



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

GIVING HEALTH AN ADEQUATE HOME BUILDING CHC THAT WORK

The Community Health and Family Planning Project (CHFP) has demonstrated that locating nurses to the community is feasible and effective. The key to this strategy has been to involve communities in the construction of Community Health Compounds (CHC). Trial and error has produced insights into strategies that work:

1) The first attempt involved a completely community-donated structure that was built entirely with traditional materials. While community members expected the CHFP to provide external funding for modern CHC construction, the CHFP project recommended simple construction utilizing community-donated resources and volunteer labour for the entire project. No plan was given to the community; instead, they were left to develop the facility without assistance or external advice. In response to this initial approach, three communities constructed two-room laterite residences with a perimeter wall, a bath area, kitchen and a latrine pit. This approach failed.



First CHC that failed: Completely traditional material

2) The failed CHC initiative was followed by improved designs constructed with traditional wall material with iron sheet roofing, cement flooring, and a cement-sealed latrine. Materials were supposed to be community donated, but progress in most remaining villages in the study area was delayed due to community resource constraints.



Second attempt: An interim design that is difficult to sustain

The need for cash outlays for construction items, such as tin roofing sheets, bitumen (for stabilising the walls), wood for windows and doors, and cement for the floors delayed construction. This was resolved in several communities that successfully approached the District Assembly for seed funds. Basic furniture and equipment was provided in this manner. This composite structure has enabled the CHFP to get started and operate since 1996. But, the use of laterite wall material has proved to be difficult to sustain and requires continuous community liaison and problem solving.

3) The CHFP experience with facility development has led to the conclusion that no existing CHC in CHFP study areas is, as yet, the optimal model. An optimal model would require external resources for cement walls, floors, and corrugated iron roofing sheets.

By trial and error some lessons have been learned

Locating CHC. Communities participating in the CHFP initially determined where to locate the nurse without guidance from project staff. In some communities, leaders assumed that a nurse would feel isolated and lonely if she lived separately and alone. CHO were therefore provided with dwelling places located in close proximity to other people. In some communities, it was suggested that this was best achieved by placing the nurse's residence either in or near the Chief's palace. But the project soon learned that this approach was not welcomed. People who shared

compounds with CHO were concerned that they were being exposed to risks of being infected with diseases since the nurse received patients in the house and treated them there. For the CHO who lived in the Chief's compound, patients and clients complained that a Chief's palace is a public place where anyone in the community could visit; there was therefore no privacy, which to them, was of paramount importance. These were genuine concerns, which the programme implementers took into consideration during the scaling-up of the experiment.

Lesson learned: Locating a CHC requires careful dialogue, not only with community leaders but also with women and men who will use the facility for care.

CHFP CHC are typically sited near markets, roads, water sources, and other accessible places. Above all, a CHC is centrally located and care is taken to ensure that no single person or groups of people are seen to have unduly influenced the location of a CHC. Privacy of patients and confidentiality of clients are guaranteed.

Making CHC too simple: Nonsustainable traditional construction

Traditional CHC are maintenance intensive. This is a labourious task without which the CHC will not last more than a couple of years. According to tradition, women are expected to plaster walls and repair roofs of compounds. The CHO is too occupied with her numerous tasks and household chores to spend time on the maintenance of the compound. Women in the community cannot make time for CHC maintenance due to their own activities that include



The ideal CHC: A CHPS CHC in Bolgatanga District

maintaining their own compounds. *The experience of the project is clear: Use of strictly traditional construction materials produces CHC that are not sustainable.* Nurses assigned to overly simple and locally constructed CHC complained of poor living conditions. While the traditional CHC construction was seemingly affordable, savings were outweighed by the cost of low morale and poor productivity.

Undermining community participation with external resources

In one community, a foreign visitor approached the Paramount Chief about constructing a CHC. Without developing a plan for community action and participation, he left funds behind for construction. While resources were available for quite an elaborate facility, construction was much slower in this community than in communities where resources were relatively constrained. Initiative was extracted from the community by external largesse. Factionalism ensued, volunteerism was undermined, and complicated diplomacy was required to foster community action. It is important to establish that community action is organized and that work begins before external resources are committed.

Conclusion

Purely traditionally designed and constructed CHC are not sustainable. The CHFP has maintained its original simple design for the CHC but the need exists for a more robust building constructed with cement blocks and roofed with corrugated iron sheets. The introduction of external resources must be pursued with care, so that supplies represent an incentive for community participation in the CHC construction programme, not a substitute for community initiative.

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

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