Primary Health Care

Motorcycles for nurses in rural health posts of Senegal
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The role of senior nurses at health posts in Senegal’s Nioro District was strengthened by supplying them with motorcycles financed by contributions from the general public through the committees running the posts. One vehicle was purchased each month, and the allocation sequence was determined by drawing lots.

In Senegal the participation of the general public in the financing of health services began before the introduction of primary care. During the 1970s successes were achieved at Gossas under a village pharmacies project; and in Pikine, a suburb of the capital, people combined forces to tackle health problems that distant facilities could not solve. Nevertheless, it was not until the advent of primary care in 1978 that the participation of the public in the state health programme became institutionalized.

Health committees

Lay people gradually involved themselves in the work of health units, and in 1992 legal status was given to health committees, for which specific obligations and regulations were laid down. In this way the people were given responsibility to increase their contribution to the financing of promotional, preventive and curative health care activities. Participation takes place through the committees established in the public health structures, the running of which is the basic task of the committees’ management groups working alongside government officials.

Contributions collected by the committees from users supplement the state funds allocated for the operation of the services. In the health posts, which provide the first level of care, the contribution of the public to running costs is much larger than that of the government. The reverse is true in the health centres and regional hospitals.

In Kaolack Region, Nioro District has a referral centre and 15 health posts, one for every 10,000 to 15,000 people. Each of these units has a health committee and in addition there is a district health committee. The committees determine charges for the various categories of services on offer, namely curative consultations for adults, curative consultations for children, prenatal and postnatal consultations, immunization of children, monitoring of...
height, weight and nutritional status in healthy children, delivery, laboratory tests, dental consultations, and hospitalization. If the individuals concerned cannot afford the charges these are met by family members or, if necessary, the health committees. Until 1992, 60% of the income thus obtained was used to purchase drugs and the remainder to run and expand the range of primary care services.

Since 1992 the drugs used have been the generic products on the national list, and their cost, plus a small profit, has been charged to patients presenting prescriptions issued by qualified personnel in health units. The money received is largely used to replenish or increase drug stocks, and it is now possible for all the other revenue to be used for the payment of community health workers, current expenditure on supplies, and the financing of additional services.

**Mobility restored**

When primary care was introduced in 1978 the nurses in charge of health posts were supplied with motorcycles to facilitate supervisory and service visits. These vehicles proved vital for the smooth running of the district health system, particularly at community level. Unfortunately, a shortage of funds eventually led to a failure to provide satisfactory replacement vehicles. Faced with this state of affairs the committees decided that every month they would jointly buy one motorcycle for allocation, in a sequence to be determined by the drawing of lots. On this basis ten health posts were supplied between September 1992 and June 1993. The fuel for the motorcycles is provided by the district authorities or the health committees.

In less than a year the motorcycles made it possible to improve children’s immunization coverage and, through better supervision, to raise the standard of services provided in health posts. All large villages located more than five kilometres from a health post were adopted as secondary immunization centres. BCG coverage rose from about 65% in December 1992 to 87% in December 1993; over the same period, DPT + polio 1 coverage increased from 67% to 81%, and the corresponding figures for measles vaccination were 56% and 66%; the figure for completely immunized children, however, fell from 57% to 51% owing to the poor coverage during the nine months preceding the changes.

The head nurses can now attend the monthly coordination meetings at the referral centre with less difficulty than when motorcycles were not available, and thus their opportunities for training and the exchange of experiences have been increased. Moreover, restocking with stationery and other supplies has become easier.

The project has demonstrated how much can be achieved by health committees when they join forces in a spirit of mutual assistance. The lottery approach seems to be a viable way of financing key health and development activities. In low-income communities that are well organized in small groups, each with some financial resources, it allows expensive objectives to be achieved which none of the groups, acting individually, could afford. However, it should be pointed out that the system, while allowing some health posts to make their purchases earlier, actually delays the acquisition of items by other posts.
The committees found the money for motorcycles without having to make drastic inroads into their operating funds. The scheme was dynamic and the contributors’ interest was sustained by the prospect that their goal would be attained in the foreseeable future: every month one post acquired a motorcycle and all the unsupplied posts had an equal chance of the same success the following month. The health posts that had already received a motorcycle were under a moral obligation to continue paying their contributions, while those that had not yet been successful had an incentive to do so. The success of the scheme has led the committees to extend it with a view to providing all the health posts with solar energy panels. Furthermore, health committees in other districts are now undertaking similar programmes.

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**Diarrhoea: how much fluid and how often**

*Provide more fluid than usual. The general rule is to give the child as much fluid as he or she wants and to continue using oral rehydration therapy until diarrhoea stops. Remember that a child under 2 years of age cannot ask for something to drink; however, irritability and fussy behaviour are often signs of thirst. Young children must be offered fluids to determine whether they are thirsty and want to drink. When a child no longer accepts fluid, it is usually because enough has been taken to replace the losses caused by diarrhoea. Infants should be allowed to breast-feed as often and for as long as they want.*

*...*

*Show the mother how to measure the approximate amount of fluid to be given after each loose stool using a cup or some other container available to her at home (or that she can take home). Explain that the fluid should be given by teaspoon to children under 2 years of age: a teaspoonful every 1–2 minutes. Feeding bottles should not be used. Older children should take the fluid directly from a cup, by frequent sips. If vomiting occurs, the mother should stop giving the fluid for 10 minutes and then start again, but give it more slowly, e.g., one teaspoonful every 2–3 minutes.*