REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

NAVRONGO HEALTH RESEARCH CENTRE

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WOMEN SPEAK, MEN LISTEN

Under the Community Health and Family Planning Project (CHFP) of the Navrongo Health Research Centre (NHRC) women have stated their preference for spacing childbirth. But has this stated preference also translated into a desire to limit fertility? How far down the road have we come in terms of bringing down fertility levels? ***What works…***brings you sizzling statistics on a study conducted among 8,998 currently married women.

High fertility in Sahelian West Africa represents a continuing issue for population policy. Fertility levels in the region are double the levels observed across the developing world. Although some coastal cities have witnessed a reduction in fertility levels, the rural hinterland of West Africa has yet to enter the global fertility decline. Many respected observers have emphasized the resilience of pronatalist social institutions in this region in noting that African religious customs, lineage and descent systems, kinship networks, and family structure reinforce high-fertility social norms, beliefs, and values. In this view, high fertility reflects the desire for children, and improving access to family planning (FP) services will have little or no fertility impact. Despite the climate of scepticism about the demographic role of FP services, most reproductive health and population programmes in the Sahelian region focus on improving accessibility and quality of FP services. Other researchers in the world have concluded that existing demand for services is sufficient to bring about a reduction in fertility if services are provided. In other words, it is widely assumed that making FP services available in community locations will inevitably lead to increased use of contraception and reduced fertility. The Community Health and Family Planning (CHFP) project of the Navrongo Health Research Centre (NHRC) tests the relative effectiveness of alternative strategies for achieving increased contraceptive use and low fertility. The CHFP represents a test of the hypothesis that reproductive ideational change can be introduced in a traditional African society. This note summarizes findings from a study that assesses the impact of experimental intervention on current use of modern methods and on fertility.

Expanding FP choices for women in community locations leads to increased use of contraception but may not result in reduced fertility

Launched in 1994, the CHFP is a two-phased programme of four experimental research cells in the Kassena-Nankana District. Three of which are new basic primary health-care and FP programmes instituted in addition to the standard clinic-based services provided by the Ministry of Health (MOH). The fourth cell maintained the standard services only and is used as the comparison area of the project. Cell 1 comprised of the *zurugelu* intervention which involves mobilizing traditional social institutions in health delivery and planning. This approach, which is based on volunteerism, promotes the idea that managing health care resources and providing revolving funds for primary health care drugs and services through community volunteers can be a sustainable means of achieving Health for All. The volunteer's main task is to sell the CHFP idea to the community, particularly to men who exert considerable influence over decisions about women's mobility to seek health care.

Cell 2 consists of a health service mobilisation intervention which tests the effectiveness of improving access to Community Health Officers (CHO) by reassigning them from sub-district clinics to community-constructed residences, known as Community Health Compounds (CHC), and equipping them to conduct door-to-door health services. Cell 3 is the combined intervention area—the *zurugelu* and CHO approaches are pursued simultaneously. This intervention tests the premise that the *zurugelu* and MOH mobilization interventions are complementary and synergistic. In the combined treatment area, close collaborative links have been established between health volunteers and the CHO.

A study which assesses the impact of the CHFP on contraceptive use and fertility reduction was carried out on a total of 8,998 currently married women gathered in an average of 2.4 panel years (from the CHFP panel surveys) for each individual over a maximum of six panel years. Each observation in the data set represents one year of panel responses from one woman. The analyses used six panel data sets compiled in 1993 as a baseline and subsequently through 1999 in order to assess the impact of the experiment on fertility behaviour and preferences. The 1994 panel was not used because it did not collect data on the background characteristics that are of interest in the study. Several descriptive and statistical procedures were employed in the analysis with estimates of the impact adjusted for underlying differences between experimental cells in fertility-related behaviour. The findings of this study can be summarized as follows:

- Educated women and women who no longer practice traditional religion are each associated with an increased likelihood of knowing about a modern contraceptive method. In addition, these women are also more likely to know a modern-method source, more likely to prefer limiting childbearing, and more likely to use a modern method. This finding may indicate that such women are more likely to exhibit nontraditional fertility behaviour.
- The desire to space childbearing is approximately two times greater than the desire to limit fertility, a finding that is consistent with other research conducted in the Sahelian region. The prevalence of the expressed desire to space the next birth rises from 42% among all women in 1993 to 59% for women receiving combined exposure or no exposure in 1999, and 57 and 52% for women receiving *zurugelu*-only or nurse-only exposure in 1999.
- The central finding is that *fertility can be reduced by one birth in three years of FP programme exposure.* Each arm of the experiment has had modest, but significant fertility effects that compound when different approaches are combined into a comprehensive community mobilization strategy.
- Although the CHFP has induced reproductive change in Kassena-Nankana District, contraceptive use is clearly not the only fertility determinant responsible for fertility declines in the district or the entire upper East region. In 1998, fertility declined markedly in all areas of the district including the comparison area, but the determinants of this change were dominated by abstinence and delayed marriage rather than by increased contraceptive prevalence.
- Minor or temporary lapses in programme intensity can lead to widespread discontinuation of contraceptive use. Just as women respond to convenient services when nurses live in villages and conduct home visits, they readily abandon contraception if programme support is disrupted.
- The impact of the project is distributed across all age groups and fertility results suggest that all cells are experiencing an impact from the CHFP. In addition, the combination of the nursing-outreach and the *zurugelu* activities caused the greatest impact. Therefore, the relative effectiveness of the combined strategies attests to the need for a balanced, gender-sensitive approach to developing male participation.

Conclusion: The results reported here lend support to the hypothesis that the Navrongo experiment induced reproductive change in Kassena-Nankana District. Implementation of the project has made contraceptive and FP services more readily available than in other rural areas in northern Ghana, and project activities may have fostered reproductive attitudes and behaviour that differ from those in communities where clinical services are more remote and community outreach is less developed. If the current treatment differentials are sustained and amplified, project hypotheses will be upheld. Thus, these results provide evidence that a supply-side programme can have an impact, even in a rural traditional setting that is widely viewed as being incompatible with FP programme success.

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 Programmemes, 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.