



# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

## BAMAKO, IS IT IN MALI?

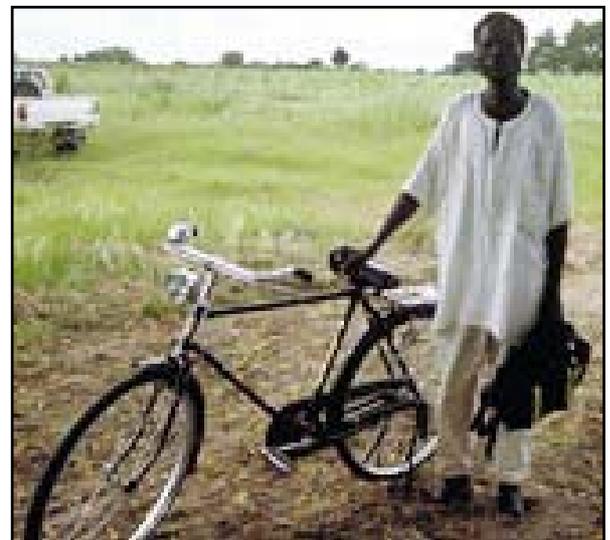
The Bamako Initiative is a regional programme sponsored by UNICEF that aims to develop low-cost, accessible, and sustainable health care by organizing health committees and volunteers for health services and backstopping their work with logistics and training. A key theme of the programme is establishing cost recovery for essential drugs and organizing logistics for resupplying village pharmaceutical kits. While the Bamako idea is appealing, the practical details of how to organize the programme have not always been thoroughly developed in settings where it has been tried. As a consequence, implementation of the Bamako Initiative has faced various operational problems.<sup>1</sup> The Community Health and Family Planning Project (CHFP) has sought ways of making Bamako work. At the heart of the strategy is the observation that Kassena-Nankana society is rich in cultural resources. Yet, until recently, these resources have not been effectively used for community health service delivery. To address the gap between traditional social institutions and community health services, the CHFP has developed the *Zurugelu* (togetherness) dimension of the Navrongo Experiment. *Zurugelu* strategies mobilize cultural resources of chieftaincy, social networks, village gatherings, volunteerism and community support to undergird the CHFP programme. Making Bamako work has various elements in the Navrongo system:



Traditional leaders can be health leaders

**Leadership.** The *Zurugelu* system is based on the observation that traditional societies have a hierarchy of traditional leaders who command respect from the people whom they govern. Furthermore, traditional social support networks exist in rural communities that can be effectively mobilized to promote health care. Specifically, there are two components to the *Zurugelu* approach: the *Yezura Zenna* (Health Aide or YZ) component and the *Yezura Nakwa* (Health Committee or YN) component. YZ represent a cadre of volunteers from the rural community that are selected by the traditional leadership to assist with local health service delivery. Volunteers are not on their own; they report to YN who maintain a stock of supplies of essential drugs, manage accounts and a revolving fund for purchasing drugs, and coordinate volunteer work with other CHFP activities. YN also mediate in disputes among volunteers or between volunteers and other members of the community, and represent the programme at community functions.

**Volunteerism.** The YZ component is premised on the notion that communities can actively and effectively participate in improving their own health status. The YZ concept has resonated with communities since they have been accustomed to utilizing resources within the community that hitherto had been limited to the services of traditional healers. The YZ component has resulted in wider coverage of health services, greater access for the community to health service provision, and community pride in their ability to contribute collectively to the improvement of their health. The YZ volunteer works in tandem with the local Community Health Officer (CHO) by delivering basic care, providing preventive health information, and referring cases to the CHO for more intensive curative health needs that may be required.



Yezura Zenna (YZ)

**Training.** Both YN and YZ are trained in various aspects of health care provision. YN are trained in record keeping and the management of accounts. YZ training includes the treatment of ailments (malaria and diarrhoeal diseases), the provision of family planning information and supply of contraceptives, nutrition information, immunization promotion, drug management and record keeping. In addition, YZ are relied upon by the community

<sup>1</sup> In Ghana, the Bamako Initiative has never been adopted as official policy. However, elements of the Bamako concept have been promulgated with the aim of developing low-cost volunteer services.

and the surrounding health service institutions for data gathering and report writing. As such, it is essential that the YZ volunteer is reliable, available and committed to the important tasks at hand. YZ training is conducted in day-long sessions every 90 days.

**Technical supervision.** A team of CHFP supervisors has been assigned to the task of community liaison, community organization, and field supervision of the *Zurugelu* programme. These supervisors represent an incremental staffing configuration of the programme that is not included in the normal MOH/GHS staffing pattern. As a matter of fact, professional community workers are crucial to the success of volunteer operations. They deal with the problems of volunteer turnover, disputes between YN and YZ, community organizational problems, and other issues that are difficult to predict but essential to resolve in the course of making volunteerism work.



**YZ conferring with CHFP staff**

**Incentives.** YZ and YN are not paid, and demands for compensation and MOH jobs are to be expected in the course of any volunteer scheme. It is important to structure community rewards in the form of strategies for enhancing the prestige and recognition of volunteers. Training can serve as an incentive, and should be conducted on a regular basis. The bicycles provided to YZ are highly prized and represent the most direct form of compensation to volunteers even though a volunteer may not own the bicycle until he/she has used it for a minimum of one year and a half.

**Logistics.** The official drug exemption policy does not work in the context of the Bamako Initiative; free drugs to children under 5 and pregnant women cannot be sustained. However, a “cash and carry” policy of charging cost recovery fees sustains the flow of resources. Special procedures are required for supervisors to maintain stocks at the district level and sustain the flow of drugs to communities on a “demand pull” system for replenishing supplies.



**Replenishing depleted stocks is a major headache**

**Conclusion.** The CHFP has demonstrated ways of mobilizing traditional cultural resources for supporting and delivering primary health care. In doing so, it provides a practical example of how the Bamako Initiative can work in a rural, traditional, and isolated district of northern Ghana. Implementing the Bamako approach requires a programme of assembling and training community committees, in close cooperation with traditional leaders. It involves convening regular public gatherings for soliciting community opinion about the programme. Finally, it involves developing comprehensive links between the volunteer system and the formal health care system so that all community health activities, including the Bamako component, function as an integrated system of primary health care service delivery.

*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.