



# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 11, December 2001

Navrongo Health Research Centre

## LIGHT AT THE BEGINNING OF THE TUNNEL

Lessons learned from the Navrongo project have important programme implications. Phase 1 of the experiment aimed to determine the most effective way (in terms of cost, coverage, cultural compatibility, and quality) of delivering health care services to rural people. Phase 2 tested the strategies in a district-wide trial. As findings emerge, important lessons are learned:

### Lesson 1 ▪ Need for Community-based Services

In remote and very rural and traditional communities, mobility of women and autonomy to seek health services is extremely limited. To succeed in providing access to quality health care to all, services must be based in the community. This has been achieved by fostering volunteer construction of Community Health Compounds (CHC) where nurses, termed Community Health Officers (CHO) live and provide services.

### Lesson 2 ▪ CHO: The Trusted Outsider

When CHC are placed too close to the Chiefs' compounds or when nurses are related to influential families, performance is less than if nurses are outsiders. This is particularly true of family planning services. Women prefer female service providers who have no links to the community and can be trusted to keep secrets about family planning supplies.

### Lesson 3 ▪ *Yezuru Zenna*: The Trusted Insider

When men are recruited as health aides, termed *Yezuru Zenna* (YZ) they are viewed as community health mobilisers who contact men to discuss and legitimize the programme. These are appropriately socially gregarious individuals who are from the communities they serve.

### Lesson 4 ▪ The Need for More Nurses

When services are restructured to reach people and staff of the MOH are redeployed more efficiently, old staffing norms become obsolete, meaningless, and constraining. A nurse living in the community is at the beck and call of people around the clock. She has no opening hours and no closing hours. She does everything from health education, curative services, counseling, midwifery, and community mobilisation. These services constitute a very large increase in her workload as compared to a nurse that lives in a health centre. A sub-district clinic nurse is instructed to start her day at 8:00am, but she rarely arrives at work before 10:00am. Her work schedule hardly occupies her full time, so she typically closes around 12:00 noon by which time the number of patients has considerably decreased.



There is the need to train more frontline staff such as these student nurses

A nurse living in the community feels lonely most of the time. She complains of being on duty 24 hours without a day without anyone to relieve her. Staffing norms must be readjusted to take care of redesigned service delivery strategies that create demand and improve service utilization. The number of CHO currently assigned to Kassena-Nankana District is too small for achieving adequate coverage of the communities with the expected quality of service. Consideration should be given to increasing the density of CHO so that they can establish contact with all compounds in their area on regular basis. The fluctuations observed in compound visitation coverage reflect demands on the nurses' time as they are withdrawn from the communities to respond to other demands such as epidemics, sickness, and or mop-up activities that of necessity take them away from the communities without finding other nurses to provide relieving duties in their absence.

### Lesson 5 ▪ Addressing Men's Concerns

An interesting finding of the experiment is the willingness of men to discuss family planning with the CHO, who are women. Women can serve quite effectively as information providers to men, so long as strict secrecy about the contraceptive decisions of

wives is maintained at all times. Using a male approach that involves meetings with elderly men also helps tremendously to defuse opposition, which is mostly based on fear of the unknown. Men make the decisions in the community, but know very little about family planning. Their opposition to family planning is therefore based on ignorance. A positive male approach to family planning yields better results in the increased use of family planning. By constituting village elders as Health Committee Members and involving them in discussions on family planning at public gatherings, legitimacy and the notion of some level of acquiescence is given to family planning and this greatly improves the atmosphere for individual family planning decisions.

## Lesson 6 ▪ A Sustainable Construction Initiative

Communities construct CHC for the CHO to use as their residence and “Level A” clinic. This is a low-cost programme that can be implemented anywhere. However, over-reliance on traditional architecture and building materials can lead to nonsustainable structures. Traditional compounds are built by men through communal labor, but routine maintenance is carried out by women. CHO are too busy to perform maintenance work on their compounds; roof leaks often develop, causing structural problems. A typical traditionally designed structure as residence for the community-resident nurse is not sustainable. Modest resources from the MOH (or through the District Assembly Common Fund) and other sources should be committed to providing building materials for the CHC and latrines, in addition to providing some funds for mobilising community labour to put up the structures.

## Lesson 7 ▪ System Support

Village work is a new challenge for the CHO because it’s a system that requires mechanisms for technical, community and supervisory support for their work. Frequent practical training sessions are needed to develop community liaison and teamwork. A new MIS system has been developed to foster “bottom-up” communication. Workers meet frequently, assemble narrative reports, discuss progress and problems, and communicate matters of concern to senior officers.

## Lesson 8 ▪ Community Participation

Mechanisms for traditional governance and group action can be utilized for communicating with communities. Liaison with chiefs, elders, and lineage heads, cooperation with village peer networks and group leaders can legitimize and explain family planning to men. Durbars are particularly useful for health education and family planning. Chiefs, elders and community leaders welcome dialogue with the MOH staff and seek regular exchanges. A regular programme of community dialogue and exchange should be part of every DHMT work programme.



**Working together works: Project staff collaborating with DHMT**

## Lesson 9 ▪ Focus on Primary Health Care

Since mortality is high and health concerns are limited, critically needed preventive health care should be taken to every compound. Health education must be compound relevant and compound specific to be meaningful to community members. This allows them to practice what is contained in the health education messages directly and observation of the benefits reinforces compliance to advice provided thereafter. Community members subsequently build trust in the health worker and the health service delivery system that they see as responsive to their needs. Under such conditions of mutual trust, acceptance of family planning makes sense and opposition to it becomes minimal, even among men.

## Lesson 10 ▪ The CHFP Works

When nurses are deployed to village locations, significant improvements in child health are realized. When *Zurugelu* activities are added to the nurse in the village condition, so that CHO services are complemented with activities for mobilising chieftaincy support, health committees, volunteers, and community durbars participation, then contraceptive use increases and fertility declines.

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

Navrongo Health Research Centre, Ministry of Health, Box 114, Navrongo, Upper East Region, Ghana  
[What\\_works?@navrongo.mimcom.net](mailto:What_works?@navrongo.mimcom.net)

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.