



# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

## THIS IS OUR CHPS

Nkoranza district of the Brong-Ahafo region lies in the transition between the rain forest and the savanna regions of Ghana. The district harbours some of the country's most fertile soil. Ninety-five percent of the people are farmers, which largely explains why the district is the leading producer of maize in Ghana. Other cash crops of commercial value include yam, cassava, groundnuts, and beans. Projected from the 2000 census, Nkoranza has a population of 134,236 spread over 1200 square kilometres. The inhabitants are heterogeneous—a mixture of Akan and people from other parts of the country especially northern Ghana. The road network is undeveloped, rendering most parts of the hinterlands inaccessible especially during the rainy season. There are 191 communities in the district with 18 functional community clinics.

The district is bounded to the north by Kintampo, to the south by Offinso, Techiman to the west, and Atebubu to the east. Nkoranza is one of the few districts to have visited Navrongo to acquaint themselves with the CHFP service-delivery strategy. By the time a Navrongo team visited to study progress of CHPS implementation, a few of the lessons had been brought to bear on the process. The Nkoranza District Chief Executive, Mr. Twumasi Ampofo, acknowledged the District Assembly's valuable role in the CHPS implementation process and pledged his support to the District Health Management Team, especially with respect to the construction of Community Health Compounds.



Navrongo team holds discussion with a designated CHO

The District Director of Health Services (DDHS), Mr. Amofa Boateng, said lessons from Navrongo have been well learnt but some modifications have had to be made to the CHPS implementation process in their district given the entirely different context. Two sub-districts, Ahyiyem and Donkro Nkwanta, have been selected and zones identified for CHPS. One CHO has been put in charge of one zone in Ahyiyem and one CHO for two zones in Donkro Nkwanta. Eighteen volunteers have also been selected and accounts opened for them at the bank to deposit drug money after sales. Stock registers have been opened for the health committee to monitor the flow of drugs. The two CHO-designates have already been deployed to provide service and supervise volunteers. Though both volunteers and CHO have been selected, neither group has yet to be trained. The settlement pattern is



A former rural clinic building converted into a CHO dwelling place

comprised of many small, scattered communities which are best served by having the CHO remain resident at Level B clinics where they ride into communities to provide health care. Procuring equipment for commuting from one village to another is the major problem confronting the effective work of the volunteers in decentralizing access to health care.

At Ahyiyem, about 30 kilometres southeast of the district capital, Ms. Agnes Adisa Amoah, the Nursing Officer in charge of the Rural Clinic, and the CHO-designate, Mr. Liptin Deyir Jacob, serve eight communities with a total population of 6,187. Mr. Liptin lives in a renovated structure formerly built by the community for use as a rural clinic before a new one was built. As a Disease Control Officer focused on preventive services, his lack of training in curative care is complemented by the nurse's background. The two of them go out on compound visits together. As

she offers treatment for minor ailments, he concentrates on MCH and FP services. Disease control officers have not been identified as core CHPS workers, but this example indicates that this is an oversight. He plays a key role in coordinating the volunteer program. An issue that remains unresolved is how the CHO's motorbike is to be fueled.

### What fails?

- *Getting CHPS implementation out of order.* Nkoranza demonstrates an axiom of CHPS failure: Community health care fails when the service-delivery cart is placed before the community-entry horse. This axiom is particularly evident when health volunteers are deployed in the communities ahead of CHO deployment.
- *Community involvement in volunteer supervision.* But even where community entry is pursued, the volunteer program has encountered serious problems suggesting that DHMT should be cautious about volunteer deployment. For myriad reasons, some volunteers did not appear when their services were to begin. For volunteers that have actually started services, supervision has been problematic, particularly in communities where the leadership structure is not clearly defined or where there is no recognised chief. Without a clearly defined role for the community in supervision, volunteers become drug peddlers rather than health workers participating in the CHPS program.
- *Educating the community on volunteer roles.* It is important to educate communities about what services volunteers *should* not provide (such as treatment of childhood febrile illness). A well-managed referral system requires community understanding about the referral system and the relative roles of CHO, sub-district clinics, and volunteers.
- *The need for volunteer training and supervision.* A well-established system for managing drugs and monitoring drug flow is needed as health volunteers can overstep their bounds—dispensing drugs and advice that may do more harm than good. If supervision is weak, health volunteers may divert parents from effective clinical services to volunteer-provided care for illnesses that volunteer-provided drugs cannot cure or treat. The volunteer system may be overtaking the CHPS initiative and there is the risk that without strict supervision volunteers would again assume the part of the dysfunctional “village doctor”—the drug peddling role of Village Health Workers in the 1970s. Volunteers have been provided with notebooks for keeping records and instructed to submit them regularly for inspection, but these rules are not always respected. Under such circumstances, deploying volunteers may do more harm than good.



TBAs at refresher training at St. Theresa's Hospital

### What works?

One of the essential components of CHPS is for the nurse to relocate to the community and live among the people—and not remain at static level B clinics. In Nkoranza the concept seems to have been well implemented but modifications have become necessary due to their peculiar circumstances—particularly with regard to terrain and settlement. What works is to adapt the Navrongo service delivery approach to local conditions and not implement a carbon copy of what was done under experimental conditions. All volunteers have been provided with notebooks to register new births. This is a laudable idea which when properly implemented will serve as the basis for establishing an efficient management information system for the communities.

The District's health system is supported by a strong network of Traditional Birth Attendants (TBA). Out of 131 TBA, 105 are active. A Safe Motherhood NGO which aims to reduce infant and maternal mortality supports the TBA. It provides training, service delivery kits, and offers motivational packages to sustain TBA interest. All TBA undergo refresher training, and are supported by ambulance and radio communication systems which are provided for all sub-districts. Navrongo suggested that TBA, who are mostly illiterate, be taken through literacy and numeracy classes to enable them not only attain functional literacy but also to boost their prestige.

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

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