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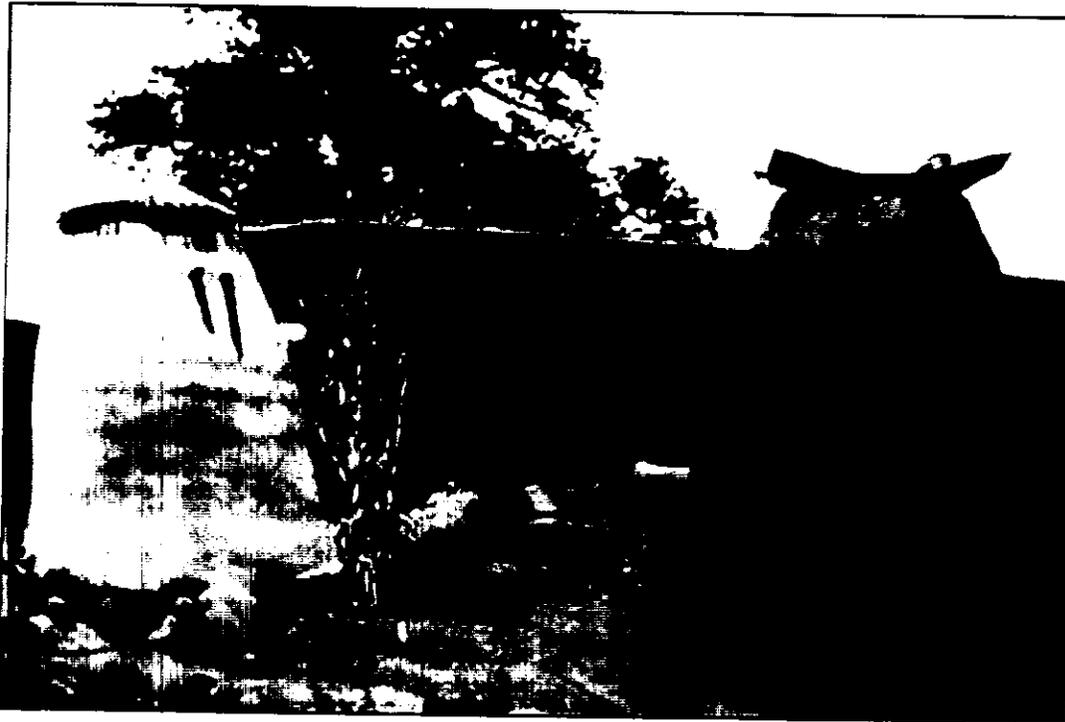
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*What works?*

*What fails?*



**...in organising community-based  
health service operations**

# *What works? What fails?*

## FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

This collection contains the current issues of *What works? What fails?*, a series of documentation notes from the Navrongo Health Research Centre Community Health and Family Planning Project (CHFP).

### *Beginnings...*

The CHFP was launched in 1994 as a pilot project and then expanded in 1996 to a factorial experiment to test the demographic significance of health and family planning programmes in a rural setting.

In 2000 the Government of Ghana adopted the preliminary findings of the CHFP and with them developed a national health policy. All 110 districts in the country have been requested to reorient health care using the Navrongo approach to community-based services.

In 2001, *What works? What fails?* was created to provide a mechanism for CHFP participants — service workers, community leaders, community members, and project staff — to communicate their experiences and insights to District Health Management Teams throughout Ghana. *What works? What fails?* aims to assist Ghanaian health workers in adapting Navrongo service strategies to local circumstances and needs.

### *Now and for the future...*

*What works? What fails?* serves as a mechanism to disseminate CHFP methods for districts in Ghana implementing this community-based health service delivery programme using the CHFP model. Along with the focus of informing the Ghanaian health community, these newsletters also enable CHFP skills to be shared more broadly in Ghana and elsewhere around the world to show what has worked and what has failed in an experiment to make primary health care more accessible to rural people.

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



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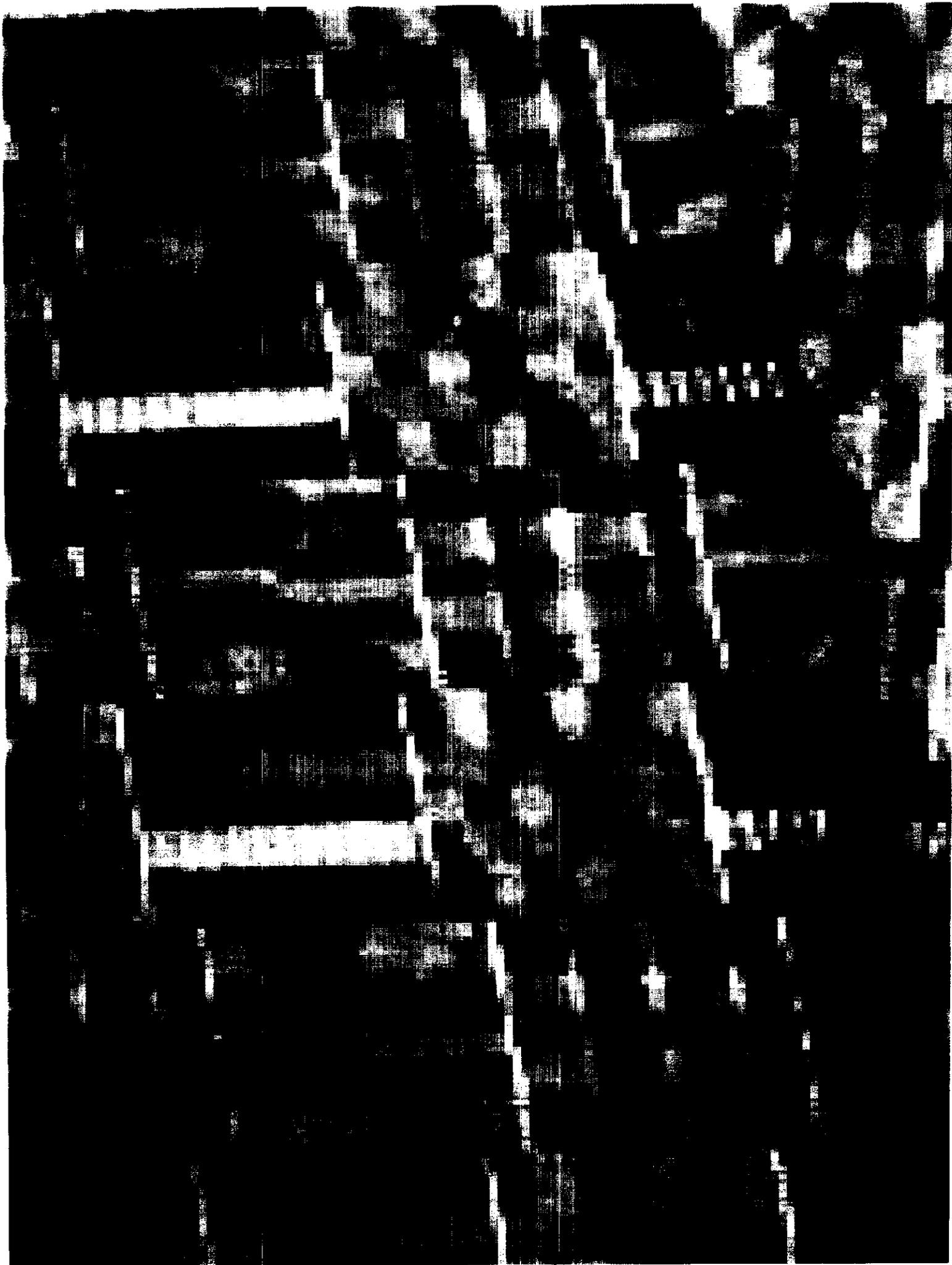
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# *What works? What fails?*



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 1, August 2001

Navrongo Health Research Centre

## HEALTH FOR ALL IN SIGHT

### THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

#### Introduction

It is a common claim that community health and family planning programmes in sub-Saharan Africa are not working. Questions concerning "what to do" in response to evidence of programme implementation problems remain the subject of considerable discussion and debate. With international financial support, programmes have often been launched that have no guidance from scientific trials. For example, the "Bamako Initiative" has been launched to make health services conveniently available through village committees, health volunteers, and revolving accounts for sustaining the flow of drugs for primary health care.<sup>1</sup> Also, "Community-based Distribution" (CBD) of contraceptives has been proposed as the best means of providing convenient low-cost family planning services. While these ideas are appealing, no systematic evidence exists to support the view that fertility and mortality can be reduced with these approaches. Does the Bamako approach work? Does CBD reduce fertility and ensure child survival? What is the best way forward for developing affordable and sustainable community health care? What should be the components of a community health system that works?

#### Health for All

In 1978, the World Health Organization convened the Alma Ata Conference to address similar concerns and to develop a consensus that "Health for All" could be achieved by the year 2000. Achieving "Health for All" through village-based Primary Health Care (PHC) became the official goal of the Government of Ghana. Yet, by the early 1990s mounting evidence showed that Ministry (MOH)PHC coverage for the country was low. Modern contraceptive uptake goals, particularly for family planning, were not being met. Building health facilities at the village level (Level A) had never been part of the government's strategies to decentralize health services. In any case, that would have been too expensive to sustain as a national programme. Community Health Nurses (CHN) who had been trained for community work remained based in sub-district (Level B) clinics that were inaccessible to a large proportion of rural households. It was time to take health care services to the doorstep of the people and involve them in the design and implementation of health policies.

Following this new thinking, a series of focus group studies was organized by the Ministry of Health to find out why health service utilization was low and why family planning uptake specifically, was not progressing. Respondents appealed for health care strategies that, in the words of one woman, would "first make sure that our children do not die." Child survival thus became crucial to the acceptance of family planning. In addition to this precondition, respondents wanted service approaches that would respect their concerns about privacy. Women appealed for approaches that would put men at ease about family planning.

#### Link to Policy

The Navrongo Health Research Centre (NHRC) has a mandate from the MOH to investigate health problems of the Sahelian ecological belt of northern Ghana. The Centre was asked to take the next step beyond the focus group studies to develop a package of services that would respond to the expressed needs of the people and test the impact of this health development



CHFP staff and community members  
discussing ways of improving health  
service delivery in rural Ghana

<sup>1</sup> The "Bamako Initiative" is the outcome of a UNICEF-sponsored regional health conference on sustainable primary health care delivery. It involves convening health committees at the village level, training health service volunteers, distributing primary health care drug kits, and operating a revolving fund for covering the cost of replenishing supplies as services are rendered. Three elements of the scheme are required to make it work: A logistics system for replenishing supplies; a financial system for managing the flow of resources; and a volunteer system for providing and supervising village-based health care.

programme on fertility and child survival. Although there was unanimity on what needed to be done, there was no consensus on how to proceed. Some policymakers advocated retraining, reorienting, and relocating CHN in ways that would make community health care a reality. Others were of the opinion that only volunteer services could be affordable and practical. Volunteer services, while representing an appealing concept, had, in the past, failed to produce satisfactory results. Debate about what to do with poorly functioning PHC village nurse and village volunteer strategies was at the core of the view that an experiment was needed. By virtue of its research mandate and reputation, the NHRC was requested to carry out the experiment and Kassena-Nankana District became the site of this trial. The overall goal of the experiment was to improve coverage and quality of health care services. Specific questions were asked by the MOH that could not be resolved without evidence from a field trial:

- Is there a way to develop sustainable and effective volunteer components of the health care programme?
- Is there a way to mobilize CHN so that they are truly community-based health care providers?
- Can CHN mobilization and volunteerism be developed jointly in ways that improve upon the effectiveness of deploying CHN and volunteers separately?
- What are the costs and marginal benefits of each option?

### Phase I: Consulting with Communities about CHFP Operations

The NHRC, with support and approval from the MOH, embarked on a series of consultations with the Chiefs and residents of the Kassena-Nankana District. The community members made constructive suggestions that helped in the design of the experiment that eventually became known as the Community Health and Family Planning (CHFP) Project or simply, *The Navrongo Experiment*. Discussions continued and services were changed and adapted to community opinion, reactions, and advice. In this way, concerns about promoting the survival of children, addressing the needs expressed by women for family planning, and respecting concerns of men could guide the actual activities of the programme as it was developed in a micro pilot.

### Phase II: An Experimental Trial

Over the initial 18 months of the project, services were launched in three pilot villages where community members served as consultants in the design and implementation of the service delivery scheme meant to respond to their expressed needs. The



A woman expressing her views at a focus group discussion

experimental trial was meant to seek answers to the following questions: was the design of the experiment appropriate? Will nurses agree to go to villages, live and work among the people? Will volunteers live up to their new tasks? How will community members respond to the new health service delivery? A great deal of care was taken to ensure that the ensuing design was culturally sensitive, appropriate, acceptable, affordable, and accessible. Once the overall system of culturally appropriate care was developed, the experiment went to scale in the entire Kassena-Nankana District in 1996. The reasoning was that community members had a fair idea about what would work and what would fail. The next challenge was to learn how to improve community health services and how to effectively deliver them as a package to communities and districts. Large-scale trial permits observation of the impact of a community-planned and culturally appropriate system of care.

### Conclusion

Programmes launched with the aim of decentralising access to PHC in rural communities—where the majority of people in many parts of the world live—have been based on speculation. *The Navrongo Experiment* has been

designed to test hypotheses that give scientific bases for such programmes. Numerous and varied lessons from the experiment attest to the feasibility of the project and make the experiences worth sharing with others, not only in Ghana, but elsewhere around the world.

*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, is 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.



## PUTTING THE EXPERIMENT IN CONTEXT

### Problem

Studies consistently demonstrate that passive clinical programmes based in district hospitals or sub-district health centres are not meeting demand for health and family planning services. Instead, a truly community-based approach to primary health care (PHC) delivery is needed that addresses stated needs. One policy response in Ghana has been to develop policies supporting the creation of the community health and family planning programme. However, the implementation of these policies is fraught with uncertainties and evidence that community health programmes can work is lacking. For example, while the placement of Community Health Nurses (CHN) in sub-district clinics seems appropriate, the clinics are underutilised and the nurses sit idle because services are inaccessible to most households. Communities have systems of governance, social organization, and communication that are well known to politicians and widely used to mobilize votes or community action. These traditional organizational institutions have not been utilized effectively for the promotion and delivery of health care. In order to determine the best path towards developing affordable and sustainable community health care, experimental studies must test the social and demographic impact of alternative programme strategies. A study located in Kassena-Nankana District of the Upper East Region of Ghana has addressed this need for experimental research.



Typical compound in Kassena-Nankana District

### Setting

The Kassena-Nankana District (KND) is one of 110 political administrative divisions, called districts, in Ghana. It shares borders with Burkina Faso in the north. Elsewhere, it is surrounded by five other districts. Latest demographic surveillance data put the current population of the District at close to 142,000, inhabiting 14,500 compounds that are unevenly spread over 1,675 square kilometres of semi-arid grassland. Residents of the District battle yearly with a rainy season from May to October and a dry season from November to April. Subsistence agriculture is the mainstay of the people, who are essentially rural dwellers with only 10 per cent urbanisation. KND has one of the highest illiteracy rates in the country with an illiteracy rate among females of six years and above reaching as high as 62 per cent. The Community Health and Family Planning Project (CHFP) has therefore been developed in the context of severe poverty and adversity. Titled *The Navrongo Experiment*, the CHFP examines policy questions with scientific tools developed for the evaluation of health technologies, permitting precise scientific appraisal of ways to help people in significant need. Mortality levels in CHFP study areas remain high while cultural traditions sustain high fertility. Traditions of marriage, kinship, and family building emphasize the



Community Health Officer providing services to community members

economic and security value of large families. Health decisionmaking is strongly influenced by customary practices, traditional religion, and poverty.

### Experimental Design

In response to these circumstances, the Navrongo Health Research Centre (NHRC) launched a three-village pilot programme of social research and strategic planning in which community members were consulted about appropriate ways to organize, staff, and implement primary health care and family planning services. Community dialogue about pilot service delivery was used to design a system of village-based services that were compatible with the social system and sensitive to stated needs. Chiefs, elders, women's groups, and other community institutions were contacted by project workers and involved in a system of support for community health service delivery. Nurses, who in the past had been assigned to underutilized clinics, were reassigned to village-based Community Health Compounds (CHC) constructed through communal labour for their use.

### Four-cell Experiment

An experimental design was developed during the pilot phase, in consultation with the three communities. Two broad sets of resources were examined, each defining a dimension of the project:

- 1) **The "Ministry of Health Dimension"** reorients existing workers to community health care and assigns trained paramedics to village resident locations.
- 2) **The "Zurugelu Dimension"** mobilizes cultural resources of chieftaincy, social networks, village gatherings, volunteerism, and community support.



**A durbar of Chiefs and community members discussing ways of improving community health**

Since these dimensions can be mobilized independently, jointly, or not at all, the design implies a four-cell experiment. One cell each is reserved for experimenting with the "Ministry of Health Dimension" and the "Zurugelu Dimension" while a third cell has normal Ministry of Health services. The joint implementation cell tests the impact of mobilizing community-based health care through traditional institutions with referral support and resident ambulatory care from Ministry of Health outreach nurses. Trial and error in the pilot phase developed service components of the full-scale experiment. In this phase, as before, community members served as consultants in designing service and mobilizing activities.

In 1996, a district-wide experimental programme was developed. Geographic zones corresponding to cells in the experimental design each represented alternative intensive, low-cost, and comprehensive service delivery operations. A demographic surveillance system, which

monitors births, deaths, migration, and population relationships, is utilized for testing the impact of alternative strategies for community health services on fertility and mortality.

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**Role of Research in the  
Navrongo Experiment**  
*Vol. 1, No. 3, September 2001*

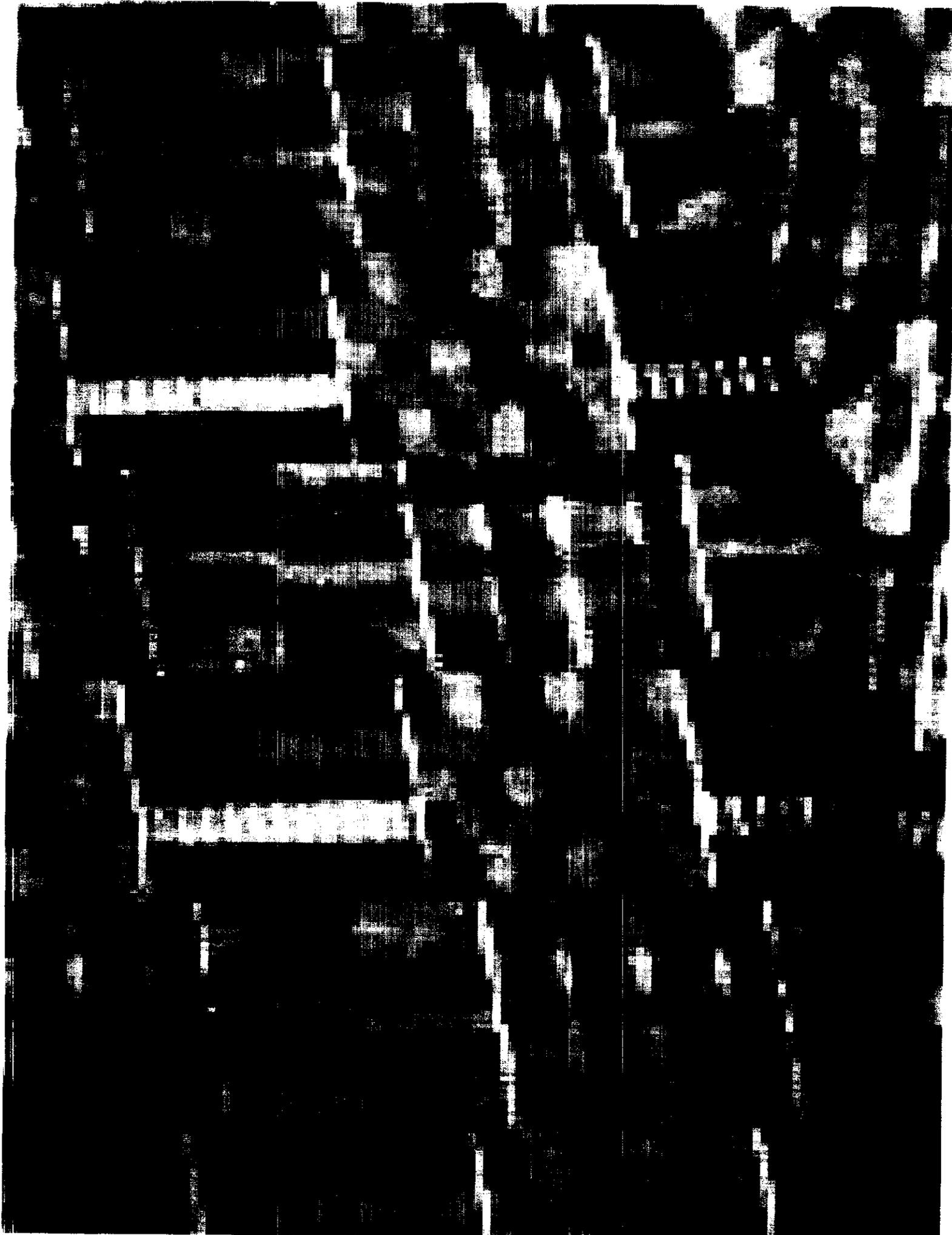
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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 3, September 2001

Navrongo Health Research Centre

## ROLE OF RESEARCH IN THE NAVRONGO EXPERIMENT

### Introduction

Launched in 1994 with the aim of finding ways of addressing the expressed health needs of rural Ghanaians, the Community Health and Family Planning (CHFP) Project or *The Navrongo Experiment*, is in line with Ministry of Health (MOH) policy guidelines for decentralising accessibility to Primary Health Care (PHC). Its ultimate aim is to test hypotheses about fertility and mortality reduction. The project design was based on the premise that existing idle human and material resources of the MOH can be mobilised in ways that improve accessibility, quality, and range of community health services. The project was also designed to test hypotheses about the health and family planning impact of mobilizing traditional leadership, social networks, and volunteerism for the promotion, delivery, and supervision of PHC.

### Why Navrongo?

Navrongo is situated in the Kassena-Nankana District in northern Ghana. The district, with about 142,000 residents in 14,500 compounds, is an essentially agrarian traditional locality where mortality is high and fertility remained unchanged prior to project intervention. Baseline contraceptive use in the district was less than four (4) per cent and fertility about five (5) per cent. Immunization rates were low, and infant mortality was 120 per 1000 live births. Possibly as a consequence of high mortality, customs emphasising the importance of large family size deeply affect the social response to services, requiring careful strategic attention in the design of reproductive health care. Survey results suggest that couples welcome family planning services that emphasise childspacing, but qualitative research shows that many men fear that the introduction of family planning and reproductive health care for women will diminish their status as heads of households. These are characteristics of a typical African rural community. Much is known about improvements in health status and survival that accompany economic development and social change; less is known about how to induce and sustain the health transition in the absence of economic development and social change. This is how Kassena-Nankana District became an ideal site for determining whether improvements in health can be attained and sustained in a traditional African setting using realistic interventions and resources without waiting for economic development or social change to occur first. The demanding features of the setting—the challenging context for developing health care and the daunting prospects for improving reproductive health care coverage—make Navrongo an ideal setting for community health research. If the health and family planning needs of this locality can be met, then it is arguable that success is possible anywhere.



NHRC had an elaborate research infrastructure to carry out the CHFP programme

Although the setting makes *The Navrongo Experiment* an important policy initiative, research resources of the Navrongo Health Research Centre (NHRC) greatly expand the contribution of the experiment to policy. The core research resource of the NHRC is the district-wide Navrongo Demographic Surveillance System (NDSS) that records all vital events and ensures that the demographic impact of health services can be subjected to systematic trial. The NDSS defines household relationships, permitting the systematic storage and retrieval of information about individuals, compounds, or treatments over time for any special study in Kassena-Nankana District. The NDSS represents the relational structure for all other data sets collected at NHRC. A Panel Survey System (PSS) has also been instituted that monitors individual characteristics, preferences, and reproductive health status over time. Panel instruments record family planning knowledge, contraceptive use, and intentions to use in the future. Shortly before the project was launched a sample of about 1,860 compounds was designated where all resident women ages 15-49 were interviewed in annual surveys about reproductive beliefs, motives, and preferences.

### Research Programme

Social research is conducted in conjunction with quantitative research systems. This qualitative research programme enables the project to get practical community advice on what works best and what does not work in this setting. Various features of the NHRC approach to research enhance the credibility of its results for policy: i) Results are based on the observation of a large

population. Results cannot be dismissed as something that chance could produce; ii) Results are based on continuous population surveillance data that are free of recall biases. Standard procedures for checking on the completeness of the NDSS show that data quality is exceptional; iii) Multiple research systems' data and research findings can be checked and cross-checked for consistency and reliability; iv) Most importantly, Navrongo research permits causal inference about what works and what fails. Longitudinal research, in conjunction with experimental designs, produces results that are not subject to challenge or alternative explanations.

### Conclusion

*The Navrongo Experiment* has demonstrated, in an inauspicious social and economic environment, practical means for implementing Ghana's longstanding goal to develop community-based primary health care that works. Early results have challenged conventional wisdom about what works and what fails. The Navrongo research systems show that long-term observation is required and that overly simplistic investigation based on single-round surveys alone may lead to spurious conclusions and inappropriate policy advice since survey responses may not permit crosschecking and careful analysis. If the experiment succeeds—and impact measured so far suggests that it will—substantive project hypotheses will be supported; no Sahelian setting is fundamentally inhospitable to the introduction and success of community-based PHC care and family planning. Establishing this insight requires the rigorous research systems that the NHRC has so comprehensively developed.



Testing the terrain before scale up

### Frequently Asked Questions

<p><b>Cost</b></p>	<p><b>Q</b> The NHRC has equipment, facilities, and resources for research that most districts lack. How can a district possibly replicate the CHFP without access to these special resources?</p> <p><b>A</b> The NHRC always separates research operations from service delivery operations. All CHFP services are undertaken by the DHMT and use resources that are deliberately constrained to replicable levels.</p>
<p><b>Contamination by research activities</b></p>	<p><b>Q</b> With so many research activities going on in Kassena-Nankana District, are the research activities changing communities in ways that bias results?</p> <p><b>A</b> The NDSS involves about 10 minutes of interviewing of every compound head in the district every 90 days. NDSS interviewing is not a significant intrusion into people's lives. The Panel Survey is conducted once a year in about 1,600 compounds. There is no evidence that panel responses differ from responses in households where there is less interviewing.</p>
<p><b>Societal gains from research</b></p>	<p><b>Q</b> Research generates findings that scientists publish and disseminate. But, do the people of Kassena-Nankana District really benefit from research? Do they even know what the research is for and what has been learned?</p> <p><b>A</b> The CHFP consults with communities about research activities and explains the goals and purposes of studies before they are conducted. Dissemination of results includes community durbars on findings. Ways in which communities have benefited from the services associated with experimental studies are reviewed and discussed at the end of studies. In the case of the CHFP, which is a multi-year effort, this process of dialogue is continuous.</p>
<p><b>Policy benefits from research</b></p>	<p><b>Q</b> Research costs money. How does the MOH benefit from this programme? Why not have a training and demonstration programme in Navrongo rather than a complicated research initiative?</p> <p><b>A</b> From the onset of the CHFP, activities have been guided by unanswered policy questions. Results are designed to produce evidence for decisionmaking. Evidence-based policy development saves resources by creating programmes that are efficient and effective. The national programme entitled the "Community-based Health Planning and Services" (CHPS) initiative is a national effort to utilize results from <i>The Navrongo Experiment</i> for large-scale health programme reform.</p>

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FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 10, March 2002

Navrongo Health Research Centre

## EVEN THE ANCESTORS WANT FAMILY PLANNING

The Kassena-Nankana of northern Ghana have no word for the supernatural; boundaries between reality and imagination do not exist. The gap between mortals and ancestral spirits is bridged by the medium of soothsaying. Every lineage is headed by a patriarch who practices religious rites for contacting spirits to explain events in the past, forecast the future, or guide decisions of current concern to families in the lineage. At the launching of the CHFP, it was expected that community members would consult the ancestors about the project. Since contraceptive use was uncommon in the Navrongo setting, it was assumed that ancestral consultation would lead men to reject family

planning. To explore this issue, social scientists from the NHRC compiled two matched interviews of male lineage heads. The first interview provided an indepth appraisal of the reproductive views and preferences of lineage heads. The second interview repeated these questions with the same individual through the medium of soothsaying, providing an appraisal of the views of ancestral spirits of nine lineages. Comparison of the responses permitted evaluation of the ancestors' role in family planning decisionmaking.



Soothsayer preparing to meet the dead on behalf of the living

This investigation was based on the assumption that confronting spirits with fertility regulation, imported from abroad, and imposed without spiritual dialogue, risks cultural conflict and social imbalance. Ancestral spirits are believed to dwell on this earth through progeny. Services and themes of a family planning programme may represent more of an affront to culture than a service to society. It is thus reasonable to expect people to fear alien ideas that risk social and spiritual disruptions. Under such circumstances, programmes will be rejected unless themes and messages are pursued in consultation with the ancestral spirits of the communities served.

To ensure salience and sustain interest, a questionnaire administered in the investigation was kept short and focused on reproductive health preferences. The questions used were:

1. *Is it good for women in your lineage to have many children?*
2. *If you think about men in your lineage, do they have more children than they want, fewer children than they want, or just about the right number of children?*
3. *If you could start your family again, how many children would you have?*
4. *In this lineage, are big compounds better off than small compounds?*
5. *When babies are born in this lineage, is it better for a woman to have a boy or a girl?*
6. *Some men and women use methods to delay or avoid a pregnancy. In general, do you approve or disapprove of couples in this lineage using a method of family planning?*
7. *A project has been launched in this village to provide men and women with health care and family planning. Will this programme help your lineage in the future? Are there ways in which the programme is bad for your lineage?*

Soothsaying sessions were dominated by ritual incantations for arousing the ancestors. Contrary to expectations that responses would be homogeneous, responses reflect considerable diversity of opinion, and often, the ancestors were more open to family planning than the lineage head.

The following is typical of the responses to the question, *Is it good for women in your lineage to have many children?*

*Lineage head: I would like each and every one of the women to have children, but I do not intend to*

*let them have too many children, because it would be good to have the number of children that you would be able to take good care of.*

**Ancestor:** *The ancestors say that it is now difficult to get an education as well as to do farming. If...a problem crops up, and the child is sick, then money is everything. You have to buy medicine, and even if you go to the herbalist, you need to take a fowl along for treatment...It is no longer the same as in the olden days, when everyone did farming.*

Some even appear to be more concerned about the consequences of having many children than the lineage head:

**Lineage head:** *I would like them to have many children because it is a large following that makes one a chief.*

**Ancestor:** *The ancestors would like them to have three children each. One would be your mother, one your father, and the other your child. (After probing:.) They would like everybody to have a small number of children, but they should not refuse to have children altogether.*

In fact, it was learned that while ancestors may have a role in a man's deliberations about the timing of childbearing, they are not consulted about preventing pregnancy. Family planning is something that is nontraditional, so tradition does not enter into decisions about it. As one young man stated:

*It is left with you and your wife to come together into agreement before you go to see the person who will help you to practice the method. There is no libation pouring in this decision. You both have to understand each other before you go for the family planning.*



**Ancestors are not shy about speaking through female soothsayers**

Numerous sociodemographic studies in sub-Saharan Africa have been directed to interviewing the living about their reproductive norms and aspirations. The Navrongo study was the first to involve respondents who are deceased. Findings suggest that religious practices are flexible and adaptive to social change. The cult of soothsaying is not emphatically pronatalist and should not be viewed as a social force that is fundamentally aligned against the family planning programme. Organizers of family planning programmes may encounter incidents whereby village events are interpreted by soothsayers, but the programme itself will not be the subject of soothsayer-mediated spiritual review and consultation. The influence of traditional religion on reproductive behaviour is often characterized in the international social science literature as constraining reproductive change, as if African religious values are somehow anti-modern or are reactionary social influences which must be subverted if family planning programmes are to succeed. Navrongo research shows that ancestors are far more accommodating to new ideas about reproduction and family planning than conventional perspectives in the literature portray. Health and family planning programmes can be developed in partnership with traditional religious leaders and in concert with traditional religious practices and precepts.



**Summoning the ancestors through ritual incantations**

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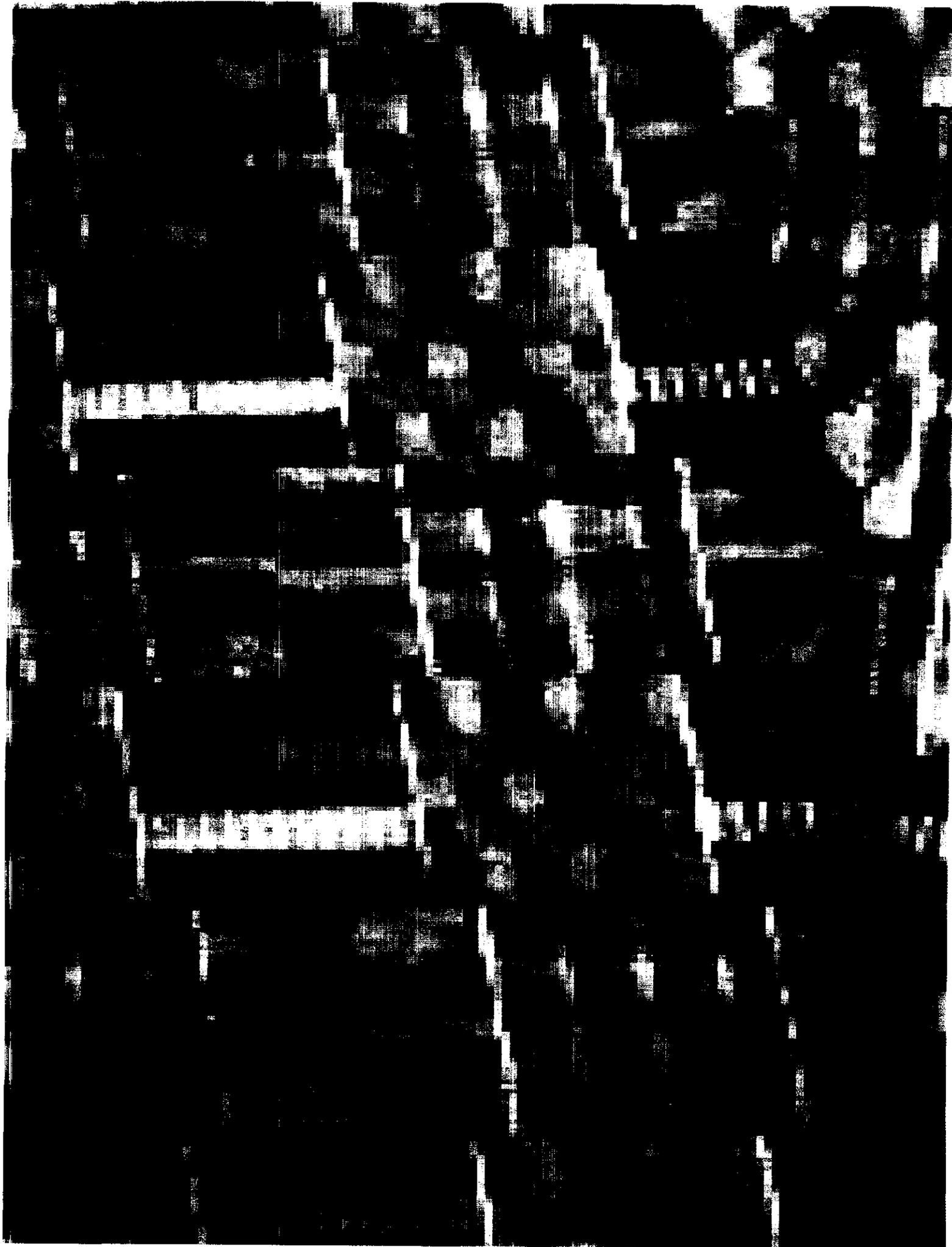
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## SWIMMING AGAINST THE TIDE

The call for "community participation" to solve problems is far from unique. Nevertheless, examples and techniques for achieving this in practical terms are uncommon. The Navrongo Health Research Centre's (NHRC) health and family planning initiatives confront a challenging context; significant institutional, economic, social, health and environmental concerns of community members must be addressed if programmatic efforts are to succeed. In keeping with the central import of community participation, the NHRC, from the outset, initiated an assessment of obstacles to programme creation in response to these constraints. Through qualitative studies on fertility norms, behavior, and beliefs, the advice of community members was used to identify and catalogue specific operational constraints and to provide culturally appropriate response strategies to them. The following were identified early in the Phase I pilot programme.

### Environmental Constraints

**Settlement patterns.** The population of Kassena-Nankana is both isolated and dispersed. Clinics are underutilized and public transportation is poor; consequently, Community Health Nurses (CHN) were installed and provided with motorbikes. Community leaders recommended that the bases of operation of CHN could be relocated effectively if assisted by the Chiefs and a community liaison officer. By charging communities with the construction of compounds for the CHN, the project elicited their involvement and support.

**Seasonality.** Fertility, mortality, and general adversity vary with the seasons in these agrarian communities. Strategic planning calls for a focus on family planning in durbars during peak conception periods, a focus in wet seasons, etc. Further, family planning service hours, cost, and location must be flexible and vary with the harvest season dry seasons<sup>1</sup>.



Community durbar

### Sociocultural Constraints

**The role of tradition.** In this traditional rural society, the strength of central bureaucracy is surmounted by strong community leadership by Chiefs and Councils of Elders. Traditional leaders, then, must be consulted and involved in programme planning, and local institutions must be employed. For example, the programme can benefit from the *Zurugelu* system of traditional action committees and community durbars, which are usually scheduled on market days for maximum attendance and impact.

**Gender roles.** In the discussions during village durbars, men demonstrated little understanding of, and interest in, family planning. Married men often are apprehensive about this outside influence on reproductive behavior. Women's access to contraceptives is limited as they may be forbidden to travel for services or may lack reproductive autonomy. An assurance of confidentiality as well as open discussions, as in durbars, may increase information about, acceptance of, and trust in family planning services.

Men can be targeted through a *Zurugelu* programme for Chiefs, elders, and husbands while women may benefit from IE&C activities addressing appropriate responses to husbands and kin who do not support contraceptive use.

If my husband marries a second woman and he does not want us to do (family planning) and she doesn't do it, he will love her; he will not love me again. If he has something small, he will give it to her and leave me...In the night I will be sleeping alone with all my family planning...

Young Naga woman

<sup>1</sup> Research has shown that fertility in the Kassena-Nankana District is highly seasonal. The period immediately following the harvest is the peak conception season. Appiah-Yeboah Shirley et al. 2001 "Impact of Agricultural Adversity on Fertility among the Kassena-Nankana of Northern Ghana"

**Religion and pronatalist traditions.** Soothsayers, who are influential members of the community, are likely to oppose family planning programmes. Consequently, the survey suggests that soothsayers be consulted about specific strategies and that respected traditional community leaders be involved in the promotion of family planning services.

**The nature of demand.** Demand for family planning is complex and contradictory in some respects. Women cite large families as ideal, yet express a desire to limit their fertility. The current term for family planning services *adog-maake*, which translates to "stopping childbearing," further complicating the apparent intentions of programmes. Spacing childbirth is, however, well understood. Health workers must be retrained in outreach strategy and in ways to conceptually link primary health care and family planning. Candid doorstep conversations, rather than simple woman-to-woman transmission of information, may foster broader and longer-term changes in attitudes.

### **Economic Constraints**

**Extreme poverty.** In an environment in which resources are scarce to find, women are compelled to turn to their husbands and family relations to pay for even things such as contraceptives. Under such circumstances, lowering the price of contraceptives does not eliminate financial barriers to access. Cost-sharing schemes and coupons may therefore be more effective at increasing family planning use. Children represent economic value; however, families increasingly favor wage earning over farm labor. Programmes may generate demand by establishing credibility and emphasizing links to child survival.

**Agrarian economy.** Cash, long-range service delivery, and exposure to mass media are all limited. Music and cultural events communicating family planning and other health themes may therefore be most effective. Family planning programmes may benefit from traditional networks such as men's cooperatives for harvesting and *Susu*, women's associations for trade, marketing, and lending, both in terms of information dissemination and in terms of employing existing means of sharing adversity.



**Consultation with traditional healers works, confrontation fails**

**Basic health care concerns.** Mortality and morbidity indicators and rates of infectious diseases are high in Kassena-Nankana District, and given limited resources and energy, family planning programmes must show their own importance. These circumstances call for a shift from the needs of bureaucracies, statisticians, and demographers towards those of the community. Durbars may therefore include discussions of sanitation, immunization, and common diseases in conjunction with family planning information and services.

**Faith in traditional medicine.** Belief in traditional healers and soothsayers' advice often causes delays in seeking allopathic and nontraditional opinions. These traditional healers must be consulted about the formation and structures of proposed interventions.

**Reproductive health and delivery problems.** Given the prevalence of reproductive health problems and the high incidence of labor complications, an efficient referral system must be put in place and community health workers trained to screen and refer patients when the need arises.

### **Conclusion**

From an assessment of these problems, the Navrongo staff proceeded to investigate what service delivery, community health education, and outreach strategies could be designed to optimally address them. Each problem was aligned with a proposed solution; each solution was tested in a micro-pilot, and focus groups were convened to gauge community reactions and to seek advice on ways to move forward. In this manner, social learning, listening, testing, and responding over time, became a resource for organizing the Community Health and Family Planning Project.

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 8, November 2001

Navrongo Health Research Centre

## JUST THE RIGHT AMOUNT OF COMMUNITY INVOLVEMENT

### Introduction

The Navrongo experiment was launched in 1994 as a pilot project testing the mortality and fertility impact on primary health care of mobilizing untapped resources and shifting the locus of care delivery. The Project's *Zurugelu* (togetherness) dimension seeks ways of involving communities in the organization, delivery, and supervision of primary health care; the Ministry of Health (MOH) outreach dimension seeks ways of moving health services from Level B Clinics to clients' doorsteps. Based on CHFP results, this note assesses community-based strategies that worked and some that failed.



Community durbar

immediate demands on the CHFP project. This community emphasis on clinical care sustains both interest in developing CHC institutions of chieftaincy, lineage, and social networks to provide support for services, supervision for volunteers, community health education, and family planning themes that nurses could continue to promote. CHC have since become central to the success of the CHFP.

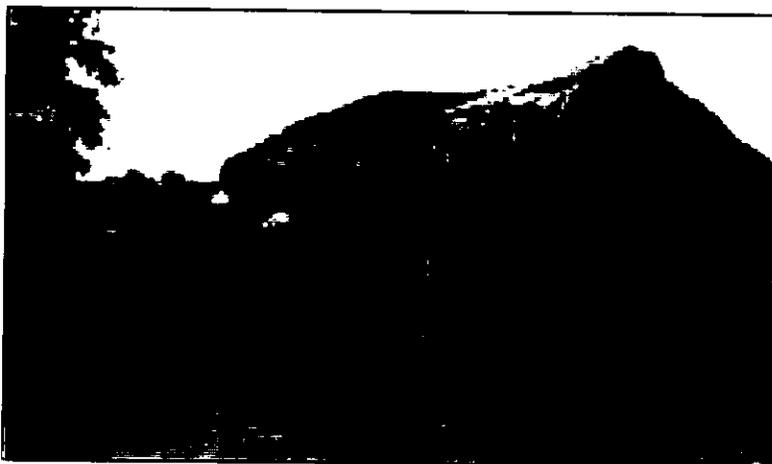
**CHC.** Community leaders can be mobilized in support of PHC and family planning services. The process of community mobilisation builds male involvement and reduces the social tensions brought forth by the promotion of reproductive health care. Community leadership can reinforce MOH supervision.

**Community-based services.** It is possible to relocate nurses to CHC. Community-based paramedical care greatly increases the volume of services, improves immunization coverage, and expands the range and quality of reproductive health and ambulatory care. The strong prefer-

ence for injectable contraception is addressed by doorstep- and CHC-based paramedical services. If conveniently accessible nursing services are combined with community mobilisation, health care and immunization coverage will improve, and family planning practice will increase.

### What works?

**Community participation.** While "community participation" is frequently deemed central to health policy, how to translate this concept into practical terms at the district level is often unclear. The CHFP addresses this knowledge gap by providing viable ways to develop community participation. Early in the CHFP pilot phase, it became evident that communities will donate labor towards constructing health facilities, known as "Community Health Compounds (CHC)." This interest is based on the widespread concern expressed in durbars that communities do not have access to health care. That primary health care (PHC) needs are not adequately addressed by subdistrict level clinical care alone places



Community Health Compound (CHC)

## What fails?

**Community participation.** A community mobilisation strategy that is entirely dependent on community resources is often fraught with delays. Alternatively, a community outreach programme that is externally supported can induce community conflict or apathy. Small, external resources are therefore needed as incentives for community action rather than as replacements for it. In Navrongo, communities that were provided with District Assembly support for iron sheets or other CHC construction materials



A Yezura Zenna (YZ) providing doorstep services

were much quicker to implement the programme than those that were either totally deprived of or completely supported by external resources.

**Community volunteers.** The Navrongo project employed volunteer workers known as Yezura Zenna (YZ)—young men and women committed to improving the standards of health and well being in their community. Cells testing community health mobilisation show that community outreach alone (without resident nurse service support) has no impact on fertility or mortality. In fact, the Bamako approach may divert parental health seeking behavior

from relatively costly, but effective, paramedical services to inexpensive and convenient, but ineffective, volunteer-provided services. This issue is unresolved, however, and further research is needed before definitive conclusion can be drawn. Nevertheless, findings suggest that community participation and volunteerism should be directed towards health promotion and service system support, but the provision of treatment and care should be left to trained MOH paramedics.

**MOH community-based services.** Doorstep family planning services had an impact on fertility only in cells of the experiment where community mobilisation was developed. Community-based delivery will fail unless traditional leaders, lineage heads, and men are mobilized to support the programme. Successful community mobilisation empowers women to exert their reproductive preferences. Failure to mobilize the community fatally weakens MOH outreach. Involving leaders, however, creates a mechanism for male involvement.

**Perinatal health and neonatal survival.** The Navrongo experiment has yet to demonstrate an impact on mortality in the first month of life. There is a need to test feasible means of providing emergency obstetric care in settings where access to delivery services is constrained by the absence of communication, transportation, or ambulatory care.

## Conclusion

Appropriate community involvement is complexly determined, and must be carefully equilibrated, accounting for programmatic, MOH, community nurse, community male and volunteer roles.



Community Health Officer (CHO)

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Navrongo Health Research Centre

Vol. 1, No. 9, November 2001

## THE COMMUNITY AS CLASSROOM

Training in reproductive health services and primary health care is often planned as a four-corner classroom exercise involving lecturing, listening, and learning by rote rather than as an exercise in learning from practical example through counterpart exchanges. Also, programme planning is something that is usually pursued in an office far removed from the communities that plans are intended to serve. Management can also take on a top-down character rather than something that is informed by community experience of service workers. The design of the Navrongo Community Health and Family Planning (CHFP) Project is based on "learning-by-doing" in which planners, workers, and leaders are guided by community opinion and leadership. All operational components of the programme have been developed on a pilot basis; each pilot involved village trial and community feedback on what has worked and what has failed. Training programmes associated with the CHFP have placed maximum attention on learning in the village and peer leadership—a concept of learning whereby workers who are experienced at an activity train counterparts while actual services are being provided. Transferring lessons from the Navrongo project to other districts has also emphasized practical demonstration. Taken together, this programme is organized as an initiative in which communities serve as the primary classrooms for developing management, worker, and trainer capacity to conduct the CHFP. Unlike other initiatives, which conduct training at the beginning of a programme, "learning-by-doing" is a continuous process in the CHFP.



Learning from fellow men

### Social Learning and Capacity Building

From the onset of the CHFP two individuals have played a crucial role in capacity building. Developing the CHFP has not been pursued with trainers brought in from outside the study area or pursued as coursework in a regional or national programme.



Community Liaison Officer, CHFP staff member, and a CHO

Developing the CHFP required DHMT commitment, direction, and leadership. Since capacity building is not a conventional DHMT role within the MOH system, it is important for the District Director of Health Services to designate two individuals in this effort: i) a Training Coordinator who will plan the content, timing, and duration of training activities, and a ii) A "Community Liaison Officer" who consults with community leaders, encourages collective action, and deals with problems through diplomacy and discussions.

**Social learning as a management tool:** The work of the "Community Liaison Officer". Ever since the CHFP was launched, community groups have been assembled to discuss activities and advise the programme about ways to improve operations. Assessing community-training resources is the job of the Community Liaison Officer. The Community Liaison Officer convenes social groups that naturally assemble in Kassena-Nankana society to assess reactions to operations, seek community advice on training needs, and identify gaps in the service regimen. Groups identified for consultation include Chiefs and elders, social networks of older women, young married women, and young married men. Assessing community

reactions by systematically convening these groups and listening to their advice provides a mechanism for community leadership in capacity building activities.

**Role of the Training Coordinator.** The Training Coordinator organises training sessions, prepares and manages timetables and budgets, documents plans and gathers resources, and identifies local resources. A district may have an unusually active and creative Community Health Officer (CHO) or a dedicated Chief or a committed Assemblyman. After the Community Liaison Officer has identified the training needs of the community by soliciting the opinion of the people, actual training activities are coordinated by the Training Coordinator who is a full-time DHMT member responsible for deploying workers to the village as well as planning training sessions.

**The "Counterpart Training" Concept.** Counterpart training represents a concept in which service delivery staff, such as CHO serve as on-the-job trainers. Under ideal circumstances, village counterpart training involves an entire cycle of community health service visitation and outreach, running for about three months. In practice, however, much shorter periods of time have been used owing to inadequate staffing, equipment shortages, and accommodation problems.

For CHO, "counterpart training" is designed to demonstrate all aspects of the CHFP service regimen: i) comprehensive immunization services; ii) safe motherhood counseling and delivery services (if opportunities for midwifery care arise); iii) treatment of febrile illnesses; iv) diarrhoeal disease therapy; v) reproductive health counseling, and family planning service delivery; and other ambulatory care or referral services. Training also involves orientation to record keeping and monitoring, community entry and mobilization activities, and volunteer programme coordination.

For supervisors, "counterpart training" involves attaching a trainee-supervisor to a role-model supervisor who serves as a guide for field activities. This involves demonstrating community diplomacy, CHO support requirements, training activities, and other elements of community health care supervisory operations.



**DHMT staff taking CHO through a training session**

process involves listening to the community, adapting services to local realities and needs, and developing training approaches that involve workers and community members. Throughout this process, the community is the basis for all learning about what works and what fails.



**Teamwork—CHO and community members working closely together**

Finally, entire DHMT and counterpart teams have been trained in Navrongo to establish "lead districts" in other regions of Ghana. At every stage of these orientation sessions, communities are involved in training visiting teams and workers at all levels serve as trainers. In this manner, the communities served by the CHFP have become classrooms for training health professionals in ways to replicate operations in other areas of Ghana.

### **Conclusion**

Using the CHFP for developing community health and family planning services elsewhere involves applying the Navrongo process of capacity building as much as it involves technical components of the programme. The

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 4, January 2002

Navrongo Health Research Centre

## WHERE THERE IS NO COMMUNITY

The ideal community is a place where people live in harmony, with activities of common interest organised by benevolent Chiefs, and implemented with enthusiasm by community-spirited volunteers. Unfortunately, such communities don't exist. In fact, in some districts there are communities that are leaderless, plagued by endless conflicts and thereby lacking social cohesion.



CHC overgrown with weeds—where is the community?

In such communities, the elegant CHFP community entry procedures for soliciting the cooperation and support of traditional authorities and community members may fail to foster community action. In the case of the CHFP—or what is now referred to as the Navrongo service model—health service planning is directed to community needs and health reorganization begins with community consultation and dialogue. Community leaders are involved in all aspects of primary health care delivery: design, implementation, monitoring, supervision, and evaluation of interventions.

Communities are mobilized to provide residences or construct community health compounds (CHC) where nurses relocate to provide door-to-door health care. Health committees are constituted to supervise the work of community health volunteers who are trained to

provide basic curative as well as preventive health services. However, in two communities where Chiefs were not involved from start to finish in the design and execution of programmes, the system was never launched until unconventional action was taken to deal with the absence of community organization.

### What Went Wrong?

For the most part the new health delivery approach introduced by the CHFP has been embraced with gusto. But, while some communities put their heads, hearts, and hands into the programme—with the active support of community leaders—others were less enthusiastic, almost apathetic. Is it possible that communities may not be interested in their own affairs, their own health? What should be done in settings where people do not show interest and participation in promoting health service delivery? What is appropriate in settings where there are no communities?



Where there is a community, even little children give the nurse a helping hand

Durbars have been a mainstay of the CHFP design, but in 'nonexisting' communities, such meetings of community members could not be organised. Messages to be delivered to its members regarding the concept of community-based health service delivery never took place. Where communities showed little interest in durbars, support for constructing a CHC was totally lacking. It was reasonable to

assume that community volunteers would not contribute their labour for CHC maintenance, which, in rural Kassena-Nankana, is a yearly necessity.

In one such community, discussions were continually held with the Chief and some elders; yet, when it came to meeting community members at a durbar, problems cropped up, most of the people did not attend. Since it was always a few people who got the health service delivery message, the request for the community to provide or construct a CHC could not take effect and that delayed the posting of the CHO at the initial stages. Several visits were made to the Regent who acted as Chief after the death of the Chief and before the enskinment of a substantive Chief. All efforts to get the Regent to call a durbar were unsuccessful. Flimsy excuses, such as a funeral preventing the people from attending the durbar, took the place of concrete actions. This community was referred to as 'a community in absentia' and the 'uncommunity'.

After several months of fruitless attempts to get the community together, a prominent member of the community visited home from a major southern city. As a well-respected personality in the community—especially by the youth—he was recognized by the CHFP as someone who could catalyze community action. When the individual was contacted he willingly agreed to organise a grand durbar where project staff could address a large gathering. Later he organised youth to mould bricks and with his supervision, the CHC was constructed. The CHFP assisted the community by providing roofing material, cement for the floor, and bitumen for stabilising the walls. Afterwards, an impressive and well-attended durbar was organised to introduce the CHO, YZ, and YN.

Chiefs and elders who had done nothing to foster this action were invited to participate in the durbars, in recognition of their traditional roles of honour. But all present knew the true dynamics of progress. Traditional leaders were motivated by the experience to take the initiative seriously and cooperation with the CHFP improved.

### What works?

Where there is no sense of community, it takes more than the Chief and his elders to organise people to participate in local initiatives to promote health. The active participation of community members in health service delivery or for that matter, any community-based activity, should not be taken for granted. To successfully deploy nurses to the communities and for them to perform effectively, an influential person may be needed to inspire people and organise them for communal work, especially when it comes to the construction of CHC or their maintenance. Therefore, the Chief should not be the only person to rely on to organise people for communal work. In some communities the Chief is regarded only as a ceremonial head who does not wield sufficient power to organise the people to carry out an activity. It is sometimes necessary to search for an opinion leader to organize community members. Various options are available: school teachers, Assemblymen, social network leaders, women's groups, church groups, and economic networks.

### Conclusion

Where traditional leadership is weak or lacking, it is important to convene discussion groups of women and men to guide the programme on feasible means for moving forward with alternative leadership designs. CHO and volunteers remain deployed throughout all experimental areas in Kassena-Nankana to offer services, clearly shows that it is possible to promote health service delivery even in areas where there are no communities!



Other communities just sing to their health

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# What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT



Navrongo Health Research Centre

Vol. 2, No. 21, June 2002

## PUTTING TRADITION TO WORK

In closely-knit societies such as those that exist in Africa, practices abound that provide the framework for understanding and defining relationships, attitudes, actions, and general behavioral patterns. Often, adherence to these cultural values is identified as a constraint on the implementation of development projects aimed at promoting the wellbeing of both the individual and the community. The potential for mobilising these cultural resources for social change has never been seriously considered.



Traditional leaders make it to the durbar grounds in resplendent regalia

Today, an experiment in a remote and rural setting in northern Ghana has dissipated the negative perception that culture is potentially inimical to progress. Contrary to conventional wisdom, the Community Health and Family Planning Project in the Kassena-Nankana district of the Upper East region has successfully demonstrated that cultural institutions can be deployed as powerful resources for promoting health and family planning in an environment where the demand and utilization of such services has been consistently low. The invaluable cultural resource in question is called a durbar or the Village Parliament. A durbar is a traditional gathering convened by Chiefs, elders, and opinion leaders of a community or village. More often than not, it is associated with festive occasions like traditional festivals or the enskinment of a new traditional ruler. Durbars are often organized to build community commitment for a new idea, course of action or to implement a new decision. Politicians

at the local, national and international level use durbars as a resource for party organization and political campaigning. During election time politicians organize durbars to inform and convince the electorate to subscribe to an agenda for bringing positive influence to the country or the local electoral area.

In the search for an appropriate approach to mobilize local communities for collective action, the Navrongo Health Research Centre (NHRC) has identified the durbar as a valuable cultural tool for health communication.

A durbar typically begins amid considerable formality, pomp and pageantry, drumming, dancing, and singing. Ultimately the gathering becomes an open public forum of dialogue, public speech, debate, and discussion of pertinent social issues. Through the village crier or some such other local level communication channel, a message, either from or certified by the Chief, is passed from house to house. Usually a person climbs upstairs and calls out to another in the nearest compound and passes on the message. That person also passes the message on to the next compound until all compounds are covered. The purpose of the gathering and the venue, which is usually at the market place, is communicated. The possibility of anyone missing the message is virtually nonexistent. On the day of the durbar, which may be a market day, everything starts slowly like a serious joke. Drummers and artists from the various sections of the community are notified. They are usually among the first to move towards the durbar grounds as a signal that the time for the Village Parliamentary session is well nigh. People put on their best attire, usually a carefully handwoven smock that attests to



Warming up onto the durbar grounds

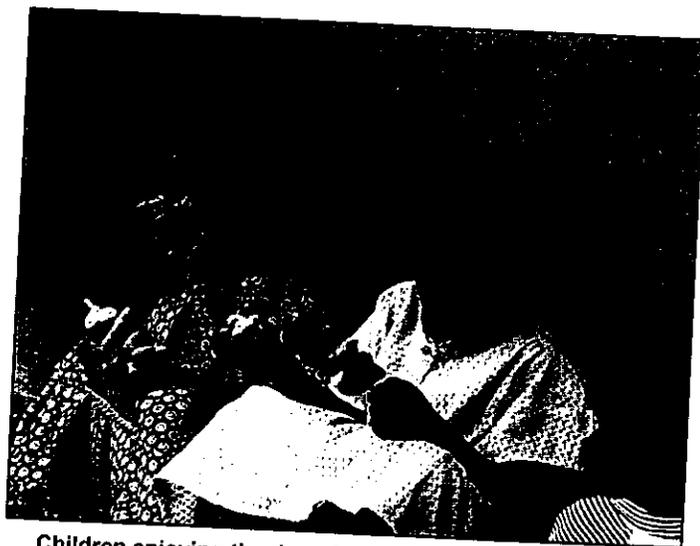
the sophisticated craftsmanship of its weaver, and begin to ooze out, nonchalantly, onto the durbar grounds. The Chief is usually the last to arrive but it is not unusual for the Chief to be among the first.

At about the appointed time sufficient numbers would have gathered for the ceremony to begin. It is normal for a ceremony to begin several minutes earlier or later since time is not measured by chronometer but by the length of shadows. The durbar itself can be a short or protracted ceremony. People usually sit in a circle so that as many people as possible have a good view of what is happening. While drumming goes on in the background, visitors go to shake hands first, and then the community leadership officially welcomes them with another round of handshakes. The chief or community leader, in this case the 'Speaker' of the Assembly, gives the welcome address before inviting the visitors to speak. The Guests state their mission. In the case of the CHFP, the District Health Management Team and the Navrongo Health Research Centre launch discussions on the health problems in the community and provoke a brainstorming session (a parliamentary debate) on how to tackle them. Decorum is strictly observed and the Speaker or his designated assistant gives 'Parliamentarians' permission to speak one after the other. Queries are raised, questions asked, and clarifications sought. Words are carefully chosen and every effort is made not to offend the sensibilities of others. In any case, there is always the 'Chief Whip' to bring errant Parliamentarians back to order. As it were, no Parliamentarian speaks to say nothing. Quite unlike in modern parliamentary sessions, there are no jeers and boos, and there are no majority and minority sides and leaders.



Keeping a watchful eye on every event

The durbar initiative provides the channel for communicating with the various villages. It provided the platform for discussing, explaining, and introducing the CHFP project. After a series of durbars the system of Village Health Volunteer and Village Health Committee was developed for health service delivery in the district.



Children enjoying the deep fries at a durbar -- outside the epicenter of vigorous activity

By using durbars as a communication tool, health development programmes that would have otherwise cause confusion in the communities are legitimized. Using durbars as a cultural resource has made it possible for health personnel to mobilise the community, disseminate health information, plan health activities, and implement them. The durbar initiative adopted by the Navrongo Experiment offers an opportunity to bring the health hierarchy and traditional authorities together to discuss health problems and find lasting solutions. By using the method, the top-down approach of the conventional health care system is gradually being replaced by the bottom-up planning of health care; one of the hallmarks of health service decentralization. Durbars also provide a great opportunity for informing the District political leadership of health problems in the community. The presence of local government officials at durbars gives health programmes political support and legitimacy. Durbars have created the grounds for mobilising all sociocultural resources and institutions like peer groups, women's groups, opinion leaders, elders, family heads, landlords, village committees, and soothsayers in the Kassena-Nankana district to implement a community-based health and family planning programme.

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**Giving Health a Home**

*Vol. 1, No. 13, December 2001*

**Giving Health an Adequate  
Home**

*Vol. 1, No. 14, December 2001*

**Where Do We Put Our CHC?**

*Vol. 2, No. 19, May 2002*

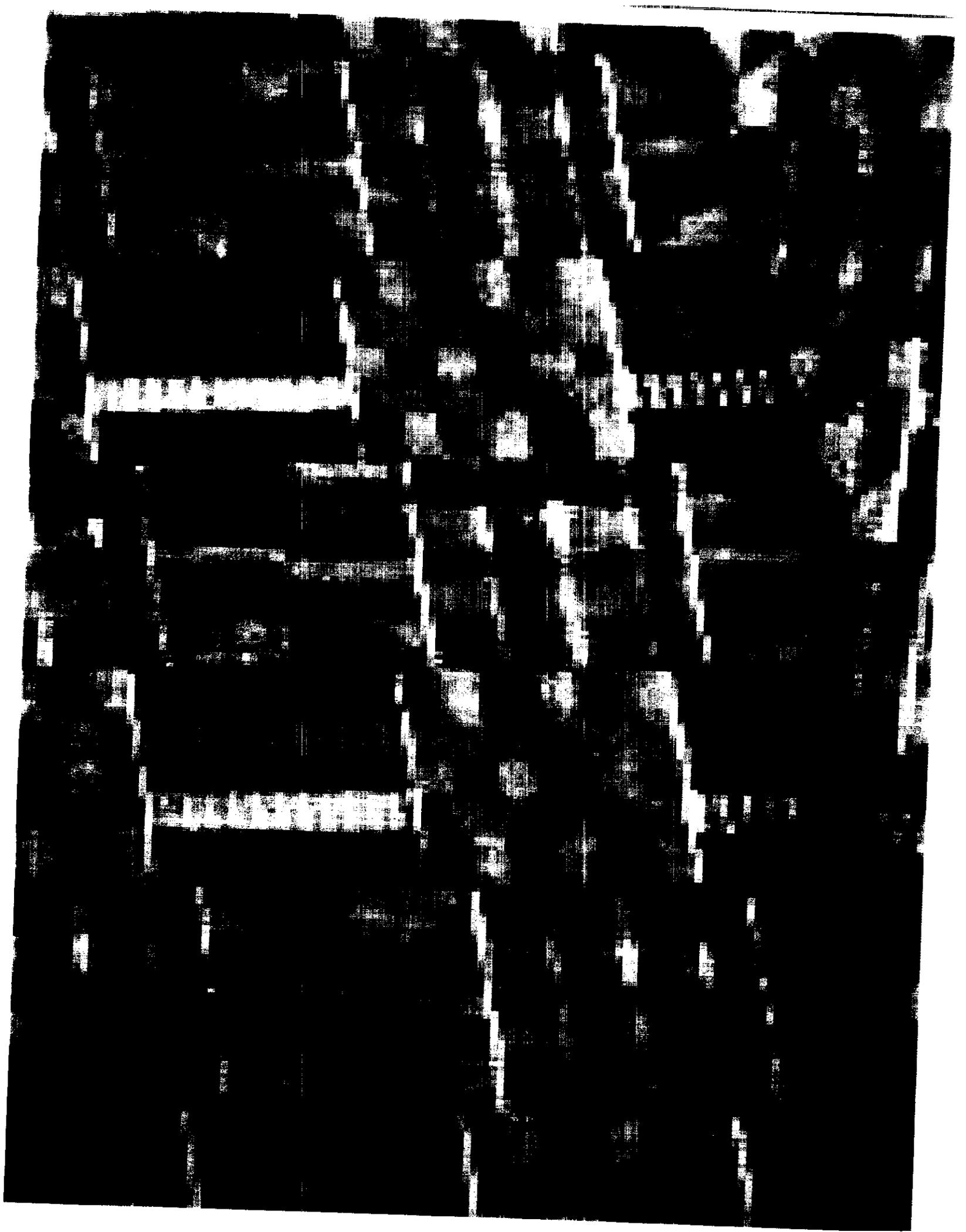
**One Brick at a Time**

*Vol. 2, No. 20, May 2002*

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Navrongo Health Research Centre

Vol. 1, No. 13, December 2001

## GIVING HEALTH A HOME

Just as the people live in communities and reside in compounds, health care can be community-resident and provided a home. The idea of a Community Health Compound (CHC) is a component of the Community Health and Family Planning (CHFP) Project that was invented by the people who are the project's target beneficiaries. At the very beginning of the project, when communities were approached and asked about their needs, leaders uniformly asked for a "hospital" to be built in their locality. When health care expectations were discussed, it was clear that the community health care needs could be met if the existing Government of Ghana plan to decentralise access to Primary Health Care (PHC), including family planning services, could be achieved. This desire from communities therefore corresponds with a longstanding policy of the Ministry of Health (MOH). Since the 1970s, developing community health care has been a priority of the MOH. But, by the early 1990s, evidence was overwhelming that no satisfactory results were forthcoming because the services of community health nurses, who were posted to work at "Level B" clinics, were inaccessible to a large proportion of rural households. This system of health service delivery was re-examined and the results were that it was time to take health care to the doorstep. The CHFP experiment, whose aim was to determine the most efficient way to go about this, was a welcome idea to the MOH. It was also a major concern of the people of Kassena-Nankana District.



Chief in his palace

### The Idea of a Community Health Compound

No district in Ghana can afford to build a "hospital" in every village. However, with community members acting as consultants, consensus was reached in every CHFP study community that traditional compounds could be built to serve as a home for health care workers. Agreements were made with each community, whereby Community Health Nurses (CHN) were to be retrained and reoriented to function as village-based health service providers. They were redesignated as "Community Health Officers" (CHO). To address the problem of where CHO would live and offer services to the community, construction teams were organized by Chiefs and elders to construct compounds with traditional materials. The logic was simple: If residents of the district can live in compounds; health care can also be CHC based. Will later developments prove or disprove this logic?



Zurugelu at work—community members putting up a CHC

### Building Community Participation by Building CHC

Community participation is sometimes difficult to develop. The CHC mechanism has

been a useful mechanism for focusing community attention on the programme and developing a sense of community ownership of the health service system. This was achieved by:

- **Approaching Chiefs and elders.** Making plans, developing health committees, constituting volunteer groups, and other organizational tasks could be initially focused on the CHC construction need. The process of dialogue and community action established mechanisms for community leadership that could be extended and developed in the CHFP.
- **Developing male ownership.** All lineal groups were expected to participate in construction. This provided a means of involving men in the planning and implementation of the programme.
- **Building community pride.** Durbars and celebration of milestones in the programme provided a basis for recognizing leadership, awarding participation, and developing community pride in the programme that they were building.
- **Nurturing support for the presence of nurses.** When communities completed CHC construction, a *durbar* was convened to celebrate progress and introduce the CHO assigned to the community. In this manner, the CHO assignment represented a reward to the community for work that they had invested in health care. Attention was directed to her assignment, not as the posting of some external worker, but as a new member of the community in charge of health development.



Community members undertaking maintenance work on a CHC

### The Essential Elements of a CHC

The 16 CHC constructed in the District all share common features. These include:

- A walled courtyard with a cement floor and secure gate;
- A shaded waiting area for patients;
- Structures which provide a room for clinical services and a separate room for a living space;
- Laterine/place of convenience;
- A kitchen, and;
- A bathhouse.

### Conclusion

The construction of CHC has been valuable to the CHFP, not only as a means of housing nurses in convenient locations, but also as a means of building community participation in the programme. While the CHC component of the CHFP represents a major feature of what works in the projects, there are also lessons learned about what fails. We turn to the question of what fails in the CHC programme in the next issue of *What works? What fails?*

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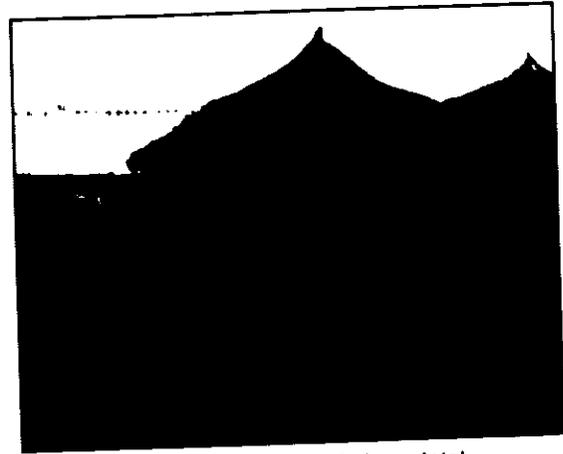


# GIVING HEALTH AN ADEQUATE HOME

## 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. 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.



Second attempt: An interim design that is difficult to sustain

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

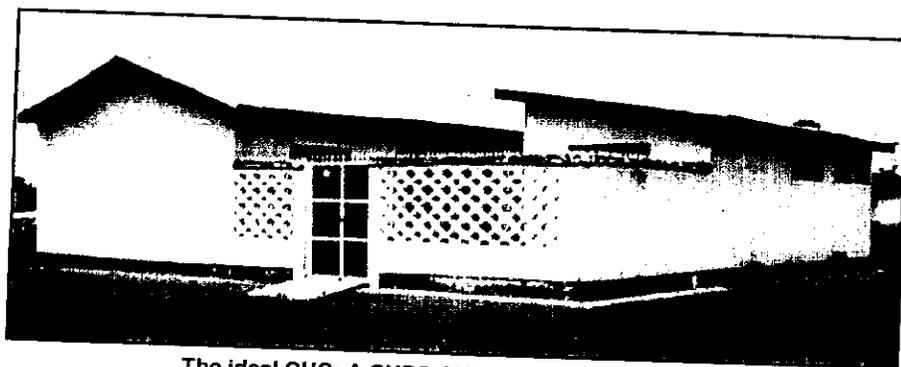
compounds with CHO were concerned that they were being exposed to risks of being infected with diseases since the nurse received patients in the house and treated them there. For the CHO who lived in the Chief's compound, patients and clients complained that a Chief's palace is a public place where anyone 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.

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Navrongo Health Research Centre

Vol. 2, No. 19, May 2002

## WHERE DO WE PUT OUR CHC?

In 1994, two villages, Kayoro and Naga, were the first Navrongo Project communities to construct Community Health Compounds (CHC). Then, as now, CHC were intended to serve as dwelling places and clinics for Community Health Officers (CHO) to serve as frontline service providers of the CHFP. The two communities share one clear thing in common—they are the most isolated communities in the essentially rural Kassena-Nankana district where everything including health service, is remote and difficult to reach. Naga is 45 kilometers to the South of the central part of the district where the district hospital is located, and Kayoro is 40 kilometers to the West and both communities are about 15 kilometers away from the nearest health facility. Residents of these remote communities are therefore the most enthusiastic participants in the project. Bringing health to the doorstep could not have been possible without their CHC.



Chief and Elders massaging the CHC idea

While it may be obvious that a community needs a CHC, the logical place to put it is often less obvious. Influential leaders may want to situate it near their compound. Or, there may be community groups vying for one location or another. In general, what works in CHC placement is finding a location that is convenient, but not so close to any community group that its construction appears to exclude others. Achieving a consensus about the location involves consultation with community leaders, group consultation with individuals who will use the CHC, such as mothers with young children, and open discussion of the CHC programme at a durbar where the construction plan is announced. Here, novel but workable ideas emerge, all of which are melted in the crucible of open discussions. Some of the most absurd views often lead to practical solutions. While there is no general formula that will always work, some guiding principles usually apply that were first worked out in Kayoro and Naga:



Where do we locate our CHC?

- Locating the CHC next to, or inside a chief's compound, typically fails. Women seek an element of privacy and social distance between the CHC and places in the community where leaders reside.
- Locating the CHC near a well or borehole helps the CHO by providing convenient access to water, and clientele, and convenient access to a service point. In some communities where water is particularly lacking, schoolgirls in the vicinity take it upon themselves to fetch water for the nurse, wherever they can find it.
- In settings where there are multiple communities to be served, it is important to locate the CHC in a place that is not perceived to be owned by a particular social group. Finding the right location in such situations can be a challenging task.

While these principles often apply, there is no general rule or formula for answering the question "Where do we put our CHC?" Situating a CHC involves dialogue with community groups. This involves dialogue with:

- *Chiefs and elders.* Community dialogue should begin by assessing the views of community leaders. These views should provide the basis for discussions that follow.
- *Young mothers.* Since women and their children are important clientele, it is important to convene groups of women from the community to be served and seek their advice about where to place the CHC. Young mothers should have ample opportunity to air their views on where a CHC should be placed.
- *Wives of compound heads.* In many compounds, the mobility of women is influenced by the senior women. Wives of compound heads are particularly important health access opinion leaders. Separate groups of older women should be convened to discuss the matter of where to place a CHC.
- *Husbands.* Men should also be involved in the dialogue so that no group is excluded in deliberations. Men have often been found guilty of exerting unhealthy influence on the health seeking behaviour of women, especially their wives.

At the end of the process of community dialogue, leaders should be reconvened and apprised of what has been learned. Consensus should be forged at this stage and a durbar planned to announce the decision and solicit open community comment on the choice of the site and plans for building the CHC. Constructing consensus about location is critical to constructing effective CHC. The people of Karyoro and Naga have taught us how to build this consensus.



Women in a focus group discussion about where to locate their CHC

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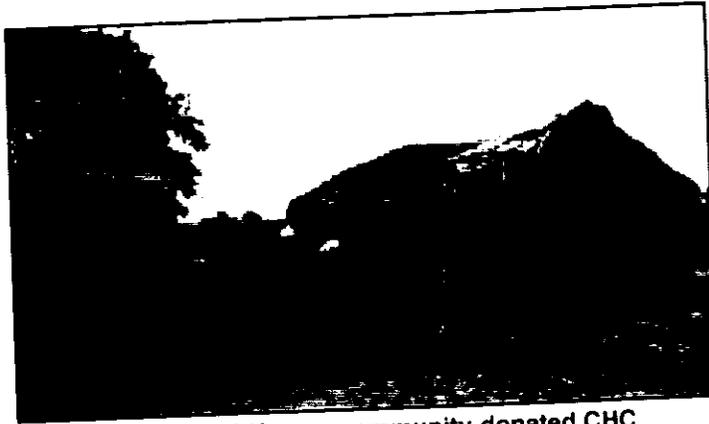
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## ONE BRICK AT A TIME

The concept of building Community Health Compounds (CHC) is often misunderstood. District Health Management Teams (DHMT) planning for the CHPS programme see the CHC as something that costs money, and therefore something that must wait for funds to arrive. Communities in the CHFP demonstrate another approach: Begin by starting with whatever resources are available to build a CHC that is constructed with local material, maintained with community labour, and supported by a broad consensus that health care cannot wait. Then, from the position of achievement and success, utilize the functioning CHC as a magnet for acquiring funds for putting up a better structure where health can be adequately housed. In short, build the primary health care programme one brick at a time. This approach is demonstrated by two Navrongo Project communities, Kayoro and Naga which built and maintained their own compounds to house the resident nurse in 1994. The buildings that were



The original Kayoro community-donated CHC

constructed are not a model for others to emulate: Torrential rains in the course of the first year collapsed exterior walls of both of these CHC, leaving them in a very bad state. But, in 1995 District resources were found to renovate the CHC with iron sheet roofs, cement floors, and simple amenities, such as a latrine. These very simple CHC functioned for the next six years. By 2002, they were once again on the brink of collapse, rendering them uninhabitable. The disruption threatened to derail health service delivery. As a result of the importance of these CHC, efforts were quickly mobilised to get them functioning again. While CHC have been a continuing source of maintenance problems since 1994, communities have received continuing doorstep health care from the Community Health Officers who worked out of the CHC. The experience of Naga and Kayoro shows that the 'one brick at a time' approach to developing adequate CHC can revolutionize access to health care.

Today, in Naga and in Kayoro, new and modern CHCs are under construction, owing to modest external funds that have been acquired to supplement community resources. The success of the Naga and Kayoro community-donated and -financed CHC has been used to seek funds for rewarding community action and initiative. Some features of the new CHC are informed by past success:

- *Location.* It is no coincidence that, in both communities the new CHC is less than 200 meters away from the old one. Community involvement in site selection produced locations that differ little from community selected sites for the original CHC.

- *Community involvement.* Building community involvement was crucial to building the CHC. This involved getting initial practical demonstration of commitment that in spite of the approach of the farming season, people can be mobilised for construction work.



Digging the foundation under the  
Supervision of the Chief and people

- *Community innovation and initiative.* It is important not to standardize the construction programme. CHC construction does not involve contractors or rigid Ghana Health Service instructions. This is important for maintaining community commitment and initiative. For example, the western part of the district is generally rocky, and stone is not readily available in Kayoro especially around the area earmarked for the CHC. The chief devised a strategy of breaking the people into groups to work by sections. Division of labour was working to perfection at the community level. Where stone is available, that section concentrated on collecting stone while other sections gathered sand. Women and children supplied water. The District Assembly, the highest political authority in the district, kept their part of the deal by providing a truck and a driver to cart the sand to the building site. They also provided an engineer and a mason to train community volunteers. The project offered building tools such as moulds, shovels, pick axes, trowels and head pans and the community members gave what they have in abundance—labour. Sometimes there were more people at site ready to work than there were tools to work with! This has been particularly the case with the Kayoro project. Then, one brick at a time, the Kayoro project was soon to overtake the Naga CHC which started one month earlier.



**Women are often prepared to risk their health to get a CHC constructed**

- *Community support for the service system.* The CHC is a crucial component of the CHFP service delivery model. Once Community Health Officers are retrained, equipped and redeployed, they need a place to live and work. One element that is often taken for granted is patronage of the services for which the CHC is constructed. People must not only be passionate about helping the nurse relocate and integrate into the community but they must, above all, patronize the services brought to their doorstep.



**Two headpans are better than one—Mason provided by the District Assembly casting the foundation concrete**

What is worth noting about the Naga and Kayoro CHC construction approach is that they started the programme with their own resources, then a better CHC was constructed with project resources such as a District Health Management Team can afford. It is the success in implementing the programme that attracted external resources for building a CHC component of the programme that works, one brick at a time.

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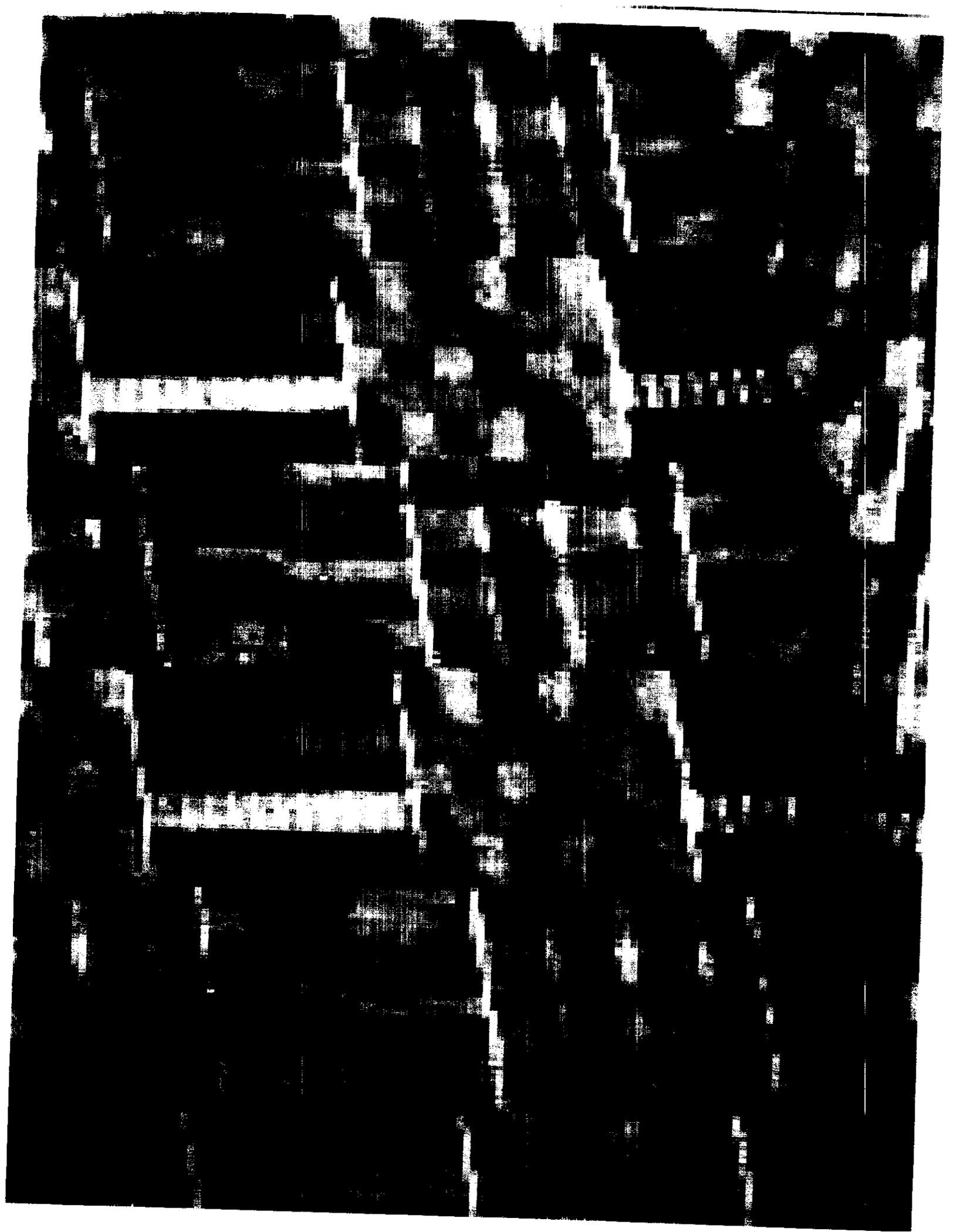
**Keeping the Drugs Flowing**  
*Vol. 2, No. 7, February 2002*

**A Good Idea that Fails**  
*Vol. 2, No. 8, February 2002*

**What Keeps the Wheels  
Turning?**  
*Vol. 2, No. 9, March 2002*

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# What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT



Vol. 2, No. 7, February 2002

Navrongo Health Research Centre

## KEEPING THE DRUGS FLOWING

### Introduction

**The Concept of Essential Drugs.** In a 1975 report to the 28<sup>th</sup> World Health Assembly (WHA), the Director-General reviewed the main drug problems facing developing countries and outlined a range of new drug policies, based in part on the experience gained in some countries where essential drug schemes have been implemented.

In 1981, an action-oriented strategy titled the "Action Programme on Essential Drugs" was established within the World Health Organization (WHO) to aid member countries in the selection, procurement, training, information, and evaluation of essential drug policies. The introduction of the action programme was aimed at providing a few specific, essential drugs that would be available on the market and satisfy basic pharmaceutical needs of underserved populations.

**Drug Policy.** The provision of essential drugs is one of the objectives of Ghana's Drug Policy, which aims to make essential, effective, safe, affordable drugs available to meeting the needs of the entire population and ensure the rational and efficient use of drugs. In 1971, hospital services were introduced through the Hospital Fee Act which removed subsidies and mandated fee collection for all health services.

**The Bamako Initiative:** The Bamako Initiative was introduced at a meeting of African health ministers in September 1987 in Bamako, Mali, with the aim of accelerating primary health care through community financing of essential drugs and other aspects of quality of services. In Ghana, essential drug revolving funds are established to sustain the replenishment of drugs and local operation costs.



CHO may offer injections; a health volunteer cannot

**The CHFP Approach:** Under the Navrongo Community Health and Family Planning Project (CHFP), Community Health Officers (CHO) and volunteers (Yezura Zenna) have been trained to provide curative, preventive, and referral services to community members. They are provided with drugs for the treatment of minor ailments. CHO treat various illnesses, including maladies that require antibiotic therapy.

From the outset it was decided that the first supply of drugs should be procured by the Project to serve as the basis of a revolving fund. Drugs flow to communities through two revolving accounts, one for each type of worker: i) CHO provide doorstep services and also provide care at Community Health Compounds (CHC). Funds generated by prescriptions are passed on to supervisors who are responsible for replenishing supplies; ii) Yezura Zenna (YZ) dispense drugs that are maintained in a community pharmaceutical kit managed by a committee. This committee, known as the Yezura Nakwa (YN), manage accounts and replenish YZ supplies. Supervisors, in turn, check accounts and replenish YN pharmaceutical kits. Taken together, the CHO and YZ service operations generate resources for the District Health Management Teams (DHMT) to use at the Central Medical Stores for restocking supplies.

Drugs for YZ include Paracetamol for aches and pains, Chloroquine for the treatment of malaria, ORS for diarrhea, Aludrox for abdominal pains, Multivite for improving nutritional inadequacies, Piriton for itching from allergic

reaction to chloroquine, condoms for family planning and protection against STDs/AIDS, Conceptrol (foaming tablet) for family planning, and oral contraceptive pills.

Each community has developed a drug-management system suited to its needs. However, all YZ and YN are trained in recordkeeping and supply management to ensure that drugs keep flowing as needed. When the drugs for each community are collected for the first time, the community decides on the price to be charged. YN training is directed to orienting committees on prices charged elsewhere and procedures for determining appropriate charges for their particular situation. A small profit margin is figured into the cost of each drug and is used to maintain YZ bicycles and provide minimal incentives for the volunteers. Selling prices to community members are reviewed whenever there is an increase in the cost of drugs.

**Management for accountability:** Drugs are collected from the DHMT/NHRC by the YN and stored in a lockable wooden box. In some communities the YN entrust money to the YZ to pay for and collect drugs at the DHMT/NHRC and, on return, hand them over to the YN before the drugs are reissued to them. The box in most cases is kept with the Chairman, the Secretary, or the Treasurer. In some communities the box is kept with one member of the YN while the key to the box is with another member to ensure security. Maintaining security and transparency is important at all times.

In two communities, Nakolo Central and Boania for instance, where the Chairman and the Treasurer cannot read or write, the box is with the Chairman, and the keys are with the Secretary. When the YZ needs drugs, he goes to the Secretary, picks up the key to the box, and together they go to the Chairman's house and the box is opened in the presence of the Chairman, Secretary, and YZ before drugs are issued. The Secretary then records the quantities of drugs issued into a ledger and locks the box. When it is time for the YZ to pay money from drug sales, the Secretary goes with the YZ to the Treasurer where the YZ settles up and the amount is recorded.

In ten communities the box is kept by the Treasurer who, in some instances, is the keeper of the key. The Treasurer collects money from the YZ for drugs sold and issues him with a new stock. In seven communities the drug box and keys are kept with the Chairman who issues the drugs to the YZ, collects money from drug sales, and then accounts the money to the Treasurer.



Accessibility and affordability are two sides of the same tablet

With an average recovery rate of 83%, overall drug management has been successful. The main problems are with respect to community members who are unable to afford the full course of treatment for ailments such as malaria. Drugs are sometimes dispensed in emergency situations even though payment is not possible and must be deferred.

## Conclusion

In general, policies that keep drugs flowing depend upon policies that recover costs. As long as resources are available for replenishing supplies, single management procedures can be developed to ensure sustainable drug flow.

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

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# What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT



Vol. 2, No. 8, February, 2002

Navrongo Health Research Centre

## A GOOD IDEA THAT FAILS DRUG EXEMPTIONS IN THE CONTEXT OF DOORSTEP CARE

The Navrongo Experiment trains Community Health Officers (CHO) to provide as wide a range of services as possible. Since they are certified paramedics of the Ghana Health Service they offer a more extensive range of drugs than the volunteer Yezura Zenna's (YZ) can provide. The main difference is that, unlike YZ who are not allowed to handle or dispense antibiotics, CHO dispense antibiotics and may give injections when the need arises. In addition to all the drugs that YZ handle, CHO, at any point in time, have the following drugs in stock:

- Folic acid for nutritional inadequacies;
- Mebendazole for intestinal parasites;
- Salbutamol for asthma attacks;
- Penicillin V, Co-trimoxazole, Amoxicillin and Metronidazole as antibiotics/anti-infectives and;
- Eye ointment/drops for eye infections.

CHO provide the full complement of family planning services: Depo Provera, oral contraceptive pills, foaming tablets, and condoms as well as counseling, treatment of minor side effects, and referral services.

In 1999, the Navrongo Community Health and Family Planning Project (CHFP) implemented the Ministry of Health "Exemptions Policy" which entitled all children under five years of age, pregnant women, and the elderly, that is, people of 70 years and above, to free drugs. Under this policy, available stocks of drugs are distributed with each prescription generating "Exemption vouchers". These in turn are accumulated for the Regional Health Administration to release funds for the purchase of new supplies to replenish stocks through the regional pharmacy. But, since CHO are so active in reaching exemption cases through doorstep services, the pace of service delivery quickly outstripped the resources of the Regional Health Administration. This led to severe lapses in the flow of drugs, and basic CHFP services were impaired. Some nurses even abandoned community-based care altogether. Without drugs for treatment, the entire programme lost its rationale.



A CHO has more exemption cases  
than she has free drugs to offer

### Responding to exemption failures

The CHFP responded to the Exemptions Policy failure by developing community participation in cost recovery. Simply imposing charges would have generated misunderstanding. However, community dialogue about the problem led to fees for drugs dispensed at the doorstep and the CHC. After dialogue with each community, as with YZ, the community determines the prices at which drugs handled by CHO are sold. Agreements are based on the notion of reciprocity. The Ghana Health Service supports CHO residency in the community and provides fuel for their motorbikes. The communities share in the costs of the programme by financing the pharmaceutical component of care. Once services are launched, drugs are stored in a lockable box and kept by the CHO who collects them from the District Health Management Team and the CHFP. She takes a small quantity of drugs at a time when she goes on compound-to-compound visits. As she treats patients and prescribes drugs the patients "cash and carry". When her drugs are running out or when she has money from an old consignment of drugs, she sends the money and renders

accounts directly to the DHMT/CHFP and collects new drugs. With regard to family planning, CHO collect family planning devices from the District Public Health Nurse (DPHN), offer them to clients and render accounts back to her.

When a DPHN is proceeding on leave and another has to relieve her, it is the DHMT, the sub-district or the CHFP that supervises the handing over of drugs to the relieving DPHN. Once a month an inventory of the drugs on hold by the CHO is checked to make sure that they are accounted for.



Children waiting for their nurse to come, with or without free drugs.

CHO face unique problems in the course of their duties with respect to the management of drugs. For example, CHO often come into contact with patients who cannot afford to pay for a simple malaria course. Some pay for drugs by installments and others plead to take the drugs on credit and pay by the next market day by which time they would have sold a fowl or two or some farm produce to raise the money. Sometimes CHO have to glean from their own meager resources to pay for drugs for one patient or another. Miraculously, the nurses not only get by but also actually succeed in maintaining excellent rapport with the community

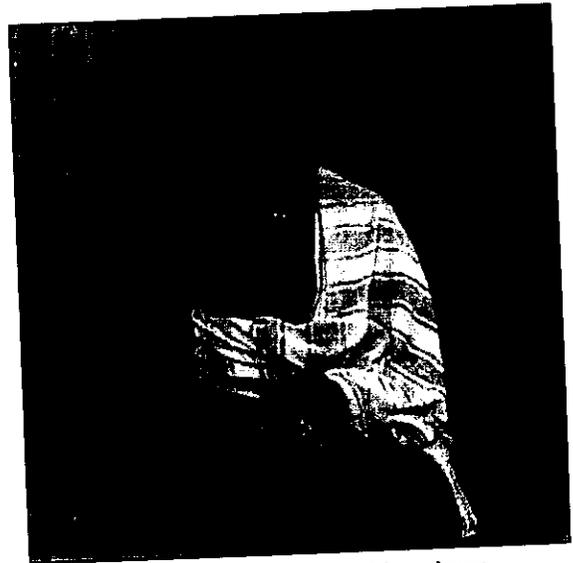
members. The nurse's main headache is how to balance the issue of sustainability with the exemptions policy. Some people in the community continue to argue that drugs should be given to them for free. Even when they could pay for drugs with relative ease they sometimes refuse to do so.

When the CHO, like the YZ, is found to owe drug money, she is made to pay before new drugs are issued to her. In most cases the balances that are due to be paid are in the form of drugs held by YZ/YN or CHO, but there are communities that fall into serious debt as they do not have money or drugs. All the same, it must be clearly stated that no CHO or community owes drugs money to the point of being unable to qualify for new supplies, and that is the major strength of the system.

Overall, the management of the drugs has been successful. The average rate of recovery on drugs taken by CHO is 89%, as compared to YN/YZ, which is 83%. This is considered to be a marvelous achievement by the CHO. The major challenge to the Ministry of Health's laudable exemptions policy has been CHO efficiency—they are able to reach more exemption cases than they have free drugs to offer them!

### What works

Community-based management of drugs can be effectively carried out when the community is involved in such activities with some support. The effective management of drugs requires accountability with regular checks and supervision. With the availability of drugs and family planning devices in the community, treatment of minor ailments and family planning services are received at their doorstep. The Exemptions Policy is a good idea when patients bear the cost of travel to distant clinics. For this reason, the policy is continued at Level B sub-district clinics and at Level C—the Nankana District hospital. But when the health service system finances care at Level A—the doorstep or community clinics—the policy is a good idea that fails. Dramatic increases in the volume of health care cannot be sustained with existing resources.



Still counting the cost of free drugs.

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# What works? What fails?



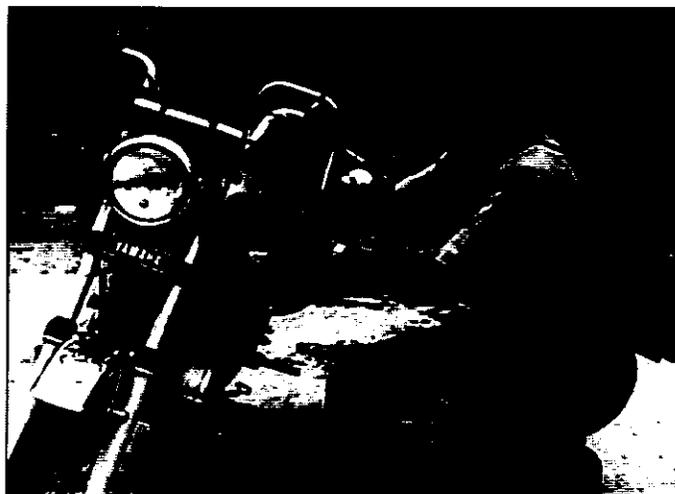
FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 9, March 2002

Navrongo Health Research Centre

## WHAT KEEPS THE WHEELS TURNING?

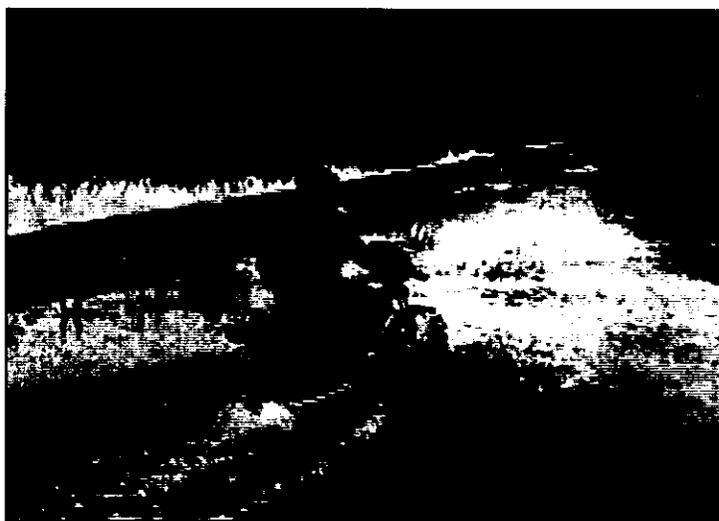
Communities in the Kassena-Nankana district where Community Health Officers (CHO) live and provide health services are distant from health facilities. Compounds in the communities are far apart and no serviceable roads exist to connect them. For community members, walking from one compound to another is a simple matter, but for the health worker who has to provide door-to-door health care, a means of transportation is indispensable to the provision of quick and quality health services. The motorbike comes in handy—it is the office of the CHO—a hospital on wheels. The motorbike is as versatile as its rider—in dew or in dust, health care can still reach the most remote communities and the farthest compounds on a regular basis. When parked in front of the Community Health Compound (CHC), her local residence which also doubles as the community clinic, it indicates that she is available for consultation. This usually happens in the morning after she returns from compound visitation. A nurse would normally leave the CHC as early as 6:00am and be back by 10:00am to attend to her clients who, by the time she returns, will already have lined up at the CHC.



First things first—A CHO checks her motorbike before riding off

CHO have speedily mastered motorbiking skills.

They meander through a maze of footpaths with admirable agility to bring health care to those who need it most. Although sometimes forced to abandon her motorbike when confronted with hostile terrain, it is now almost unthinkable to talk of a CHO without mentioning her motorbike.



Tough times don't last but tough bikes do

Motorbike riding is now part of the curriculum of Community Health Nurses' Training Schools. Training not only teaches basic riding skills, but covers fundamental maintenance as well. The importance of this component of the Community Health and Family Planning Project (CHFP) is underscored by the employment of two full-time mechanics by the Navrongo Health Research Centre (NHRC) and a Workshop Manager who is a General Motors Senior Mechanic. This highly skilled staff ensures proper maintenance of the Centre's motorbikes.

### Routine maintenance

Use of motorbikes for community health service delivery is very intensive. Regular maintenance is an absolute necessity if the life span of these motorbikes is to be prolonged. Routine maintenance is carried out based on a scheduled period. This may be based on the number of kilometres covered as advised by the manufacturers or on a monthly schedule drawn up by the garage. During routine maintenance, lubricants are

ance is carried out based on a scheduled period. This may be based on the number of kilometres covered as advised by the manufacturers or on a monthly schedule drawn up by the garage. During routine maintenance, lubricants are

replaced and parts are greased. Engine performance is also checked, loose parts are adjusted, and worn out or damaged parts are replaced.

### Preventive maintenance

Weekly preventive maintenance is carried out on the motorbikes when they return from the field. Mechanics check for minor problems that might have arisen during use and include checking engine performance and other minor repair work.

### Repairs

Repairs are carried out on the motorbikes whether or not the motorbike is due for routine or preventive maintenance. When a part of the motorbike is damaged or worn out, repairs or parts replacement are carried out immediately. If parts are not readily available the motorbike is grounded until parts have been procured. These checks are to ensure that, while on duty, at least the motorbike should never leave its rider on the way. According to the Workshop Manager who oversees the maintenance of the CHFP motorbikes, experience has shown that the Yamaha brand is ideal for the CHO. At the moment the fleet includes Yamaha Escort, YT, Super and AG. Use records have proved that the AG 100 is robust and appropriate for even the most inhospitable terrain that a CHO may confront in her daily service operations.

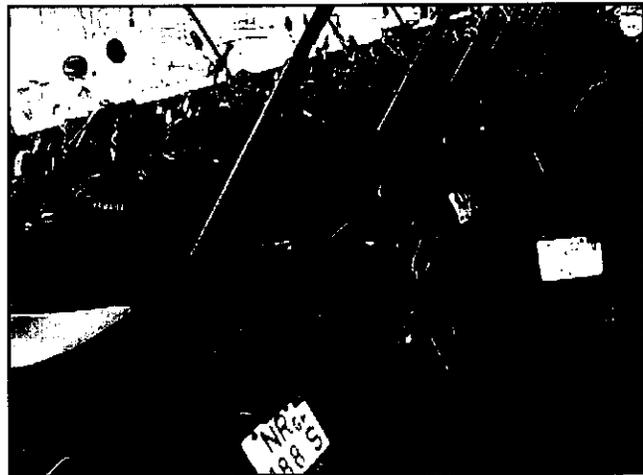
The period between zero and 1000 kilometres is the most important period in the life of a motorbike. The engine is brand new and its various parts wear and polish themselves to the correct operating clearances. Care must therefore be taken not to put excessive load on the engine for the first 1000 kilometres. With due adherence to manufacturer guidelines, the general routine maintenance procedures for CHFP motorbikes is to replace the transmission oil after the first 500 kilometres. Thereafter, the motorbike goes for regular service every four weeks. Periodic inspection, adjustment and lubrication will keep the motorbike in the safest, most efficient condition possible. The motorbike goes for major maintenance after the first 1000 kilometres. During this period the oil is changed and carbon fumes are removed from the exhaust system. If these important points of motorbike maintenance are maintained, a machine *should* last up to five years without major problems. Yet, despite these precautionary measures, motorbike replacement must occur every three years due to weather conditions, harsh terrain, and intensive use.

Though accidents are very rare and fatalities almost unheard of, carelessness has been noted among some of the riders. Some nurses are known for speeding and a few others have been observed deliberately or inadvertently allowing their spouses or relatives to ride the bikes in clear contradiction of the rules governing machine use. This particular offence has attracted a penalty: The privilege of using the motorbikes over the weekend has been withdrawn. CHO are now required to return all motorbikes to the CHFP every Friday evening and pick them again on Monday morning.

Motorbike tyres usually last for up to three months. A 100cc motorbike is the minimum size of machine that can withstand daily CHO use. Less powerful machines have been tried, but have been shown to be uneconomical in the long run. Nine litres of fuel per week is what a CHO needs and receives for her work.

### Conclusion

With the above maintenance guidelines, nurses enjoy the comfort of riding their motorbikes with less fear of having major problems with them while they are in their communities far away from town.



A large fleet of motorbikes to choose from

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**Health on Wheels**

*Vol. 1, No. 4, September 2001*

**View From the Front Line**

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**The Perfect CHO**

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**Moving Up the Health**

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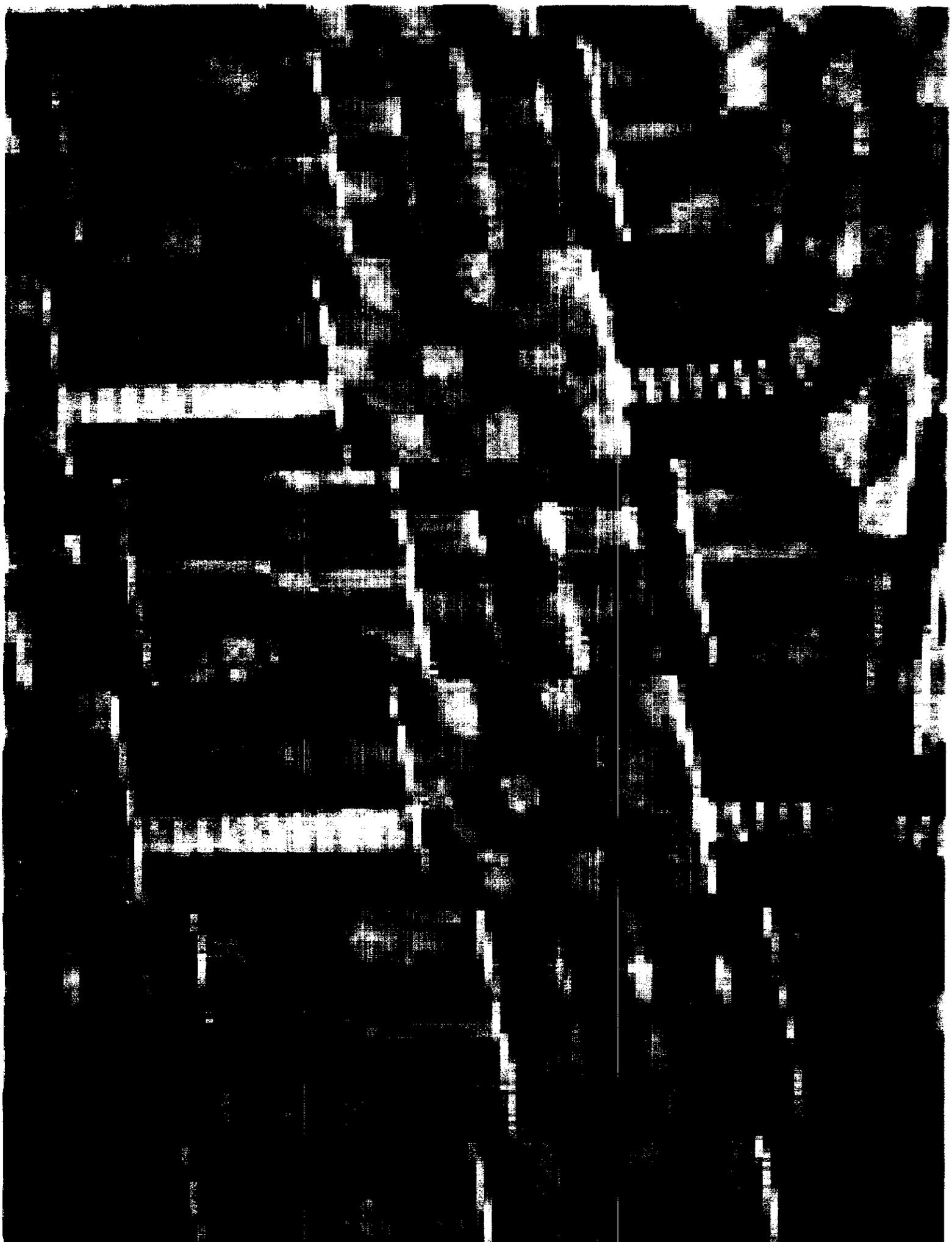
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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 4, September 2001

Navrongo Health Research Centre

## HEALTH ON WHEELS

Ever since the Alma Ata Conference in 1978, Government of Ghana policies have called for placing trained Community Health Nurses (CHN) in village locations where over 70 percent of the population resides. The cost of constructing clinics is high, however, and CHN that have been trained for community work typically work in Level B clinics that are inaccessible to most rural households. It is clear that building more clinics and hospitals will not bring health to rural households.

To address the need for partnership in community health, village leaders were approached by the Community Health and Family Planning (CHFP) project prior to fieldwork and asked to convene an open forum for the discussion of health service needs.<sup>1</sup> Without exception, every community asked the CHFP to "provide a clinic." Since funds were not available for construction of clinics in every village, agreements were developed whereby each community contributed labour or materials for constructing a traditional compound (termed the Community Health Compound (CHC)).<sup>2</sup> Once CHC were ready, nurses could be reposted to communities where they lived and worked. Nurses were trained in community diplomacy and health education, reoriented to new management information systems, and retrained in health technologies. Since motorbikes were needed, a training course was provided in motorbike riding and care. These upgraded Community Health Nurses were redesignated as Community Health Officers (CHO) to emphasize their status as upgraded workers. Relocating nurses involved more than constructing CHC and issuing administrative orders. Support systems were developed for assuring that workers had technical, community, supervisory, and peer support, as follows:

**Technical support.** Introducing the CHO model represents an opportunity to improve technical competence through training. CHO were trained in midwifery, a component of care that was missing from the CHN programme. Delivery care and Traditional Birth Attendant (TBA) training are essential elements of community-based care.



Hospital in a knapsack

CHO were also trained in basic diagnostic services, referral, and treatment care. Most importantly, CHO were trained in community entry, diplomacy, counseling, and work planning, all of which represent essential elements of community-based care. Both facilitators and participants evaluated training courses; each course was associated with a report. Training emphasized field-based practical training for problems that workers encounter during the course of village-based service delivery.



Community Health Compound (CHC)

**Supervisory support.** Too often supervision is interpreted as a programme of checking on subordinates, policing work, and correcting mistakes. From the onset of CHFP operations, there has been recognition of the need to develop supervisory systems that avoid this mechanical and demoralizing approach to supervision

<sup>1</sup> The CHFP is a collaborative program of field research involving service delivery supervised by the Kassena-Nankana District Health Management Team and research conducted by the Navrongo Health Research Centre.

<sup>2</sup> The CHC initiative will be described in other *What works?* notes. Also, other notes will focus on detailed lessons learned about posting nurses to village locations.

through a process whereby managers visit subordinates to see how they are working in their own environment and to offer assistance to them. Assistance may involve organizing meetings with community leaders to discuss problems, arranging equipment repair or replacement, advising on health care service activities and needs, and linking CHO with their peers for exchanges and collaborative support.



**CHO being introduced to the community**

improve the quality and efficiency of health care. In recent years, CHO trainees have been assigned to work with experienced CHO. This programme of peer exchange and peer leadership is viewed as an important element of the CHO support system.

**Familial support.** CHO who are assigned to CHC are removed from relatively comfortable MOH provided housing at the sub-District Health Centre and assigned to villages without moving their families. At the initial stages, CHO were posted to villages without prior discussion with the affected spouses. Establishing familial support has been a critical element to the smooth running of the programme. Meetings to liaise with spouses, hear their concerns, and respect family needs have been crucial to the success of the CHO initiative. Husbands often have no experience in cooking and minimal involvement in child care. Conventional gender-stratified roles therefore constrain the initiative. Moreover, posting a nurse to a village has real costs associated with it: CHO had to buy utensils, flashlights, and personal supplies that turned out to be too costly for affected families to bear. The CHFP therefore developed a "settling-in kit" to provide essential household effects. In keeping with policies of the Ghana Educational Service, a small community hardship allowance is paid to defray the cost of operating two residences, arranging support for child care, or other family needs.

**Conclusion.** Placing a nurse in a CHC involves more than issuing instructions and supervising activities. Support systems are required that deal with the impact of this programme on CHO personal lives. Relocating nurses to villages will fail if nurses are left on their own. However, the CHFP has demonstrated ways in which this relocation programme can succeed by supporting workers at the periphery.

**Community support.** A key element of the success of the CHO programme has been to address worker needs for continuous support. Doorstep service delivery can place workers in the middle of community problems that require urgent attention. Moreover a worker who lives in the village may have essential needs that cannot be addressed without community support: Facilities maintenance for the CHC, water for household chores, security needs that require organized support, and diplomatic needs that may call for the intervention of chiefs and elders.

**Peer support.** Peer support is the process whereby workers at one level of a work system provide advice, support, and leadership to colleagues at the same level of the system. CHO benefit greatly from contact with each other. Carefully planned exchanges can reduce the sense of isolation and vulnerability that goes with living in a village and working alone. Exchanges, organized as meetings, encourage the sharing of information, mutual advice on problem solving, and peer leaderships to



**CHO in the community**

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FINDINGS FROM THE NAVRONGO COMMUNITY  
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Navrongo Health Research Centre

## VIEW FROM THE 'FRONT LINE'

The retraining and transformation of nurses into Community Health Officers (CHO) and their transfer from expensive, overstaffed, underutilized, and inaccessible sub-district health clinics to purposely built residential Community Health Compounds (CHC) (at the doorsteps of their rural communities) lies at the heart of new efforts by the Ghanaian Ministry of Health to win the battle to provide, '...adequate, efficient and equitable Primary Health Care Services to all Ghanaians'. CHO are the 'front line' staff in this daunting and difficult 'battle'.

The Navrongo Community Health and Family Planning Project (CHFP) was designed to investigate the fertility and mortality impact of mobilising two sets of resources for the promotion of primary health care (PHC). The first, the 'Health at Every Doorstep Dimension' is concerned with bringing CHO into communities, while the second, the 'Zurugelu (togetherness) Dimension' entails the mobilization of the rich and diverse local 'cultural' resources, (chieftaincy structure, social networks, community conventions, volunteer arrangements, etc.).

What is the front-line view of the battle and what lessons have been learned from the experiences of the CHO under the Navrongo Community Health and Family Planning Project? *What works? What fails?*

### What works?

**Autonomy and confidence.** Community Health Nurses provide on-site, situational, health care to the communities under their charge. There is ample evidence to suggest that



Village volunteers constructing a CHC

the greater responsibilities demanded of these CHO—as they work independently and in tune with their local contexts—have translated into a sense of greater autonomy, confidence and professional worth. One CHO was recently cited as saying, 'Now I can do things by myself. I don't go to someone to ask (for advice). Now I do things without panicking. I have built a lot of confidence'.

**Situation and relevance.** CHO are trained to conduct situational analyses of the conditions that they encounter during their daily rounds and to respond to immediate circumstances. It would appear that CHO welcome the relevant and timely nature of their interventions. One young CHO for example, said that during her training as a sub-district nurse, and throughout her initial posting at a MCH clinic, new mothers would come to the clinic well dressed, in expensive new clothes, presenting an aura of relative affluence. The nurses would then give detailed talks on nutrition using visual aids depicting fish and other comparatively expensive sources of protein. Now that the nurses are working in the homes of their patients they see that the women are poor and can't afford fish so CHO can advise them on what to eat based upon the resources at hand.

**Supervision and support.** All CHO are assigned to—and visited by—a supervisor who periodically appraises technical skills, takes note of welfare concerns and keeps a log of the condition of CHC and motorcycles. The supervisory process is welcomed by the CHO as the supervisors offer support and counseling on a range of professional and personal issues.

### What fails?

**The importance of social distance.** At the pilot stage of the CHFP, there was a view that building upon the strong support of chiefs and elders could be formalized by placing the CHC in close proximity to the chief's compound. Some chiefs were eager to help by providing land for construction and even materials for the project. Also, there was a view that having a CHO who was originally from the village where she worked would strengthen the project, since she would know families and feel comfortable



Daycare on wheels

with this new role. Both initiatives failed: Both men and women objected to the idea that chiefs would know about family planning services or possibly be in a position of knowing who was seeking health care. Moreover, nurses who were too close to the village socially could not be trusted to keep secrets. An element of social distance was sought whereby CHC would be constructed in a setting not closely linked with community leaders and CHO would be trusted outsiders.

**CHC: construction and location.** The most widespread criticism made by the CHO themselves (of their front-line situation) concerns the condition and location of their CHC. The local building materials used to construct the compounds (built as they are by the communities themselves using meagre resources) are not durable and the compounds frequently suffer structural damage, particularly in the rainy season. The comfort and safety of CHO is therefore being jeopardised. One CHO noted that, 'some [compounds] are falling down' and another commented that, 'our lives are at risk'. A further complaint concerned the location of the CHC and the isolated positioning of some, far from the communities they serve. Several nurses expressed the view that they feel lonely and vulnerable to attack. 'You are sleeping in the community alone'. 'Imagine if something happens. You will just be crying alone and no one will come'! This sense of isolation was noted by one CHO when she said that initially when they moved into their CHC they, 'were given wireless sets to stop [them] from being too bored'. Some of these radios had broken down and had not been replaced. As a result the CHO said that they feel like they are 'cut off from the world, not even [just] the country...so [they] don't know if [they] are going to heaven or hell'!

**Workload and welfare worries.** The Community Health and Family Planning Project (CHFP) has identified the 'domestic problems of the nurses' as one of the eight challenges faced by the experiment. The daily workload of a CHO is intense. It is not uncommon to hear the nurses suggest that two CHO were required to staff each CHC. As one nurse stated, 'when you return from compound visits your bench is full! One [CHO] [ought to] be taking care of the patients at the CHC while the other is on her compound visits'. A CHO supervisor noted that the workload is such that the nurses don't even get a chance 'to breathe'. The supervisor identified a range of potentially serious welfare issues faced by CHO: because of their intense workloads some don't have time to cook in the evenings and have been known to fall sick and even show signs of malnourishment; access to potable water is another basic problem as they are often in isolated locations far from sources of safe water; if they are married then there are issues over the care of their children as well as their husband's acceptance of their profession; some of them start dressing like members of the community and stop wearing their uniforms, therefore making it difficult for them to be identified as nurses.



CHO supervisory session

**Community fatigue.** As part of their routine work, CHO complete detailed registers, on the health of women of reproductive ages and children under the age of two, within their catchment areas. These registers require the cooperation and time of members of the community. There is some evidence to suggest that this frequent questioning is fatiguing some communities and leaving the nurses frustrated in their daily rounds. As several CHO remarked, 'some families welcome us and some claim that we are worrying them'! 'They feel that we are wasting their time'. 'Even during compound visits some are fed up with us—everyday the same questions! In the rainy season they are busy farming so if they see a motorbike they walk away'!

**Practical problems.** CHO require greater access to and regularity of supply of basic medical equipment. CHO complain that 'First Aid' kits containing bandages, gauze, etc. were not available to them for the treatment of minor injuries. As a result they had to turn down clients and send them to other medical establishments for the most basic of treatments. CHO also did not have facilities for the disposal of used injections, as they had not been supplied with incineration kits.

## Conclusion

Evidence from the Navrongo experience suggests that the 'front line of the battle' (to provide basic primary health care) is a challenging, harsh and sometimes isolating place. However, being on the front line appears to impart a sense of professional and personal achievement, gained from the knowledge that the battle is being valiantly and appropriately fought. Nevertheless, more concerted and intense efforts ought to be directed into ensuring that the basic welfare needs and technical requirements of the fighters are being met.

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



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

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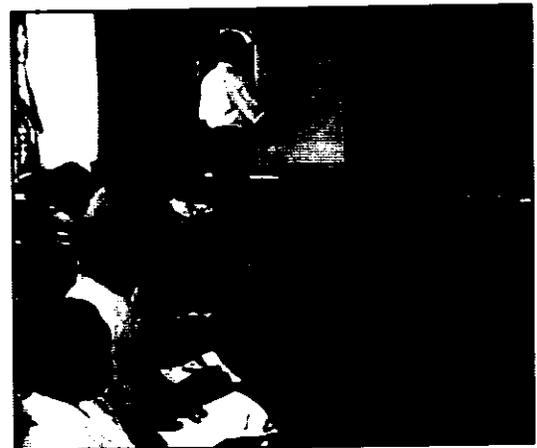
Navrongo Health Research Centre

## THE 'PERFECT' CHO

While there will never be a 'perfect' Community Health Officer (CHO), it is helpful to reflect upon the personal qualities of such a worker so that training can orient nurses to the type of person who is most successful in community work. Community Health Nurses (CHN) become CHO after undergoing specialized training to prepare them for life in the community as sole health care providers. Training modules are designed to make CHO as independent as possible and enable them to offer primary health care and family planning services to clients with a minimum amount of resources. They are trained to become part of the communities to which they are posted. In order to be successful, they must possess special personal characteristics allowing them to become members of the communities they serve. The perfect CHO serves as a motivating goal that all CHO can aspire to and requires the following characteristics:

### Empathetic

Philomena Bemba (fictitious name) graduated from the Community Health Nurses Training School a year ago with distinction. She is young, hard working, and eager to learn. She works at the health centre in town. Already within the first few weeks her work at the health centre is outstanding. Whenever the Medical Assistant is not available, she becomes the natural person to take over, even though there are more senior nurses and midwives around. Her humility allows her to work well with both patients and hospital staff. She is smart and always neatly dressed. She is jovial and obliging. The common phrase she jokes around with is 'People matter more than money'! For this reason, other nurses call her 'People'. She is always chatting with her family planning clients. Patients like her and ask for her first when they come to the health centre. She has a three-year old daughter, and her husband is away overseas on a three-year course of study. When it is time to choose a nurse to undergo training in order to be deployed as a CHO in a village, she will be the obvious choice. All the senior nurses highly recommend her. There is no doubt Philomena Bemba fits the criteria for highly deployable nurses to village locations.



It takes more than training to produce a CHO

### Competent

The ability to tell the difference between what training does or does not allow you to do is what is referred to here as 'discernment'. Sometimes, doing nothing helps more than doing something that will put a client's life in danger. One CHO says, 'it depends on what your motives are'. One should do the best that one knows how. Sometimes regulations are a problem. If a CHN knows how to give injections but rules don't permit it, should she? There are very competent CHN who are able to perform as efficiently as a Medical Assistant or even a Medical Doctor in some cases. A nurse with discernment is a great asset and makes a perfect CHO. She knows when to refer the patient upward in the health system to a service point where the expertise and resources exist to deal with the problems she cannot handle.

### Respectful

A CHN must possess that special regard for community leaders, Chiefs and elders, and their way of life. She should not be one to 'lord it over' the community because of her control over some health resources and her privileged position. She must possess that ability to merge into the community and hold conversations with women at water sources such as the riverside or at the well. She should be one who can attend village functions such as weddings and

most importantly, funerals of community members—especially women who have lost their children or have themselves died during childbirth.

### **Adaptable**

In light of the above, an aspiring CHO must not be individualistic, radical, quarrelsome, or eccentric. She must believe in the spirit of community, be socially minded, and be able to find the middle ground when she has to deal with culturally sensitive or controversial issues.

### **Independent**

Nurses who are most suited to be CHO are the ones who—at least for the defined period of community residence—have very few social obligations. This allows them to be truly and continuously resident in their assigned communities and remain there for as long as possible to provide uninterrupted services. CHN who are newly married, have too many children or dependents, have business in town, or other trades in conjunction with their work and other encumbrances are harder to keep at the community level. It is important to talk to the spouses of CHN prior to sending them into communities. CHN who are experiencing marriage problems with their partners are the least deployable; often sending them away tears apart their marriage or causes difficulties between spouses.



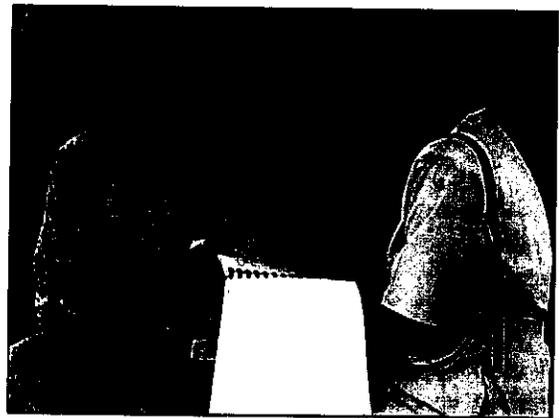
**A perfect CHO knows the middle ground when talking about culturally sensitive issues**

### **Trustworthy**

CHO must necessarily be persons who do not have 'okro mouths' or what others term 'oral diarrhea'. It is important in small communities that CHO keep information about clients' health, especially their family planning choices, in confidence. If a CHN is by nature a person who gossips a lot or 'talks too much' about people and is generally known to be untrustworthy with confidential information, she will be diagnosed as unsuitable for CHO work.

### **Energetic**

An ambitious nurse—who is made aware that if she successfully spends the two years of community residence, the District Health Management Team will recommend her for further studies and career improvement—works even more diligently. If they are encouraged that documentation of their work can help them to use the data they have collected and the community experience as material to further their public health careers, they faithfully, dutifully, and with excellence, carry out their assignments.



**An ideal CHO spends quality time with her clients, providing personalized and confidential services**

### **Conclusion**

CHN need special qualities to become CHO. Above all, they must have something unique that can be brought to bear to community-based health service operations. Hello there, do you have them; those vital innate characteristics that make CHN deployable?

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Navrongo Health Research Centre

## MOVING UP THE HEALTH LADDER



Doorstep services at level A—CHO and CHC

### Introduction

The Community Health and Family Planning Project (CHFP) is referred to as the Navrongo Project, though at the Navrongo Health Research Centre (NHRC) there are presently more than five ongoing major projects. The Government of Ghana has adopted findings from the project for implementing a National Health Service delivery initiative known as the Community-based Health Planning and Services (CHPS) Initiative.

### Secret of Success

The success of the CHFP as opposed to similar programmes in the West Africa sub-Region stems from a unique combination of factors: deployment of the Community Health Officer (CHO) in the village; a system of village volunteerism that supports the nurse; mobilization of traditional authority through village health committees, and support of the political leadership of the district.

### Complicated Cases

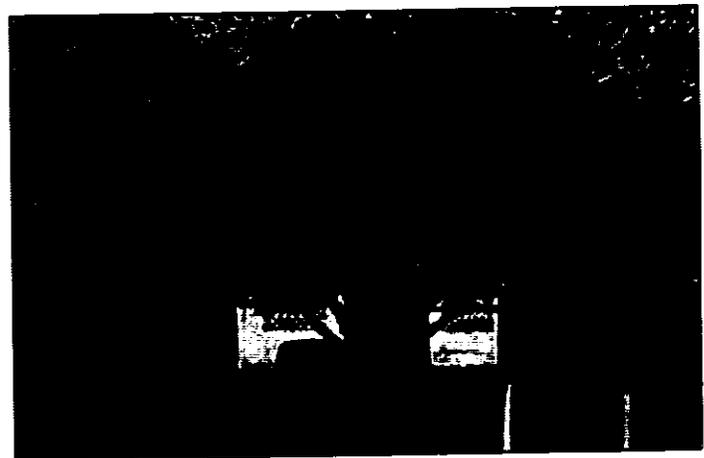
This combination of forces comes into play in all aspects of CHO work. One area of interest that has been discussed by project investigators and the District Health Management Team is the issue of referral. What happens when the CHO is confronted with a situation involving a client that she cannot handle? Such situations may involve seriously ill children, women with complications of labour or family planning clients who require specialized attention and need to be sent on to the sub-district health centre or the district hospital. In short, how do patients move up the health system from the community level where CHO and YZ are outfitted to handle a variety of the most basic ailments, to a hospital which is equipped to deal with complicated cases?

### 'Village Director of Health Services'

The CHO occupies a unique position in the village—she is seen as the village director of health services—an extension of the government health authority in the village. She is expected to lead the decisionmaking process as to when and how a patient should be sent upward in the health care hierarchy.

### When to Say Go?

When should a patient be sent upwards in the system, from the village to a health center or hospital? Only CHO, who are trained to recognize cases requiring referral, can answer this question. How promptly CHO refer patients depends on their understanding of what constitutes an emergency and their ability to assess and classify a case as a complicated one. For example, if a CHO has been trained to know that Coca Cola-coloured urine in a patient is a sign of renal complications of malaria then she will effectively advise the parent that the child must go to the hospital.



A sub-district clinic (level B) is the first point of call for referral cases from the CHC

## Special Instincts

CHO should be trained to quickly recognize conditions such as severe anaemia, convulsions, dehydration, and the need to refer such cases to the hospital. Training should help them acquire those special instincts that allow a health care provider to tell what is beyond his or her own capabilities or resources, without feeling guilty or incompetent. Awareness of what a prolapsed limb means in a woman in labour or what a fit in a pregnant woman implies, and the urgency with which CHO should facilitate transfer to hospital in each case is crucial to instill through regular training and retraining.

## To Where Should the Patient be Referred?

The problem of whether a patient should be referred to a health center or a district hospital should be simplified for the CHO. All patients referred by her should go to the next level above her, that is, the health centre to see the Medical Assistant. Admittedly, in some cases, valuable time may be lost if patients are sent to a health centre instead of directly to the hospital. However, it is assumed that health centres will be manned by competent and experienced Medical Assistants and be logistically prepared to deal with many issues such as giving an IV infusion to a severely dehydrated child and cut short the long distance travel that would otherwise be made. A health centre must therefore have the prescribed cadre and resources to be able to handle at least 75% of the cases that are referred by the CHO.



A district hospital (level C is equipped to receive patients from levels A and B)

## How Do We Go to the Hospital?

This is perhaps the most discussed as well as the most difficult decision to be made in many parts of the world. People who live in communities that have accessible roads and telephones may take these for granted. In most parts of Ghana, there are no telephones and motorable roads are not commonplace. Dusty roads become muddy in the rainy season and floods wash bridges away. CHO must consult with community leaders ahead of any emergencies about what must be done. In many villages, the people can be so innovative and resourceful that situations that may appear hopeless from a distance may not be completely so. Throughout the developing world major innovations like converting a bicycle into a cart on which a child or a mother can ride and be driven to hospital has been seen in parts of Asia and South America.

## Always Prepared

Before an emergency happens the CHO should first consult teachers, pastors, Chiefs, and other community leaders and devise a plan for the physical transfer of patients. Sometimes the main issue is lack of money to hire the only village truck to send a bleeding woman to the health centre. The community should be sensitized ahead of time to create a sort of common fund to deal with such situations. An established CHO should alert pregnant women about the possibility of transfer and have them prepare ahead for such possible situations through organizations like mother's clubs. It is possible to get all nursing mothers with children under one year to contribute a chicken each and sell them to create a children's transfer fund. The CHO should effectively make the community responsible for how a patient gets to the next referral level. There is always the danger of taking on this responsibility alone. This is not strictly a medical issue, but an issue that must be taken up by Assemblymen and Women in the village, the Village Health Committee, and other identifiable groups and opinion leaders.

The District Health Management Team should provide all referral cases with cards that indicate that a client or a patient has been referred to the hospital. This entitles the patient to priority attention at the referral point. Under no circumstance should a referred patient be treated as a new case and made to start at the beginning of the health system. They must be seen as having already been taken into the custody of the health system from the village level and treated as such. There should be feedback to the CHO at the periphery to help them recognize shortfalls in patient management.

## Conclusion

The use of walkie-talkies to solicit assistance in case of emergency would clearly boost efficiency in the health service delivery chain on account of referrals. Roger, Roger, can you hear me? Help needed, over!

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**Bamako: Is it in Mali?**

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**Where There is No Name  
for Doctor**

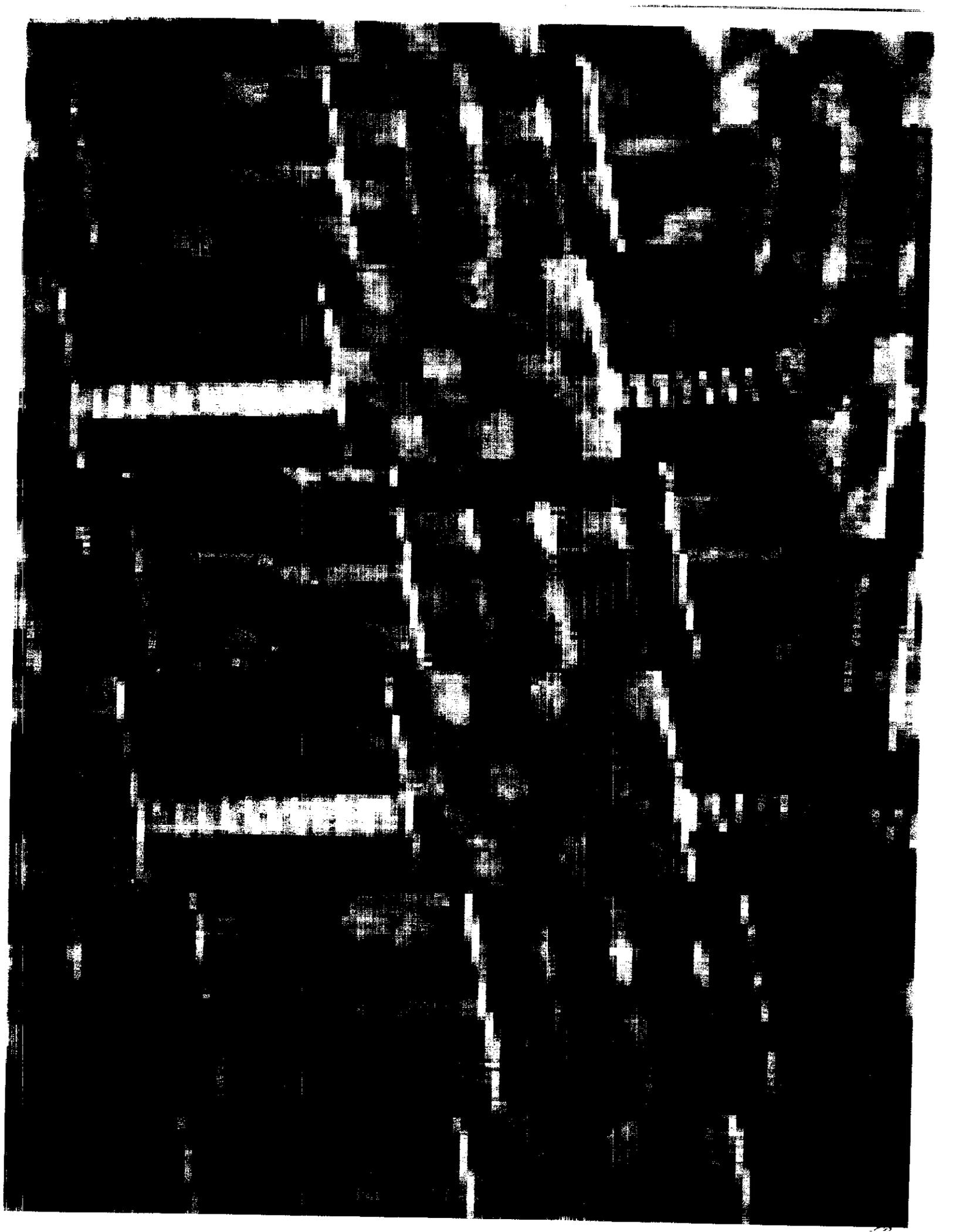
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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 5, October 2001

Navrongo Health Research Centre

## ZURUGELU: TOGETHERNESS FOR HEALTH

Ghana is widely acclaimed as a country with rich and complex sociocultural institutions. Utilizing these institutions in a programme of health care delivery can greatly improve the effectiveness, sustainability, and relevance of health care operations. This principle has been demonstrated by the Navrongo Community Health and Family Planning Project (CHFP) which has established a collaboration between the key social institutions and the community health care delivery system: This system of care has involved connecting the traditional social organizational system, with the Ministry of Health (MOH) structure, and the political system. In the local language, this is called the "Zurugelu Approach." *Zurugelu* is the Kasem word meaning "unity is strength" or "community togetherness." Thus, a *Zurugelu* Approach represents an attempt to marshal resources from various societal stakeholders. More specifically, however, the *Zurugelu* Dimension of the CHFP refers to all efforts that incorporate traditional and community institutions into the design of the project.

The *Zurugelu Dimension* was born from a practical need to incorporate cultural sensitivity into the project design, and was fuelled by the recognition of numerous cultural resources in Kassena-Nankana society that had not been tapped by the MOH programme. In many communities throughout the Kassena-Nankana District, traditional systems of village leadership and social organisation play fundamental roles in fostering volunteerism as well as in influencing individual behaviour. The *Zurugelu Dimension* of the CHFP has mobilised these effective and well-established traditional institutions for the planning, organisation, and management of family planning and primary health care. The CHFP operational plan for the *Zurugelu* scheme involves mobilisation of the following village components: chieftaincy and lineage system, social networks, *Yezura Nakwa* (health committees), *Yezura Zenna*

(health volunteers), traditional communication, and non-traditional communication. By integrating the organisation of service delivery into the existing social system, the CHFP has attained legitimacy, respect, and cooperation from local communities.



Traditional leaders attend a community durbur

The primary aspect of community entry and mobilisation involves an understanding of the traditional structure of authority. In Kassena-Nankana societies, Chiefs and elders command a great deal of respect, and serve as primary decision makers for all important village affairs. Knowledge of and cooperation with this authority has allowed the CHFP to conduct affairs appropriately and to facilitate the generation of understanding, organizational preparation, and active communication from community leaders. Traditional leaders are key players in legitimising, launching, and sustaining various initiatives, thus their support is essential for project success.

**Yezura Nakwa.** Unit Committees (UC) are well-established, community-level political structures, and are responsible for the actual implementation of activities that have been sanctioned by the Chiefs and elders. In order to carry out its duties, the UC constitute Implementation Committees (IC) among interested community members and also coordinate peer networks, which are traditional associations that join youth, men, and women together for various social and communal activities. The CHFP has mobilized this traditional system of task leadership through the Paramount Chief and his Council of Elders who established an IC for health, termed *Yezura Nakwa* (YN) (health welfare committee).

YN are now responsible for health administration in their respective communities and serve as internal supervisors for village volunteers known locally as *Yezura Zenna* (YZ). YN stock and supply drugs to the YZ, oversee the maintenance of bicycles, settle community disputes regarding YZ, and develop the scheme for pricing, cost recovery, and compensation. As elders and respected members of the community, the YN serve as valuable sources for information dissemination, community motivation, and assessment of community actions and reactions.

**Yezura Zenna.** The most fundamental aspect of the *Zurugelu Dimension* is the use of community volunteers as primary service providers. The CHFP developed the *Yezura Zenna* (YZ) programme in response to the shortcomings of the now defunct MOH Village Health Worker scheme. This new approach involves the use of local community members to serve as *Yezura Zenna* or volunteer health aides. Selection of the YZ is the responsibility of the community. Initially, Chiefs, elders, and other community members nominate permanent members of the community who they feel are reliable and trustworthy, and who have also demonstrated a keen spirit of volunteerism. The final adoption of YZ requires the consensus of the community; this is extremely

important, as community support is critical for the successful execution of YZ responsibilities. Additionally, if any problems arise during the YZ's course of service, which the YN cannot settle, Chiefs and other community members are consulted to mediate the dispute.

YZ are trained in various aspects of primary health care provision and are utilised to improve accessibility to low-cost essential drugs. Their roles involve treatment of minor ailments and ambulatory care for certain illnesses such as simple malaria and diarrhoea. YZ are equipped to dispense the following drugs: Paracetamol, Chloroquine, Piriton, Multivitamins, Aludrox, and nonprescription contraceptives such as condoms, and foaming tablets. In addition, YZ are responsible for the dissemination of information regarding, nutrition, immunization, and family planning. They are relied upon to gather accurate and complete data and to write descriptive reports. In order to effectively carry out their duties, YZ are provided with bicycles, which also serve as incentives for participation. Possession of a mode of transportation assures community recognition and prestige; both represent a form of compensation. Both YN and CHFP staff regularly supervise YZ.

**Traditional communication.** Another critical factor of the *Zurugelu Dimension* is utilisation of the community's traditional system of communication and mobilisation. In Kassena-Nankana communities, Chiefs hold traditional meetings called *durbars* in order to discuss issues of common concern or to rally participation for various community activities such as farm labour or development projects. Recognizing the effectiveness of this approach, the CHFP has adopted the use of *durbars* as a means to establish credibility and community support, as well as to serve as a forum for discussing project activities. *Durbars* are usually



YZ on his daily rounds

well attended by various community members, including Chiefs, sub-Chiefs, elders, youth, Assemblymen and women. The occasion involves speeches by community leaders and CHFP staff, and is made lively by drumming, dancing, and songs about health.



Students act out a drama for a film

**Nontraditional communication.** The CHFP has also introduced a nontraditional form of communication, which the communities have wholeheartedly embraced. The drama troupe is a very important part of the CHFP design. The troupe acts in films that are screened in communities during the evenings. Films of particular interest are on issues such as "Male Involvement in Family Planning" or "Female Genital Mutilation". The scripts are written by a CHFP staff member and acted in either of the two main languages of the District by students of Saint John Bosco's Training College in Navrongo. Every effort is made to ensure that the scenarios, dialogue, and characterization are a slice of Kassena-Nankana way of life. Though the subject matter is rather serious, it is subtly woven into a humorous and entertaining drama. Communities have indicated substantial interest in and appreciation for the films, as large crowds often gather and watch the films intently. At the end of every film show, a discussion session is held so that community members can ask questions or raise issues of concern. CHFP staff and a resource person such as a medical doctor, nurse or midwife are available to respond and offer clarifications. Though the logistics involved in film showings are often difficult, the overall impact of this initiative appears to be positive.

**Conclusion.** Implementation of a viable health service delivery scheme in rural, traditional Ghanaian societies requires support from traditional community leaders and networks. Additionally, modes of communication and task implementation must be adapted to suit the existing community structure. The CHFP has made a significant effort to incorporate each of these factors into its project design. Collectively termed the *Zurugelu Dimension*, these efforts offer the project a unique system of implicit accountability and sustainability. The CHFP experience has demonstrated that indeed, "cooperating together is strength".

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Vol. 1, No. 6, October 2001

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## BAMAKO, IS IT IN MALI?

The Bamako Initiative is a regional programme sponsored by UNICEF that aims to develop low-cost, accessible, and sustainable health care by organizing health committees and volunteers for health services and backstopping their work with logistics and training. A key theme of the programme is establishing cost recovery for essential drugs and organizing logistics for resupplying village pharmaceutical kits. While the Bamako idea is appealing, the practical details of how to organize the programme have not

always been thoroughly developed in settings where it has been tried. As a consequence, implementation of the Bamako Initiative has faced various operational problems.<sup>1</sup> The Community Health and Family Planning Project (CHFP) has sought ways of making Bamako work. At the heart of the strategy is the observation that Kassena-Nankana society is rich in cultural resources. Yet, until recently, these resources have not been effectively used for community health service delivery. To address the gap between traditional social institutions and community health services, the CHFP has developed the *Zurugelu* (togetherness) dimension of the Navrongo Experiment. *Zurugelu* strategies mobilize cultural resources of chieftaincy, social networks, village gatherings, volunteerism and community support to undergird the CHFP programme. Making Bamako work has various elements in the Navrongo system:



Traditional leaders can be health leaders

**Leadership.** The *Zurugelu* system is based on the observation that traditional societies have a hierarchy of traditional leaders who command respect from the people whom they govern. Furthermore, traditional social support networks exist in rural communities that can be effectively mobilized to promote health care. Specifically, there are two components to the *Zurugelu* approach: the *Yezura Zenna* (Health Aide or YZ) component and the *Yezura Nakwa* (Health Committee or YN) component. YZ represent a cadre of volunteers from the rural community that are selected by the traditional leadership to assist with local health service delivery. Volunteers are not on their own: they report to YN who maintain a stock of supplies of essential drugs, manage ac-

counts and a revolving fund for purchasing drugs, and coordinate volunteer work with other CHFP activities. YN also mediate in disputes among volunteers or between volunteers and other members of the community, and represent the programme at community functions.

**Volunteerism.** The YZ component is premised on the notion that communities can actively and effectively participate in improving their own health status. The YZ concept has resonated with communities since they have been accustomed to utilizing resources within the community that hitherto had been limited to the services of traditional healers. The YZ component has resulted in wider coverage of health services, greater access for the community to health service provision, and community pride in their ability to contribute collectively to the improvement of their health. The YZ volunteer works in tandem with the local Community Health Officer (CHO) by delivering basic care, providing preventive health information, and referring cases to the CHO for more intensive curative health needs that may be required.



Yezura Zenna (YZ)

**Training.** Both YN and YZ are trained in various aspects of health care provision. YN are trained in record keeping and the management of accounts. YZ training includes the treatment of ailments (malaria and diarrhoeal diseases), the provision of family planning information and supply of contraceptives, nutrition information, immunization promotion, drug management and record keeping. In addition, YZ are relied upon by the community

<sup>1</sup> In Ghana, the Bamako Initiative has never been adopted as official policy. However, elements of the Bamako concept have been promulgated with the aim of developing low-cost volunteer services.

and the surrounding health service institutions for data gathering and report writing. As such, it is essential that the YZ volunteer is reliable, available and committed to the important tasks at hand. YZ training is conducted in day-long sessions every 90 days.

**Technical supervision.** A team of CHFP supervisors has been assigned to the task of community liaison, community organization, and field supervision of the *Zurugelu* programme. These supervisors represent an incremental staffing configuration of the programme that is not included in the normal MOH/GHS staffing pattern. As a matter of fact, professional community workers are crucial to the success of volunteer operations. They deal with the problems of volunteer turnover, disputes between YN and YZ, community organizational problems, and other issues that are difficult to predict but essential to resolve in the course of making volunteerism work.



YZ conferring with CHFP staff

**Incentives.** YZ and YN are not paid, and demands for compensation and MOH jobs are to be expected in the course of any volunteer scheme. It is important to structure community rewards in the form of strategies for enhancing the prestige and recognition of volunteers. Training can serve as an incentive, and should be conducted on a regular basis. The bicycles provided to YZ are highly prized and represent the most direct form of compensation to volunteers even though a volunteer may not own the bicycle until he/she has used it for a minimum of one year and a half.

**Logistics.** The official drug exemption policy does not work in the context of the Bamako Initiative; free drugs to children under 5 and pregnant women cannot be sustained. However, a "cash and carry" policy of charging cost recovery fees sustains the flow of resources. Special procedures are required for supervisors to maintain stocks at the district level and sustain the flow of drugs to communities on a "demand pull" system for replenishing supplies.



Replenishing depleted stocks is a major headache

**Conclusion.** The CHFP has demonstrated ways of mobilizing traditional cultural resources for supporting and delivering primary health care. In doing so, it provides a practical example of how the Bamako Initiative can work in a rural, traditional, and isolated district of northern Ghana. Implementing the Bamako approach requires a programme of assembling and training community committees, in close cooperation with traditional leaders. It involves convening regular public gatherings for soliciting community opinion about the programme. Finally, it involves developing comprehensive links between the volunteer system and the formal health care system so that all community health activities, including the Bamako component, function as an integrated system of primary health care service delivery.

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

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 17, May 2002

Navrongo Health Research Centre

## WHERE THERE IS NO NAME FOR 'DOCTOR'

'A bisem'. This is a usual greeting by a Yezura Zennu (YZ) as he enters a compound to offer health services to members of the compound. The term is derived from the *Zurugelu* concept (coming together and doing things together). This is a traditional system of getting things



The YZ is a solution looking for problems

done for individuals and communities. This concept was introduced to replace the Village Health Worker (VHW) Scheme introduced in the 1970s by the Ministry of Health. This concept failed because volunteers were not properly monitored, resulting in their overstepping the scope of their work. Equipped with basic data in simple primary health care, a YZ goes on compound visits offering health services to members of a community to which he/she belongs. Owing to the fact that he is a volunteer, he is not assigned compounds to visit in a specified period of time as is done with Community Health Officers. He works three days a week; this enables him to attend to his personal activities to earn income.

### YZ selection

The process for selecting YZ is very rigorous and meticulous. After several consultations between the Community Health and Family Planning Project and community members, a YZ is chosen by a Chief and members of his community. In some cases, the selection is done in collaboration with formal political structures at the community level such as an Assemblyman or Unit Committee members. Selection of the YZ is based on certain criteria such as having a spirit of volunteerism, dedication and honesty, a willingness to stay relatively permanently in the community, an ability to ride a bicycle, and being functionally literate. (Although functional literacy has eluded many a YZ and some communities have stark illiterates serving as YZ and who, surprisingly, are doing well.)

Right from the outset, it is made known to the candidate that the job is a purely voluntary service. First he/she is introduced to the community at a durbar for community acceptance or rejection. If the person proposed is accepted, the District Health Management Team (DHMT) in collaboration with the Community Health and Family Planning Project team of the Navrongo Health Research Centre (NHRC) then trains him for two weeks.

### Content of YZ training

During training, the YZ is taken through environmental sanitation, health education, personal hygiene, water sanitation, nutrition, maternal and child care (including immunization), treatment of minor ailments, counseling on family planning, use of family planning devices, and simple bookkeeping techniques. The YZ also goes on practical attachment in the consulting room of a hospital.

After his training, a durbar is again organized and the YZ is presented to the community as being ready to start work. Here, he is told all the do's and don'ts of his/her work in the presence of community members. He is not to give injections, handle or dispense antibiotics, and should not provide ambulance services but rather, refer patients to the nearest health facility.



Training the 'Village Doctor'

## Refresher training

Subsequently, three-day training workshops are organized every quarter. The content of these workshops is drawn from problems encountered by the YZ or identified by supervisors in the field. Sub-district supervisors who are DHMT staff organize the workshops in collaboration with the training coordinator of the NHRC. YZ are taken through effective conduct of home visits, proper organization and submission of monthly reports, and any other topic the supervisor and the training coordinator deem appropriate. Certain YZ are trained to distribute oral contraceptive pills to women. During refresher training sessions YZ are given the opportunity to share their experiences and problems in order to learn from each other.

## YZ working tools

YZ working tools include drugs, a drugs storage box, a rucksack for transporting drugs, two notebooks for recordkeeping, and a bicycle as his means of transport. At a durbar to present the items to the YZ, decorum is strictly respected—the project first gives the items to the Chief, who in turn hands them over to the Yezura Nakwa (YN, a health committee usually made up of five members). The Yezura Nakwa then hand the items to the YZ in the presence of community members. The YZ is admonished to work hard and not disappoint the community and should use the bicycle to do the work for which it is given—health delivery. Since YZ work is voluntary, an appeal is made to community members to assist the YZ to function effectively by helping out on his/her farm during the rainy season and also helping with building or renovation work on his/her house when the need arises. The YZ is then given an opportunity to speak if he/she so wishes.

## YZ Scope of Work

YZ give treatment to anyone with minor ailments such as malaria, headache, abdominal pains, diarrhoea, etc and refers patients to the resident nurse in the community known as the Community Health Officer (CHO) or the nearest health facility where necessary. If there is no one needing treatment during that visit, the YZ gives situational health talks. Other functions of the YZ include:

**Community mobilization.** The YZ does not only seek the health of his community members, he is also a social mobilizer of people to undertake communal labour when the need arises. When there is the need to build or renovate a Community Health Compound (CHC), construct a ventilated improved pit latrine, keep the surrounding of a borehole clean or undertake any other health-related community project, the YZ educates community members as he goes on compound visits on the need to undertake a particular project. He also actively participates in executing the project.

**Outreach clinics.** The YZ also assists the CHO or the sub-district outreach team to run Child Welfare Clinics. His role is to inform mothers by passing the information of an impending clinic to all sectional heads of his community so that they will in turn make announcements on the eve of the clinic when all members of his community are supposed to be at home. The YZ also reminds mothers of impending clinics as he does his compound visits. At an outreach clinic, he weighs children and records their weight on their Road-To-Health Cards. He also educates mothers who have defaulted on the need to attend outreaches. Children of mothers who have persistently defaulted are identified by the YZ who informs the CHO, who, in turn, traces the child/children for the necessary immunizations.

**Disease surveillance.** The YZ also serves as a link between the community and any health facility within the community. He alerts health authorities of any strange disease in the community for action to be taken before an epidemic occurs.

**Referral.** For many families, the YZ replaces the traditional healer as the first source of health care. YZ are trained to recognize cases that they are not qualified to treat, and to refer these cases to CHO or sub-district Health Centres.



The "Village Doctor" providing doorstep service

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HEALTH AND FAMILY PLANNING PROJECT

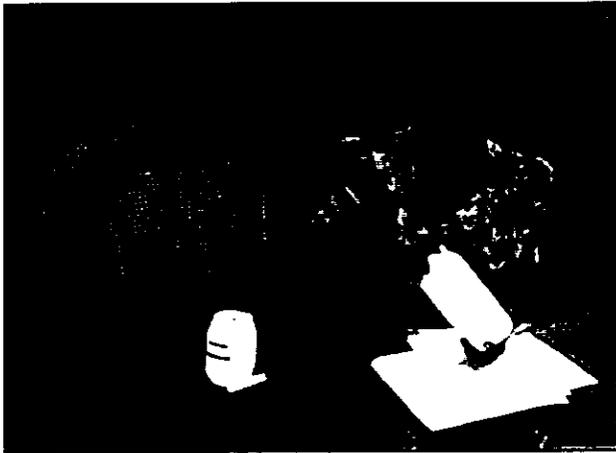
Vol. 2, No. 18, May 2002

Navrongo Health Research Centre

## WHAT KEEPS THE VOLUNTEER GOING?

In spite of their limited professional training and restricted scope of activities, health volunteers enjoy considerable respect for their role in health service delivery at the community level. In earlier times this respect from community

members was responsible for pushing the Village Health Worker to assume roles he was not qualified for. Under the CHFP, the role of the volunteer has been reviewed and a strict regime of supervision has been instituted to guide the 'village doctor' in his daily activities.



Project supervisor checking YZ drug stock level

Supervision and monitoring are tools used to ensure that things go as expected and that YZ are not left to operate entirely on their own. Supervision and monitoring are done at six different levels: sub-district, District Health Management Team (DHMT); the Community Health and Family Planning Project (CHFP); the community resident nurse (CHO); the Yezura Nakwa (YN, Health committee); and the entire community where YZ operate.

Supervision entails checking the YZ's two record books— one for patient treatment records; the other for drug records. The treatment book is checked to see the number

of patients treated for the month, drugs used and if there are referrals of patients or family planning clients. The supervisor also looks at the drug records to see how many drugs the YZ has received from the YN, when the drugs were collected, total cost of drugs received, expiry dates of drugs, cash on hand, and how much has been paid to the YN. This is to ensure that the YZ does not keep money at home but pays the YN on a regular basis to enable them settle their indebtedness and collect more drugs from the project office.

The monitoring role of community members of the YZ's work is vital because the YZ are chosen by them and live among them. Community members may report any misconduct on the part of the YZ to the YN, CHO, and supervisors from the sub-district, DHMT or project staff or simply make known their impressions about the YZ's activities at durbars.

### Limit to Volunteerism

The volunteer concept has generally served communities well. Yet, like any human endeavour, the YZ concept has its share of problems. When communities are approached to select someone to train as a YZ, some Chiefs single handedly choose their relations to be trained. In such cases the YZ does not see himself as answerable to the health committee or community members. Then, as time goes on, he does not meet the community's expectations. There are instances when a YZ squanders drug money and cannot pay the YN, or absconds with funds or drugs, or refuses to go out into the community, thus bringing health service delivery to a stand still. When this happens, discussions are held with the Chief and his community to find a way of resolving the problem.

Some people accept the YZ position with ulterior motives (such as being absorbed into the Ministry of Health work force some day) and when this is not forthcoming after working for some time, they start agitating and making demands. They give all kinds of excuses to supervisors for not working during a particular period. There is a limit to volunteerism. When a YZ is tired of working, sometimes he informs the community to get somebody to replace him; but there are instances when he is removed by the community because he does not meet their expectations.

## Sustaining volunteerism

The YZ concept can be sustained by concerted efforts from the DHMT, the District Assembly, the traditional leadership, the recipient community, and the volunteers themselves. At the DHMT level, the programme for YZ training should be strictly followed to get the volunteers together every quarter. The training programme should be reviewed periodically to include current health problems in order to put YZ on alert all the time.

The DHMT should figure prominently in the discussions to select volunteers, in order to let YZ know that they are going to work with the sub-district management team and not with the CHFP project or the Navrongo Health Research Centre. This will curb misplacement of loyalties militating against sustainability of the concept. Supervision has always been part of the duties of DHMT team members. YZ should be supervised as regularly as CHO are.

The community should see the volunteer concept as their own initiative to help themselves and should therefore be involved in consultations to select a volunteer for the community. Logistics such as raincoats, Wellington boots, and torchlights should be provided by the community to assist the YZ to work effectively even under unfavourable weather conditions. Above all, community members should



**Health committee undergoes training—gaining the tools to supervise the work of volunteers**

contribute money to set up their drug fund, which can be used to pay for drugs at the district medical stores. This will lead to accountability.

With proper training, monitoring and strict supervision, communities can play an active part in health care delivery, and bring health services within their own doorsteps. With the YZ around, community members no longer have to travel long distances for the treatment of minor ailments. In addition, the activities of quacks are also held in check.

Clearly, there is a limit to volunteerism and people cannot volunteer forever. For various reasons the spirit of volunteerism and the enthusiasm with which people work declines over time. The spirit of volunteerism may die either because a YZ accepted the assignment with an ulterior motive that is not being realized. There may be some commitments that conflict with YZ work or a more lucrative opportunity has opened up elsewhere. Others simply get tired of being a volunteer. Female YZ are more



**Community members looking intently into YZ activities**

dedicated to their work than male YZ, although it is more difficult for communities to nominate females as YZ. Female YZ are more meticulous, sell more drugs, and submit reports more promptly than their male counterparts.

## Conclusion

One clear advantage is that the YZ concept has allowed community members to be active participants in health service delivery instead of being passive recipients. The regular training has made the YZ a multi-purpose health worker first to his family and his community at large. YZ have reported that they find prestige in their work. YZ are happy to put smiles on people's faces, and that probably is what keeps them going.

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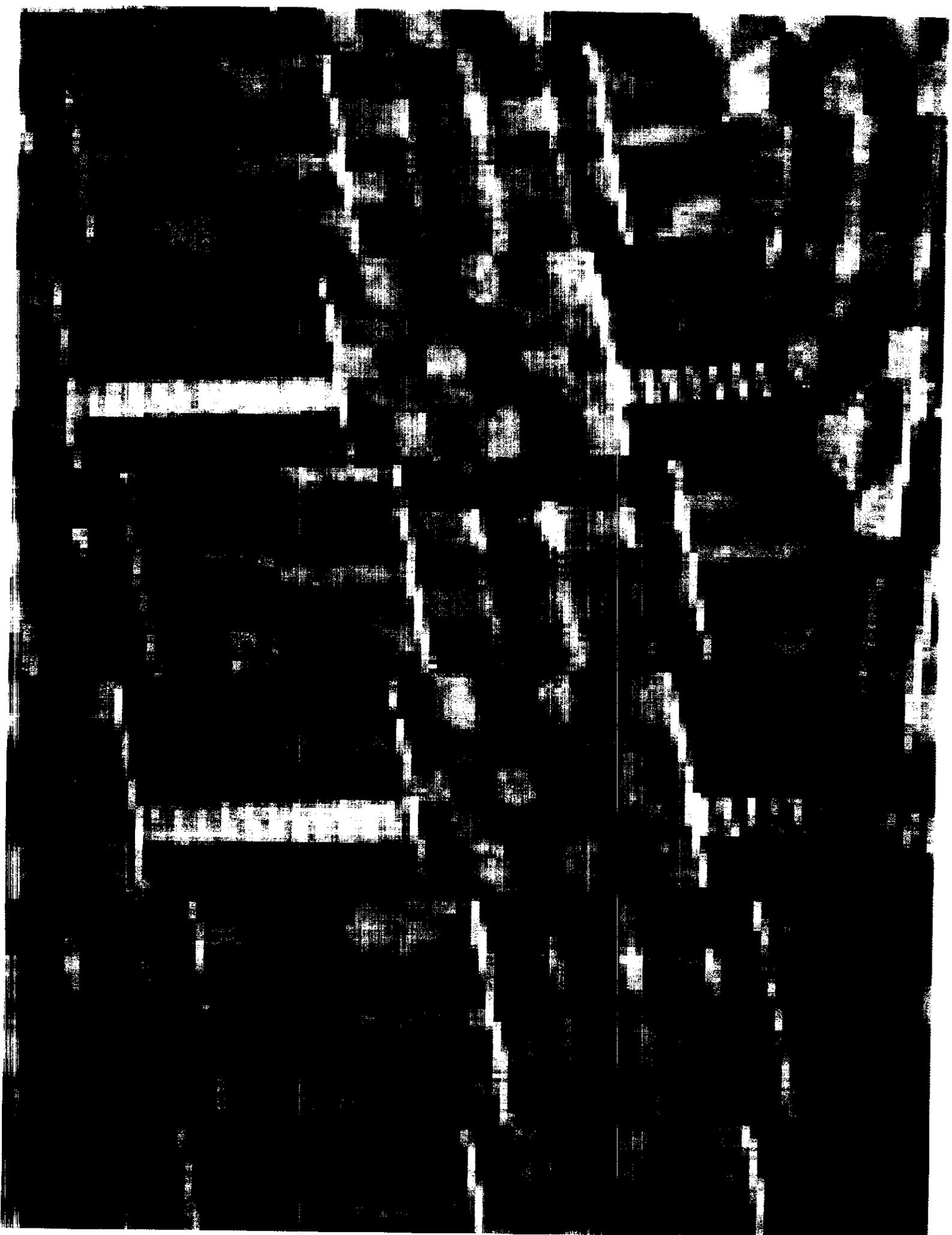
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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

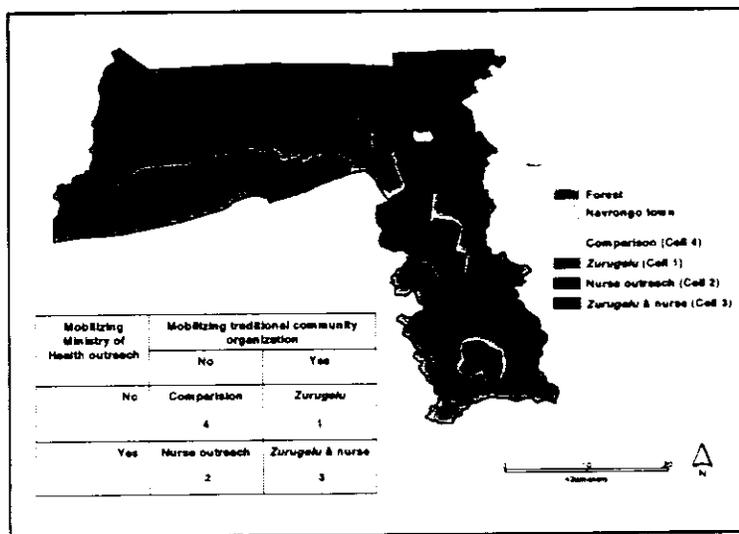
Vol. 1, No. 10, November 2001

Navrongo Health Research Centre

## BREAKING GROUND, PLANTING SEED, AND HARVESTING RESULTS

Results from Phase I of *The Navrongo Experiment* on developing a new health delivery approach were more than just encouraging. They defined the broad outlines for raising the quality and efficiency of health service delivery in rural communities. The Community Health and Family Planning (CHFP) Project has origins that date as far back as 1977 when the Ministry of Health (MOH) promulgated a policy that called for primary health care services at "Level A:"

*Because most disease problems that cause the high rates of illness and deaths among Ghanaians, are preventable or curable if diagnosed promptly by simple basic and primary health care procedures, the major objectives of the [Ministry of Health] are to extend coverage of basic and primary health services to the most people possible during the next ten years. In order to provide this extent of coverage it will be necessary to engage the cooperation and authorisation of the people themselves at the community level. It will involve virtual curtailment of the sophisticated hospital construction and renovation and will require a reorientation and redeployment of at least some of the health personnel from hospital based activities to community-oriented activities.<sup>1</sup>*



Geographic zones corresponding to CHFP cells in Kassena-Nankana District

*The design.* The CHFP has two experimental dimensions: i) The "Zurugelu Dimension" involves mobilizing existing traditional social institutions of chieftaincy, lineage, village governance, and community communication for primary health care. In the local language, *Zurugelu* literally means, "unity is strength". In this context, it stands for "togetherness." *Zurugelu* volunteers, termed *Yezura Zenna* (YZ) have been trained and deployed in half of the district; ii) The Ministry of Health outreach dimension is designed to make existing health service resources community based. In all, 16 Community Health Nurses were retrained and redesignated as Community Health Officers (CHO), and deployed in village locations in half of the district where they move from compound to compound and provide health education, immunization, treatment of minor ailments, family planning counseling and services. Since the mobilization of *Zurugelu* and MOH outreach resources can be undertaken independently, jointly or not at all, the two dimensions of the experiment imply a four-cell design. Each of these four cells corresponds to a

catchment area of a "Level B" sub-District Health Centre (see figure above). Cell 1 is an area utilising the Village Volunteer or *Yezura Zenna* (YZ)/*Yezura Nakwa* (YN) concept which consists of mobilising traditional cultural resources at the periphery. Cell 2 involves posting Community Health Officers (CHO) to Community Health Compounds (CHC) and mobilising existing MOH resources to support community health care. Cell 3 is a combination of both CHO and YZ/YN in health service delivery. Cell 4 is a comparison area where usual clinic-based services and the usual MOH outreach clinics are conducted.

*Operational results.* A pilot phase of the CHFP demonstrated mechanisms for achieving the long-standing goal of developing community health care by: i) consulting communities and approaching them to construct CHC where nurses could live and provide health services; ii) retraining CHN and redesignating them as CHO to function as community-based health workers; iii) equipping CHO with motorbikes and training them to provide compound-to-compound services in regular work cycles; iv) supplying an initial allocation of essential drugs to be distributed on a cost recovery basis; and v) developing administrative

<sup>1</sup> Source: Health Policies for Ghana, p.1 National Health Planning Unit MOH, Accra, 1997.

support systems for village services to include health system supervision, management information systems, community liaison, communication, and logistics support.



One of the first CHO deployed in the field

The *Zurugelu* arm of the experiment utilizes a new and comprehensive community-managed programme of volunteer health service delivery. This involved approaching chiefs and elders and constituting village health committees, training committees in the requirements of managing volunteer effort, guiding committees in the selection of volunteers, training volunteers in recurrent training sessions, and providing community health committees with simple-to-use village worker-based MIS for the control of essential drugs and the monitoring of the service performance of volunteers. Close supervisory liaison procedures are designed to develop community-based accountability for volunteer service activities

Coverage for health services has greatly increased. For the first eleven months of 1997 (January to November) eight CHN that have been redeployed to work as CHO, each in defined catchment communities in the Central sub-district of the Kassena-Nankana District, managed a total of more than 10,000 outpatient cases. Over the same period of time a fully functional health centre in the Kassena-Nankana East sub-district, with a Medical Assistant and a full complement of health workers totaling over twenty, saw less than 3,000 OPD cases. The CHO, in addition, visit on the average seven compounds a day where they provide compound-relevant

and compound-specific health education. Since the average number of people in a compound is 10, it means the CHO is able to provide health messages to about seventy people each day. A single CHO can therefore outperform an entire sub-district health centre.

*Demographic results.* The project has had both fertility and mortality effects:

- **Fertility.** In Cell 1, the project has had an impact on fertility in the first year, but this effect was temporary, suggesting that couples will adopt contraception when *Zurugelu* activities are launched but that sustaining programme effects requires more comprehensive community health care than can be managed by volunteers alone. In Cell 2, there has been no fertility effect up through the year 2000. This suggests that the role of *Zurugelu* activities is a necessary component of the programme. In Cell 3, where services are combined, the Total Fertility Rate (TFR) declined by about one-half of one birth in the first project year and declined by an additional 0.1 birth subsequently. This effect is significant and observed in all age groups in contrast to patterns observed in Asia and Latin America. Early results also suggest that limited mobility of women and lack of autonomy to seek services requires strategies for doorstep service delivery. When the *Zurugelu* approach is combined with CHO community care, the programme works.
- **Childhood mortality.** It is too early in the project to make definitive conclusions about survival effects. When preliminary results are examined, findings demonstrate a need for continuing health research and strategic review of operations. None of the CHFP treatments have reduced neonatal mortality, although health technologies that are being investigated independent of the CHFP may have had beneficial effects. In Cell 1, there is no apparent under-5 survival effect of the project. In fact, in the second year of life, mortality risks may even increase slightly. Hypotheses, which explain this effect, are under investigation. However, the CHFP has reduced childhood mortality. This impact of the CHFP is likely to operate through improved treatment of acute respiratory infections, malaria, and diarrhoea, or possibly improved childhood vaccination coverage. The precise causes of the survival impact of the CHFP remain the subject of investigation and observation. However, preliminary evidence suggests that childhood mortality may be substantially reduced by CHO community-based health care.



Child survival became a crucial issue in the CHFP

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 1, No. 11, December 2001

Navrongo Health Research Centre

## LIGHT AT THE BEGINNING OF THE TUNNEL

Lessons learned from the Navrongo project have important programme implications. Phase 1 of the experiment aimed to determine the most effective way (in terms of cost, coverage, cultural compatibility, and quality) of delivering health care services to rural people. Phase 2 tested the strategies in a district-wide trial. As findings emerge, important lessons are learned:

### Lesson 1 • Need for Community-based Services

In remote and very rural and traditional communities, mobility of women and autonomy to seek health services is extremely limited. To succeed in providing access to quality health care to all, services must be based in the community. This has been achieved by fostering volunteer construction of Community Health Compounds (CHC) where nurses, termed Community Health Officers (CHO) live and provide services.

### Lesson 2 • CHO: The Trusted Outsider

When CHC are placed too close to the Chiefs' compounds or when nurses are related to influential families, performance is less than if nurses are outsiders. This is particularly true of family planning services. Women prefer female service providers who have no links to the community and can be trusted to keep secrets about family planning supplies.

### Lesson 3 • *Yezuru Zenna*: The Trusted Insider

When men are recruited as health aides, termed *Yezuru Zenna* (YZ) they are viewed as community health mobilisers who contact men to discuss and legitimize the programme. These are appropriately socially gregarious individuals who are from the communities they serve.

### Lesson 4 • The Need for More Nurses

When services are restructured to reach people and staff of the MOH are redeployed more efficiently, old staffing norms become obsolete, meaningless, and constraining. A nurse living in the community is at the beck and call of people around the clock. She has no opening hours and no closing hours. She does everything from health education, curative services, counseling, midwifery, and community mobilisation. These services constitute a very large increase in her workload as compared to a nurse that lives in a health centre. A sub-district clinic nurse is instructed to start her day at 8:00am, but she rarely arrives at work before 10:00am. Her work schedule hardly occupies her full time, so she typically closes around 12:00 noon by which time the number of patients has considerably decreased.



There is the need to train more frontline staff such as these student nurses

A nurse living in the community feels lonely most of the time. She complains of being on duty 24 hours without a day without anyone to relieve her. Staffing norms must be readjusted to take care of redesigned service delivery strategies that create demand and improve service utilization. The number of CHO currently assigned to Kassena-Nankana District is too small for achieving adequate coverage of the communities with the expected quality of service. Consideration should be given to increasing the density of CHO so that they can establish contact with all compounds in their area on regular basis. The fluctuations observed in compound visitation coverage reflect demands on the nurses' time as they are withdrawn from the communities to respond to other demands such as epidemics, sickness, and or mop-up activities that of necessity take them away from the communities without finding other nurses to provide relieving duties in their absence.

### Lesson 5 • Addressing Men's Concerns

An interesting finding of the experiment is the willingness of men to discuss family planning with the CHO, who are women. Women can serve quite effectively as information providers to men, so long as strict secrecy about the contraceptive decisions of

wives is maintained at all times. Using a male approach that involves meetings with elderly men also helps tremendously to defuse opposition, which is mostly based on fear of the unknown. Men make the decisions in the community, but know very little about family planning. Their opposition to family planning is therefore based on ignorance. A positive male approach to family planning yields better results in the increased use of family planning. By constituting village elders as Health Committee Members and involving them in discussions on family planning at public gatherings, legitimacy and the notion of some level of acquiescence is given to family planning and this greatly improves the atmosphere for individual family planning decisions.

### **Lesson 6 • A Sustainable Construction Initiative**

Communities construct CHC for the CHO to use as their residence and “Level A” clinic. This is a low-cost programme that can be implemented anywhere. However, over-reliance on traditional architecture and building materials can lead to unsustainable structures. Traditional compounds are built by men through communal labor, but routine maintenance is carried out by women. CHO are too busy to perform maintenance work on their compounds; roof leaks often develop, causing structural problems. A typical traditionally designed structure as residence for the community-resident nurse is not sustainable. Modest resources from the MOH (or through the District Assembly Common Fund) and other sources should be committed to providing building materials for the CHC and latrines, in addition to providing some funds for mobilising community labour to put up the structures.

### **Lesson 7 • System Support**

Village work is a new challenge for the CHO because it’s a system that requires mechanisms for technical, community and supervisory support for their work. Frequent practical training sessions are needed to develop community liaison and teamwork. A new MIS system has been developed to foster “bottom-up” communication. Workers meet frequently, assemble narrative reports, discuss progress and problems, and communicate matters of concern to senior officers.

### **Lesson 8 • Community Participation**

Mechanisms for traditional governance and group action can be utilized for communicating with communities. Liaison with chiefs, elders, and lineage heads, cooperation with village peer networks and group leaders can legitimize and explain family planning to men. Durbars are particularly useful for health education and family planning. Chiefs, elders and community leaders welcome dialogue with the MOH staff and seek regular exchanges. A regular programme of community dialogue and exchange should be part of every DHMT work programme.



**Working together works: Project staff collaborating with DHMT**

### **Lesson 9 • Focus on Primary Health Care**

Since mortality is high and health concerns are limited, critically needed preventive health care should be taken to every compound. Health education must be compound relevant and compound specific to be meaningful to community members. This allows them to practice what is contained in the health education messages directly and observation of the benefits reinforces compliance to advice provided thereafter. Community members subsequently build trust in the health worker and the health service delivery system that they see as responsive to their needs. Under such conditions of mutual trust, acceptance of family planning makes sense and opposition to it becomes minimal, even among men.

### **Lesson 10 • The CHFP Works**

When nurses are deployed to village locations, significant improvements in child health are realized. When *Zurugelu* activities are added to the nurse in the village condition, so that CHO services are complemented with activities for mobilising chieftaincy support, health committees, volunteers, and community durbars participation, then contraceptive use increases and fertility declines.

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Vol. 1, No. 12, December 2001

Navrongo Health Research Centre

## FAMILY PLANNING: GOOD FOR SOME; A WORRY FOR OTHERS<sup>1</sup>

Since the inception of *The Navrongo Experiment* in Ghana in 1994, the prevalence of contraceptive use has increased in areas of the district where nurses live and work in villages and where *Zurugelu* activities are also launched. The success of this strategy demonstrates that appropriately formulated family planning programmes can succeed, even in a rural and traditional social environment. But, the status of women in this setting is constrained by customs that define their roles at the time of marriage. Owing to the custom of bridewealth, many men view wives in the manner of property, extended families involved in marriage arrangements assign great value to childbearing. In this context of social support for childbearing and constrained women's autonomy, community-based family planning program can generate tensions between men and women. The CHFP launched an investigation of the potential for tensions and developed program interventions to prevent them from arising.

**What sustains women's interest in contraceptives?** Survey results suggested that women were more willing than men to discuss family planning, which may indicate stronger female interest. Contraceptives allow women to reconcile a tension with which they are faced. To sustain their health, women must space childbearing. Traditional beliefs ensure that this will happen. For example, women report that semen and mother's milk are incompatible. Nonetheless, women are expected to fulfill their husbands' desires. Caught between sexual obligation to husbands and personal need to care for children and the need to space childbearing, family planning provides a woman with means to reconcile these seemingly incompatible goals.

Even when you tell your husband that you would not like to have another child (yet), he will tell you that he paid the bridewealth, so that he can have children with you and that you have no right to tell him not to have sex with you. He may get physical. In order to avoid any confrontation, you will go and use a method, so that he can have sex with you while you plan your family.

Old woman, Naga

If my husband marries a second woman and he does not want us to do [family planning] and she doesn't do it, he will love her; he will not love me again. If he has something small, he will give it to her and leave me...In the night I will be sleeping alone with all my family planning...

Young woman, Naga

**Women's fears.** In spite of, and in part because of, its uses, family planning has strained gender relations, with significant repercussions for women:

- **Domestic violence.** Women often adopt family planning in secret. And yet, more women than men felt that wife beating was a justified response if a husband discovers this.
- **Losing favor.** Women expressed concern that men would lose affection for their wives or even favor other wives if they disapproved of contraceptive use—an especially potent threat in this polygynous society. Indeed, contraceptive use without spousal approval may be grounds for divorce.
- **Monetary cost.** Within this context of extreme poverty, even minimal fees incurred for family planning can represent a significant burden. As men control primary household funds, their disapproval further limits women's access to family planning.
- **Disapproval of extended family.** Though members of the extended household are less influential than in the past, conflicting views about contraceptives extend beyond the immediate family.
- **The sanctions of traditional religion.** Some women state that they fear that family planning will provoke the ill will among ancestors.

**What's at stake for men?** In a patriarchal society, gender stratification is deep-seated; a conduit for independent female action is consequently threatening:

- **Women's obligations.** Bearing children is part of a woman's wifely duties to her husband and to his lineage, as required by the payment of bridewealth. In discussions, men emphasized the security of having many children, a security threatened by enabling a woman to limit childbearing.

<sup>1</sup> This *What works? What fails?* note draws on Bawah, Ayaga et al. 1999. "Women's fears and men's anxieties: The impact of family planning on gender relations in northern Ghana," *Studies in Family Planning*, 30(1).

- **The question of fidelity.** A woman's use of family planning may allow for or encourage infidelity to her husband, which embodies an affront to the image of the husband and the household. Further, contraceptive use is tantamount to abandonment of the tenets of, or a lack of investment in, the marriage.
- **Who's in charge?** Insofar as the Navrongo programme vests women with the possibility of asserting their reproductive preferences, it engenders anxiety among men. Women who make independent family planning decisions run the risk of harming the name of the household if problems arise; men, meanwhile, are precluded from a clear assertion of their reproductive choices.

Some women...may not feel free to do so [practise family planning] because there is a belief among many women that the ancestors are against such practices, and that one may die or may not get any blessings from the ancestors if she practices those things.

Young woman, Paga

**Ways to cope and programmatic responses.** Given this environment of gender stratification and imbalanced authority and autonomy, the possibility that women may regulate their fertility is undoubtedly menacing. The Navrongo project has devised three areas of programmatic response:

- **Supporting women.** Kassem and Nankam women have, in their own right, protected themselves amidst social tensions. Focus groups discussed women's attempts to explain uses of contraception to their husbands, women earning their own income (for instance, by gathering firewood), wives publicly shaming husbands who did not support their choices, and women clandestinely using family planning. In addition, the Navrongo project has assembled teams of male supervisors who attend to family planning-related conflicts by visiting identified households and drawing community attention to the husband in question. Furthermore, the involvement of community leaders has effected more subtle changes in relations between the genders.
- **Involving men.** Through specially organized sessions, through meetings of male village associations, or through the personal involvement of fieldworkers, the project's family planning and health messages were addressed to men, and as the programme has become increasingly known, these efforts have begun to converge with outreach to women. Community visits by programme volunteers are intended to legitimize contraceptive use.
- **Mobilising community support systems.** By involving the cooperation of chiefs, elders, and lineage heads, the Navrongo project made use of *darbars*—community meetings convened to discuss specific issues—to present its health research programmes. Paramount Chiefs voiced their support for family planning during these discussions, which have, since the Navrongo project's involvement, been held more frequently, and focused more on health and contraceptive themes.

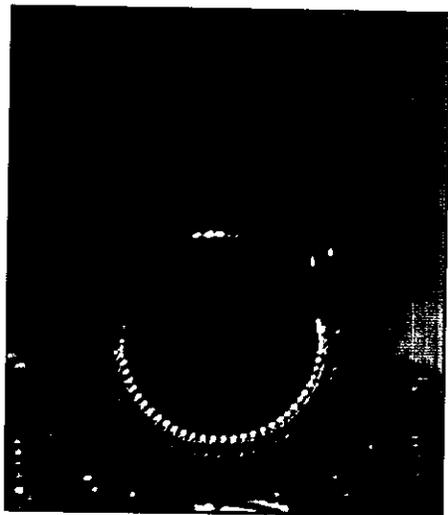
The contraceptives really help, and we are not against the use of these methods, but if a woman comes to the clinic without the husband, [you should] insist that she bring her husband.

Young man, Naga

Further, the traditional *darbar* custom has been expanded to include women in an effort to foster more open exchanges about family planning.

### Conclusion

Developing family planning services on the Navrongo model requires strategies for putting men at ease, involving male leaders, and supporting women in their desire to implement reproductive preferences. The CHFP demonstrates simple-to-replicate means of mobilising cultural resources for supporting couples who adopt family planning.



**Family planning enables women to assert their reproductive choices**

Send questions or comments to: *What works? What fails?*  
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 What\_works?@navrongo.mimcom.net

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## WHERE DID CHPS COME FROM?

Over a third of all districts in Ghana have activities underway aimed at converting static-based services to community-based health and family planning care. This national programme is known as the Community-based Health Planning and Services Initiative, or CHPS for short. Various Directorates of the Ghana Health Service are involved in implementing this programme; Regional Health Administrations are also involved. Donors are contributing in various ways; private voluntary agencies such as EngenderHealth, JPHEIGO, the Johns Hopkins Communications Centre, the Population Council, and PRIME II, all have activities designed to contribute to the CHPS programme. This issue of *What works? What fails?* asks the question: Where did CHPS come from?

### Step 1: Getting it right: The three-village pilot

Ever since 1994, the Navrongo Health Research Center (NHRC) has been engaged in research on community-based service delivery in the Kassena- Nankana district in the Upper East region of the country. A pilot programme of strategic planning was conducted to develop the service model.

When Navrongo presented preliminary findings of the CHFP, a national policy statement emerged declaring that community-based health care, built on the Navrongo model, was a priority programme of the Ministry of Health. Since then CHPS has had a history of its own.

### Step 2: Testing it out: The Navrongo Experiment

The pilot was scaled up to a district-wide experiment. Results were disseminated demonstrating the feasibility and usefulness of reorienting health care at the periphery. The experiences and lessons of the experiment reinforced the Ministry's commitment towards community-based health service delivery through the replication and adaptation of this approach in other parts of the country.

### Step 3: Telling the story: Dissemination and diffusion

Initially, deliberations on the potential use of Navrongo focused on the possibility of extending operations to the three northern regions (Northern, Upper East, and Upper West) where the health indicators, cultural institutions, and

ecological zone were similar to Navrongo. However, this option was redirected by the Ministry in favour of an approach that would foster the diffusion of operational change throughout Ghana. All regions of the country were to have a district where Navrongo operations would be adapted to local conditions, scaled up, and used to inform the process of change. Several consultations were held with the Deputy Minister of Health, the Director of Medical Services, the Director of Human Resources Division, the Health Research Unit, and the NHRC. All key policymakers were in favour of replication and expansion of the Navrongo experience but all acknowledged the need to build a sense of ownership of the change process by the Ministry. It was decided that Navrongo would focus on its mandate



Where it all began

(conducting research on a broad range of health and policy issues in Kassena-Nankana District) and would not administer the scaling-up programme. However, Navrongo would continue to play a key role in disseminating lessons from its research by orienting visiting teams to the Navrongo experiment. Any district that showed committed and enthusiastic leadership was to be assisted in initiating scaling-up activities after certain key structures were put in place. Almost immediately, in the dissemination period, several districts (Bawku West and Bolgatanga districts in the



**Trainee nurses looking forward to the new health service delivery initiative**

Upper East region; Nkwanta, Ketu South, and Sogakope districts in the Volta region) visited the NHRC and used the experience to plan replication of the Navrongo approach to community-based service delivery in their respective districts. This spontaneous replication soon demonstrated the feasibility of adapting and using the Navrongo community health system in other areas of the country.

The first consultative conference involving directors of the various divisions of the Ministry, and funded by the Rockefeller Foundation, was convened by the Director of Medical Services and coordinated by the NHRC at Ada Foah from September 3-5, 1998, to discuss the Navrongo community-health strategy and the way forward. Policymakers, directors, division representatives, and programme heads of the Ministry attended the meeting. The meeting developed a common vision and defined the roles of the various units of the Ministry in reorienting health care delivery at the periphery and encouraged contributions from

the directors. Nkwanta District played an instrumental role by discussing experience with replicating Navrongo, thereby demonstrating that utilization of the experiment, with local resources, was feasible in other districts of the country. Critical discussions were held on human resources as well as financial, monitoring and evaluation, and capacity-building implications of the initiative.

#### **Step 4: Scaling up**

A National Dissemination Forum was convened at the La Palm Royal Beach Hotel, in Accra in October 1999. This meeting established wider dissemination of the lessons and experiences of the *Navrongo Experiment* to all health service provider stakeholders nationwide. Implementing this programme would involve the various directorates and the Regional Health Management Teams, but the effort to coordinate the programme would be known as "CHPS." From that point on, CHPS has had a history of its own.



**CHPS has come a long way—there's a lot to smile about**

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**Real Problems, Reel Solutions**  
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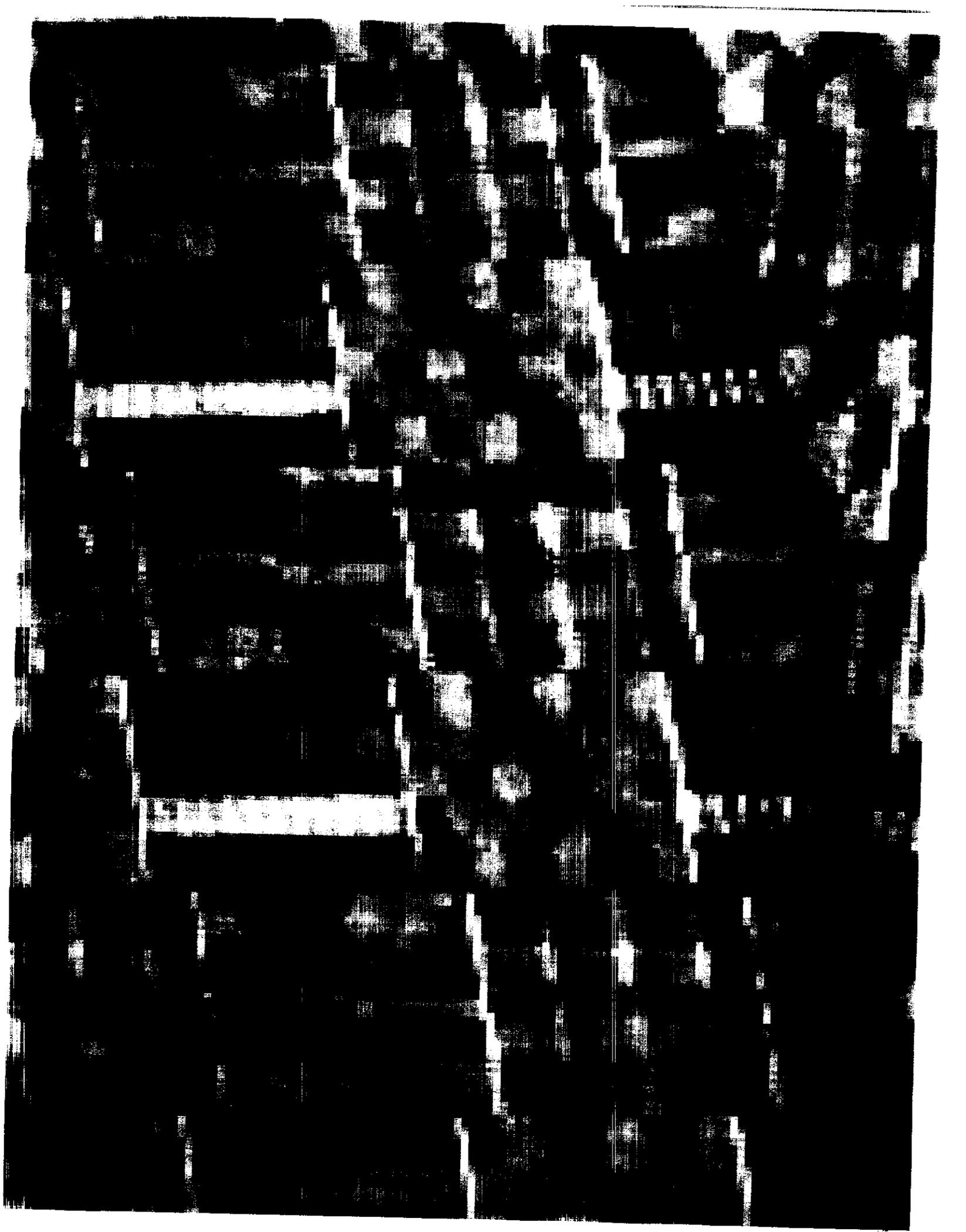
**Give Us This Day Our Day School**  
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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 5, February 2002

Navrongo Health Research Centre

## REAL PROBLEMS, REEL SOLUTIONS USING FILMS FOR HEALTH EDUCATION

### Introduction

The idea of using drama film shows to disseminate health messages to the communities within the Kassena-Nankana District was first proposed in 1998. Ms. Charity Assibi Bukari, the Yezura Zenna (YZ) Coordinator, thought about a more lively way of putting health messages across to the community. The initiative was embraced and the drama troupe of the St. John Bosco's Teacher Training College in Navrongo was asked to collaborate on film shows for health education. The College authorities and the drama troupe were ready and willing to take up the challenge and an agreement was soon reached for the project to begin. The two main objectives of this initiative were to maintain closer links with the communities, and to disseminate health information more effectively.

Drama can focus communication on themes that would be controversial to discuss in an open forum. Moreover, drama can portray everyday problems in a manner that ordinary people can identify with. But drama is expensive and unwieldy to replicate on a large scale. Filming provides a low-cost alternative to village drama that increases coverage and expands the audience. Using a projector powered by portable generators makes it possible to attract community members to evening viewing sessions. Crowds are large and the demand for "night durbars" is now apparent throughout the district.



Reel solutions to improving people's lives

### How Themes are Determined

- Problems are usually identified from the field during CHO, YZ/YN supervisory visits and community durbars and also from research findings and survey reports. A single theme is identified and a script is developed around the theme.
- The drama troupe conducts a number of rehearsals. The last rehearsal is normally done at the Navrongo Health Research Centre (NHRC) in order for the staff to appraise the performance. Comments and suggestions are incorporated into the final script after which shooting is only a few communities away. The drama is acted in Kasem and Nankam, the two main languages in the district.
- A community is identified in which to perform and film the final production of the drama. The Communication Unit is responsible for video recording onto VHS videocassettes.
- The videocassettes are edited and prepared for showing to other communities usually at evening durbars. A health specialist goes with the night outreach team to answer questions that may come up after people have watched the film.

### So Far, How Far?

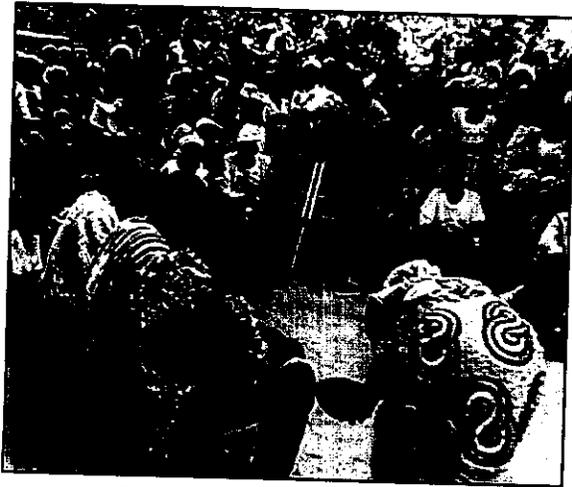
The first script had the title *Male Involvement in Family Planning*. This theme was deemed necessary because, from observation, it is mainly women who get involved in family planning, although they are not able to assert their reproductive choices. To succeed in family planning, men must necessarily be involved since they are the family heads and can prevent the women from accessing family planning services.

*Male Involvement in Family Planning* portrays two families. Members of family A do not plan their family and have more children that they can care for. Some of the children drop out of school, one teenage girl gets pregnant while still in school, another takes to loose living and ends up contracting HIV/AIDS and succumbs to the disease, one boy takes to drugs and goes mad, and another resorts to armed robbery for a living and ends up in jail.



Taking advantage of the darkness to get health messages across to the community

There is general unhappiness and rampant quarrelling in the family. Family B, on the other hand, plan their family and are able to educate their children. The little they have is enough for all of them and an atmosphere of happiness and cheerfulness pervades the household. This film has been shown in Cell 1 to boost family planning messages given by YZ. It has also been screened in Cell 2 where CHO operate.



Play-acting is serious business

Two anti-female genital mutilation (FGM) scripts have been developed and filmed and are being used in the eastern part of the District where an intervention to eradicate the practice is taking place. Two other films currently being shown are:

**The 'Spirit Child'.** This film is a direct attack on the practice among some communities to kill babies who are born with disabilities based on the claim that they are spirit children who would, if not eliminated, kill their mothers. In the drama, a child is born with a big head and twelve fingers. It is declared a spirit child and a spirit doctor is called upon to kill it before it hurts its parents. The baby is secretly sent to an orphanage for protection. The child grows up, completes his education, and becomes an Agricultural Extension Officer. He returns to work in his own village and supports his people.

**The Story Is Told.** This film educates people on the HIV/AIDS pandemic—symptoms, ways of acquiring it, and how to cope with someone who has contracted HIV/AIDS. The main character who failed to stay faithful to his wife contracts HIV. He infects his wife and child who die. When he himself tests positive, he decides to educate the society by using his own life as an example.

### Impact

These films—especially **Male Involvement in Family Planning**—are a tremendous success. Comments gathered during night outreach indicate that the shows have had an impact on both couples and the youth. Some suggestions have been made to include a scene in which parents advise their children to desist from engaging in premarital sex and remain faithful in marriage. People have also lauded the film as very educational and recommended that more films in that vein should be shown to communities. Men have reportedly gone to YZ with their wives to request family planning services. During one session an old man was apparently overwhelmed by what he saw and expressed sentiments interpreted as regret: *"The film is very educative. Unfortunately it is too late for old people like me. I will make it a point to get my children, both boys and girls, to practice family planning and have just the number of children that they can adequately take care of. Things are rather difficult these days..."* Others have not been so enthusiastic about our efforts. They have expressed disagreement with the promotion of family planning services accusing health workers of assisting their wives make reproductive choices without the knowledge or consent of their spouses. These concerns may be genuine but when the weights are put in the scales, the promotion of family planning seems worthwhile and the idea seems to be steadily gaining acceptance in the district.

### Challenges

Even though the authorities and officers in-charge of the drama project are doing their best, there are a few challenges to overcome.

- The night outreach crew confronts difficult terrain, which is made even more difficult because of night travel. A video van, instead of a pick-up truck, is needed to appropriately transport, protect, and prolong the life span of the video equipment
- Some communities are often not punctual so the night outreach programmes do not start on time—causing programmes to go deep enough into the night that community members become too tired to ask questions at the end of the show. A solution is sought to this problem so that the full benefit of these night outreach sessions is reached.

### Conclusion

The Kassena-Nankana District has recorded favourable indicators in health. More couples than ever before go to family planning clinics for advice on how to plan their families. The practice of FGM is on a steady decline. The films have obviously had some influence on the audience but the extent of this impact cannot be stated in categorical terms until an impact assessment in the experimental area has been done. To improve the quality of the films community members should be co-opted into the cast and also given the opportunity to view dry runs and give input before the final filming.

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 13, April 2002

Navrongo Health Research Centre

## CHIPPING CHPS TO SIZE

*What works?*... recently sat down with Dr. Alex Korshie Nazzar, former PI of the CHFP and now at the Health Strategy Development Unit of the Ghana Health Service.

**WW:** *You have been directly in charge of the Community Health and Family Planning (CHFP) Experiment before, what were the problems with the scale-up and how did you manage them?*

**KN:** The problems of the scale-up of the lessons from the CHFP had to do with understanding the import and policy implications of the findings from Navrongo.

**WW:** *What is your understanding of the Community-Based Health Planning and Services (CHPS) initiative?*

**KN:** CHPS is a strategy to deliver PHC services based on the conviction that communities cannot and should not continue to be passive recipients of health technology but must be active players in the full process. What people seem to be doing currently regarding CHPS is putting a nurse in the community and saying they are implementing CHPS. The concept is about extending health care planning and service delivery into the community with the community itself mobilized to accept and utilize the services. The nurse is sent to the community to perform three main functions: (1) "Reconnaissance Agent" who goes to the community to better understand the community needs, and to communicate these needs to the sub-



Dr. Korshie Nazzar feeling the impact of improved health coverage on child survival

District to enable the DHMT to plan a more effective and relevant service delivery intervention; (2) "Technical Assistance" provider for better home management of common ailments through health education activities, and (3) "Change Agent" to facilitate the adoption of better health-seeking behaviour.

**WW:** *What's the best approach to CHPS implementation?*

**KN:** The first step in getting this going is building understanding in the community. First of all you must understand that you are going to make a major change in the pattern of service delivery. Usually when you talk about health in a community, members immediately tend to think and talk about the availability or otherwise of a fixed-facility Health Centre or a Hospital, because that is the paradigm they have always known. But that is exactly the paradigm you want to change. You would discuss with them that you are talking about health but you are not talking about a fixed facility. If you don't go through that process thoroughly to get the community to understand and accept this new concept of health care delivery they will be dissatisfied with the nurse when she eventually comes to live in the community.

**WW:** *Are you talking about a mobile clinic of sorts?*

**KN:** No. We are talking about preventive health. The primary purpose of the nurse going to the community is the provision of health education for disease prevention and health promotion. Her presence in the community and her consequential knowledge of the health conditions of the community will assist the sub-districts in identifying the problems that the sub-District Team Managers will plan to address adequately. The concept is not to put a nurse there to "solve" the community's problems. The nurse cannot do it—no nurse can, without the support of the sub-District team and the community; do what is currently being conceptualized as the role of the nurse in the community. No nurse can go to the community and single-handedly do deliveries, treat malaria, treat diarrhoea, carry out immunizations and so on. It cannot work. We were conscious of the fact that once the tag 'nurse' is put on the community health service provider, it would raise expectations of clinical services. But in actuality her main training had been in preventive health care. So it was decided that while in the community providing health education, the Community Health Nurse should be redesignated as Community Health Officer and equipped to provide basic treatment for minor ailments—but this was never to be her main preoccupation in the community. She was never to replace the Health Centre. In fact the Health Centre is still the backbone to the CHPS strategy.

**WW:** *Is that the reason why CHPS is running into problems?*

**KN:** There are many reasons why CHPS is running into problems.

**WW: Community based... Health Planning...**

**KN:** ...and Services. People distinctly hear "service"; they don't hear "planning" so clearly and even if they do the real import is lost on many. They equate "service" to clinical activity.

**WW: A typical community does not have complex health problems. In Kassena-Nankana district, if a nurse is trained to do deliveries and treat malaria much of the health burden is taken off.**

**KN:** That is where the concept of CHPS has been misconstrued. CHPS is a service delivery strategy beginning at the periphery. Once you improve service delivery at the periphery the services at the sub-district have to be improved too. The structures around to which the nurse can refer cases must also be improved. There must be efficient communication and regular supervision. Here I am talking about effective facilitatory supervision where you go to find out what difficulties the nurse is facing—to see if the health delivery strategy of the sub-district is on course and to offer assistance to make this happen. As a "Reconnaissance Officer" in the community she is best placed to let the sub-district know how well-targeted their plans and interventions are.

**WW: What is the difference between CHFP and CHPS?**

**KN:** CHFP tried to find out which ones of many strategy options work. CHFP tried to see what happens when you involve communities in health planning and service delivery. CHFP dialogued between health professionals, political leadership, and traditional leadership to look at options to widen access to and raise the quality and efficiency of health care delivery. That is why the experiment looked at various options and combinations thereof. In Cell I only volunteers were put in a mobilized community. Cell II had only the health worker without mobilizing the community and in Cell III we combined the strategies in Cells I and II. Cell IV was the control where no intervention took place. In short, CHFP is an experiment whose results uncovered new ways of doing things. CHPS is an innovation that took the CHFP findings and fashioned out a strategy for delivering health service outside experimental conditions.

**WW: What does it take to move from CHFP to CHPS?**

**KN:** You need to develop counterpart technologies, which were relevant lessons learnt from the CHFP experiment that needed to be pointed out and developed further. There was a strong level of community dialogue, dialogue with the nurse, supervision, education, motivation and many others. All these were under experimental conditions. Some failed, some performed poorly, and others excelled. The lessons from these were looked at and formulated into a feasible strategy and improved upon for delivery within a nonexperimental arena. This ensemble of strategies constitute CHPS.

**WW: Have we really got it wrong?**

**KN:** Yes we have. It's like you make a car. The beauty of the car attracts people and they buy it. They take it away and try it. It starts and moves a little distance then it stops. And the conclusion is that the car is not good.

**WW: The customer does not have the manual!**

**KN:** He hasn't taken time to study the manual. When we went outside of Navrongo and started disseminating findings of the CHFP, concerns were raised that this thing could only work in Navrongo. We emphasized that what mattered from the experimental findings was the concept of community dialogue and process of community consultations and not the particular style of community organization that was used in Navrongo.

**WW: Could it be that Navrongo is not disseminating properly?**

**KN:** No, no. This thing was talked through carefully. Communities have a lot of resources in terms of suggestions, capabilities and abilities that can be mobilized using our professional skills. This is the fact Navrongo is disseminating. When it came to scale up, we looked back and honestly realized that we didn't arrive at the end product without problems and that was communicated clearly. Dialogue with the communities is indispensable to the success of CHPS but that is exactly what people are sidestepping.

**WW: How do you see Navrongo pulling all these loose ends together?**

**KN:** I don't want to sound presumptuous. But put your ears to the ground. If you look at what is happening to the CHPS scaling-up process, there are lots of issues for clarification, investigation and further research.



**Dialogue with the community is central to community-based health service operations**

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 14, April 2002

Navrongo Health Research Centre

## DANCING TO CHPS TUNE

*What works?*... recently conducted an enlightening interview with Dr. Sam Adjei, Deputy Director General of the Ghana Health Service and former Director of the Health Research Unit.

**WW:** *You haven't been to Navrongo for a long while!*

**Dr. Sam Adjei (SA):** Oh no, it's not a long time. I love research. I was actively in charge of research. The Ministry is not yet fully set up and I have to do many of the things myself. I have to back the Minister up with a lot of work and policy decisions. This does not leave me with sufficient time to visit the field. When you become administrator you run the risk of losing touch with the people.

**WW:** *We have developed the "What works? What fails?" newsletter to disseminate findings of the CHFP, which fed the CHPS initiative. We are interested in opinions of people who played roles in the CHFP or were directly concerned with CHPS. What's the main challenge in implementing CHPS?*

**SA:** The main issue is with translating research findings into policy and programmes for implementation. We have to continue to disseminate the findings that came out of Navrongo, which is different from CHPS, because CHPS is not necessarily a carbon copy of CHFP. Other things come in but they are building blocks of issues that came out of Navrongo. There are clear, systematic steps. The problem I have is with people not wanting to follow the steps. I have been in the system long enough to know how to move from research findings to policy to programmes and then to implementation.

**WW:** *What are people supposed to do with CHPS?*

**SA:** Sometime in 2000, we wrote the policy framework for CHPS and a draft was prepared and circulated. Unfortunately people did not respond to the draft policy. What is happening now is that donors are taking bits and pieces.

**WW:** *Why is it so?*

**SA:** Well, for a long time there was no central leadership direction for the programme. There was a lot of political enthusiasm but that was not getting translated into the package of programmes needed to move forward. We met in Kumasi with teams from the regions to look at an action plan. The regional directors of health services came at the tail end to discuss with their teams so that we can have a common understanding of the way to go.

**WW:** *Remember the concept of the lead districts?*

**SA:** Yes of course. I kept reminding them that even in Navrongo we started off with two or three villages so the idea was to pilot with two districts in each region to get an idea of how to interpret the research findings within the policy framework on the ground.

**WW:** *What type of problems did the "lead districts" unveil?*

**SA:** Staffing problems were the first to come out. Some programme policy issues also came up. Nkwanta, for example, wanted to allow Community Health Officers to insert IUDs. That is against policy. What is the most appropriate package of logistics for service delivery; who pays for the drugs at the community level? These were issues coming out of implementation which needed to be tested out in the two lead districts.

**WW:** *Were the lead districts being closely monitored?*

**SA:** This was the main reason for instituting the coordinating meetings at Headquarters. The idea was to make programme heads and development partners who support the CHPS initiative meet on a monthly basis for discussions. For that purpose I have produced a summary framework of what the programme components are; what the activities are as well as mapping out responsibilities for the various divisions. As the Deputy Director General I took it upon myself to coordinate these activities. We defined the components of the programme, the service delivery package was coming in, the monitoring and evaluation element, logistics and human resources element was also coming in and so on.



Is the Ghana Health Service dancing to CHPS tune?

**WW: The programme seemed to have been well rolled out, what went wrong?**

**SA:** To be frank with you, some of the project heads and directors did not grasp the programme, others were also complaining that they were not involved. I was surprised because we were at Kumasi where all these were streamlined so I expected that they should be coordinating the implementation process. I even encouraged the donors to go straight to the regions and the regional directors should take them on board. Others misunderstood this, claiming the administrative hierarchy was being bypassed.

**WW: The lead districts concept is causing anxiety now.**

**SA:** The issue is that the Regional Directors are not enthusiastic about the concept of the lead districts but the idea of the 2x2x2 was to have an area where you intensively look at issues before going to scale. If the idea of the lead district is not working we all need to sit together again to review it. The bottom line is that to implement CHPS the way we want it requires a lot of money, much more money than people realise.

**WW: Where is the money to come from?**

**SA:** That is the crux of the matter. The Ministry certainly does not have all the funds needed. Communities would have to make a contribution before we beef that up with external funding.

**WW: Is the country really interested in CHPS?**

**SA:** Of course we are interested in CHPS and we are looking for ways to get around the problem of funding. Sometimes I really wish we had not used the name CHPS. It creates the impression that it is some vertical specialized structure but CHPS is just a strategy for reaching communities in terms of health service delivery. There are two things that I have done. One, community-based service delivery has become the central theme in our new five-year programme of work. The second thing that I have done is to make it also central to the Ghana Poverty Reduction Strategy (GPRS) so that if HIPC money is made available to us that is where it is going to go. I have produced a document, which maps out a service delivery package, logistics, infrastructure development, financing of services, role of private sector, civil society, and community political leadership.

**WW: Are the GPRS strategies and yours similar?**

**SA:** Oh yes, they are and we have made a lot of input into them. GPRS is earmarking four regions: Upper-East, Upper-West, Northern Region, and the Central region. We have suggested and it has been accepted that deprived districts outside these regions should be included whilst the more endowed districts in these regions should be taken out. So we now have about 65 deprived districts to work with.

**WW: What crosses your mind about facilitating CHPS implementation?**

**SA:** Improving radio communication; expanding the training institutions to be able to train more nurses for CHPS. We have to change the whole strategy for training—we have to look at taking people from the community, the sub-district or the district to be trained and come back and serve their communities. We have to redesign the school to make it a modular system so the students go to school for three months and come back to the communities and serve for another three months to get a fair idea of what is on the ground. I am going to discuss the strategy paper with the regional directors and exhaust the contents for implementation.

**WW: What can Navrongo do for CHPS?**

**SA:** Most of the donors who say they are providing technical support have not seen a village or compound before! I will be very happy if Navrongo can continue to do operational research. Mr. Asobayire or Master as we use to call him, is no more, but there are others like Rofina Asuru who have practical experience. They can constitute themselves into a team that can be used for monitoring and also for providing technical support. So that if the monitoring system picks up some trouble spots they can go and assist people to overcome them. Navrongo can also experiment with Community Health Nurses inserting IUD or Norplant. Findings from an experiment like that can inform the CHPS implementation process. If Navrongo can do all these, I'll be glad.



**Dr. Adjei counting the cost of CHPS implementation**

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 22, June 2002

Navrongo Health Research Centre

## WHERE DO WE GO FROM HERE?

### Introduction

The Ministry of Health, the Ghana Health Service, and the ultimate beneficiaries of excellent, accessible, and affordable health care now know what works and what fails in reorienting health service delivery at the periphery. The Navrongo Community Health and Family Planning Project has proved that retraining and redeploying community health nurses to live and provide doorstep services in rural settings widens access, reduces cost, and improves health care delivery. Thus the desire of the Government of Ghana to achieve the long-term goal of growth and development for its people is being met. This desire is captured in the vision 2020 document which has identified five main areas for priority attention in the medium to long term. Among them is maximizing the healthy and productive lives of people. The Medium Term Health Strategy (MTHS) towards vision 2020 sets the direction and provides a framework for guiding reform and development in the health sector. It describes how

the health sector can contribute to the improvement of the health of the people. Notably among them is strengthening the human resource planning, management, and training as a means of providing and retaining adequate numbers of expert and well-motivated health teams to provide services (MTHS 1999).



Infants look up to policymakers to make the right decisions about bringing down mortality figures

Two major problems associated with human resource development have been the overextension of already inadequate numbers of staff as well as uncoordinated training not related to priority needs. Addressing these problems calls for guidelines that would give priority to peripheral human resource training and distribution, with an appropriate mix to provide services. The objectives of the MTHS are to provide universal access to primary health services and improve quality as well as foster linkages with other sectors. Strategies outlined in the MTHS document aimed at achieving the above objectives include reprioritization of health services, expanding existing facilities, evaluating the possibility of starting new training institutions, and changing the nature of training to reflect the needs of the new health service.

Despite tremendous improvements in the health status of the ordinary Ghanaian over the years health for all is only now in sight. The state of the Nation's report (2000) indicated there are still significant variations between regions and between the urban and rural areas. For example, while the national average of infant mortality is 66/1000 live births, that of the Upper East Region (UER) is 105/1000 live births. This figure is even higher in the districts. The IMR for the Kassena-Nankana District was 124/1000 in 1995 (Binka et al. 1999) and the MMR is currently estimated at 600/1000 (Ngom et al. 1999). Under-five mortality in 2000 was 153/1000 falling to 116/1000 in 2001 as against the national average of 110/1000 and 95/1000 respectively according to the Ghana Living Standard Survey 4 (GLSS4). The second Five Year Programme of Work (5YPOW — 2002-2006) with the theme "Partnership for Health — Bridging the Inequalities Gap" seeks to do more to address these problems.

The Ghana Poverty Reduction Strategy (GPRS) has also identified deeper inequities in access to quality health services in the four most deprived regions of Ghana. The UER remains the most deprived among the four with poverty levels well above the national average. Among the many objectives of GPRS is the goal to increase access to quality health services.

The ruling New Patriotic Party Government's manifesto on public health states that government will ensure that at least a Community Health Nurse (CHN) is located in every hamlet of the country. It goes further to indicate that more CHN shall be trained to carry out the campaign against malaria, typhoid, and STDs including HIV/AIDS (p. 31). All these objectives can only be achieved when schools are set up to train more nurses to take up responsibilities.

**The national picture and the Community-based Health Planning Services (CHPS) Initiative:** At Ada-foa in August 1999, the directors of the Ministry of Health gathered to discuss the logistical implications of scaling up the project. In the course of this meeting, the Director of Human Resources, Dr. Ken Sagoe, noted, among other things that one of the major challenges that scaling up will face is acquiring the numbers of community health nurses required by districts to implement the programme.

**Staff refusing postings:** At present, national nurse training facilities seek applicants from a national pool of eligible women. Eligibility is defined by schooling level-SSCE or GCE graduates with credits or passes in English, Mathematics and Science. Trained nurses are assigned to a regional staff pool and are posted and distributed from the Regional Health Administration. This design of the programme is associated with problems that further constrain the availability of nurses. Individuals posted to a community are often from another ethnolinguistic group. Language deficiencies diminish work effectiveness and morale. Lack of social amenities, good schools for their children, opportunity for career progression, and family commitments compound the problem. Moreover, the procedure that is used does not adequately involve communities in the selection and posting of nurses. As outsiders posted to the communities, Community Health Officers (CHO) require extensive system support to enable them to build community knowledge, trust, and participation in the health programme. The use of outsiders also elevates the requirements of residential quarters, since nurses assigned to communities are far from their homes and families. Use of local, trusted, and well-trained nurses would obviate the need for the payment of village hardship allowances and other measures that make community residence palatable to the CHO involved in the programme.

**The problem of numbers:** The UER is characterized by dispersed settlements, seasonal flooding, and inadequate roads, making it hard for health workers to reach various communities. It is listed as one of the most deprived regions in Ghana and experiences a growing shortage of health staff. There are five CHN training schools in the country with an average intake of fifty students each per year. As a consequence, no more than ten CHN are posted to the region annually, and for the past five years the number of CHN providing services in the region declined from 200 to 97 because attrition far outpaces the arrival of new nurses. With the current level of service coverage, the region presently has a staff shortfall of 40 percent, a dilemma that will grow unless action is taken to address the problem. The population of UER is 917,251 (2000 census) living in 475 communities giving an average of 1 CHN per 9897 people and 1 per 5 communities. These numbers are woefully inadequate if the inequalities in health are to be bridged.



**The way forward is to find an inexpensive and sustainable way to train more nurses for doorstep health care**

It is clear to all planners that individuals seeking positions as community health nurses are not in short supply; rather, the causes of the low numbers of nurses in the districts are threefold: attrition of trained nurses to higher grades as staff registered nurses within the Ghana Health Service; attrition outside the health profession due to burnout or other personal reasons related to marriage and family, other economic opportunities and, lateral movement into health NGOs and private sector roles.

The acute shortage of community health nurses across the country is exacerbated by the fact that the capacity to train replacement nurses is very low. At present, the annual output of nurses is barely sufficient to sustain current numbers and is far below the extra 2000 additional nurses that are required for the CHPS programme.

In the Ada-foa meeting, discussion of possible solutions to the problem of the shortage of Community Health Nurses focused on the need for every region to have a training school for community health nurses. Lack of resources stifled this initiative from the periphery. But the issue cannot be shelved anymore and the way forward is to find cost effective and sustainable means of providing the required numbers of nurses for the CHPS programme.

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# What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT



Vol. 2, No. 23, July 2002

Navrongo Health Research Centre

## POOLING RESOURCES, PULLING TOGETHER

The Kassena-Nankana District is leading the way in establishing an effective and sustainable system of providing community health nurses in support of the national Community-based Health Planning and Services (CHPS) Initiative. The District is starting a Day Community Health Nurses Training School in Navrongo. Scarcity of nurses has earlier been identified as the biggest obstacle impeding the effective operation of door-to-door health service delivery. The Navrongo plan is a collaborative work between four identifiable stakeholders who have combined their forces.

### Navrongo Health Research Centre

The NHRC has a pool of social scientists, computer scientists, public health nurses, reproductive health practitioners, and communications specialists from which teaching staff for the school will be drawn. The Centre has a library, which will be upgraded for student use. A canteen is also available at the Centre's premises and students will be allowed to use this facility. Computer sessions will be arranged in the Centre for students.

### District Health Management Team

The DHMT will offer office space; team members will participate in the training and supervision of trainee nurses.

### District Assembly

The Kassena-Nankana District Assembly will facilitate the acquisition of land as well as sponsor some students from the district. The Assembly will also engage student tutors from tertiary institutions to provide extra study for students to enable them to pass their final examinations and qualify for admission into the school.

### Traditional Authority

The chiefs and elders are very interested in the idea and agreed to take girls' education seriously; they will release land for the construction of permanent structures for the school.



Working together works — stakeholders sharing ideas  
on the Navrongo Day Nurses Training School

## STRATEGIES

**Consultative meetings:** Consensus-building meetings have been arranged with the Regional Minister, the District Chief Executives, Coordinating Directors, District Health Management Team members in the region, and other stakeholders. Meetings will also be held with the Nurses' and Midwives' Council to solicit their views and guidelines for setting up the school. Personnel from the Council will be invited to Navrongo to meet with the Regional and District health directorates as well as the District Assembly and inspect the school premises.

**Study tours to Community Health Nurse Training Schools:** Visits aimed at interacting with authorities and developing lessons will be paid to Esiamah in the Western Region where a school opened last year. Visits will also be paid to traditional nurse training schools such as in Tamale and Akim Oda.

**Rehabilitation of existing structures:** To minimize delay, an interim training facility will be borrowed from the DHMT and renovated for classroom, library, and office accommodation.

**Orientation of teachers:** Teaching staff will be oriented in teaching methods and subject content. Lecturers from the University of Cape Coast and resource persons on teaching methods will be invited for intensive orientation.

**Acquisition of Teaching/Learning material:** Requisite teaching and learning materials are to be identified with the assistance of the Nurses' and Midwives' Council. Regional and Central Medical Stores will be the main sources while Cooperating Agencies remain a potential resource.

**Curriculum development and entrance examination:** The same curricula used in the traditional Community Health Training Schools will be used—with modifications to emphasise increased fieldwork and practical experience. Since the entrance exam for

2002 has already been conducted by WAEC, regional candidates will be recruited who previously have not been granted admission to Tamale or other schools due to lack of space. If the required number of students has then not been met the Human Resources Directorate (HRD) will be requested to conduct a similar exam for 30 students who will be selected from the region. Each district will be given a quota of four students with Kassena-Nankana making up the remaining 10 spaces. Students will be bonded to stay and work in their respective districts for at least five years after completion before they will be eligible for transfer outside the district. They will also be required to work for three years before going for further training. The immediate concerns are outlined as follows:

1. **Demonstrate a "Lead District" CHO training programme for a Regional Health Administration:** At present, the CHPS initiative lacks a coherent model for developing service capacity in the 10 regions of the country. By developing a coordinated programme of CHO-certified training, the UER will demonstrate ways in which other "Lead Districts" in Ghana can develop health capacity.
2. **Demonstrate an approach to health services that solves more general reproductive health needs:** Youth employment now represents a growing crisis. In all, nearly three thousand secondary school students drop out in the region every year. Employment opportunities are often limited only to dressmaking and hairstyling. Social research has suggested that the lack of opportunities for girls may be an important factor in the rapid rise of sexually transmitted diseases, HIV/AIDS and early pregnancies among youth. Like the NHRC which now provides employment to some 400 youths in the district, the Community Health Training School will provide an occupation for at least 30 girls a year in the region.
3. **Recruitment of students:** Two options will be explored. i) Students from the UER who have passed the entrance exams but could not gain admission into the boarding schools could be recruited; ii) A special exam could be conducted by the HRD for candidates who have the required SSSCE grades before a selection interview.
4. **Certification:** Graduates of the school will take the same final examinations as students from the established community health schools and thus go through the same process of certification by the Nurses and Midwives Council.
5. **Absorption into the GHS:** It is hoped that plans will be made to recruit graduates of the school into the GHS and be paid by the Ministry of Finance.

A Community Health Nurse Training School in the Kassena-Nankana district will provide a constant stream of nurses for the Upper East Region, be a base for further developing the curricula for nurse training in the other schools, and motivate other regions to set up their own training facilities to support the national Community-based Health Planning and Services (CHPS) Initiative. When fully functional, the School will help in a substantial way to stem the tide of an estimated 500 teenage girls that leave the region every month to work in demeaning and unproductive roles as 'Kayayoos' and maid servants in the southern parts of the country.

### Long-term Plan

1. **Stage I.** First, communities will be approached about the proposed programme, a site will be selected, and work will commence on a community-supported construction effort. (Paramount Chiefs of the District have expressed great interest in the underlying ideas of this proposal and one has offered to provide land.)
2. **Stage II.** In addition to running as a school, the site will be used as a dissemination and orientation facility for national health officials, Regional Health Administration, and District Health Management Teams. This programme will orient visitors to the opportunity of developing "Lead District-based" CHO training facilities throughout Ghana. The well-drilled nurses who have had years of experience in the programme can be counterpart supervisors and consultants to the school, serving as village mentors to trainees assigned to work in the community as CHO interns.
3. **Stage III:** It is often difficult for many girls in the three Northern regions to obtain required grades that will qualify them to enter CHN Training Schools because of poorly resourced schools, poverty on the part of parents preventing them from investing in girls' education, and lack of role models. Sensitization, career guidance, and counseling will be vigorously carried out in Junior and Senior Secondary Schools to encourage girls who are interested in community health nursing to work toward that goal.

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# What works? What fails?



FINDINGS FROM THE NAVRONGO COMMUNITY  
HEALTH AND FAMILY PLANNING PROJECT

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Navrongo Health Research Centre

## TWO BIRDS, ONE STONE<sup>1</sup>

**Navrongo:** We have come here to tap your expertise for setting up a Day Community Health Nurses Training School in Navrongo. This is an attempt to find solutions to staffing challenges raised by the Community Health and Family Planning Project (CHFP), which addressed questions about the impact of health interventions on child survival and family planning. After demonstrating that it works, Nkwanta District in the Volta Region addressed questions about transferability of the Navrongo model in resource-constrained environments. This culminated in the formulation of the Community-based Health Planning and Services (CHPS) Initiative which is now the government's policy for widening access to health care and a strategy for alleviating poverty. Over a third of districts across the country are now implementing a CHPS programme. While communities hail CHPS as an initiative tailored to their health needs, the health system still has not answered the question of how to raise the required number of staff for CHPS. It is now being seriously considered that for sustainable CHPS implementation, communities must be able to train their own nurses who would come back and serve their communities as Community Health Officers<sup>2</sup>.



The Navrongo Day School project aims to kill two birds with one stone—training more nurses for door-to-door health delivery and finding jobs for school dropouts.

We are happy to inform you that the Kassena-Nankana District Health Management Team (DHMT) and the Navrongo Health Research Centre are leading the way in starting a Day Community Health Nurses Training School in Navrongo. The School will use the same syllabi used in other community health training nurses schools and all efforts will be made to maintain the high standards associated with the training of nurses in Ghana. The Upper East Regional Director of Health Services, the Ministry of Health—particularly the Human Resources Directorate (HRD)—are committed to seeing this idea become a reality.

**Tamale:** That is a laudable idea. Next step is to seek government commitment to support the project with both human and material resources<sup>3</sup>.

**Navrongo:** We are exploring a variety of sources to supplement what the government can provide. We have contacted some NGOs and the response is great. What are some of the obstacles in our way?

**Tamale:** One of the biggest problems is how to get qualified and committed tutors for the School. Students who enroll in the programme these days are so academically weak that it takes skilled and committed tutors to train them to become good nurses.

<sup>1</sup> Highlights of a discussion between the Navrongo Health Research Centre (NHRC) and the Kassena-Nankana District Health Management Team (KND-DHMT), and the Tamale Community Health Nurses Training School (TCHNTS) on modalities for establishing a model Day Community Health Nurses Training School in Navrongo.

<sup>2</sup> The Navrongo team was made up of Ms. Rofina Asuru, PI, CHFP; Dr. Kweku Enos, District Director of Health Services, KND; and Santuah Niagia, Communication Specialist, CHFP.

<sup>3</sup> The Tamale team comprised the Principal of the TCHNTS, Ms. Agatha Moibila; two Tutors, Ms. Juliet Atinga and Ms. Mercy Chimsi; and Ms. Hawa Amadu, Teaching Assistant.

**Navrongo:** The Director of HRD has promised to support us; Navrongo has some expertise; a large pool exists of experienced, retired nurses in the Upper East Region who would benefit from finding themselves useful again. We have also contacted the University for Development Studies for assistance.

**Tamale:** Mobilizing local resources is essential to the sustainability of a programme like this.

**Navrongo:** What should we look out for in selecting students for the school?

**Tamale:** You need to know that students who are very intelligent may not necessarily be morally fit to train as nurses. With day students it will be difficult to supervise their assignments. Some of them have family problems to solve when they leave the classroom. This hampers their studies. There are financial implications in getting accommodation, securing academic materials, and food. All this can affect the student's academic work.

**Navrongo:** We are tackling the financial issues from a variety of angles. The Kassena-Nankana District Assembly sponsors students in training colleges to come back and serve the district. It should be possible for the Assembly to sponsor students to train in the Day Nurses Training School too and we are presently discussing this with them. We are also exploring the possibility of the Navrongo Health Research Centre offering part-time jobs to students so that they can earn something to buy books. We have big dreams but we are not overly ambitious. We are looking at killing two birds with one stone—as we get nurses for our district we help the young girls find useful employment. We want to start with a small class of 20 students by September 2002.

**Tamale:** With the Research Centre to back you, you are already up to a good start.

**Navrongo:** How many subjects do you teach here?

**Tamale:** Formerly we taught Maternal and Child Health, Personal and Environmental Hygiene, Control of Communicable Diseases, First Aid, Community Health Aid, Nutrition and School Health. The Nurses and Midwives Council (NMC) have added Computer Training, Communication Skills, and Research Methods. Other additions include, Liberal Studies, African Studies, Mathematics, Statistics, and Pharmacology for which we have had to employ part-time tutors.

**Navrongo:** What are the essential things for a Demonstration Room?

**Tamale:** We use a list of items obtained from the NMC. You would need, among others, about 2 beds, admission bed, a crutch, a screen, a table, 2 chairs, some charts, the anatomy of a pregnant woman, a normal woman, a baby, and a placenta. You also need the Pelvic Chart or the whole of the anatomy on a chart, the structure of the teeth, the breast and the female pelvic, bed sheets, sandals etc. The visiting bags for each of these items are very important. Most of the items cannot be obtained in Ghana and may have to be imported from abroad.

**Navrongo:** I have seen some Ghanaian training models used by some NGOs. I think these can be very useful. How are your courses organised now? What about practical training?

**Tamale:** There are four semesters and the students have six weeks of practical attachment to district health directorates.

**Navrongo:** Thank you for the insight. This will guide us in establishing a day nurses training school in Navrongo.

**Tamale:** I assure you that you can make it. You have the commitment and all that it takes to succeed. Good luck!

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