

Primary health care: back to basics in Madagascar

The name might have changed but primary health care remains a key policy of the Malagasy state. Rivonala Razafison reports on the challenges that health workers face in Madagascar.

When the first batch of 1500 young health aides were dispatched in 1980 to Madagascar's villages, it was thought to herald a new era in health care for the island nation off the south-east coast of Africa. The project was the centrepiece of the country's primary health care policy, launched in 1978 with high hopes of meeting the Alma-Ata goal of health for all by 2000.

The drive to improve health services was not before time. Despite declaring its independence from France in 1960 and undergoing the Malagasy Socialist Revolution resulting in the Second Republic in 1975, health care in Madagascar remained inadequate, a throwback to colonial times when it served the ruling elite, with its infrastructure and staff concentrated in the towns.

In the intervening 30 years, the much-vaunted primary health care initiative has brought mixed results, making strong advances in some areas while failing to deliver in others.

On the plus side, Professor Dieudonné Randrianarimanana, the cabinet director of the Madagascar Ministry of Health, Family Planning and Social Protection in the capital Antananarivo, says that the islanders have never been more motivated to look after their health as they are today.

The general situation is getting better, says Randrianarimanana. Average life expectancy is 55 years; poliomyelitis is about to be eradicated; the prevalence of leprosy is less than 1 per 10 000; and infant mortality is decreasing (in 2006 the probability of dying in the first year of life was down to 58 deaths per 1000 live births compared with 98 in 1993 and 74 in 2003). The government is aiming for a 100% success rate in preventing and treating malaria, while AIDS is not a major health problem, he says, because HIV prevalence is relatively low compared with the rest of sub-Saharan Africa; an estimated 0.95% of the island's population of 18.6 million are infected.

However, Randrianarimanana says Madagascar has failed to achieve the health for all by 2000 target laid down by the Alma-Ata Declaration, and estimates only 60–70% of Madagascar's inhabitants – that is those who live in regions served by roads – have ready access to primary health care. Many people still have to walk 10 kilometres or more to receive treatment, though mobile health centres have been introduced in remote and sparsely populated areas.

In an organizational reshuffle in the mid-1990s, all 1500 original primary health care centres, and others that had come into operation, were reclassified as Basic Health Centres or *Centres Santé de Bases* (CSBs). In 2004, almost 3000 CSBs throughout the country were listed on the health ministry web site. While the name has changed, the CSBs still operate essentially as primary health care centres.

Dr Dieudonné Rasolomahefa, the Director-General of Health at the Ministry of Health, Family Planning and Social Protection, says a level 1

basic health centre (CSBs are classified level 1 or 2 according to the size of population they serve) is now staffed by a nurse rather than a health aide. Rasolomahefa says the nurses and midwives (paramedical workers) receive a higher level of training via the health ministry than the health aides of the past, for whom training programmes ceased in 1982. The health aides continue to work as such until retirement.

Indeed, though the term, primary health care, is not generally used in official quarters these days, the primary health care programme in Madagascar has been reinforced, Rasolomahefa says.

The Madagascar Action Plan 2007–2012 (MAP) has become the key policy of the Malagasy state, comprising eight commitments towards a prosperous future. Commitment five outlines the government's strategy on health, family planning and the fight against HIV/AIDS. Under the plan, the government has committed itself to providing quality health services to all; eradicating major diseases; HIV/AIDS control and prevention;



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Villagers outside a house with a stubble roof in a rural area of Madagascar. Only 60–70% of Madagascar's inhabitants have ready access to primary health care. Many people still have to walk 10 kilometres or more to receive treatment, though mobile health centres have been introduced in remote and sparsely populated areas.

implementing a successful family planning strategy; reducing infant, neo-natal and maternal mortality; improving nutrition and food security; and providing safe water and promoting hygienic practices.

As of 2006, after MAP had noted many of the CSBs were understaffed and ill-equipped, 197 of them were rehabilitated and equipped with essential drugs.

The Alma-Ata declaration remains the foundation stone of primary health care in Madagascar, though changes to the constitution in September 2007 place the goal of health for all mostly in the hands of individual communities. A major impediment to primary health care, however, is the high cost of prescription drugs, Randrianarimanana says. He advocates the use of cheaper generic drugs, dispensed by village pharmacies.

Like Randrianarimanana, nurse Florentine Odette Razanandrianina has experienced the ups and downs of primary health care. She arrived in the village of Ambohimiarintsoa, 200 kilometres from the capital Antananarivo, in October 2006 to run the CSB, having previously worked in the towns of Antsirade (1998–2004) and Betafo (2004–2006).

“The basic health centre I run covers two areas, Ambohimiarintsoa and Bemahatazana, which have 1200 and 2560 inhabitants respectively,” she says. “All the recommended drugs are

available on the spot every time, and as a result, many successful treatments can be carried out.”

At her centre, she provides twice-weekly prenatal and postnatal check-ups. On average, 12 babies are examined every week and six delivered every month. She also offers child immunization and vaccination, family planning services and disease treatment.

Convincing people of the benefits of good health care requires sensitivity and adaptability, she says. In recent times, fewer patients sought treatment. “Probably, the most obvious reason is linked to the issue of comfort,” she says.

The centre was built by the villagers in 1978, based on an agricultural granary, but the building was soon divided into seven small rooms. One is used as a dispensary, another for living quarters. The other five, including a delivery room and one for malaria treatment, are in a poor state of repair and lack sufficient equipment, Razanandrianina says. “We have five mattresses for only one bed. Consequently, we are often obliged to let patients sleep [on the mattresses] directly on the soil.”

Chief of Area Ignace Randrianarivelo, the mayor’s representative in the village, also notes the poor state of the centre. “It is the only CSB in Madagascar where the roof is made of stubble (dried grass),” he says. The ministry is aware of the problem and has said it will have it repaired. Rasolomahefa says there are many other health centres in



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Dieudonné Randrianarimanana

a similarly poor state of disrepair across Madagascar.

Promoting cleanliness in Ambohimiarintsoa is a constant challenge, Razanandrianina says. For instance, she advised villagers to remove the sisal plants, warning them that the fleshy leaves were a refuge for rodents who spread infectious diseases, including plague. The villagers declined her advice, saying the plants helped protect their cattle against thieves.

The villagers sometimes resisted her attempts to educate them in better personal health care, Razanandrianina says. “Since I moved to this village, I have applied myself to teaching the people, especially the pregnant women, about the need for prenatal check-ups and personal hygiene (to prevent post-partum infection). But very quickly, my initiative was interpreted in a nasty way and caused a psychological barrier to be formed that prevents people seeking treatment at the centre. The health worker in Madagascar is not always in a position to be accepted.”

Rasolomahefa says the nurses and remaining health aides are generally accepted, but frictions arise when modern practices are perceived as counter to traditional customs.

Despite these setbacks, Razanandrianina has not curtailed her efforts. For example, when villagers have chosen not to attend – some are reluctant to visit the centre because they do not want to leave their fields and families, fearing they might meet ‘gangsters’ on the roads – she has taken her vaccination campaign to them. She is accompanied on these missions by Jean Georges Rakotonindrina, who is in charge of the dispensary at the centre. “Every time we



WHO/R. Elisa

When Madagascar launched its primary health care drive in the 1970s, health aides were sent off across the country on foot, on bicycles, mounted on oxen and on carts to deliver health care.

visit the remotest villages, people wait for us in a group. They really appreciate our visits,” Razanandrianina says.

Razanandrianina's predecessor Jean Rajoaharivahoaka was one of the original health aides trained in 1978 and worked in Ambohimiarintsoa until his retirement in January 2007. He, too, cites the joys and frustrations of the job.

“Initially, the people didn't take an interest in primary health care,” he says. “They were unaware of its importance. They didn't trust the health aides trained by the ministry. That was the biggest problem that meant health for all by 2000 wasn't achieved,” Rajoaharivahoaka says.

“But little by little, we attracted the villagers. They began taking a particular interest in family-planning practices. Educating rural people was the real challenge, especially about drinking water and the need to build latrines.” ■



Three mothers wait with their babies at the entrance to a primary health care centre for routine postnatal checkups. In the 1970s, maternal and child health took high priority in the work of Madagascar's new primary health care workers or “health aides”.

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