research period. The participants were also informed of their right not to answer some questions if they did not wish to answer them

and also that they were allowed to leave or stop the discussion if they feel not willing to participate further. Owing to anonymity and confidentiality, the participants, besides assuring them that the research would maintain confidentiality throughout the process, their real names were not be appended to the information gathered, they were also assured that the original information will remain under one custodian.

On transparency and beneficence issues, the participants were informed of the role and interests of the CBHI project, the research team and MUHAS.

3.10. LIMITATIONS

The principal investigator could not overrule the fact that regardless that this research followed the standards of study measures, it also had some limitations, which could not be overlooked.

1. Selection bias brought by purposeful selection might not have given an equal chance to other potential participants to contribute to this study, therefore may limit the generalisability to other areas/districts.

2. The field duration limited flexibility of arranging for appointments with stakeholders. Thus the study missed a few of the intended participants who could have not been replaced.

3. In addition, giving prior information to the CBOs my have skewed their responses.

4. The presence of other respondents in group interviews might have also skewed the individual responses.

5. The fact that most of this research was retrospective, which involved discussing past experiences- some of which were more than two years old, may have invited some recall bias.

6. Another possible bias could come from me, as the researcher. My age, sex, language, education, background knowledge, experience, and also my subjectivity may have biased this study by affecting people's responses and my perception of the responses.

CHAPTER FOUR: RESULTS

This chapter gives the evaluation findings which are results of various facets that were focused on the planning, implementation and management of the sexual and reproductive health interventions of CBOs supported by the CBHI Project in Dodoma Region.

4.1 DESCRIPTION OF PARTICIPANTS

Table 5: Demographic Distribution of the Interviewed Stakeholders in Kondoa and Dodoma Urban.

DEMOGRAPHIC CHARACTERISTIC	CODE	CBO LEADERS	CBO MEMBERS	BENEFI-CIARIES	HEALTH FACILITY REPS	VILLAGE/ WARD LEADER	TOTAL, % per code
SEX	F	10 (77%)	24 (56%)	35 (92%)	2 (67%)	0 (0%)	**71 (67%)**
	M	3 (33%)	19 (44%)	3 (8%)	1 (33%)	9 (100%)	**35 (33%)**
EDUCATION	1	0 (0%)	10 (23%)	22 (58%)	0 (0%)	0 (0%)	**32 (30%)**
LEVEL	2	7 (54%)	22 (52%)	12 (32%)	0 (0%)	3 (33%)	**44 (42%)**
	3	4 (31%)	7 (16%)	4 (10%)	2 (67%)	6 (67%)	**23 (22%)**
	4	2 (15%)	4 (9%)	0 (0%)	1 (33%)	0 (0%)	**7 (7%)**
MARITAL	S	0 (0%)	2 (5%)	0 (0%)	0 (0%)	0 (0%)	**2 (2%)**
STATUS	M	13 (100%)	35 (81%)	32 (84%)	3 (100%)	6 (67%)	**89 (84%)**
	W	0 (0%)	6 (14%)	6 (16%)	0 (0%)	3 (33%)	**15 (14%)**
AGE	1	4 (31%)	6 (14%)	6 (16%)	0 (0%)	0 (0%)	**16 (15%)**
CATEGORY	2	5 (38%)	15 (35%)	19 (50%)	0 (0%)	1 (11%)	**40 (38%)**
	3	4 (31%)	18 (42%)	11 (29%)	3 (100%)	8 (89%)	**44 (42%)**
	4	0 (0%)	4 (9%)	2 (5%)	0 (0%)	0 (0%)	**6 (6%)**
		13	**43**	**38**	**3**	**9**	**106 (100%)**

KEY:
Sex: F= Female, M= Male
Education Level: 1= No school, 2=Primary, 3=Secondary, 4=Tertiary(College, University)
Marital Status: S= Single, M= Married, W=Widowed
Age Category: **1**= 15 to 29 years, **2**= 30 to 49 years, **3**= 50 to 59 years, **4**= 60 onwards

Table 5 above shows that women who participated in this research were 67% of the total participants but none were village or ward leaders. Men were mostly leaders (100%) while majority of the women were the beneficiaries as well as CBO leaders. The table also shows that about a third of the participants had no education. Beneficiaries (90%) and CBO members (75%) were people with minimal education. aged between thirty and fifty nine years.

4.2 PLANNING FOR THE COMMUNITY-BASED INTERVENTIONS

4.2.1 The Idea

From the interviews with the CBOs leaders and members, this study found that all the seven CBOs had prior plans or had actually started conducting interventions on sexual, reproductive health before receiving CBHI support. The CBHI project funding to promote the health interventions came as reinforcement. One CBO leader explains, *'....we heard about sexual and reproductive health problems in one of church seminars.....we formed a group to educate outside the church....we heard about CBHI from the village office.....'* (CBOL5, age 40 yrs, male, secondary education, married)

Six out of seven CBOs leaders reported to have received the CBHI advertisements mainly through flyers, followed by radio advertisements. One however complained of the communication modes that had been used to advertise these opportunities. He complained that he came to hear of the notice just by chance through his good relationship with the community leaders.

4.2.2 Situation analysis

The CBOs followed various approaches of doing the situational analysis in order to assess the need for community-based health interventions in the communities that they intended to serve. The situational analysis was nonetheless not standard but rather informal. Six CBOs did their situation analysis during the times when the group members were participating in their other activities. They were exposed to the suffering of their fellow community members. An example of such concern was seen by this comment made with emotions *'.....when we visited homes, you could find a wrinkled old woman with a baby or pregnant and a child with a child, this made us think twice....'* (CBOM1, 41yrs old, female, primary education level, married)

Two groups reported getting data from the health facility nearby. These data included women who attended antenatal clinics, hospital deliveries, people with sexually transmitted diseases and children who get immunized. The rest of the baseline information was from past experiences, the observations of the 'visible' trends in the community.

All groups confirmed that their activities were streamlined and the CBO properly established after being motivated by the advertisements from the CBHI project through the radios, friends and flyers.

The health problems which the CBO members and beneficiaries thought contributed to poor reproductive health in their communities included; Lack of education on the matters of sex and reproduction, economic hardship forcing people put low priority in caring for themselves,

drunkenness leading to irresponsibility of parents especially men in the community, desire for large families, illiteracy in general, making it difficult for people to understand health risk, constant farm work leading to neglect of health issues, culture which forbade women to make decisions and imposing on them early marriages and female circumcision and on the other hand poor health service provision where distances, costs, schedules and unqualified workers were listed.

All groups except for one reported to have seen the health problems manifested in different ways. The problems were reported to require one type of intervention: education this education included in some groups entertainment which contained educational information, fliers, home visits, seminars, and sensitization meetings. However, one group selected only a small group of girls and provided them with constant counseling, personal needs and even school fees for many years until they manage to sustain themselves. The research team confirmed this by talking to one of the beneficiaries who received a sewing machine and now owns a small tailoring business financed by the CBO.

4.2.3 Community Participation

Some community members who were indirect beneficiaries complained of not being involved in selection of what was being brought for their communities without public consultations.

The CBOs never considered involving any other people in the core group especially in planning and or joining the core group... This was however stated by other community members to be understandable as volunteering long hours and family's meager resources can

not be forced. However, one group managed to increase 3 members after CBHI completed their funding. Groups collaborated in other ways with the community, they trained temporary volunteers for some activities, hoping that they will continue to train others *'……if I educate you, and you go and educate others, others that are in your age group, that I can not reach then the age group will understand you more and welcome you better……..'* (CBOL1, 37 yrs old, male, primary education level, married)

4.2.4 Participation of Government Leaders

All the nine interviewed community leaders complained of having been left out in the whole process of decisions making but also admitted that volunteering work needs to involve only committed people who can work together for long times without payment. However, they claimed to give assistance to the interventions whenever requested by the groups. All the leaders went further to recommend the group members to other national and regional health promotion activities.

The CBO members were recommended for sensitization on national health campaigns including immunization days, giving health-related speeches in general village meetings, participating in health trainings in the district, Participating in drama, dances and songs which have educative content during official gatherings and participating in village health planning meetings.

Only one group which had minimal public activities was criticized for involving the leaders only at the initial stages of inauguration of the CBO's project but not in the later stages when

the CBOs had started operating. The leaders complained saying that it seemed that their only job was just to endorse the already-formed group but later on they were not involved. They also were not aware of the continuity of the group.

4.2.5 Training and Supervision for the Interventions

All the groups participated in trainings from the CBHI project, members were selected from each CBO, when they came back they imparted the knowledge on the rest of the CBO members so that all could contribute to the group activities, however, it could be observed that some had greater knowledge than the rest. The training was given to all attendees without regard of their background. Some CBOs could be observed to have a greater knowledge than members of other groups depending on their background. The rest of the community also agreed that more education was required for the CBO members so that their work would be more convincing, accepted and could lead to more behavior change. All groups and government leaders agreed on the fact that supervision from the CBHI project was the greatest single non financial assistance which brought a difference. All of them confirmed that the number and the quality of visits could be improved and extended to after the funding period.

4.3 IMPLEMENTATION OF INITIATIVES

Implementation of sexual and reproductive health activities was the process through which the desired interventions were carried out to achieve project outputs. The process indicators of reproductive health address operational issues. They measure quantity of goods and services created or provided with inputs.

4.3.1 Intervention Approaches and Methods

Table 6: Approaches used by CBOs to tackle problems in Dodoma during CBHI support

APPROACHES DURING FUNDING	UMOJA NI NGUVU	MEENA WOMEN GROUP	UPENDO WOMEN GROUP	MT. AUGUSTI NO	MT. GABRIEL	WAKUNGA WA JADI	UHAI WOMEN GROUP
conducted public meetings	Yes	Yes			Yes	Yes	Yes
conducted meetings for age groups	Yes	Yes		yes			
distributed reminders; leaflets	Yes	Yes				Yes	Yes
Dramas, songs, movies, dances				yes	Yes		Yes
house to house visits			yes		Yes	Yes	Yes
used other gatherings				yes	Yes	Yes	
provided incentives	Yes		yes		Yes		
Health specialists in their trainings	Yes	Yes			Yes	Yes	Yes
Follow up house visits			yes		Yes	Yes	Yes
collaborated with govt leadership	Yes	Yes		yes	Yes	Yes	Yes
fundraising within the group		Yes					
economical activities		Yes			Yes		Yes
multi-tasked CBO				yes		yes	
Total of diff. approaches used	6	7	3	5	9	6	8

Table 7: Approaches used by CBOs to tackle problems in Dodoma after CBHI support

APPROACHES AFTER FUNDING ENDED	UMOJA NI NGUVU	MEENA WOMEN GROUP	UPENDO WOMEN GROUP	MT. AUGUSTI NO	MT. GABRIEL	WAKUNGA WA JADI	UHAI WOMEN GROUP
house to house visits			yes			yes	Yes
used other gatherings	Yes	Yes		yes	Yes	yes	
Provided incentives			yes				
Follow up house visits		Yes	yes			yes	Yes
collaborated with govt leadership	Yes	Yes				yes	Yes
fundraising within the group		Yes	yes				Yes
Group economical activities		Yes			Yes	yes	Yes
Other health intervention activities	Yes	Yes		yes	Yes	yes	Yes
Total of diff. approaches used	6	7	3	5	9	6	8

Responses show that there is a great change in approaches after the funding year ended (refer table 6 and 7). During the time when groups had money from CBHI, they could call their own public meetings and the community would attend. In these meetings, included was distribution of food, leaflets, songs, dances, dramas or an invited health specialist to assist in more technical matters. The above inclusions (table 6 and 7) were either all combined in some meeting or at least one of them included. The choir groups Mt. Augustino and Mt Gabrieli naturally incorporated songs and drama, while Uhai group which was originally and entertainment group continued with singing and they once showed a movie in the village.

Upendo which did not conduct their interventions in public provided to the selected target groups the life necessities like soap, deodorant, body jelly, pads, etc as incentives.

The information was confirmed by the beneficiaries and the village leadership. Stopping the above approaches after the end of funding brought a major change in the response of the population, there were no major crowds during educational meetings, the interest to listen to them decreased immensely. Umoja from Ipala who used to provide meals during the day long meetings could not conduct a meeting because most people could not spend a whole day without food.

All these intervention methods ceased immediately after the funding year ended. Only Upendo continued to support the girls in smaller ways and searched for other funding to assist and they managed to get funding from TASAF to purchase sewing machines for some of the girls and they are now involved in their own economical activities. This was confirmed by talking to the girls.

Because of their built-up credibility, and commitment, the CBO members and mostly the leaders reported being called to people's homes for health consultations and sometimes they visited the homes themselves without being called when they heard of intervening reason to intervene: this was done by Meena Women Group, Uhai Women Group, and Wakunga wa Jadi. Confirming the acceptance of the groups' advise by the community.

Those groups (6 out of 7) with good relationship with village leadership were being called each time a government or other meeting is called and one or two group members would go and deliver some sensitization or reminder speech on behalf of the groups. The groups could not intervene as a whole group any more: they either separated or gave each other turns to participate in the public meetings.

The other interventions besides reproductive health included environmental cleaning, nutrition, immunizations, community health fund, child health and cleanliness etc. These areas of intervention were the immediate needs of the particular community and as these group members were volunteers, they could be used by the village leadership to move from door to door to deliver and follow up the implementation or behavior change.

Another thing which seemed to be common in the women groups is the monthly contributions which were there even before CBHI support: these funds could be used somehow in health intervention activities. For instance Uhai Women group used the funds to buy stationeries or to send selected group members to do voluntary work as they no longer worked as a whole group.

4.3.2 Management and Supervision of the CBOs

The CBOs' structures and systems of management and supervision were found to be appropriate.

After the interviews with the CBO members, community leaders and the beneficiaries on these two aspects, three things emerged. First, the CBHI management team was reported to have conducted routine supervisions. The frequency of these visits fluctuated with the remoteness of the areas. Some areas, especially the most remote areas, reported to have only had three visits per year from the CBHI management while, on the other hand, some had up to nearly 12 supervision visits per year. This supervision from CBHI team was reported to have contained

brief refresher trainings, joint evaluations of the CBO progress and finances and site visits to the beneficiaries of the CBO interventions.

Secondly, within the CBO structures, the roles of the chairpersons, treasurers and the members seemed well outlined.

Except for three CBOs, Umoja ni Nguvu, Mt Gabriel choir and Uhai Women, the levels of education, experience, gender or position in the community leadership of the top three officials (the chairperson, the secretary and the treasurer) seemed to have taken an excessive control of the group. This was evident in many instances when majority of the ordinary members could not respond to anything concerning the financial management and major decisions, instead they told the research team that they totally trusted the leadership to advise them wisely.

It could be clearly seen that there were no structures in place to allow the ordinary members to have a share in the supervision, management or evaluation of the CBOs. In the above mentioned three groups by contrast all the members and the leaders had almost the same knowledge and participated in the same level.

As explained above, community leaders were involved during the startup of the interventions. Some of the groups maintained the relationship and thrived on it. In groups like Uhai, Wakunga wa Jadi, and Meena and Umoja ni Nguvu the team atmosphere could clearly be observed.

The two parts grew to depend on each other's support. Village leadership depended on the volunteering, knowledge and commitment spirit of the CBOs to support in all health mobilization and sensitizations.

'..... I feel very sorry for village leaders who do not have health CBOs in their areas, ...I once had to take 3 days to fix posters to advise people to attend to some health campaign or health meeting and the response was still small, there was also great expense in photocopying all the papers. .....these women, they move door to door and finish the village in two days, they even follow up on those who do not attend. This simplifies my work immensely and results are excellent.....' (ComL1, *40* yrs old, male, secondary education level, married)

Health officials reported to be very happy about the CBOs volunteering spirit and involvement in health promotion. Some claim that even home deliveries have decreased to a large extent: once a woman in Ipala, where Umoja ni Nguvu CBO is, delivered on the way to the dispensary and instead of turning back as she would have done some time before, she continued and went to the dispensary to be checked together with the baby. This was a great milestone to the village leadership. It proved to them a change in attitude and behavior. There were cases where dispensary officials were called to assist in home deliveries or deliveries on the way to the dispensary.

Meena Women group managed to participate in lobbying, together with the ward leadership, so that a private dispensary nearby entered into an agreement with the district government to conduct antenatal clinics for free (under Public Private Partnership) to the nearby community two times a week. Due to great response and awareness, as a result, mainly by the CBO

activities, the waiting lines are too long. The CBO and the ward leaders are now working to request an increase in the number of days that women could be attended for free.

Despite the good relationship the leaders complained of being left out of groups day to day planning, these leaders have their own proposals for prioritizing sexual and reproductive intervention activities. Most leaders felt that this education would have been much more profitable if it would have included school meetings, and provision of incentives to school children so that they decrease the element of temptation which is the single major cause of school pregnancies.

Table 8: Indicators After the end of the CBHI Funding in Kondoa and Dodoma Urban

INDICATORS AFTER THE FUNDING PERIOD	UMOJA NI NGUVU	MEENA WOMEN GROUP	UPENDO WOMEN GROUP	MT. AUGUSTI NO	MT. GABRIEL	WAKUNG A WA JADI	UHAI WOMEN GROUP
number of people reached	Have decreased	Have decreased	None	have decrease d	Have decreased	Have decreased	have decreased
number of public meetings organized by CBO	None	None	None	none	None	None	None
Time volunteered	Have remained the same	Have decreased	Have decreased	have decrease d	Have remained the same	Have decreased	have remained the same
Volunteers trained	None	None	None	none	None	None	have increased
Partnerships made	None	None	Yes	none	None	None	None
addition or change of objectives	Yes	Yes	None	yes	Yes	Yes	Yes
Personal benefits	Yes	Yes	Yes	yes	Yes	Yes	Yes
Availability and uptake of health services	Yes	challenging	n/a	yes	challengin g	Challengin g	Challenging

There was no CBO among the ones which were interviewed which considered schools to be a major intervention area. This indicated that participation of local health officials and government officials is of great importance.

Table 8 above shows how complicated it was for the CBO to continue to intervene without outside funding. Outreach after the end of CBHI funding greatly decreased as there were no public meetings and there were no longer incentives or handouts which were the major crowd pullers. In Upendo which intervened only by education supported with incentives, they were no longer able to recruit new girls since ending of the support period. The CBOs met people only in other meetings and they were given only a short address time. This is despite the fact that group members volunteered almost the same amount of time. Another major change was that very few times could the whole group appear at once in public as a health promoting group. Most of the times the groups split and took turn in health promotion activities.

Although the groups trained a lot of temporary volunteers during the support period, this could not continue without any sort of funding for motivation. Only Uhai group managed to attract three women to join in volunteering work, and this was by joining the core group.

As explained above the Upendo group managed to get some funding to assist in upkeep of their target group. The funds were received from the TASAF project. Other groups did not have collaboration with any outside groups. Some of groups however, were constantly being recommended by the community leaders or health officials to participate in other health intervention activities. E.g. the women groups of Wakunga wa Jadi and Uhai were being officially used by the village to assist in antenatal and children clinic days, immunization days,

as emergency birth attendants, or as Community Based Distributors of family planning advice and provisions (CBD).

4.4. THE SUCCESS AND SUSTAINABILITY OF THE INTERVENTIONS

Among other indicators, this study put weight on the following success indicators in order to gauge the effectiveness and appropriateness of these community-based interventions towards improving the health status of respective local communities.

Table 9: Selected Indicators on Effectiveness, Appropriateness and Relevance of CBO Interventions in Dodoma Urban and Kondoa Districts after CBHI Funding

SPECIFIC OBJECTIVES	UMOJA NI NGUVU	MEENA WOMEN GROUP	UPENDO WOMEN GROUP	MT. AUGUSTI NO	MT. GABRIEL	WAKUNGA WA JADI	UHAI WOMEN GROUP
Practicality of the intervention *(relevance and appropriateness)*	Strong	Strong	Outstanding	Strong	Strong	outstanding	Outstanding
Local practice and applicability *(appropriateness and relevance)*	Outstanding	Strong	Outstanding	Strong	Strong	outstanding	Outstanding
Use of more than one approach of intervention *(effectiveness)*	Strong	Strong	Strong	Strong	Strong	Strong	Strong
Continuity of the interventions *(effectiveness)*	Weak	Weak	Weak	Weak	Weak	Weak	Weak
Local partnership synergies, *(effectiveness)*	Outstanding	Strong	Weak	average	average	Strong	Strong
Meeting the objectives *(effectiveness)*	Strong	Strong	Outstanding	Strong	Strong	Strong	Strong

4.5. RELEVANCE AND APROPRIATENESS

All the groups had either strong or outstanding report on practicality and local applicability of the intervention approaches as reported by beneficiaries and local leaders (ref tab 9). CBOs used local inputs and relied on local information to plan for the interventions, all plays, songs and teaching material were locally prepared. All of the interventions managed to apply only available resources. CBOs scaled down the interventions or stopped some of the activities after the end of the funding.

Worth noting are the outstanding approaches from the Upendo women group which the selected few girls were followed up with constant counseling, and provided with necessities through out the year of support and beyond.

'……..they give us local examples and we know they are speaking the truth. For example the woman who nearly died. This girl was having her first baby and the old woman there looked at her once and told her not to let any other traditional birth attendant to touch her instead she should go straight to the hospital. ……..she had an operation and she delivered safely. But the doctors and nurses told her to thank the TBA who advised her to go to hospital. ...you know everybody, even the men trusts advise from the birth attendants, they are trusted old people……..' (Ben1, 28 yrs old, female, no education, married)

4.6. EFFECTIVENESS

Effectiveness as evaluated in this report: measures the extent to which the CBOs achieved their purpose or whether they can be expected to do so, on the basis of their outputs. In other words it is the CBOs' ability to have inputs and utilize them to yield required results. This study showed that all groups were more effective during the CBHI project funding than after it ended. Tables 6 and 7 show the change in the effectiveness of the interventions caused by the change in their ability to afford the expenses involved. The groups reported not being able to afford the cost of combining approaches soon after the funding completed. This decreased the effectiveness of the interventions. However, knowledge that combination of approaches was required for a more effective result was reported throughout. One respondent said that the project could not conduct interesting meeting anymore. *'……I have not heard of them calling one of their interesting meetings for a long time now, they are no longer seen in groups and performing, these days we just see their leaders in village meetings……'* (Ben3, 31 yrs old, female, no education, married)

CBOs' ability to continue with the magnitudes of outreach was greatly reduced as they could not come up with the money for them move to the remote place as they used to during funding period.

4.7. FACTORS PROMOTING THE SUCCESS OF CBO RUN S.R.H. PROMOTION PROJECTS IN DODOMA REGION

These were results from the questions; 'what do you consider to be the successes achieved by the CBO so far?' and 'What do you consider to be the challenges these CBO face?'

From the focus group discussions, observations and interviews, factors which were considered to be enablers or hinders of the CBO intervention or their success were identified.

Success Stories

Basically every stakeholder who participated in the research agreed the interventions were a success and should be continued in any way possible. Here are just a few comments

'……..these days things have changed. You can see a woman attending clinic and you can wonder where they are going, as the pregnancy is not even showing then. Only later on will you notice....They attend clinic throughout as they are being advised……' (ComL2, 45 yrs old, male, secondary education level, married)

'...we are sure that what they tell us is true, as we have seen women die when their husbands refuse to let them go to hospital as advised by these women.....'(Ben2, age 37yrs, female, primary education, married)

'.....during national immunization days we pass door to door, you can imagine as thirteen of us take three days to cover the whole village, nobody else can do it. We also follow up on

those who do not appear to know what their challenge was.....' (CBOM9, 45 yrs, female, primary education, married)

This was echoed by the village executive officer

'.....these women cover the whole village, door to door during immunization campaigns: turn out is incredible, more than 96%.....we give them only what we have and they are appreciative.....' (ComL6, 40 yrs old, male, secondary education level, married)

Echoed by a health representative, *'.....in areas where CBO are practicing, a difference in community response in health promotions can clearly be seen. These people are in touch with the real situation on the ground so it is easy for them to communicate.....'* (HRep3, 45 yrs old, male, tertiary education level, married)

1. The six out of seven groups which intervened by public meetings reported also success in attracting a lot of listeners to their public meetings, sometimes more than they could prepare for.

2. Upendo Women managed to train, provide for and counsel 26 girls from extremely poor families, making sure they went to school and vocational training, some of them have now opened up their own tailoring businesses.

3. All the group members considered the recognition given to them by the community members is a success resulting from their health promoting activities under CBHI. They reported to be called for advice and counseling in all health matters.

4. The group members also reported thriving on the improving relationship among the group members which enhances their motivation for volunteering work.

5. Six groups reported improved relationships with the local government officials as a success resulting from group activities.

6. Managed to see some immediate project results like closure of some brothels- reported by Meena Women Ward leader and Upendo Women Ward leader; start up of football team in the village- reported by Umoja ni Nguvu

7. All the groups reported success in keeping their financial and management records in an improved manner as a result of the CBHI trainings.

8. Although not sustainable, Upendo women were reported to have succeeded in opening up an office during the funding period. This was for counseling and it helped many young girls throughout the year, as reported by the ward chairman.

9. Meena Women managed to lobby, together with the local leaders so that a private clinic entered into a Public, Private, Partnership with the government to provide free ANC clinics to the ward.

10. All the groups succeeded in incorporating other health promoting activities in their lessons, i.e. Immunizations, environmental cleaning, toilet use, clean water, Community Health Fund, good nutrition, etc.

11. Group members managed to be called by village or wards to be involved in other health promoting activities which sometimes are income generating.

12. Uhai Women, Wakunga wa Jadi, Umoja ni Nguvu, Meena Women groups reported increase in hospital deliveries, decrease in home deliveries, increase in clinic attendance as a result of their activities.

13. Meena Women have seen other people who have benefited from their health promoting activities train and sensitize other community members, they consider it as a beginning of a chain reaction.

14. Meena Women also has reported benefiting from the education themselves. They themselves have changed their behavior especially in child spacing.

15. Upendo Women reported to have managed to secure funding from other sources to continue financing their activities. The rest of the groups have managed to start income-generating activities to finance some of their activities.

16. Two CBO members from Uhai Women reported that the little incentive given to them as food and transport allowance has helped them in providing for their families and improved family relationships.

17. All the group leaders reported that the training from CBHI has improved their capabilities as leaders. About 50% of the interviewed CBO members reported that they have more confidence.

Factors which were considered to be enablers of the CBO success as reported by all the stakeholders

1. The CBHI funding; reported unanimously by all the stakeholders interviewed that it covered the major costs involved in health promoting activities and enabled the CBO to begin more formal approaches of interventions.

2. The CBHI training; reported by all the CBO leaders and members that it enabled them to be more organized and increased their capacity to train others and to communicate the right message.

3. Collaboration with the local community leadership; reported by all the CBOs that it assisted in breaking through to the community and improved their relationship with the community members.

4. Effective leadership within the groups; was reported by the group members that it was the major holding factor for the group to remain active even after the funding ended

5. Hard work and volunteering spirit of time and resources from all the group members was mentioned by 7 out of 9 community leaders and also by all the CBO members and leaders.

6. Meena Women considered that the fact that the CBO's formal activities were established on a group which had other strong ties helped them in staying together even after CBHI funding ended and the intervention required self funding.

7. The fact that the group members managed to transcend the religious, age, educational and gender barriers in their activities was said to have impacted on the community perception of the message.

Challenges felt and observed by the stakeholders regarding the activities of the interviewed CBOs in Dodoma Region

These challenges were deeply felt only after the end of the CBHI funding and were reported by the CBO members, CBO leaders, the local leaders and health officials including the DMOs. The challenges were also considered as the main hindering factors from the CBO realizing more success and sustainability

a) Finances.

When CBHI contributed to finances of the groups, things moved faster and more efficiently. The funds provided were considered stimulation for the groups' interest in health promotion for behavioral change intervention. All groups said that the interventions requires a volunteering spirit, however, there were unavoidable costs involved like; food during day-long activities, transport, protective gear like umbrellas and boots during rainy season, stationery etc.

1. Lack of funds was reported by all groups as the major challenge especially after the cessation of the CBHI funding period. As a result the groups could not afford to prepare and conduct public addresses as they used to do during funding. As one beneficiary reported missing the performances of the local CBO *'.....I do not know what is happening to them these*

days, they do not perform as they used to do earlier. We miss them, It was easier for us to sit all day during our clinic days, nowadays when they tell us to stay some do not. They are never together to perform these days……..' (Ben2, 32 yrs old, female, primary education level, married)

2. Difficulty in continuing long term volunteering activities while neglecting family duties and income generating activities. As one DMO claimed that there is no such thing as total volunteering *'……..There is no such thing as complete volunteering, the people have to survive, it is very tricky to let your family die of hunger and go to save some other people you do not know, these people need some incentives, otherwise the whole thing will collapse very soon……'* (HRep8, age 32, male, University education, single)

'.....one time when I went to have a sensitization meeting, only leaders were present, the rest of the CBO members were not present. This was because there was no money involved that day. The volunteering spirit is very difficult to maintain if there is no incentive…….I could volunteer because I at least am sure of some income at the end of the month, this is not the case for everybody……..' (HRep8, age 32, male, University education, single)

3. Inability to secure funding from outside sources to maintain CBO interventional activities. Stated by one CBO leader, *'....we have not tried to ask for funds from another organization, but we hope that CBHI will consider us next time, or you can recommend us to someone, we do not know anybody else……'*(CBOL4, age 44 yrs, male, secondary education, married)

4. The funding was provided in too short a time to enable sustainability of the interventions. This was echoed by every stakeholder, to quote one who was amazed by how short one year was for a health intervention *'.....people were just beginning to know us, to trust us, and the year was over!!.....'* (CBOM4, age 32 years, female, primary education, married)

b) Knowledge and Capacity

1. Level of knowledge, or capacity to communicate, and to convince the target groups of the health messages. Reported by a health representative *'.....there is a large problem regarding knowledge and scope of the CBO members when delivering their education in public. Some groups which have higher educational level could be more creative, more convincing and also more knowledgeable. The formation of the group should take into consideration the target group when selecting a CBO to intervene ...You will see by yourself, they get a hard time convincing people of these health matters, ...the difference is clear between those with some education background and those who have a very low education, CBHI needs to look at that.....'* (HRep9, age 32, male, University education, single)

2. How to incorporate the whole or greater community in planning and implementation so that community participation is increased. As contributed by one community leader *'....I would wish that more of my community members would join this group as the work which is being done by these few women is so huge, what if others join in?.....I know their regulations are tough, not anyone can join the group, maybe they just teach others to organize other groups.....* (ComL4, age 55 yrs, male, primary education, widowed)

3. Supervision from CBHI was not enough also training from CBHI was regardless of the background of the individual CBOs and could be improved in quality. A health representative contributed the following *'.....training from CBHI was necessary, but there is a great need for the CBHI staff to be more close to these volunteers, when they need to know much more and need constant supervision.....'* (HRep1, age 35 yrs, male, college education, married)

'.....after the year ended, these women changed, they did not bring me the reports they used to do, they do not conduct meetings as they did before, I am not sure what is happening to them..... we still need them but they also need to meet and give each other feedback and plan their way ahead.....' (ComL4, age 55 yrs, male, primary education, widowed)

'.....I wish I was able to monitor them and advise them, I know they need me or people like us, leaders, but we do not have the capacity to assist and advise.....' (ComL6, age 50 yrs, male, primary education, married)

'.....we used to take problematic children to them and follow up with them at home, but I am not sure what is happening with them these days. I see the women, I do not know about the group.....' (ComL4, age 55 yrs, male, primary education, widowed)

c) Availability of nearby health services for uptake of health promotion activities

Meena, Wakunga wa Jadi and Uhai women groups: beneficiaries sighted the inaccessibility of nearby public dispensary to be the main hindrance for them to adhere to the education provided. The nearest hospital about 25km away has a maternity dormitory. Women were instructed to go there sometime before the due day. At the same time, the Wakunga wa Jadi

and Uhai and Meena groups managed to lobby for an ANC clinic to be held in their village twice a month. Records were kept with the village government and are very helpful as they remain locally accessible: many women prefer these outreach clinic services to those offered very long distances away.

d) Culture

Breaking the behavior patterns was reported not to be easily noticeable in one or two year's intervention. Sometimes culture was mentioned as a hindrance as women could not decide about their own bodies, as expressed in this statement from a CBO leader on women who understand their need for family planning, but culture does not allow them to make decisions *'……..she could not keep the pills at home, her husband checks every corner……..'* (CBOL2, 45 yrs old, female, secondary education level, married)

e) Illiteracy of some of the community members leading to inability to bother about health promoting activities. *'.....I understand that they tell us to wear new slippers to the hospital, that is all……..'* (Ben4, age 34, female, no education, married)

CHAPTER FIVE: DISCUSSIONS

This section discusses the findings, their significance and their contribution to literature on CBO activity on reproductive health promotion. It also discusses the limits of the methodology used and also tries to compare the findings with other studies. It can be noted that the scarcity of literature on this field is among the factors which necessitated a qualitative approach in order to find facts on CBO activities

Result of the study shows that most community members who participated in the study were women. But more significantly, 92% of the beneficiaries were women. This shows that women are most likely to be interested in reproductive health matters than males, and much more willing to enter into related discussions. (VanDevanter, 2005)

The fact that CBO members and the beneficiaries were all in the education range of secondary school and below, shows that the CBO initiatives are undertaken by the general population and did not require people to be more educated than the rest of the community, this could be the reason why it is easy for them to study and feel the community actual needs, merge into it and impart health knowledge. These CBO members shared the same emotional needs, interests and are committed to the community they are living in. (Gazian, 2000, Steuart, 1993)

The composition of the CBO members, having little difference from that of the community, could also be among factors leading to their inability to sustain themselves without outside assistance. Despite the fact that income was not among the indicators of the study, the inability of the CBO to fund their activities and to train themselves in reproductive health matters

indicate their meager resources. This is also supported by a study which argues that health promotion in grassroots requires outside force to assist in the CBO to be able to impart superior health education and promotion activities and also be able to afford the expenses of members to survive while not working their normal daily hours. (Assai, 2006)

The study showed that most CBOs stopped or minimized their health promotion activities after funding period ended also indicating that health promotion activities requires more than just determination and commitment. (Bell, 2007) It requires more time and proper planning and more resources than ones available in the communities. It is also worth noting that the areas where the study was conducted are areas where there is a minimal government health service and are considered to be hard to reach. It is not possible to expect the population which is considered to be isolated to come up with a complete health solution to fill the gap where the government has failed. (Douthwaite and Schultz, 2001)

Among the strengths of CBO activities is their ability to commit themselves to the cause. As CBOs are formed by community members, this quality unique and sets them apart from any other health promotion activity. CBO members showed an ability to sacrifice their meager resources including time. They worked long hours and long distances to facilitate the spread of their health message. This fact increased trust from their fellow community members perhaps the fact that CBO activity improved the CBO members status in the community contributed to their increasing willingness to volunteering.

Other enabling factors based on the interviewed and according to their own definition of success and failure, included: combination of different ways of providing health education

ability to demonstrate the desired behaviors, making sure that the core messages spread include all important aspects of the health problem and are comprehensible, availability of incentives and motivation to the group members and volunteers, good management and leadership and sufficient knowledge of the subject were seemed to be significant. However factors like commitment of CBO members in continuing with their health promotion activities, availability of incentives and motivation to the group members and volunteers, good management and leadership and sufficient knowledge of the subject of intervention were not a priority to the beneficiary in general, they were content with delivered information. In contrast the health personnel unanimously stressed upon the improved quality of information being taught to the community. This shows that although the general population could not see gaps in the content of the education material, it can be assumed that it lacked some useful information which the health personnel thought to be necessary. Participation of community members in planning and implementation of health promotion, good cooperation with community leaders were only stressed by the CBO members and community leaders. This can lead to the conclusion that the beneficiaries only need to see the output are not interested the preparation part of the programs. (Schmitz, 2008)

Observed challenges including illiteracy of the target group which hindered understanding of the message and its relevance to health or well- being, poverty, unavailability of health services and provisions including long distances and poor service, cultural factors, lack of funding for implementing health promotions, and the lack of interest of communities in issues which protect women are reasons which have been documented widely in other studies and are being used as a stepping stone for the government plans of improving reproductive health in

the country especially rural areas. (URT-MoHSWc, 2008) These challenges seem to require multisectoral collaboration approach to solve. When the challenges have been overcome, one can clearly see that improvement will not only be in reproductive health of the population, but also the general health and well being of the population. One shortcoming observed but not mentioned by any of the participants was the exclusion of community in planning for the interventions. (URTa, 2004) Other studies can go deeper into this issue to see whether there is a difference in results when the groups are being formed by the community for the single purpose of health promotion or are groups which were formed for other purposes and are used for health promotion the community. One suggestion made by a Village Executive was to include the CBO members in village health committees and so tapping on their commitment, volunteering spirit while being officially recognized in the village as official representatives of the population. This will enable them to participate in village health planning and other health promoting activities. In doing so the CBO members can also earl little income from the village budget and other donors who support the area also they will be able to participate in trainings and improve their knowledge in health matters.

Although the analysis of the perceptions of factors promoting or hindering success showed that all types of stakeholders (the health personnel, the CBO members/leaders, the beneficiaries/community members and the Local government officials) had the same responses, these groups emphasized different clusters of responses as being of particular importance: CBO members perceived factors related to the attitude as well as the disease-related knowledge of members as highly relevant, while the health personnel stressed the importance of soft skills regarding project implementation Community members and

beneficiaries stressed on the practicality of the delivered message. Government representatives highlighted that particularly resources and tools, as well as institutional aspects, e.g. frequent meetings, were factors promoting the success of CBOs. These clusters shows the difference in ideas which are thought to contribute to the effectiveness of the CBO. However, the most significant test of the CBO would be its perceived contribution to improved reproductive health of the community. The study having been undertaken very shortly after CBO begun their activities, the question can not be answered with confidence. This will require time and a larger research sample and a different methodology.

Government officials proved to be among the factors which contributed to sustaining the CBOs especially after the funding period. This could be because of maybe the need of the CBO to have an external overseer, ability of the government to expose the CBO members to extra training and paying for some health promotion activities replacing the CBHI and in demanding reports and action. This could also be caused by the fact that the government is the CBO's only link to other health projects in the area and can afford to pay little for health activities. For those CBO members who managed to forge a good relationship with the government official, activities did not go back to a standstill but changed direction to suit the demands of the village or ward. This set those CBOs apart from those which did not have a relationship with the government, stressing the point of the importance of intertwining the CBO activities to the villages or wards will be assisting in sustaining the CBO. Intertwining the government management system also proved fruitful in exposing the CBO members in other trainings too.

The CBO members being community members themselves and knowing reproductive health demands of the population were driven to solve them. They used models which could maybe not replicable in other areas but suited perfectly in their particular communities. (Gaziano, *et al.*, 2007, Barrio, 2000) The CBO members' decisions were not influenced by other outside force or by any other model seen anywhere else. The models of intervention used by each CBO being adjusted to suit their respective areas as seen perceived by the CBO members themselves is proof that they are appropriate. This is also a unique quality of CBO activity whereby all interventions conducted by the groups are bound to be appropriate, transcending any boundaries which might be a cause of failure to other health promotion activities imposed on the community and acted upon by foreign facilitators.

Change in effectiveness of the CBO activities and its effects is a clear indication that the community members however committed they might be, they can not afford to spare enough funds, time and other resources to be able to sustain fruitfulness of the interventions. (Douthwaite and Schultz, 2001) The fact that all the CBO groups still existed, can not prove that they can sustain health promotion activities to meet expectation, but are proof only those community members can stick together for longer times and can begin health promotion activities in full swing in any time resources are available. Most of the CBO can be considered to be dormant and are back to their original existence. Most of the CBO groups being social groups before funding from the CBHI returned to their social activities while participating in small scale heath promotion shows that they are committed to matters of health promotion and they just need support to conduct health promotion activities in the same scale as during the funding period

Lessons Learnt

The study managed to reveal that formal education, even up to secondary school on the part of the CBO members who are delivering the sensitization message was not as important as their trustworthiness. CBO members can choose among themselves members with a good reputation to be their spokesperson. This can make the community willing to change their attitudes and change.

It was also learnt that health promotion for behavior change in the grassroots levels needs external funding to sustain its activities. CBOs should not be expected to finance their activities and that it is much effective for health promotions in the grassroots to utilize the CBOs that have been established in a village or ward, by refresher courses than to involve new people every time.

Anther lesson was that collaboration between the government leadership and the CBO in the village/ward is important: it increases chance of acceptability, accountability of the CBOs and community participation even after the funding period ended.

CHAPTER SIX: CONCLUSSIONS AND RECOMENDATIONS

It is therefore being concluded that CBOs have potential to promote health and prevent disease, but many lack financial capabilities and high level of knowledge for planning and developing goals and objectives. They have low levels of skills. These deficiencies have been self acknowledged and call for more technical assistance to maximize Sexual and Reproductive illnesses prevention capacity.

The examination of the perceptions of the CBO core stakeholders- CBO members, the health officials, the DPCs, government representatives and the communities have led to a conclusion that all the seven CBOs have been successful in their own ways. All CBOs managed to achieve immediate outcomes. All CBOs managed to sustain their groups after cessation of the CBHI funding in different ways. This was achieved in different conducts including changing of objectives, changing of the implementation strategy or searching for other sources of funding. Change of behavior was mentioned by many groups as achieved by the group intervention, but due to the time limit they could not be completely attributed to the groups. There was however an indication of increase in utilization of health services which was directly linked to the groups' activities.

Concepts relating to best practices like sustainability, effectiveness and appropriateness were studied and it was learnt that they depended on factors which were either within the CBO themselves or related to the approach chosen to intervene. Other studies can go deeper into this issue to see whether there is a difference in results when the groups are being formed by

the community for the single purpose of health promotion or are groups which were formed for other purposes and are used for health promotion the community.

Although the analysis of the perceptions of factors promoting or hindering success showed that all types of stakeholders (the health personnel, the CBO members/leaders, the beneficiaries/community members and the Local government officials) had the same responses, these groups emphasized different clusters of responses as being of particular importance: CBO members perceived factors related to the attitude as well as the disease-related knowledge of members as highly relevant, while the health personnel stressed the importance of soft skills regarding project implementation Community members and beneficiaries stressed on the practicality of the delivered message. Government representatives highlighted that particularly resources and tools, as well as institutional aspects, e.g. frequent meetings, were factors promoting the success of CBOs.

This study leaves the following questions to be answered by further researches:

1. How volunteers can be motivated, or given incentives in order not to loose interest in implementing long-lasting health interventions.

2. How the government can directly be involved in health promoting CBOs.

3. How the whole community can be involved in planning for the health intervention and still have a committed group of CBO leaders for the implementation.

4. How can the CBO reach more of the target groups.

5. What is the right amount of money to be given for interventions? What is the right timing, the right CBO membership combination.

6. Are there benefits in cooperation between CBOs and NGOs during implementation.

7. How can the technical capacity of the CBO be improved while maintaining the low cost of implementation?

This study would like to recommend the following:

1) The government through its ministry of health should take active part in supporting and supervising CBOs before, during and after the funding.

2) The awareness of stakeholders of all types of factors with the potential to promote the success of CBO-run health promotion projects should be raised. After the agreement has been reached, a document declaring an understanding of the modes of operation of the CBO on behalf of the community might be signed.

3) An exchange or consultation among stakeholders including community leaders and members in the initial planning phase on both views of success and factors relevant for success could help to focus and streamline the efforts of all stakeholders.

4) On the part of CBHI Project there should be some arrangement of visiting and continuous supervision of all CBOs including scheduled visits to CBOs which are not in the current funding period.

5) The period of funding should be increased to enable the group to establish trust and support in the community so as to increase accountability of CBO members.

REFERENCES

Assai M, Siddiqi S and Watts S, (2006), **Tackling social determinants of health though Community based health initiatives.** British Medical Journal: 333: 854-856

Barrio C, (2000), **The Cultural Relevance of Community Support Programs**, Journal of American Psychiatric Association, Psychiatry Service: 51: 879-884

Bell SG, Newcomer SF, Bachrach C, Borawski E, Jemmott JL, Morrison D,Stanton B, Tortolero S. and Zimmerman R., (2007), **Challenges in Replicating Interventions**, Journal of Adolescent Health: 40(6): 514–520

Bobbitt-Cookie, M., (2005), **Energizing Community Health Improvement: The Promise of Microgrants**, Preventing Chronic diseases Vol: 2; http://www.cdc.gov/pdc/issues/2005/nov/05_0064.htm

Bogdan, R. C. and Biklen, S. K., (1982), **Qualitative research for education: An introduction to theory and methods**. Boston: Allyn and Bacon, Inc.

Burke, R.J. and Onuwegbuzle, A.J. (2004), **Mixed Methods Research: A research Paradigm**Burke RJ and Onuwegbuzle AJ (2004), **Mixed Methods Research: A research Paradigm whose time has come,** https://www.aera.net/uploadedFiles/Journals_and_Publications/Journals/Educational_Researcher/Volume_33_No_7/03ERv33n7_Johnson.pdf

DHS (2007), **Female Circumcision** http://www.measuredhs.com/topics/gender/FGC-CD/pdfs/Tanzania1996chapter.pdf (accessed on 15/5/2009)

Douthwaite B. and Schultz S. (2001), **Spanning the Attribution Gap: The Use of Program Theory to Link Project Outcomes to Ultimate Goals in INRM and IPM**. Paper for presentation at the INRM Workshop 2001, California, Colombia.

Economic and Social Commission for Asia and the Pacific (2003), **Handbook on Reproductive Health Indicators**, United Nations.

Evaplan (2005), **Assessment and Planning of Community Based Health Initiative Project-Dodoma Region**, Hans-Bunte Sts. 8-1,Heidelberg University

Field, A. (2004), **Research Methods and Statistics**. In G. Davey (Ed.), Complete Psychology (pp. 636-71

Gaziano AT, Galea G. and Reddy KS. (2007), **Scaling up interventions for chronic disease prevention: the evidence**, The Lancet: 370, (9603): 1939-1946

German Embassy Dar es salaam, (2006), Tanzania-German Development Cooperation; http://en-tanzanian-german-cooperation.pdf

Gillam S., (2008), **Is the declaration of Alma Ata still relevant to Primary health care?** J British Medical Journal: 336: 536-538

GTZ (1998), **Community Health Communication: Guidelines through the Maze of IEC Methods**, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, CBS-Project, Eschborn

Haddad L., (1999), **Women's Status: Levels, Determinants, Consequences for Malnutrition, Interventions, and policy, Asian Development review**, Asian Development Bank, (Vol 17): 96-131

Kitzinger J. (1995), **Qualitative Research: Introducing focus groups**, British Medical Journal: 311:299-302

Koepsell, T.D., Wagner, E.H., Cheadle, A.C., Patrick, D.L., Martin, D.C., Dier, P.H. and Perrin, E.B., (1992), **Selected methodological issues in evaluating community-based health promotion and disease prevention programmes**, Journal of Ann. Rev. Publ. Health: 13: 31-57

LaFond, A.K., (1995), **Improving the Quality of Investigating in Health: Lessons on sustainability**, Health Policy and Planning, 10 (Supplement), 63-76

Mansuri G., Rao V., (2004), **Community-Based and -Driven Development: A Critical Review.** The World Bank Research Observer, vol. 19, no. 1 (2004)

Marek, L.I. and Mancini, J.A. (undated), **Sustaining Programs and Supporting Families: A training program for human services professionals**, Family and Community Research Laboratory, (540)231-6306

Scheirer M. A., (2005), **Is Sustainability Possible? A Review and Commentary on Empirical Studies of Program Sustainability**; American Journal of Evaluation, Vol. 26, No. 3, 320-347

Schmitz K. (2008), **Factors promoting the success of community-based projects in HIV/AIDS and malaria prevention Best practices gained in the "Community Based Health Initiatives" Project in Tanzania**, Thesis for MSc. in International Health, University of Heidelberg, Department of Tropical Hygiene and Public Health

Seifer, S.D., (2006), **Building and Sustaining Community-Institutional Partnerships for Prevention Research**, Findings from a National Collaborative, Journal of Urban Health: Bulletin of the New York Academy of Medicine: 10 (1007): 11524-9113

Sobo E.J., Simmes, D.R., Landsverk, J.A., Kurtin, P.S., (2003), **Rapid Assessment with Qualitative Telephone Interviews: Lessons from an Evaluation of California's Healthy Families Program & Medi-Cal for Children**, American Journal of Evaluation ; 24; 399

Shediac-Rizkallah, M. C. & Bone, L. R. (1998). **Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy.** Health Education Research, 13, 87-108

Steuart G.W., (1993), **Social and cultural perspectives: community intervention and Mental Health,** Health Education Q:20(1):99-111

Swerissen, H., Crisp B. R., 2004, **The Sustainability of Health Promotion Interventions for Different Levels of Social Organization**, Health Promotion International,Vol. 19, No. 1, 123-130

UNFPA, (2004), **Population and Reproductive Health Indicators**, http:/lao.unfpa.org/defcon.htm#indicators, accessed on 23/3/2009.

United Republic of Tanzania (2004), **2002 Population and Housing Census, Central Census Office,** National Bureau of Statistics.

United Republic of Tanzania a, (2004), **Poverty Reduction Strategy: The Third Progress Report 2002/03**, http://poverty2.forumone.com/files/Tanzania_PRSP_APR.pdf

United Republic of Tanzania-National Bureau of Statistics b, (2005), **2004 Tanzania Demographic and Health Survey**, ORC Macro Calverton, Maryland, USA

United Republic of Tanzania-Ministry of Health and Social Welfare c, (2008), **The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015**, Reproductive Health Section

WHO (1978), **Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR**, 6-12 September 1978, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf , accessed on 14th April 2009

World Bank (2002), **Beneficiary Assessment: An Approach Described: Social Assessment Series**, Paper No. 023 update, Social Development, The World Bank, 1818 H Street, N.W.