

Factors constraining the scale up of the Navrongo Experiment's fertility impact in northern Ghana

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Introduction and Objectives

High levels of fertility and unwanted pregnancy persist throughout sub-Saharan Africa, often with dire consequences for women and children. In Ghana, a family planning project of the Navrongo Health Research Centre demonstrated dramatic success in the 1990s by reducing fertility and saving lives. Piloted in the early 1990s, Ghana's Navrongo Community Health and Family Planning (CHFP) Project posted nurses in isolated rural villages, where they worked with community elders and key social networks to develop and deliver community-based health care services. The *zurugelu* (togetherness) arm of the experiment mobilized the cultural resources of chieftaincy, social networks, village gatherings, voluntary activities, and community support. Volunteers working in support of nurses effectively engaged men in the program in ways that catalyzed reproductive change. Activities sought to build male leadership, ownership and participation in reproductive health services, and to expand women's participation in community activities that had traditionally been the purview of men. This social-action agenda was designed to enhance the autonomy of women in seeking reproductive and child health care, thereby reducing the social costs of women's participation in the program.

The resulting services of the CHFP reduced fertility by a full birth per woman and resulted in rapid declines in child and maternal mortality. In fact, the CHFP was so successful that it was ultimately scaled up in districts throughout Ghana as a national program called "Community-based Health Planning and Services" (CHPS). While CHPS is now a major contributor to Ghana's health care system, vital reproductive health care service components are languishing, and CHPS' impact on fertility may be falling well short of the potential for community based care to address unmet need for contraceptive care. While fertility has continued to decline in villages where the Navrongo experiment originally succeeded, fertility has not declined in comparison villages where the scale up of CHPS was initially instituted.¹

This study revisited both the villages where the Navrongo Experiment's family planning services achieved dramatic success and the comparison villages where this success was not demonstrated in order to clarify social and behavioral changes that have occurred and not occurred over the past 15 years as CHPS services were scaled up. The goal was to gather in-depth information on the manner in which community-based health care services have been implemented in the post-project period. Through such efforts, the study has sought to improve understanding of the ways in which training, supervision, and program management may have diminished the original focus on family planning, thereby explaining continuing fertility differentials in the experimental area. Based on lessons learned from the investigation, results will be used to reposition family planning in a new health systems initiative of the Ghana Health Service (GHS).

¹ Phillips, James F., Elizabeth F. Jackson, Ayaga A. Bawah, Bruce MacLeod, Philip Adongo, Colin Baynes. 2012. "The long term fertility impact of the Navrongo Project in northern Ghana," *Studies in Family Planning* 43(3):175-190.

Methods

The research team has pursued this objective by conducting an in-depth qualitative research project. The team revisited the villages where the CHFP was conducted in order to learn about the original provision of family planning services in these areas during the Navrongo experiment and ways in which these strategies may have atrophied or changed with their scale up. To pursue this agenda, researchers gathered information on the ways in which training, supervision, and program management may have changed over time and whether the key focus on family planning in the original programming has diminished. Two types of interviews were pursued; in-depth interviews (IDI) and focus group discussions (FGD):

- *IDI*. All IDIs focused on implementation issues: The extent to which family planning is on the agenda of current training, deployment strategies, worker selection, refresher training, supervisory encounters, discussion at meetings, community durbars, encounters with village leaders, and exchanges with district politicians and administrators. Open ended discussions were designed to determine what topics or activities are spontaneously mentioned, and end-of-interview probing sought to determine whether family planning is a focus of health sector activity. In all, 68 IDIs were conducted with key stakeholders, including managers, supervisors, frontline workers (both nurse and male volunteers), and community leaders with stratification designed to separate interviews of health personnel from the CHFP era from personnel recruited and deployed during the post-CHFP scale up of CHPS services.
- *FGD*. The research team conducted 16 focus group discussions with men and women, stratified to target groups of older men and women who were exposed to the CHFP over the 1996-2001 period and groups of younger men and women who were not exposed to the CHFP, but instead are familiar with scaled-up CHPS services. In all of the focus group interviews, initial questions focused on primary health care and were designed to determine what, if any, reference to family planning spontaneously arose. Interviews then turned to discussion of the current climate related to the provision of family planning, perceptions of the importance of these services, and perceptions of social change or reproductive change over the past 15 years that may have affected family planning demand or service supply.

All IDIs and FGD were audio-recorded and transcribed. The IDIs and FGDs with community members conducted in local languages were transcribed into English. Data analysis is ongoing utilizing NVivo9 qualitative software and a content analysis approach. Themes emerging during review of the transcripts are sorted and grouped according to key categories.

Preliminary Results

Based on preliminary analysis of the qualitative data, it is evident that key functions of the health system structure that fostered community engagement and the “zurugelu” approach during the CHFP have atrophied during the scale-up of CHPS, due to limited human and financial resources and a concurrent increase in the package of interventions included in CHPS services. Many respondents noted a decline in the frequency of household visitation, the quality of services, and the supervision of health workers and community volunteers, as well as deficiencies in the training of these cadres to perform community-engaged work, especially in relation to the promotion of family planning. Current health leaders and nurses remarked that there are insufficient funds for fuel and vehicles to perform frequent home visits, which was a cornerstone of the CHFP approach for dialoguing with clients and changing attitudes surrounding contraception. Furthermore, as CHPS has been scaled up, other essential services have been added to the package of care provided by CHPS nurses, thereby decreasing the amount of time and focus that nurses and supervisors devote to community-engaged promotion of family planning. While several respondents commented that increased education for men and women might improve the uptake of family planning, this theme does not appear to be as important to the lack of success in current the CHPS family

planning strategy as the lack of basic logistics for properly training, equipping, and supervising community-based nurses and volunteers to promote and provide family planning.

Anticipated Conclusions

Demand for family planning remains fragile in the societal setting of Sahelian northern Ghana. Pervasive unmet need for spacing is overlaid by widespread ambivalence about childhood limitation, concerns about male support for contraception, and constrained social support for fertility regulation. While these social constraints were offset by the strategies of the “zurugelu” approach of the CHFP, which engaged traditional social structures and male networks, sustaining these strategies was essential in reducing fertility during the Navrongo experiment of 1990s. While the fertility decline has languished during the scale-up of CHPS services since then, from this qualitative investigation it does not appear to be due to a deliberate neglect of the “zurugelu” approach, but rather limited resources across the health system that have diluted the focus of nurses and their supervisors on family planning and reduced the amount of time and energy available for community engagement for family planning uptake. Activities to change community attitudes toward family planning may be more fragile and difficult to sustain than other components of CHPS services in the face of financial and human resource constraints. There is a need for CHPS services to be restored to the original model of the CHFP, not only in regards to community engagement for family planning but also in regards to the focused training, supervision, and support of staff to perform these essential functions. A challenge that must be overcome is how to sustain efforts in overcoming social barriers to the use of family planning while other health interventions are continuously added to the package of services provided by CHPS nurses.