



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

WHOSE CRAZY IDEA WAS IT?

What works?... conducted an informal interview with Dr. Moses Adibo, former Deputy Minister of Health, about his leadership role in the development of the NHRC, CHFP, and CHPS.

WW: *You know the Upper East region very well. Tell us about the opening of the Chiana Health Centre.*

MA: I came to the then Upper Region in October 1972 as the Regional Director of Health Services. Chiana Dressing Station had just been upgraded into a Health Centre. There was a young man who had been trained for six months at Kintampo as a Health Post Attendant. I sent him to Bolgatanga for retraining to enable him to man the laboratory. Then I sent a midwife and community health nurses. I introduced them to the Chief and said 'go and provide doorstep services and tell the people that a Medical Assistant is coming soon'.

WW: *Where were you when the CHFP started taking health to the doorstep of the people?*

MA: When the CHFP started in 1994 I had just retired from the Ministry of Health as Director of Medical Services and the Ministry had engaged me as a consultant to assist the Ministry in developing the Medium Term Health Development Strategy which I had initiated.

WW: *Whose crazy idea was the CHFP?*

MA: The initial project funded by the Population Council was to design a country-specific model of providing Family Planning (FP). The proposal was put together by Fred Binka, Jim Phillips, and Korshie Nazzar.

WW: *So CHFP was another attempt at promoting family planning?*

MA: Exactly! When it started the nurses lived in the community and visited homes providing health education and family planning services and advice to the family as a whole and not just to women. When we started promoting FP in Ghana in 1969 the strategy was targeted towards women with the belief that when the woman was convinced she would be able to convince her husband. Unfortunately, however, the men just ignored what the women said and nothing happened. We had underestimated the fact that as a people we are very patriarchal. Women are not involved in decisionmaking in the traditional setting.

WW: *How different was the Navrongo approach from the 1960s?*

MA: The Navrongo approach was completely different because the nurse was now discussing with the couple in their home. In that case people from outside did not know what messages were being transmitted. This time, the women were very smart. They knew their position in the home and allowed the men to lead in the discussions. They knew that once the men were convinced, things would work. And things did work out to everybody's satisfaction.

WW: *And the story ended there!*

MA: On the contrary, that is where it all began! The doctors were excited and came to share the very positive findings with me. I congratulated them for a very innovative approach which was obviously yielding good results. However, I was a bit skeptical; I told them and cautioned that soon the success curve on the graph would develop a plateau. They became disconcerted and asked me why. Then I explained that the main reason why women want many children is because they know that if, for example, they have eight children about half of them would die. Now that they have been convinced to accept FP they are going to have fewer children. They would need a guarantee that if for example, they have four children, all four would survive. And the doctors asked me, 'so what is the guarantee?' And I said, 'the guarantee is that when the baby falls ill in the community, there is a service provider—the nurse who would provide the much-needed care. So we should teach the nurse to handle emergencies when they occur'. When they started training the nurses to treat minor ailments I said to myself, 'at long last the age-old problems of lack of access to health care has been overcome'.

WW: *Were people really enthused about it?*

MA: Oh yes. When I went to the field and asked the women what they liked about the nurse in the community, they said, 'oh, now that the nurse lives in the community with us when our children fall sick she's there'. Otherwise they would have to travel to the nearest Health Center or the Navrongo Hospital both of which are often too far away. Formerly, going to the hospital meant losing a whole day from the farm or doing household chores. Secondly the transportation cost to the hospital was taken care of.



Bringing political weight to bear on
health care delivery

WW: *That must have been a big relief?*

MA: Yes. But what really puzzled me was a remark one woman made. She said, ‘Now if the nurse tells me something and I forget I can ask her about it when we meet at the market place’. So I asked them, ‘what prevents you from asking the nurse in the hospital?’ Then they she replied, ‘but they don’t even look friendly’. In the hospital you are just a number but in the community you are special—you are assured of personalized services. There is trust between the service provider and the client. These experiences were an eye opener.

WW: *What did you do with those experiences?*

MA: I came to Navrongo when Prof. Fred Binka was Director of the Research Centre. I told them to organize a dissemination seminar at which the nurses would tell the world how they were doing it in Navrongo. That seminar was organized at the Novotel. Regrettably, the then Minister of Health wasn’t there; the Director of Medical Services wasn’t there either. In fact there was no one from HQ who could influence policy at that meeting. I was very disappointed. Anyway, that is how we started. When I became Deputy Minister of Health I said we must scale up the CHFP across the country. That is how in October 1999 we organized a meeting at La Palm Royal Hotel and the then Vice President came and launched CHPS as the new strategy to rapidly increase access to basic health care to all Ghanaians both in the rural areas and in the deprived/under-served peri urban areas.

WW: *How do you feel about your role in the CHFP, which gave birth to CHPS?*

MA: I feel proud about it, and I must tell you that I am impatient that things are not moving as fast as they should.

WW: *What is holding CHPS down?*

MA: People don’t understand CHPS and its importance. When we sit in the comfort of our offices in the cities, we forget about what is happening to poor people in remote parts of the country who have no access to health care. Under those circumstances when you see a nurse coming to live with you so that when you have a problem there is someone to run to, then you would begin to appreciate CHPS. If the Directors can appreciate what the poor folks are suffering they would be the first to say, ‘No, let’s do something about it’.

WW: *What has to change for CHPS to move?*

MA: We have been trained to sit in our clinics for the people to come to us. Under CHPS it is we who have to go to the people. This reversal of roles is incomprehensible to most health workers. So a lot of reorientation is needed. The so-called big people would have to move into the regions—into the district. They should go to Navrongo like I did. I went to Katiu, Kayoro, and to other communities to see where the nurses live; I talked to the chiefs...if they are able to do this then they will begin to understand. The other thing is that many people don’t know that this nation has about 55,000 human settlements and that Ministry of Health (MOH) is not operating even in two thousand (2000) of them. But then that is the size of the problem.

WW: *Do we need another dissemination seminar?*

MA: Not one but a series of them! Dissemination should be done from region to region. It is important that the Regional Minister, the entire Regional Administration as well as the Regional House of Chiefs should be present at these dissemination seminars. They would understand the problem because every chief in this country knows the number of communities under him. Then take the census book and find out how many communities are there in the various regions and districts and see in how many of them the MOH is operating. Then ask yourself, ‘what do we do with the rest of the communities that the MOH does not reach?’ Since it is expensive to build hospitals, would it not be better to train a nurse and put her in the community because all you need is a two-bedroom house and a motorbike?

WW: *What more can you expect from Navrongo after the experiment?*

MA: That is why I recommended that you allow the nurses in the field to come and tell their story. Now you can team up with Nkwanta because Nkwanta is the first district that successfully replicated the most important ingredients of the Navrongo experience using its own resources. Usually the problem is that people say they cannot replicate Navrongo because they do not have that much money. You can easily answer this question if you have Nkwanta with you, then they would say, well we have been able to replicate Navrongo using our regular budget, so you can also do it.

WW: *Is CHPS sustainable?*

MA: Yes, it is. But for CHPS to work it takes a lot of imagination. The Directors both at the top and at the Regional and District levels must have a vision and be creative, but above all, they should share that vision with their staff.



Liaising with the traditional leadership to get the CHFP off the ground

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

Navrongo Health Research Centre, Ghana Health Service, Box 114, Navrongo, Upper East Region, Ghana
What_works?@navrongo.mimcom.net

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