



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

LEADING THE LEADERS

"If the followers agree to lead, the leaders will follow" is no longer just an adage—Juabeso Bia district has proved that it's fact. Once a district where no health staff wanted to be exiled, Juabeso Bia has managed its operations so well that today health personnel are queuing up to be posted there. For Juabeso Bia, CHPS progress has made the district an attractive place for health service work! But how did they get there?

For starters, Juabeso Bia has sent its staff to other districts to learn about operations, and adapt innovation to local needs and realities. For example, 30 district staff have visited the Navrongo Health Research Centre (NHRC)—the



Following the leaders so
as to lead the followers

highest number of health personnel from any district to have visited the NHRC for CHPS orientation. The District Director of Health Services for Juabeso Bia, Dr. Jack Galley, contacted his friend, Dr. Abraham Victor Obeng Hodgson, the Director of the NHRC in Navrongo. He was invited to participate in a DISHOP, an In-Service Training Programme for Health Personnel across the country, in Navrongo in July 1999. On his return, he and his staff decided to start Navrongo-like operations in Juabeso Bia. Once the seed was planted—after consultations with Chiefs, Elders, and Assembly members—Juabeso Bia has not looked back since. The District Health Management Team (DHMT) proceeded to visit other districts, even after they started CHPS. The entire team also visited Nkwanta in 2002. Seeking togetherness with others is the *zurugelu* approach to getting things done. Juabeso Bia has put everyone in the picture from start to finish, but mainly from the start!

Juabeso Bia is a large Western Region district—both in surface area and population. It stretches from north to south for 150km and has a 2000 census population of 242,119. The district is bounded to the west by La Cote d'Ivoire, to the south by Sefwi Wiawso, to the north by Dorma, to the north-east by Asunafo, and to the east by Aowin Suaman.

Big things begin small

The problems for CHPS to address in the district were daunting. As of 1994-95 Juabeso Bia had only six MOH health delivery points in only three out of the six sub-districts. But the district was blessed (or some would say cursed), with many scattered private clinics and maternity homes. The main referral points were Sefwi Asafo, Dorma, Berekum, Sunyani, and Komfo Anokye—all over five hours drive away for the lucky few who could afford transportation. By December 1999, there were only two State Registered Nurses (SRN), one SRN Midwife, two Enrolled Nurse Midwives, one Senior Medical Officer, one Senior Nursing Officer, (General), one Public Health Nurse, and one Nursing Officer (PH) in the entire District. The rest of the staff were either Community Health Nurses or Enrolled Nurses.

Staff shortages were only the beginning of the challenge. The district was plagued with numerous health problems which were compounded by several inaccessible communities due to poor road networks and tough terrain. The district was reporting the highest number of communicable and childhood diseases such as measles and malaria in the region. Services were not reaching the majority of the people, and the limited number of health services with an inadequate health infrastructure resulted in high maternal and infant morbidity.

There was therefore an urgent need to upgrade the Juabeso Health Post into a district referral health centre that will eventually become the District Hospital.

Foreseen problems

Staff understanding of the CHPS concept was poor and motivation for implementing it was predictably low. Private practitioners had every reason to resent competition with the CHO whose services were soon to be readily accessible,

more efficient and affordable to the people. Financial support for moving forward was a nagging pain in the neck. But Juabeso drew inspiration from the fact that no matter the odds health could not wait.

What works?

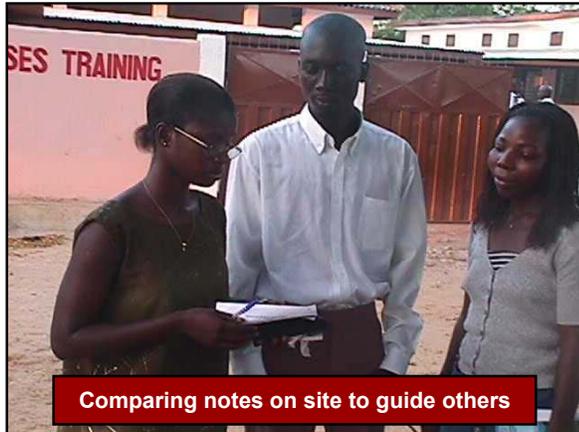
Before anyone thought about CHPS, private nurse practitioners were already effectively deployed throughout the district—providing compound-specific health care. Instead of seeing them as competitors in the delivery of health care, the DHMT took them onboard as partners—training and legitimising their work—much to the consternation of unqualified practitioners and quacks. All manner of skilled personnel available were slated for training. Both regular staff of the DHMT and private medical practitioners were invited to be part of the teams that visited Navrongo to receive counterpart training. The biggest advantage of using private practitioners is the potential for improving service quality with low investment. Sustainability is also guaranteed because there is very little or no attrition of health workers. Moreover, ignoring private service providers is tantamount to creating a competitive rather than a cooperative climate for CHPS development.



Juabeso Bia team members learn by doing

Juabeso Bia has also been innovative in its use of health volunteers. Unlike in Navrongo where volunteers are trained in the “Bamako Initiative” approach for administering basic drugs and contraceptives as well as treating minor ailments, Juabeso Bia has restricted the work of the volunteers to health mobilisation—assisting nurses in organizing vaccination coverage (NIDS) and distribution of Avermentin, NMT, and CBS. They are also used in defaulter tracing for DOTS and EPI. But above all, volunteers in Juabeso Bia are social mobilisers for health and family planning—community animators and CHO backstoppers who involve men in social support for reproductive and child health.

The district has also relied extensively on identifying and efficiently managing resources within the DHMT. To build morale and support for the programme, CHO are provided with a television set and cooking utensils as they leave for community postings. Monthly meetings are also organized to exchange ideas and discuss ways of handling challenges encountered in the field. For the future, Juabeso Bia is looking at the role of CHOs in the Community Health Insurance Scheme, CHOs and HIV/AIDS—especially people living with the disease (PLWHIV/AIDS), strengthening the referral system with radio telephones, and improving the district's data capturing system.



Comparing notes on site to guide others

Have these innovations worked?

First, take a look at the PPME maps of Ghana: Juabeso Bia has achieved more coverage of doorstep care than any other district in Ghana. Obviously, Navrongo counterpart training has left its footprints on the health chart of Juabeso Bia. After the sensitisation visit, staff became enthusiastic and moved to their own chosen stations. Now services are reaching larger numbers of people than ever before. Communities have started

showing open appreciation for the efforts of the DHMT—especially in the pilot areas. Health services coverage has increased and the most remarkable achievement is that maternal mortality tumbled by 37% in 2002. Staff willingly accept posting to Juabeso Bia and the district is now advancing the concept of CHPS in the Western Region. The CHN in the pilot areas are particularly happy with their work, as their roles have now changed to that of multipurpose health worker. But Juabeso Bia has to keep trotting just to keep still, and if it must advance then it must keep running. The most refreshing of their future plans is the goal to complete more study tours! Not only is the district the leader of leaders, it is still seeking ways to learn from others.

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, are 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. The Community Health Compound component of the CHFP has been supported, in part, by a grant from the Vanderbilt Family to the Population Council.