



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

HIV: SOUNDING THE ALARM!

The Community Health and Family Planning Project tests the hypothesis that improved health care delivery can induce a demographic and health transition in rural Ghana. Will the high and rising HIV/AIDS prevalence rate in the district impede CHFP efforts in programme outcomes? If so, can community mobilization strategies be an effective tool for changing health-seeking and sexual risk behaviour to stem HIV transmission in the population? *What works...* takes the lead in sounding the alarm.

It is often said, “ignorance is bliss”. Indeed, sometimes it is good not to know—however, more often than not, the truth eventually has a way of showing up, often to the confusion of those concerned!

The HIV/AIDS situation in the Kassena-Nankana district is still to be unravelled. We have only recently started to come to grips with a rapidly worsening problem. The little we have learnt about HIV/AIDS in two years is probably too small to start calling it a crisis. However, the alarm bells must start sounding and must be heard even in the most remote parts of the District—Kayoro, Nakong, Kulya, Bui, Naga, Yua, and beyond! Bad news is always news, and if a

leap from an HIV prevalence rate of 2.4% to 5.1% within twelve months is not news then we may have to look at our definitions again!

Since Ghana first documented her first HIV-positive cases in 1986, the country has come a long way from the days when most of the recorded cases were people living outside the country or women. What probably hasn't changed is the stigma attached to the condition, which appears to have deepened over the years as people increasingly see and hear of people living with HIV/AIDS. The plethora of adverts on national TV and radio asking people to show compassion for people living with HIV/AIDS is enough indication that there is a fight to be fought on that front.

One of our major problems as a developing country is about being able to collect accurate data to reflect existing situations. It is no secret that hospital data grossly underestimates the burden of disease and mortality in Africa south of the Sahara. Many people who suffer chronic illnesses do not attend hospital,

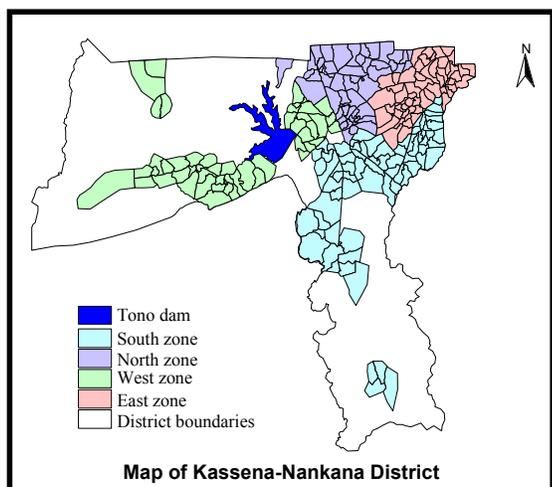
for reasons relating to, among others, accessibility, belief systems, and disease causation. As a result, hospital data cannot be relied upon to give reasonable estimates of the extent of the problem of HIV/AIDS. The sexual transmission of HIV further worsens the situation as many people continue to associate the disease with prostitution and sexual immorality.

The National AIDS Control Programme (NACP) quickly realised that hospital records are but a tip of the proverbial iceberg! The long incubation period of the HIV virus also means many people are living with the condition but are well and do not need to go to the hospital. These people are not likely to be captured by hospital records. This lack of accurate reporting led to the initiation of the National Sentinel Serosurveillance Programme in 1990.

Estimates of the prevalence of HIV in the sentinel populations tested have been obtained. Trends of the disease in these populations have also been monitored over time. The data obtained has helped to provide information to evaluate the HIV/AIDS prevention and control programme. Most of the sites used for the survey only test pregnant women. However, two sites have been used for testing STD clinic patients as high-risk populations.

Blood used for HIV testing is obtained in an unlinked anonymous way, that is, after the routine laboratory tests for which blood was originally drawn have been completed and all personal identification has been removed. This programme has opened our eyes in Navrongo—inaction on our part has potentially far-reaching effects that could undermine the lofty achievements of the Navrongo Health Research Centre (NHRC) and even affect projects being envisaged such as vaccine trials.

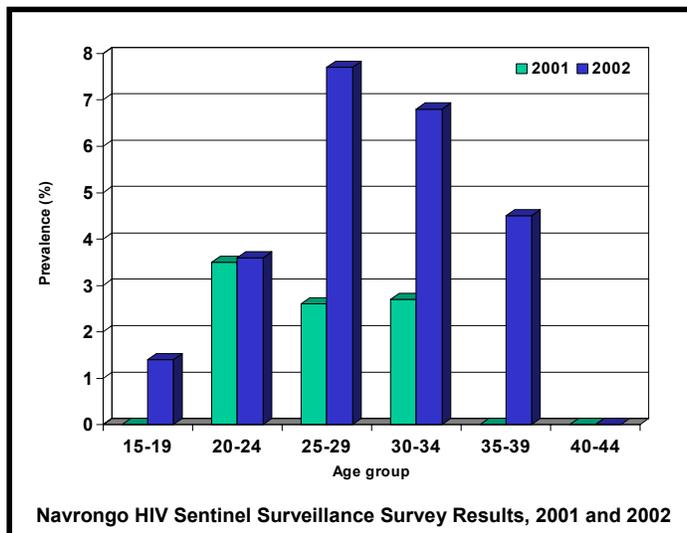
In 2001, Navrongo was added to the list of sentinel sites for HIV testing. In that year, HIV prevalence among pregnant women was 2.4%. This was below the then national average of 3% but higher than the average for northern



Map of Kassena-Nankana District

Ghana of 1.6%. Among the 23 sentinel sites, that figure put Navrongo at the 17th position on the league table, barely escaping relegation!

Then the bombshell! In 2002, the prevalence of HIV among pregnant women shot to 5.1% and significantly moved Navrongo up to the unenviable position of number six on the league table. This is alarming and most worrying because in spite of the impressive gains made by the Community Health and Family Planning Project in reducing fertility and childhood mortality, the CHFP has not halted the onset of the HIV/AIDS. Full effects of the CHFP are unknown, however, because prevalence trends are not available by treatment. Nonetheless, the trend for the district as a whole is cause for concern. It is known that some of the worst hit countries in southern Africa experienced explosions of their HIV prevalence when they started going beyond 5%. This is because when prevalence exceeds 5% the epidemic starts to spread more in the general population, beyond high-risk groups. This is the new situation that is suggested by current trends. Some facts clarify the course of the upsurge, although it is too early to conclude that there is a definite acceleration of trends. For example, all cases are HIV-1, the type found elsewhere in the country; none of the positive cases has been HIV-2. The age group with the highest prevalence in 2002 was the 25-29 year age group, which mirrors what is found on the national scene. In 2001, there was no positive case among the 15-19 year age group. However, one positive case surfaced in that age group in 2002. The implication of this is not yet



known. Is the initial detection of HIV among youth an indication of trends to come? Fears have always been expressed about potential problems associated with HIV/AIDS owing to certain prevailing characteristics in the district. Already the district is grappling with malaria, cerebrospinal meningitis, filariasis, schistosomiasis, occasional outbreaks of anthrax, and other health problems. Who needs this “spirit child” added on?

Navrongo happens to be close to Paga, a busy border town. In recent times, there has been a high influx of human and vehicular traffic across the Paga border as a result of increasing political instability in Ghana's neighbouring countries. Notably all three neighbouring countries have HIV prevalence rates that are much higher than Ghana: the Ivory Coast – 10.76%; Togo – 5.98%; Burkina Faso – 6.44% as against Ghana's 3.0%. Political instability and changing patterns of commerce and road traffic between Ghana and her neighbours may be conspiring to change the epidemiology of the disease in Ghana. More needs to be done to understand the onset of this epidemic in border areas.

We need to prevent further transmission of the virus and we need to take care of people who are already infected. As researchers, we need to look at the various interventions being implemented across the country and see how we can assist to make them achieve the most impact. We need to ensure that young people delay their initiation of sexual activity and for those who have already set sail, encourage them to practise safe sex. The Adolescent Sexual and Reproductive Health project has these as some of its objectives and if success comes our way as we hope it would, then the “window of hope” can start to become a reality. A major headache will come from adults who have already adopted enjoyable bad habits, which are difficult to give up. It will require deep thinking and innovative ideas to get such people to adopt healthier sexual behaviours. One of the most important things to be done is to start a Voluntary Counseling and Testing (VCT) programme. The NHRC will soon begin a programme of research using lay counselors and Community Health Officers in the community for a VCT programme.

Conclusion. The activities of the CHFP have improved community health, but HIV-prevalence monitoring results indicate that there is now a need for a new project with a focus on finding community strategies for HIV/AIDS prevention. Can community entry and mobilization strategies become an effective tool for changing health-seeking and sexual risk behaviour? This should be the subject of experimentation by the NHRC in the near future.

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.