



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

PUTTING THE EXPERIMENT IN CONTEXT

Problem

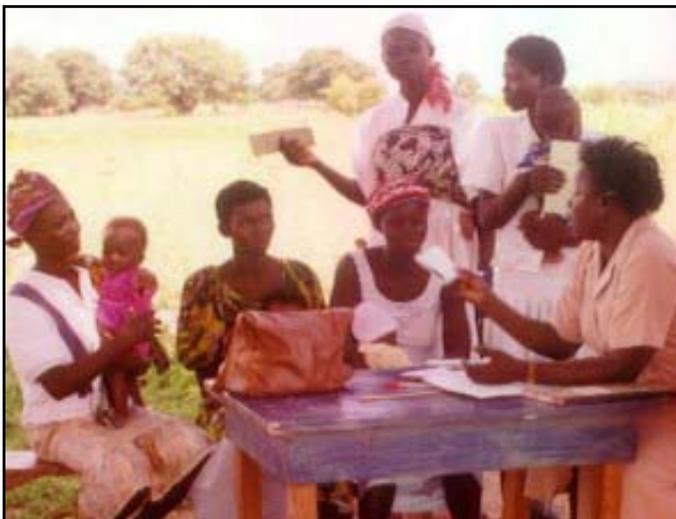
Studies consistently demonstrate that passive clinical programmes based in district hospitals or sub-district health centres are not meeting demand for health and family planning services. Instead, a truly community-based approach to primary health care (PHC) delivery is needed that addresses stated needs. One policy response in Ghana has been to develop policies supporting the creation of the community health and family planning programme. However, the implementation of these policies is fraught with uncertainties and evidence that community health programmes can work is lacking. For example, while the placement of Community Health Nurses (CHN) in sub-district clinics seems appropriate, the clinics are underutilised and the nurses sit idle because services are inaccessible to most households. Communities have systems of governance, social organization, and communication that are well known to politicians and widely used to mobilize votes or community action. These traditional organizational institutions have not been utilized effectively for the promotion and delivery of health care. In order to determine the best path towards developing affordable and sustainable community health care, experimental studies must test the social and demographic impact of alternative programme strategies. A study located in Kassena-Nankana District of the Upper East Region of Ghana has addressed this need for experimental research.



Typical compound in Kassena-Nankana District

Setting

The Kassena-Nankana District (KND) is one of 110 political administrative divisions, called districts, in Ghana. It shares borders with Burkina Faso in the north. Elsewhere, it is surrounded by five other districts. Latest demographic surveillance data put the current population of the District at close to 142,000, inhabiting 14,500 compounds that are unevenly spread over 1,675 square kilometres of semi-arid grassland. Residents of the District battle yearly with a rainy season from May to October and a dry season from November to April. Subsistence agriculture is the mainstay of the people, who are essentially rural dwellers with only 10 per cent urbanisation. KND has one of the highest illiteracy rates in the country with an illiteracy rate among females of six years and above reaching as high as 62 per cent. The Community Health and Family Planning Project (CHFP) has therefore been developed in the context of severe poverty and adversity. Titled *The Navrongo Experiment*, the CHFP examines policy questions with scientific tools developed for the evaluation of health technologies, permitting precise scientific appraisal of ways to help people in significant need. Mortality levels in CHFP study areas remain high while cultural traditions sustain high fertility. Traditions of marriage, kinship, and family building emphasize the



Community Health Officer providing services to community members

economic and security value of large families. Health decisionmaking is strongly influenced by customary practices, traditional religion, and poverty.

Experimental Design

In response to these circumstances, the Navrongo Health Research Centre (NHRC) launched a three-village pilot programme of social research and strategic planning in which community members were consulted about appropriate ways to organize, staff, and implement primary health care and family planning services. Community dialogue about pilot service delivery was used to design a system of village-based services that were compatible with the social system and sensitive to stated needs. Chiefs, elders, women's groups, and other community institutions were contacted by project workers and involved in a system of support for community health service delivery. Nurses, who in the past had been assigned to underutilized clinics, were reassigned to village-based Community Health Compounds (CHC) constructed through communal labour for their use.

Four-cell Experiment

An experimental design was developed during the pilot phase, in consultation with the three communities. Two broad sets of resources were examined, each defining a dimension of the project:

- 1) **The “Ministry of Health Dimension”** reorients existing workers to community health care and assigns trained paramedics to village resident locations.
- 2) **The “Zurugelu Dimension”** mobilizes cultural resources of chieftaincy, social networks, village gatherings, volunteerism, and community support.



A durbar of Chiefs and community members discussing ways of improving community health

Since these dimensions can be mobilized independently, jointly, or not at all, the design implies a four-cell experiment. One cell each is reserved for experimenting with the “Ministry of Health Dimension” and the “Zurugelu Dimension” while a third cell has normal Ministry of Health services. The joint implementation cell tests the impact of mobilizing community-based health care through traditional institutions with referral support and resident ambulatory care from Ministry of Health outreach nurses. Trial and error in the pilot phase developed service components of the full-scale experiment. In this phase, as before, community members served as consultants in designing service and mobilizing activities.

In 1996, a district-wide experimental programme was developed. Geographic zones corresponding to cells in the experimental design each represented alternative intensive, low-cost, and comprehensive service delivery operations. A demographic surveillance system, which

monitors births, deaths, migration, and population relationships, is utilized for testing the impact of alternative strategies for community health services on fertility and mortality.

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, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, 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.