



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

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FERTILE GROUNDS FOR RESULTS

Some “experts” from distant lands claim that family planning cannot work in rural Africa. According to this argument, fertility has always been high because that is what people want. But, surveys show that women often say they need family planning, even though they are not using it. These results suggest to other “experts” that if unmet need for family planning is met with quality services, fertility will decline. But, when experts disagree, one wonders if they are experts at all. The Community Health and Family Planning Project (CHFP) experiment makes men and women in communities the true experts. Their response to the programme is the last word on who is right and who is wrong in the family planning debate.

The Navrongo experiment was designed to provide a basis for understanding the process of reproductive change by measuring the relative impact of different types of health delivery strategies in a rural community in northern Ghana. Baseline characteristics of the population of women of reproductive age and their husbands were documented. Follow-up panel surveys and a longitudinal demographic surveillance system monitored changes in contraceptive knowledge, reproductive preferences, reproductive behaviour, and fertility. Four cells represented different health service delivery strategies. The bureaucratic approach of the Ministry of Health focused on static facility health care delivery under which basic resources were lacking, community mobilization and supervising systems were weak, and community accountability was rarely developed.

The CHFP introduced a nurse outreach arm involving the deployment of a community-resident nurse (Community Health Officer (CHO) to provide doorstep and compound-specific health care. This approach bridged social distance between service provider and client, thus making services user-friendly. The *zurugelu* arm mobilized community-level cultural resources to organise health care delivery. This approach involved constituting health care action committees from existing social networks, and implementing supervisory services with active traditional village self-help schemes. Services were provided through the use of community health volunteers chosen by the community and trained by project staff to provide basic health care services, reproductive health education, outreach to men, and contraceptive supplies. Outreach to men was undertaken by community gatherings known as *durbars* at which discussions focused on health and family planning themes to give men an open forum to discuss their reactions to the programme. The gender strategies and communication activities of the *zurugelu* arm of the experiment were expected to alter the social context of reproductive change by seeking the support of men for the concept of family planning,



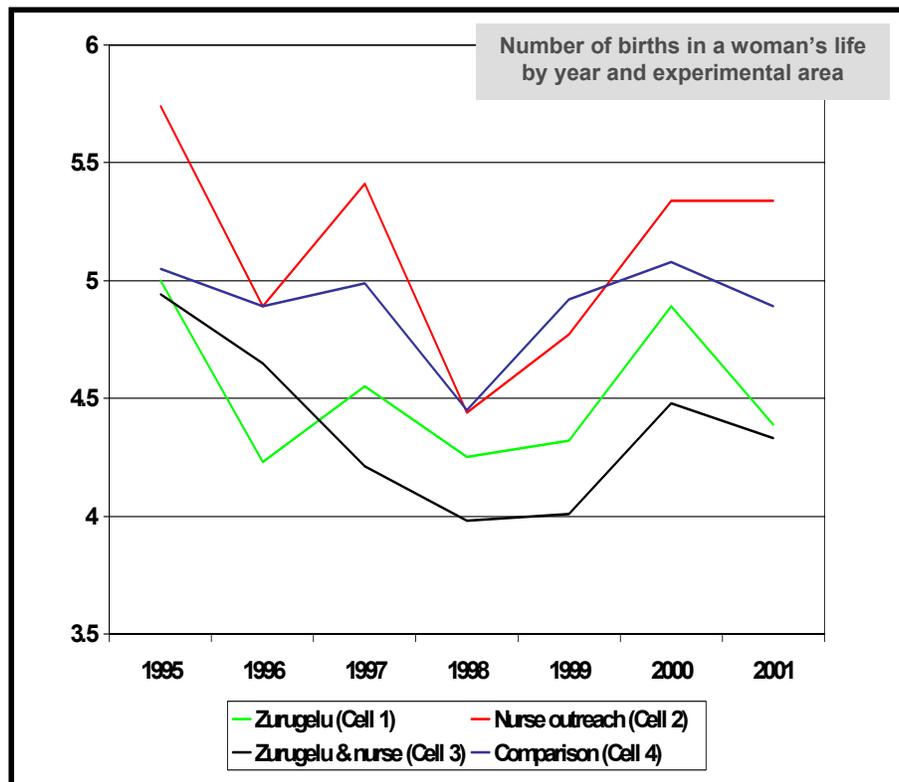
by opening community dialogue about health and reproductive matters that traditionally were not discussed between spouses, and by involving women in social leadership that previously had been the monopoly of men. The third arm of the experiment combined nurse outreach services and the *zurugelu* approach. The hypothesis to be tested was that the social costs of contraception could be reduced through community mobilization and more readily available client family planning provision.

Results are coming into focus. When the CHFP started, it had an immediate impact on knowledge of contraception. Family planning use increased, but only in areas where nurses were posted in combination with *zurugelu* activities. Making family planning convenient is not enough. Community entry, mobilization, and male participation are essential to success. But, *zurugelu* activities without nurses is also not enough. Women require comprehensive and convenient services, and volunteers distributing a single method does not meet their needs. Putting it all together—with volunteers working closely with nurses, communities mobilized, chiefs on board, and health services well developed—family planning can work, even in Kassena-Nankana District where traditions are strong and the role of family planning is debatable.

These conclusions are demonstrated by the trends in the figure below. In all cells of the experiment, women were having, on the average, five children in 1995. Where there have been no CHFP activities—only clinics—fertility declined by a half a birth in 1998, but then returned to baseline levels by 2001. This pattern was also followed in the “nurse only” area, which had even higher fertility throughout the study period. But, where *zurugelu* activities were introduced, fertility decline is evident, and where nurses and volunteers work in the same communities, fertility decline was pronounced—from five to four over the 1995 to 1999 period, although increasing in 2000 to 4.5, and then declining again in 2001. Fertility has changed yearly in all study areas, but where treatment activities are most intensive, the programme works.

So, a general conclusion is evident from the CHFP: Despite the inauspicious social and economic context for reproductive change, the CHFP has had an impact on fertility. In rural Ghana, where traditions of chieftaincy, lineage, and consensus-building remain vibrant, outreach to key male leaders and mobilization of their networks can put men at ease about family planning, and can ultimately determine whether or not women can exercise their preferences.

Caution is nonetheless warranted. While fertility impact has been achieved, results changed as the programme progressed. As the figure shows, the impact was less in 2000 and 2001 than in 1998 and 1999. While the CHFP has worked, the reservations of some sceptics are well founded. But, while results are not huge, impact is much greater than many experts expected.



Send questions or comments to: What works? What fails?

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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programmes, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant of the Vanderbilt Family to the Population Council.