CHASE Africa- Breaking the Cycle of Poverty

"The evidence is clear – when you invest in women and girls, the good deed never ends. Barriers are broken and opportunities open up that not only lift women out of poverty but can elevate society and bring about economic gains. No other single change can do more to improve the state of the world."

Beth Schlachter, Executive Director of FP2020

Try to imagine what it would be like to bring up five children on a couple of dollars a day. What is more, you are pregnant with your sixth, and soon your already meagre resources will be spread even more thinly. Try to imagine being Peninah Bahati Kitsao, whose story recently caught the world's attention when it was aired on the BBC. She sat cooking stones in a saucepan, hoping her eight children would fall asleep as they waited for a meal. It was women like this, struggling to give their children a better life, that brought CHASE Africa into existence. However, CHASE Africa's story doesn't start here. It would be a few years before I came to realise that the simple act of meeting the unmet need for family planning could have such a profound impact.

The story starts 20 years ago with the Rift Valley Tree Trust (RVTT), an organisation I set up to try and protect the Mau, an indigenous forest that was disappearing at an alarming rate. We became involved in many small-scale tree planting projects, and the provision of fuel-efficient stoves which reduced the consumption of firewood coming from the forest.

A long 5 miles home with firewood to cook the family's meals

Being engaged in these projects meant I was invited into people's homes and began to learn the rhythms of their lives. Most of the women I met had five or more children. Their days were busy from dawn to dusk; carrying water, collecting firewood from greater and greater distances, and looking after the children and the home. I learnt that many of these women, if they'd had the chance, would have chosen to have fewer children, but they never had the opportunity to learn about the different methods of family planning, and even those who had, had no way to access them. I admired the determination of these women to try and provide a better life for their children and to give them the chance of going to secondary school, an opportunity most had never had because of the cost.

I was also horrified to learn that many women finding themselves unintentionally pregnant, faced the agonising reality of bringing another child into the world while already struggling to provide for existing children, or, making the equally difficult choice to pursue an illegal abortion. These often have devastating consequences. Currently, it is estimated that 450,000 such abortions are carried out each year in Kenya, with approximately 120,000 leading to serious medical complications and sometimes death(1). Large numbers of women were clearly desperate to escape the continual cycle of unintended pregnancy.

Some initial research confirmed what I had learnt in the field. In the four decades leading up to 2012 the population of Kenya had nearly quadrupled from 12m to 44m, as mortality rates declined and birth rates remained high (2). One in four women of childbearing age had no access to family planning and this was higher amongst poor, rural women (3). A report from the Population Reference Bureau estimated that almost half of women had indicated that their most recent birth was an unplanned pregnancy. Seeing the Mau forest disappear, it was clear that there was a direct link between a lack of access to family planning and growing pressure on natural habitats.

The picture had become very clear, and the answer was very simple. If we were to be serious about trying to improve the quality of life of these communities, and stand a real chance of protecting forest and wildlife habitats in perpetuity, we needed to give women the chance to choose how many children they would want to have.

In 2012 I was introduced to a Kenyan based NGO called Communities Health Africa Trust (CHAT) which had also been set up in 2000. CHAT has adopted a Population, Health and Environment (PHE) approach to human development, which recognises the interconnectedness of people and their environment. The PHE approach has been proven to deliver better outcomes for human welfare and conservation efforts (4). CHAT clearly understood the consequences of the lack of access to health care and family planning, and were focusing their efforts on areas where people and nature co-existed within fragile ecosystems. With a growing population and the added effects of climate change, these fragile ecosystems were becoming increasingly degraded, deepening the cycle of poverty. CHAT operated a series of mobile clinics which allowed them access to Kenya's isolated rural locations. Even under the challenging conditions, they provided a number of services, including childhood immunisations, family planning and testing and counselling for HIV.

We realised that we needed to change the name of the Rift Valley Tree Trust as our focus shifted to encompass both the health of people, and the environments they live in. Community Health and Sustainable Environment encapsulated the essence of what we wanted to do, and so CHASE Africa came into being.

We were very fortunate that Henry Pomeroy resigned from his job at Send A Cow, and as a Trustee of the RVTT to become the organisation's Director. With his extensive experience working for international NGOs, he has positioned CHASE as an organisation punching well above its weight.

Ever realistic, CHASE played to its strengths in the early days, and focussed on fundraising for the critical work that CHAT was doing in Kenya.

We chose to support their projects in the counties of Laikipia and Samburu where the people have traditionally lived a semi-nomadic pastoralist lifestyle and come from a number of ethnic groups, including the Samburu, Pokot and Boran. This region experiences frequent droughts, and has very limited healthcare services.

Traditionally, cattle and goats are seen as a sign of wealth and with increasing numbers of people this swelled the number of livestock. With finite grasslands, overgrazing is leading to increasingly depleted natural resources, which has led to violent conflict over grazing rights.

CHAT moved the mobile clinic from community to community using a trusted Land Rover, and in the most challenging terrain, the clinic was moved on a string of camels. By providing these free primary healthcare services, CHAT gained the trust and respect of these far-flung communities and gave them the opportunity to discuss the benefits of family planning.

A CHAT mobile clinic on the move

Working within a patriarchal society, many of the women CHAT met required the permission of their husbands to use contraception. Polygamy is common, as are myths and misconceptions around family planning which can be big barriers in the uptake of contraception. Many men feared their wives would become barren if they started using contraception. This was a big concern for them, as having many children was a sign of wealth, and it was the norm to have enough children for the father to name them after all his uncles and aunts. Some men were concerned that contraception would make their wives promiscuous.

A key component of CHAT's work is the role of community health volunteers (CHVs). Like in many sub-Saharan African countries, CHVs are found in many communities in Kenya. They are elected by their own community and support the work of the Ministry of Health (MoH). They are tasked with

improving the community's health and well-being and are responsible, for example, for making sure that mothers get their children immunised when the MoH puts on a vaccination drive. From their unique position, CHVs have the ability to change attitudes within communities, helping to break down the myths and misconceptions that abound around things such as contraception. These invaluable members of the community are seen by the MoH as volunteers and as such do not receive any payment. Many NGOs recognise that CHVs are key players in delivering their projects and are happy to pay a wage or allowance for the help they give in promoting community health, as CHAT does.

Unusually, CHAT had also trained its CHVs to discuss the issues which are causing so much environmental degradation: overgrazing, deforestation, reduced water flow and how large families and increasing numbers of households are putting pressure on natural resources.

When natural resources are scarce and the prospects for education and employment are poor, an increasing number of men are becoming aware of the benefits of having fewer children to support. It is very encouraging to see how attitudes are changing and how more men are allowing their wives to use a modern method of contraception.

While working with CHAT we have clearly seen how family planning could improve health and wealth, with a better long-term outcome for the environment.

Our challenge was how we could give many more women in Kenya the life changing benefits of family planning, and in 2013 we began to look for an organisation who would benefit from starting a community health project.

We were introduced to Mount Kenya Trust (MKT) who were established in 1999 to try and help protect Mount Kenya National Park and the reserve that surrounds it. Mount Kenya is an extinct ancient volcano and is Africa's second highest mountain. To local people Mount Kenya is sacred as they believe that this is God's earthly home, and many build their houses with the doors facing towards the mountain.

Jomo Kenyatta, Kenya's first president, described the importance of the mountain to the local communities, saying that it "supplies their material needs and enables them to perform their magic and traditional ceremonies in undisturbed serenity".

In 1949 when the Mount Kenya National Park was created, the population of Kenya was six million. When MKT started working in 1999 the population had grown to 31 million (2). The evidence of the damage a growing population was having on Mount Kenya's natural environment was becoming increasingly obvious. Farms grew in quantity, and reduced in size, as they crept up the mountain's slopes. Cooking in Kenya, especially in rural areas, is fuelled by wood or charcoal. The well-forested slopes of Mount Kenya, some of Kenya's last remaining indigenous forests, were being targeted as a source of wood. Livestock are part and parcel of rural life, but with limited grazing outside the park more farmers were taking their livestock to graze within the park's boundaries.

As the forest cover reduced, many of the streams and rivers flowing off the mountain were becoming increasingly seasonal, causing great problems for the local communities who relied on them as their water supply. The mountain is also a vital water tower for Kenya's capital city Nairobi. This problem was intensified by disappearing glaciers on Mount Kenya. At the turn of the 20th century there were 18 glaciers, today only 11 remain and in recent decades, the rate of recession has accelerated. This was not a problem caused by local people, but by climate change principally driven by carbon dioxide emissions thousands of miles away, directly affecting the amount of water flowing off the mountain.

With a fragmenting landscape around Mount Kenya, wildlife was losing much of its habitat. The National Park should be a safe refuge for wildlife, but poaching was a growing issue MKT was trying to tackle, and incidents of human/wildlife conflict were increasing. Tourism contributes up to 14% of Kenya's GDP (5). Protecting wildlife is key to protecting this vital source of revenue.

MKT realised quickly that if their conservation projects were to be successful and, more to the point, enduring, they needed to engage the local communities. They started to work with local communities to reforest parts of the mountain that had been illegally felled, and to do this they needed tens of thousands of tree saplings. What better way than to use local women's groups to grow these trees? MKT then bought these trees from the women, stimulating the local economy. When CHASE approached MKT in 2013 with the idea of starting a Community Health Project (CHP), they could see the benefits this would bring to the women's groups they were working with, as being close to the forest boundary they were a long way from any medical facility.

How do you start to build a community heath project? It seemed sensible to learn from an organisation who was already doing this, so we arranged for two MKT staff to visit our existing partner CHAT. The next step was to arrange a meeting with the county Ministry of Health. The Chief Medical Officer in Meru County was very supportive of the idea, and a Memorandum of Understanding was agreed. Work began to plan a three-month trial project.

Four CHVs were identified and given training which focussed primarily on the far-reaching benefits of family planning, the allaying of misconceptions and detailed explanations of how the different contraceptives work. When a woman can decide the number and spacing of her children she has more time between pregnancies to give her body time to recover, and to satisfactorily breastfeed the current baby. She will have more opportunity to work either growing food or earning an income which will contribute to better nutrition and health of her family. As household income increases, families can afford to educate their children. The education of boys is often prioritised when funds are short, so an increased income will give daughters more of a chance of going to school. Research published in 2017 showed that a woman in Kenya who had no education had on average 7.4 children, whereas a woman who had completed secondary and went onto tertiary education had 2.5 (6).

The CHVs were paid an allowance and given a smart, printed T-shirt, clearly stating the point that they were CHVs working for MKT, the Ministry of Health and CHASE Africa.

CHVs are permitted by the MoH to distribute the contraceptive pill and condoms, but other types of contraception have to be provided by people with the correct medical training. To give the women's groups they were working with the option of long-term types of contraception, MKT would need to bring a medically staffed clinic to those communities. MKT's main role was to organise the logistics for putting on a mobile clinic while the medical aspects would be attended to by medical staff, hired on a locum basis from the local MoH. Before the clinic's arrival the CHVs needed to meet and talk with as many women as possible. They also distributed posters advertising the forthcoming clinic. The first mobile clinic set out on the 24th July 2014. Compared to the number of women attending a CHAT clinic the numbers were modest. 15 women chose the pill and 21 women chose to have the 3-month Depo-Provera injection. Interestingly, although it was available, no one chose a long acting contraceptive implant.

From a small beginning, MKT's community health project has grown into a much-valued service used by a growing number of people. During the four clinics put on in December 2015, 408 women chose to take the pill, 202 the three-month Depo-Provera injection, and 369 women decided to use the 3 or 5 year contraceptive implant.

It is important that a mobile clinic returns to the same location every three months, for at least a year, especially for the women who choose the three-monthly contraceptive injection, but running mobile clinics is expensive and not something that can be sustained on a long-term basis.

Government medical facilities are meant to offer free family planning, but are usually poorly attended. There are multiple reasons for this. In 2010 the national health system was decentralised, moving healthcare decision-making and delivery to the county level. National stocks of contraceptives are held by the Kenya Medical Supply Agency (KEMSA) in Nairobi. If a county owes money to KEMSA it will not release any further supplies, which is why, although FP commodities should be freely available at a county level and paid for from the county health budget, our partners regularly have to buy FP supplies. The government's own figures suggest that every $1 spent on FP saves $4.48 in direct healthcare costs in Kenya(7) but politicians at the county level often see health issues as a lower priority to others and consequently, unpaid bills are common in leading to low stocks of contraceptives at local MoH facilities. Many women assume they will be charged (there have been alleged cases of illegal charging) for contraception and there is still a great reluctance in rural areas for women to use contraception.

To encourage long-term use of family planning, MKT has started a referral programme which is run by the CHVs. After talking about all the issues around family planning with a CHV, if a woman decides she would like a longer-term method of FP, the CHV fills out a triplicate form. One form is kept by the CHV and two are given to the woman herself. She will present one copy when she attends the government clinic to have her chosen method of free contraception and the third copy she keeps herself. A month later the CHV will check that the woman did indeed receive the contraception she wanted, at no cost. This system is working well and is substantially cheaper than the running of mobile clinics, as the main cost is the payment to the CHVs. Once a woman has benefitted personally from the benefits of FP she is more likely to make the effort to enable herself to continue using contraception.

The county MoH is supportive of this developing referral programme as it shows that they are contributing to the national government's stated aim, to make family planning available to all women.

By the end of 2019 the Community Health Project was operating in remote communities in four counties on the Mount Kenya forest boundary – Meru, Embu, Kirinyaga and Tharaka-Nithi and was employing 35 CHVs. To keep up with an increasing amount of data all the CHVs have a smart phone on which they record all the relevant detail. This is uploaded to MKT's office enabling the data to be analysed. By the end of 2019, MKT's Community Health Project had delivered 75,681 FP services and 51,585 primary healthcare treatments.

Emboldened by our project with MKT, we started working with our third partner, Dandelion Africa, a dynamic NGO set up by Wendo Aszed and based in Baringo County. Dandelion had started a small family planning programme and they were also tackling the issue of Female Genital Mutilation. Despite FGM having been made illegal in 2011, its practice is still widespread. With financial help from CHASE Africa, Dandelion were able to greatly expand their activities by starting to run mobile clinics. They have also employed a 'back pack' nurse, who regularly visits 16 villages by motorbike, carrying her medical supplies in a backpack.

Another partner who we encouraged to start a Community Health Project is Community Health Volunteers (CHV) – a rather confusing name for an organisation working with so many CHVs! They were set up by Gabriel Musundi. Before starting CHV, Gabriel was a bird guide in the Kakamega Forest, like his father before him. This national park is a remnant of the rain forest that once stretched across all of Central Africa. Gabriel is passionate about trying to save the birds in the forest, but he was also

shocked to see the number of people who contracted jiggers, a parasite that burrows into the sole of the foot where it grows, causing itchiness and pus-filled sores that often become infected. From his desire to help people cure jiggers, Gabriel now runs regular mobile clinics which have over the last three years delivered nearly 300,000 primary healthcare treatments and over 40,00 family planning services.

A long queue of patients at a CHV Clinic.

With four projects up and running, we knew that our work was making a real difference to women, and we had proved that CHASE Africa could encourage organisations who had no previous experience of running community health projects, to set them up. With limited funding all NGOs face the same dilemma of where you concentrate your efforts. We took the decision to try and encourage conservation organisations working close to important ecosytems to adopt the model we had developed with our other partners.

Having made this decision, we approached The Big Life Foundation who operate around Amboseli National Park. Big Life works on the ethos that winning the hearts and minds of the local Maasai community and improving their standard of living through conservation, is the only way to protect wildlife and wild lands far into the future. They have an existing educational programme which funds teachers' salaries and provides scholarship funds for local students. A community health project seemed a good next step for Big Life, and in July 2016, CHASE paid for Dandelion's Wendo Aszed to meet with them.

Critical for a successful collaboration in Amboseli was getting the local MoH and tribal Elders on board, something Big Life could do with their understanding of the local socio-political environment. In May 2017, Dandelion staff travelled to Amboseli and put on four mobile clinics. Large numbers turned up for various health complaints, but as was to be expected, only a few women attended for family planning. The important thing was to persevere, as we had learnt. After Dandelion's initial help in starting the project Big Life took it over, and by April 2020 had delivered 26,671 primary healthcare treatments and 5,248 family planning services. It has been very encouraging to see the number of women from this very traditional Maasai community who are prepared to start using family planning grow over time.

Our most recent project started in October 2019, working with the Maa Trust (TMT) close to the world-renowned Maasai Mara National Park. As with Big Life, TMT, based in Narok County, is working towards ensuring the success of conservation through sustainable community development. The Maasai Mara ecosystem stretches down into Tanzania and is renowned for its biodiversity and its numbers of large mammals.

The Maasai people have traditionally been nomadic livestock grazers, living mostly on milk and blood from their cattle and cutting thorn trees and scrub to make enclosures in which to keep their cattle safe from predators at night. In recent years, the Maasai are increasingly living a sedentary lifestyle as they have lost access to much of their traditional grazing grounds. What had been communal land is now sub-divided into private ownership, and large areas of land are being ploughed up to grow wheat for Kenya's rapidly growing population.

The wildlife in the Mara ecosystem is in sharp decline. A study in 2011 reported that wildlife numbers in the last 100 years have crashed by up to 70% (8). Historically, the Maasai have been a polygamous society where large families are still seen as a sign of financial and social prosperity. In the area where TMT is working, the population is growing at around 10.5% a year resulting from an 8% natural growth and a 2.5% net in-migration (9). This growth rate, which is three times the national average, places ever more pressure on the environment on which both people and wildlife depend.

The lack of provision of Sexual Reproductive Health (SRH) services is one of the issues driving such a large population growth rate. Narok County has an average family size of six compared to the national average of 3.8. It also has one of the highest child pregnancy rates in Kenya with 41% of girls having their first baby before the age of 19. The majority of girls are still forced to undergo female genital mutilation and some are married at only 14 years old. These figures have stark implications for the County's agenda as it puts increasing demands on provision of health and education services (10).

TMT's Community Healthcare Project, in partnership with CHASE is gradually introducing SRH education and services to rural communities working in partnership with six medical facilities. As with our early involvement with Big Life, we expect numbers of women willing to use contraception to be low initially, but as an increasing number of women and men come to understand the benefits of family planning, numbers will grow.

We are now working with nine partners, seven in Kenya and two in Uganda. By April 2020 these projects have helped to deliver more than 774,000 primary healthcare treatments and more than 246,000 family planning services with a Couple Year Protection (CYP) figure of 398,842. Each CYP refers to a woman having 1 year's contraceptive protection from unintended pregnancy, and removes the distortion between someone having a 3-month injection, the pill or a 5-year implant.

As an organisation which started out planting trees, which we still do, we have shown that meeting the unmet need for family planning is well within the ability of other well-run organisations. Meeting that need is crucial for the future prosperity of people and the environment they depend on in rural Africa. If one considers the big picture, it is very clear that we are not making a significant impact on reducing poverty or protecting the fragile environments that support both humans and wildlife alike.

How do we make more of an impact? Most conservation organisations are well aware of the increasing issue of human/wildlife conflict but very few are prepared to address what is driving this conflict. In 2004 the UN were predicting that Africa's population would be 2.4 billion by 2100, but in their most recent prediction they have revised this and are now suggesting it will be over 4 billion, which is an extraordinary revision in just 16 years.

Addressing sexual and reproductive health rights is critical to achieving all the sustainable development goals agreed by the UN. CHASE believes that a joined up, holistic approach is the best way to work towards a sustainable future. The unmet need for family planning must be addressed. Offering women and girls increased opportunities and power over their bodies is one of the most impactful actions we can take.

Given that our work is predominantly focused on Kenya, it is useful to look at the situation there. In 1967 the Kenyan Government took the bold step of launching a nationwide family planning programme, the first in sub-Saharan Africa, but sadly this was not backed with the appropriate funding. In 1977 the findings from the first World Fertility Survey showed that Kenya's total fertility rate (TFR) was 8.1 children per woman, one of the highest in the world. This prompted funding from both the national and international governments, allowing a comprehensive FP program to be introduced. As contraceptive use increased the TFR declined: from 8.1 to 4.7 by 1998 (6). However, in the late 1990s the national political will waned, international attention moved to the HIV crisis and fertility rates over the next twenty years fell more slowly, from 4.7 to 3.5 (11).

Many people might understandably think that if the TFR keeps falling, future population levels will not be a matter of concern, but fertility rates matter much more than most people realise. If Kenya's fertility rate continues to fall, and reaches 2 by 2050, the population is projected to be 85 million. If the rate falls more slowly to 3, the population will be approximately 106 million. However, look ahead another 50 years to 2100 and the difference that fertility rates make should be a matter of great concern. If the fertility rate from 2050 to 2100 stabilises at 2, the population in 2100 would be 95 million, but if, on the other hand, it had remained at 3 (a very big decline from 8 in 1978) the population in 2100 will be 206 million (12).

In our day-to-day work, we know that lack of knowledge and access to FP are the most important issues we have to address. For those in government who make decisions about long term planning, TFR can be a useful indicator of issues that lie ahead. There are many countries in the world with a TFR well below the replacement rate and some governments, for example, are concerned that there will not be enough young people of working age to provide the tax revenues to look after their ageing populations.

Based on the level of poverty and access to services in Kenya today, one can only assume that should the population approach 206 million people, the consequences for poverty reduction and wildlife will be very serious. The Government will struggle to provide the most basic infrastructure and services to a large portion of the population, potentially tens of millions. Furthermore, most of the habitat necessary for Kenya's wildlife will have disappeared. Much of the growth in the population will occur in rural areas where there is the highest unmet need for family planning and where medical provision is much lower than in more urban areas. These are the same areas where conservation organisations are concentrating their work.

In many western countries, our modern way of living and farming has had devastating consequences on the environment and yet we are all too quick to condemn the environmental problems in the developing world. Too late, we have realised the importance of maintaining bio-diversity as an essential part of a sustainable environment. Having destroyed so much of our natural environment across the globe, an increasing number of people see the immense value in rewilding. Africa still has its wild places and large mammals. Wouldn't it be wonderful if they could hold on to these priceless assets rather than following the path the 'developed' world has taken?

Looking to the future CHASE Africa will work hard to continually improve the quality of our existing projects, and to use these examples to encourage other organisations to adopt the model we have developed over the last decade. We believe that by giving women the simple choice over how many children they would like to have, and when they would like to have them, millions of Africa's most vulnerable people will be given a much brighter future.

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