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CASE STUDY

Conservation and family planning in Tanzania: the TACARE experience

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Abstract Community-based distribution (CBD) programs present an alternative way of effectively reaching people in rural areas of developing countries where conventional methods of delivery do not exist or fail. This paper reviews the experience and findings from the Jane Goodall Institute's (JGI) TACARE program in the Kigoma region of Tanzania. It focuses on the family planning CBD program and its integration within the TACARE program to meet the broader mission of JGI's conservation efforts. Both qualitative and survey data suggest that the CBD program meets the needs for contraception in participating rural communities and is a complementary and acceptable strategy to ultimately contribute to reduce population pressure on the villages around Gombe National Park.

Keywords Family planning · Community-based distribution (CBD) · Population · Environment

Introduction

As the project manager of TACARE (Lake Tanganyika Catchment Reforestation and Education Project) I have witnessed first hand the impact of a holistic and grassroots approach to family planning. TACARE has worked in family planning for nearly a decade, during which time there have been both successes and learning experiences. The following is an account of a brief history of TACARE, how family

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planning came to be an inherent aspect of our conservation work, and some preliminary results of our activities in the area of Reproductive Health.

History of the organization

TACARE is a project of the Jane Goodall Institute. Founded in 1994 with financial support from the European Union, it works with communities surrounding the Gombe National Park in Western Tanzania. Our mission is to improve community livelihood through the improvement of natural resource management—especially the remaining indigenous forests. In the 40 years since Dr. Goodall began her study of chimpanzees, most of the indigenous forest outside the Gombe Park has been cut down or seriously degraded. Small patches of land within the forest were cultivated to supply human community with cassava, the staple food, and some oil palms. Gradually, the farm sizes and numbers increased as the local population grew. The rapid increase in population density—exacerbated by the influx of refugees from the Democratic Republic of Congo and Burundi—and increasing demand for natural resources has put substantial stress on the area. In 1990 the forests were disappearing at a rate of 1% per year, more than twice the national rate (Kigoma remote sensing survey, 1990). People had to cultivate on the river banks and steep slopes and land productivity decreased tremendously. Some water streams that used to flow permanently in the area have become seasonal or disappeared completely. Historically, the Kigoma Rural District surrounding the park has had one of the highest population growth rates in the country and in 2005 it was the highest at 4.8% annually, compared to a national level of 2.9% (The United Republic of Tanzania population and housing censuses, 1988 and 2002; NBS & ORC Macro, 2005). It follows that the total fertility rate (TFR) in Kigoma was also the highest in the country, estimated at 7.4 children on average (NBS & ORC Macro, 2005).

Family planning is seen as an extension of the TACARE mission as it reduces the pressure on the environment while addressing an unmet need of the communities in which we work. However, family planning activities were not always included in TACARE's work. The project's initial interventions were tree planting and the improvement of food security through better agricultural production. As the work proceeded however, other community needs began to emerge. As TACARE staff repeatedly visited villages, held meetings, talked to individuals and exchanged ideas, they came to better understand the important over-arching needs within the communities of Kigoma. By far the most important needs included concerns over health, poor water, and sanitation. TACARE staff observed a high demand for family planning methods—particularly in the remote rural villages. It became clear that sustainable land use practices and conservation would only be achieved by addressing the immediate concerns of these impoverished communities—concerns that appeared to be rooted in large part to the problem of large families. TACARE introduced a Health Program to better meet these needs and in 1997, with assistance from the David and Lucille Packard Foundation, TACARE expanded their health services to include family planning. Today TACARE has five main service areas: community development, including micro-credit program, village construction

projects and scholarship for girls; Health; Forestry; Agriculture; and Roots and Shoots, the youth program of the Jane Goodall Institute.

Incorporating family planning

Traditional beliefs

Family planning is not a new phenomenon in Tanzania; our ancestors used various traditional methods to space children. In Kigoma District traditional methods that are recorded include wearing the ''hirizi'' (a small stick from a special tree that is tied to a chain and is to be worn all the time around the waist) provided by traditional healers. Upon weaning their child, women then take off the ''hirizi'' and conceive. Some women drink herbal medications that purportedly prevent them from conceiving. These women say that their main motivation to do so is that if they are breast-feeding and conceive another child, the breast-feeding child will die.

Community-based distribution

Modern family planning methods have been available in the country since before the 1970s. Government hospitals and health centers offered family planning, however discussions of contraceptive methods were limited to women during pre- and post-natal appointments. Only people living in towns or close to the health centers had access to family planning education and contraceptive methods. Furthermore, service quality was variable and depended upon the training of those staffing the health center. In 1996, just prior to when TACARE began its work in reproductive health, approximately one in four married women in Tanzania had an unmet need for family planning, for either limiting or spacing the number of births. While nearly 90% knew of at least one form of modern contraceptives, only 18% of married women were using a modern method (Bureau of statistics & Macro international, 1997). Kigoma Rural District was no exception. While 86.4% of women and 94.7% of men reported knowledge of at least one form of modern contraceptives, only 10% of married women used a modern method (Bureau of statistics & Macro international, 1997). It appeared to TACARE staff that only a fraction of the community who had heard of family planning used a method.

In 1993, with financial support from key national donor agencies (USAID, GTZ, UNFPA, and DFID) the Tanzanian government launched a National Family Planning Program to improve access to family planning methods using community-based distribution. However, due to limited resources, the program could not start in all regions concurrently. The Kigoma region was not scheduled to start until 2005, however TACARE successfully petitioned the Kigoma district government to initiate the program earlier than planned.

In 1999, in conjunction with public health officials, TACARE initiated a program for family planning education and community-based distribution (CBD) of contraceptives. During that time the Maweni regional hospital, two other health centers (Bitale and Mwamgongo) and 9 out of 13 dispensaries were the only

facilities that offered family planning services. However, family planning services were not accessible to those living in remote areas. It was not uncommon for some people in the area to travel to up to 120 km by boat to reach a health center and about 40 km to a dispensary that offered family planning services.

The CBD model of service delivery was deemed appropriate for this rural area because it would bring counseling and commodities directly to the doorsteps of potential beneficiaries. Capitalizing on their existing relationships from their agro-forestry and community development efforts in the villages, TACARE staff trained 157 local people to counsel and provide non-clinical contraceptive methods to those in need. These community-based distributors travel from house to house talking to groups of people and individuals regarding family planning methods and their availability. CBDs also discuss sexually transmitted disease prevention and symptoms and provide assistance in accessing health services. If the beneficiary decides to take non-clinical contraceptive methods like pills or condoms, the CBD provides them immediately, free of charge. If they elect a clinical method like Norplant, vasectomy or tubal ligation, the CBD refers the client to a health center.

CBDs are selected among the community by a local supervisor. Supervisors are selected by the District Medical Officer, TACARE staff and village leaders. They are typically health care workers from the local village dispensary or health center. In a given village, half of the CBDs are required to be women and all must be literate. CBD work is based purely on volunteerism. Currently, they do not receive any payment from clients nor from the implementing project. While these men and women work without pay, they do gain prestige in the community and the right to house and dispense reproductive health commodities from their home. Only during the two-week CBD trainings held in the town of Kigoma, are their expenses paid. Otherwise the only other direct benefit CBDs receive is an umbrella, flashlight, bag and notebook and the opportunity to attend meetings with TACARE staff and CBD supervisors. In 2000, TACARE implemented a field monitoring system requiring CBDs to report the number of clients visited and track the number of commodities dispensed in a given village. While all contraceptives donated by USAID have historically been provided for free to villagers, there is discussion of allowing CBDs to charge a nominal fee and pocket a small profit in order to add motivation to the distribution process.

Early program efforts

I have vivid memories of our early efforts in family planning. When the project staff went to a village to introduce family planning services, there was no formal or official information as to how many were already receiving these services from the dispensaries or health center. When we conducted meetings in various villages, some people were hesitant, others angry (Box 1), but women especially expressed enthusiasm for a means to control their fertility. Following several meetings, some women followed our staff and told them that they never knew such services were available at the dispensary and that their traditional methods were failing. This lack of knowledge was possibly because family planning services at dispensaries were

limited to women attending Mother and Child Health clinic services. Furthermore, reproductive issues often are considered secret among local people. There were no educational outreach programs that catered to women who did not visit the clinic but relied instead on traditional birth attendants and other community members .

Box 1

Why didn't you come earlier?

''Where were you since all the ages? You have waited until things have gone worse and now you came with your intervention. What will I do with the 23 children I already have? Life is so difficult now. Children need to go to school, eat, get clothing and be healthy. I used catch enough fish with my fishing boat and my wives could produce enough cassava to feed our children. Now a days we don't get enough neither from fishing nor from the farms''

–Male, 63 years old, July 1999, Mwamgongo Village

Despite the apparent demand for family planning services, traditional, religious and cultural beliefs presented obstacles. Traditionally people prefer large families because of the prestige they convey and the practicality of more people to work the farms and fishing. It was commonly felt that having many children guarantees future support for parents during their old age. Reproductive issues are considered women's issue so men would prefer not to hear any advice about it. In this case family planning appeared to contradict community beliefs.

Additionally, misconceptions regarding the use of the modern family planning methods impaired the initial efforts made by the CBDs. For instance, it was not uncommon for villagers to believe that modern contraceptives caused cancer, that children born by mothers who use them would be handicapped and infertile, or that tubal ligation would cause impotence in men. CBDs also faced mistrust and opposition from villagers. For instance, a pervasive belief was that family planning was a tool of ''the white men'' to eliminate Africans. To assuage these difficulties and to gain entry into a community, TACARE staff began to approach religious and female leaders first. Subsequently a village-wide ''sensitization'' meeting was held to discuss facts about fertility and contraception. Given these efforts, CBDs are currently active in 26 of the 74 villages in Kigoma Rural District, representing a population of approximately 147,000 people–approximately two-thirds of whom are of reproductive age (15–49). To date, CBDs have served 3,789 men and women, many of whom are repeat clients.

Family planning survey results

In 2005 TACARE staff began monitoring family planning knowledge, attitudes and practices among men and women of reproductive age. Staff successfully surveyed 210 households in 22 villages. In a draft survey report conducted recently, we have observed that modern family planning methods user rates have now reached 45% in TACARE villages in 2006—a level never previously recorded in Kigoma Rural

District (Kigoma district social services profile, 2006). Among clients of CBD services (n = 60), the user rate was an impressive 93% for any modern method. Additionally, our survey results show that 79% of those surveyed know of the CBDs and slightly fewer (65%) had heard them give a talk about family planning. Among those who had heard a CBD discuss family planning, nearly all heard them in their home (98%), while approximately half (51%) had also heard CBDs speak in public markets and a third (29%) in health facilities. Nine out of ten people surveyed knew at least one modern method of family planning, the most commonly cited methods being the pill (88%), injectables (78%) and condoms (58%). Few reported knowledge of permanent methods. Not surprisingly, the primary source of family planning information for CBD clients were the CBDs, however for non-clients (n = 150) the majority (60%) received their family planning information from local dispensaries. Among the 84 women surveyed who did not use family planning, the most commonly cited reasons were fear (18%) and family's disapproval (15%). Other reasons cited were a desire to have more children and that they were currently pregnant or lactating. For male non-users (n = 34) the most commonly cited reason was a desire for more children.

Conclusions

While knowledge of family planning methods is reported to be nearly universal throughout Tanzania today, significant disparities exist between urban and poor populations in access to services. Not surprisingly, the 2005 Demographic and Health Survey for Tanzania, reports the unmet need for family planning is highest among women in Kigoma Rural District (as well as Zanzibar and Shinyanga regions). Despite gains in the villages we serve—most notably our increased contraceptive-user rates, TACARE has more work to be done. Ninety-two percent of individuals surveyed reported intent to use modern contraceptives in the future—what is unclear is whether we will have the capacity to meet that demand. The ideal ratio of CBD to households is 1:100 but the current staffing level is about 1:376.

The family planning program run by TACARE has been significantly cut back for lack of adequate funding. Salaries for CBDs or training more CBDs would allow the program to expand, however both require additional stable funding. Currently USAID funding for family planning efforts is only secure through the next 5 years and can only maintain the current level of activities. Yet we have identified key areas for future efforts, specifically in the involvement of men, maximization of CBD household visits, expansion of CBD services to other villages, inclusion of HIV information, and collaboration with local dispensaries—key venues for commodities, information and education for villagers. For conservation efforts to work, population issues must receive equal attention otherwise the demand for natural resources will grow unchecked. Our hope is, despite the fragility of today's funding environment, we will have the means to continue our valued work (Box 2). TACARE's environmental successes are a product of its innovative, community-centered approach to conservation. Indeed, if the Gombe chimpanzees are to

survive, both sustainable conservation practices and our community wellness projects—including family planning must be promoted together .

Box 2

Finally I am living again

''After I got married, I never rested. Every year of my life I had either a young baby to take care of or pregnancy to be sick from, until I had 6 children. I could not work properly in the farm nor could I do small economic business to get income for my family. There was no time to involve myself in social gatherings. With an increasing number of children I could never satisfy even basic needs of my family. I was not happy with the ways of life but also didn't know what to do about it.

When I received the information about family planning methods from a CBD I was so glad and went right away to use them. Although my husband did not want me to because he has heard that they cause cancer I took them anyway and was hiding from him. I have to confess that they have helped me regain my life.

I have been using family planning methods for almost 10 years with no problems at all. Now I have joined a micro credit group where I got a loan to start a fish smoking business. I can cultivate bigger farms now and am getting enough food and money to buy clothes, school items and medical bills for my children. I am healthier and happier than ever before. Finally I am living again.''

–Female, 40 years old, September 2003, Bugamba Village

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