



What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT

Vol. 4, No. 21

Navrongo Health Research Centre

WHAT'S IN THE BASKET?

When clients are consulted about health care, most prefer services from a nurse in their community to care at a distant health centre. They claim a client or patient has no identity in the hospital setting, but at the community level, services are customized to the needs of the individual or household. Roles and responsibilities are reversed—when community members fall sick they don't have the added burden of traveling to seek medical care—someone will come to their doorstep and attend to them. When a nurse is relocated to the community level, economic costs for seeking health care are considerably slashed, geographical and social distance is bridged, and quality of health services improves. The impact of placing a CHO in a community, even without a health volunteer system to support her, is great. Thus there is strong evidence that supports the Community-based Health Planning and Services (CHPS) Initiative policy of building Community Health Compounds (CHC), posting CHO to live in them, and mobilising communities to support their service delivery work. Results of the Community Health and Family Planning Project (CHFP) clearly show that doorstep and community CHO services represent an important step towards achieving Health for All. The question is, what is it that the nurse does to improve health at the community level?

The mere presence of the CHO in the community is palliative. For instance, experimental findings under the CHFP show that infants exposed to CHO services have 12 percent lower mortality than those not exposed. In late childhood (ages 24-59 months), exposure to two years or more of CHO service activity is associated with nearly a 60 percent decrease in mortality among children.



It's not what's around the basket that matters, but what goes into it

CHO have a wide range of responsibilities while posted to the community. These include, but not limited to: disease surveillance; community mobilisation for health promotion and disease prevention. This is done through routine and special home visits; conducting immunizations for both children, pregnant women and nursing mothers; offering family planning counselling and providing family planning devices; conducting emergency deliveries and providing technical support to Traditional Birth Attendants (TBA) to conduct deliveries; monitoring the growth of children through child welfare clinics; treating minor ailments such as headaches, abdominal pains, diarrhoea, coughs, colds, malaria, dressing of cuts and sores; referring cases to the next rung on the health ladder; and supervising the work of a network of community health committees which in turn supervise health volunteers.

CHO cannot simply go on community posting with nothing in the basket. As a matter of fact, the Policy, Planning, Monitoring and Evaluation Division (PPME) of the Ghana Health Service (GHS) is in the process of compiling a list of essential logistics for CHO in order to have a uniform package countrywide. For effective service delivery the following list, which is by no mean exhaustive, is highly recommended:

Essential logistics for CHO	Specific need
Direct service delivery	
Motorbike, crash helmet, lock	Indispensable for doorstep health care delivery
Radio set (dry cells or solar powered)	Entertainment /stay in touch with the outside world
Rain coat	Protection
Lighting system (electricity/solar light/gas lamp, lantern, flashlight)	Night activities
Wellington boots	Protection
Electronic calculator	Calculations and report writing
Ruck sack	Carrying drugs during compound visits
Variety of drugs	Prescribed for CHO work
Drug box	Drug storage
Variety of family planning devices	Prescribed for CHO work
Stationery (Notebooks and pens)	Recordkeeping
<i>Where There is no Doctor, Treatment Guidelines MOH/GHS, Essential Drug List</i>	Reference books
Blood pressure apparatus	Taking blood pressure of FP clients ¹
Weighing scale	Weighing children and mothers—especially FP clients
Steel cabinet	Storage certain categories of drugs
Table and chair	Writing
Benches	Client/patient comfort during service delivery at the CHC
Thermometer	Taking temperature of children—especially those with malaria
Diary/field notebook	Recordkeeping
Palpation table	Palpating pregnant women
Cold chain equipment	Vaccine storage and preservation (six childhood killer diseases)
Gloves, bleach	Emergency deliveries ²
Personal convenience	
Bed, mattress	One
Blanket	Two
Sauce pans	One set
Coal pot/two-burner gas stove	One
Metal bucket	At least one
Kitchen stools	At least one
Water storage container	At least one
Plastic basin	At least one
Living room furniture	One set

Note: ¹Some devices such as the Pill and Depo Provera are known to increase blood pressure; it is therefore necessary to monitor the pressure to avert unpleasant consequences. ²These cannot be offered for free so will have to be paid for as a revolving fund to enable replenishment.

Even when all these logistics are provided the CHO workload can be crushing. Though ordinarily work does not have to be backbreaking, in the Kassena-Nankana District CHO have more satellite clinics than required due to the many other research projects being undertaken by the Navrongo Health Research Centre (NHRC).

When CHO activities are structured to make nurses work closely with the sub-district, community-based health care delivery becomes less burdensome. Sub-districts for instance, should be responsible for taking vaccines to CHO during immunisation days and returning the cold chain equipment after the activity. CHO do not also have to submit cluster registers as happens under the CHFP experiment. Submission of monthly reports on cases seen should be submitted to the sub-district.

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 of the Vanderbilt Family to the Population Council.