Primary health care centres in Madagascar

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The successes and failings of Madagascar’s programme of primary health care centres are reviewed, and suggestions are made for strengthening it.

In 1976, Madagascar committed itself to establish 1500 primary health care centres in three waves of 500, each to be run by a community health agent (aide-sanitaire). The communities selected sites for the centres, nominated candidates for the posts of health agent, built and maintained the centres and accommodation for the health agents, supplied the centres and undertook the tasks necessary for their operation. The government organized the recruitment and training of the agents, paid their wages, and provided equipment and drugs.

The procedures for establishing each wave of centres were as follows.

- The sites were inspected and discussions were held between Ministry of Health officials and community representatives.
- A competition for the recruitment of trainee health agents was organized. The candidates came from the cantons in which the centres were being set up; they were aged 18–28 years and had completed two years of secondary education.
- The centres and the agents’ accommodation were built.
- Training lasted 14 months and enabled the new agents to provide basic health care in the curative, preventive and educational fields. It took place at the administrative centres of the country’s health zones, each of which comprised between one and five districts.

- The centres were opened after inspections conducted by the health zone chiefs to ensure that everything was in order.

Successful outcomes were largely attributable to political will, the enthusiasm of the people, and the arrival of external aid.

Primary health care coverage

In addition to the services given by the primary health care centres, primary care is provided by nursing posts, maternity units, health posts, urban clinics, health centres, secondary-level hospitals, and national referral institutions. In 1991 the country had 1935 facilities that were providing primary care, 1039 of them being primary health care centres, all in remote locations.

Personnel

Some 85% of the health agents have remained in the primary health care centres for over ten years; 50 agents have moved out on becoming nurses or midwives. The health agents are almost as knowledgeable as nurses and midwives about common treatment procedures; the agents can deal, for instance, with normal births, family planning, vaccination and health education. In-service training is planned to close the gap that remains.
Finance and management

Financial support for the programme comes from the state, external donors and the people, although contributions from the latter source have declined. Overseas aid has been provided notably by UNICEF and Coopération Suisse at the national level, and provincially by GTZ, Médecins sans Frontières, and others. The success of the programme has been underpinned by in-service training, on-site supervision, and education of the population in health matters.

Nonoperational centres

Of the 1500 planned primary health care centres, 461 are not functioning, mostly because the communities concerned have not adequately built and maintained premises for the health agents. Other factors are:

- the absence of health agents for various reasons (the government supplies temporary replacements in such instances);
- natural disasters, usually cyclones (the government helps the affected communities to rebuild facilities that have been damaged or destroyed, sometimes backed by foreign aid);
- lawlessness, sometimes resulting in the abandonment of entire villages.

Transfer of health agents

By 1991, 478 health agents had been transferred away from the centres to which they were originally posted, principally because:

- they had married and were required, by law, to reside with the spouse whose job was always in the towns;
- they had suffered chronic illness and needed long-term follow-up in hospital;
- they had been promoted;
- they had failed to relate satisfactorily to the public or to persons in charge.

Failures attributable to the national health system

The annual budget of the Ministry of Health has been shrinking during the long economic recession, and consequently all health services have been undermined. The primary health care centres are less frequently attended than formerly because equipment is aging and drugs are in short supply. Only about a sixth of the needs for medicines are being met. The health agents no longer receive a travel allowance and have lost their motivation for making home visits, promoting sanitation and imparting health education.

In-service training and the supervision of health agents have turned out to be quite inadequate. Only a few highly motivated chief physicians of health zones who had some resources at their disposal visited over 80% of their primary health care centres once every two years and organized annual training courses for their health agents. Unfortunately, some health agents have not worked conscientiously, partly as a result of the economic crisis and partly because discipline has been lax. This state of affairs has confirmed the public in its poor opinion of the centres.

Prospects

In order to maintain the programme of primary health care centres the following measures should be adopted.

- More public education should be provided with a view to keeping the community mobilized.
Primary Health Care

- The planning of health coverage should be made more flexible so that greater attention is given to the people's aspirations.
- The effectiveness of intersectoral collaboration should be increased; the incomes of small farmers need to be raised through improved agricultural techniques, and measures are needed to combat banditry.
- Cost recovery should be widely adopted in the national health system. The principle of universal free medical treatment should gradually be abandoned, and the large and medium-sized hospitals should become self-financing. The government is in fact already sponsoring a small number of cost-recovery schemes, among them a village pharmacies programme.

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- More in-service training should be provided for health agents, and more tours of inspection should be carried out.
- Community health workers should be given a new role and should be managed entirely by the community in accordance with a formal contract; the Ministry of Health should take charge of their training.
- There should be a renewal of the country’s commitment to the Accelerated Programme for Health for All by the Year 2000, inaugurated by WHO’s African Region in 1985.

Although primary health care in Madagascar has largely proved its worth, some doubts have been expressed as to whether the programme of primary health care centres deserves to be continued. If the economic handicaps can be overcome, however, the programme is likely make a valuable contribution to the achievement of the health-for-all goals.