

Dominique Desplats

The feasibility of community-based private medical practice in Africa and Madagascar

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The Feasibility of Community-Based Private Medical Practice in Africa and Madagascar

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Abstract. An ever-growing number of doctors are being trained at the Faculties of Medicine of French-speaking Africa and Madagascar, and yet the shortage of general practitioners in rural and periurban areas continues to be a cause for concern, even though there are more unemployed young medical graduates than ever. More than 20 years ago, the non-governmental organization (NGO) *Santé Sud* developed the concept of community-based general medicine, along with a professional mechanism that enabled more than 200 doctors to set up practice in Mali, Madagascar and Benin. Five external assessments are now available for evaluating the relevance and feasibility of this new form of local healthcare provision and determining under what conditions it might be extended or integrated into existing healthcare systems. The creation of mixed public/private bodies, with funding allocated under the International Health Partnership (IHP+), is put forward as a desirable way of spreading this experience.

Keywords. Rural medical practices, Medicalization, Community healthcare, Family medicine, Health care systems.

1 Introduction

According to a World Health Organization (WHO) estimate, 76% of doctors in developing countries practice in urban areas, although rural populations still represent the majority¹. In Sub-Saharan Africa and Madagascar, the proportion is even higher: the medical profession remains concentrated in the capitals and major regional cities, although between 60 and 80% of the population (depending on the country) lives in rural areas, which, even today, are healthcare deserts.

For a long time – during the twenty years that followed independence (1960-1980) – this disparity could be imputed to the limited number of doctors in each country. But that argument no longer stands, now that those countries have made considerable efforts to open their own Faculties of Medicine, with the aim of training enough doctors to eventually meet the needs of the entire population. Every year, these Faculties produce between 100 and 300 new graduates, depending on the country. In Mali, for example, the numbers have risen from 75 doctors at the time of independence to more than 2,000 in 2010. There is now 1 doctor for 6,500 people in Mali, 1 doctor for 3,000 people in Madagascar, and 1 doctor for 7,500 people in Benin. Health policies, initiated

by international organizations, have failed to take this predictable development into account. Since Alma Ata, in 1978, diagnostic and therapeutic responsibility has been entrusted to professionals other than doctors. In the words of the WHO representative in Yaoundé, Dr. Helène Mambu-Ma-Disu: “*medical practitioners have been largely overlooked in primary health care*”.

In its 2008 World Health Report², the WHO explicitly acknowledged this anomaly, which had resulted in the implementation of programs that were “*dangerously oversimplified in resource-constrained settings*”. Unfortunately, this recognition has not led to a rethink of models and strategies. The quality of healthcare, especially in rural areas, remains mediocre. Low patient satisfaction is evidenced by health center attendance rates 30% below what is needed, whereas many young doctors, despite long and difficult studies, often find themselves disempowered, unable to practice their vocation under satisfactory conditions. An ever-increasing number are seeking to emigrate or to reconvert to some other line of work.

2 A pragmatic search for a solution

Mali in late 1980s provides an instructive example. To conform to the structural adjustment measures recommended by the International Monetary Fund (IMF) and the World Bank, Mali organized a freeze in civil service recruitment, which had until then been very receptive to doctors. The first

¹ Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. World Health Organization 2010.

² WHO. 2009. The World Health Report 2008 – Primary health care (Now more than ever). World Health Organization.

entrance exam, in 1987, offered just 2 positions for 60 new graduates, leading to a deep sense of dismay among the disappointed candidates and their teachers. One World Bank expert even suggested closing the recently-opened medical school to stop it from becoming an “unemployment factory”! What were they supposed to do?

At the initiative of the school’s director and some of the teaching staff, the idea emerged of encouraging young doctors to go and become established by themselves in villages to practice “family medicine”, an idea that took off after a meeting with the French NGO *Santé Sud*, a humanitarian body founded by a group of general practitioners committed to helping their young colleagues pursue this option. The hypothesis was that young doctors were ready to take the plunge, provided they received guidance and support. Thus it was that the first volunteer set up practice in September 1989, in a village 370 km from Bamako, soon to be followed by others. In 1993, the 11 pioneers who had decided to practice this local rural medicine came together to found the Malian Rural Doctors Association – *Association des Médecins de Campagne* (AMC)³.

3 Defining a concept and a professional mechanism

The initial empirical action in Mali was encouraging and rich in insights. It rapidly came to set an example, addressing recurrent questions that also concerned other African countries: How do we find a place for these young people who are the future of their country? How do we create the conditions that will enable them to exercise their profession and make a living from it – without belonging to the civil service – and help improve the health of the population, especially the more numerous and more vulnerable groups that live mostly in rural areas?

During the 1990s, convinced of the validity of this new approach, we conducted numerous interviews with doctoral students and young graduates by organizing focus groups in several university towns: Bamako, Dakar, Conakry, Ouagadougou, Abidjan, Cotonou, Parakou, Yaoundé, Tananarive and Mahajanga. We found a large degree of convergence in their responses, which can be grouped into four main categories:

- 1 Our training, being essentially hospital-based, does not prepare us to practice local medicine, especially on the front line, far from towns;
- 2 There is no advice and no assistance – or even access to credit – to help us set up our own practices;
- 3 Primary healthcare structures are poorly equipped and often poorly managed, which doesn’t incite people to attend;
- 4 The standard of living in the bush, the social and professional isolation, and the security problems, are a serious concern for us. We are going to be forgotten!

³ Annaheim-Jamet I., Traore S., Balique H. 1997. Réinventer la médecine de campagne. In « Brunet-Jailly - Innover dans les systèmes de santé : expériences d’Afrique de l’Ouest » (in French). 137-152. Ed. Karthala.

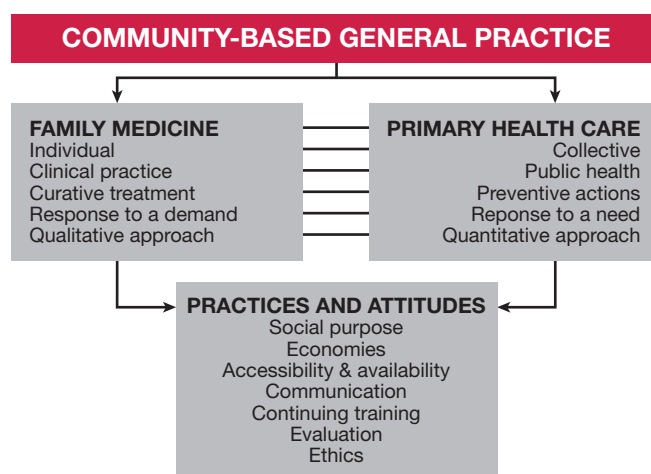


Figure 1. “Concept of Community-Based General Practice”

It was gradually becoming clear that, to respond adequately to the recurrent questions, we needed a coherent overarching methodology that would address all the problems raised. The experience gained from the setting up of community-based private doctors in other countries, particularly Madagascar since 1996 and Benin since 2009, is now sufficiently conclusive for us to present, in this paper, a concept and a professional mechanism that have demonstrated their effectiveness.

3.1 The concept

The concept developed out of a dual concern that local medicine faces in the field: meeting the demands of individual treatment – caring for the person and their family – while keeping an overall vision of the health problems of a community. This dual function, of clinician and of public health center manager, had somehow to be integrated within the same practice (Figure 1).

It is this combined strategy of Family Medicine plus Primary Health Care that gave rise to what we called community-based general practitioners (CBGPs), adopting a definition validated by the doctors themselves: “*the community-based general practitioner works independently in a spirit of public service, living at the place of practice, providing family medicine, and addressing the health problems of the area under his or her responsibility*”⁴.

3.2 The professional mechanism

The process of setting up CBGPs follows 4 successive and inter-dependent stages. It is implemented by an *ad hoc* technical cell capable of monitoring the quality aspects.

These 4 stages can be outlined as follows:

Stage 1: Linking supply to demand

- Supply:

⁴ Desplats D., Kone Y., Razakarison C. 2004. Pour une médecine générale communautaire en première ligne (in French). *Médecine Tropicale*, 64 (6): 539-544.

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- Raising awareness among young doctors;
- Training candidates in community-based general medicine (4 one-week theoretical modules + internship at the practice of a mentor CBGP);
- Demand:
 - Identifying local demand (rural communities, local mayors, community health insurance schemes, etc.);
 - Opinion of the health district's chief doctor.

Stage 2: Feasibility study by the candidate

- Delimitation of the area of responsibility and the reference population;
- Study of the socio-medical environment, simulation of projected activities and financial results over 3 years;
- If needed, identification of a practice/medical center, and conditions of acquisition.

Stage 3: Contractualization and installation

- Private contract with the management of community healthcare structure, or a public service partnership agreement for a strictly private undertaking;
- Mobilization of targeted aid on a case-by-case basis: medical kit, solar panels, initial stock of essential medicines, means of transportation (motorbike), etc.

Stage 4: Follow-up and professional network support

- Training and monitoring: 4 follow-up visits over two years;
- Group participation: membership of the professional association, exchanges on practices within peer groups, participation in research-action networks (e.g. on chronic diseases: epilepsy, HBP, HIV-AIDS, etc.).

The importance of **contractualization** must be underlined; it enables the new CBGP to integrate into the health system, occupying a legitimate place and a clearly defined role.

4 Results

At the time of writing, more than 200 doctors are in practice, having been aided by this support mechanism: 150 in Mali, 60 in Madagascar (one third of them women) and 15 in Benin. As each community-based general practitioner has an average of 12,000 people in his or her area of responsibility, the number of beneficiaries can be estimated at about 2.7 million persons.

These are CBGPs in current practice: the figure does not include instances where existing doctors have been replaced by newcomers. The total number of doctors trained and installed is in the order of 300. This turnover has, on the whole, been well managed so as to ensure medical continuity at each site where a doctor was present.

There have been five external assessments to date:

- two in Mali: ORSTOM, 1998; WHO, 2008
- three in Madagascar: INSPC, 2007; COEF Ressources, 2008; AFD, 2010⁵.

Comparative analysis of the five assessments shows significant homogeneity in the results observed, despite the specificities of each country (see Box).

Mali, Madagascar, Benin.

Community-based general practice was first initiated in Mali, as part of the reform of the country's health system, under which, in the 1990s, primary health structures were entrusted to community management. The Community Health Care Centers are managed autonomously by Community Health Care Associations, while being overseen by the supervisory team of the health district to which they belong. The Associations can recruit the staff of their choice, with a registered nurse or a doctor to direct the Center. Most of the doctors sponsored by Santé Sud were recruited by Associations under private contract, while a minority (10%) chose to set up as independents. In Madagascar, where there are no such Centers, the CBGPs are private doctors linked to the state by a public service partnership agreement. In Benin, they are community-based private doctors installed, using the same support mechanism, under a partnership agreement approved by the Ministry of Health. The CBGP concept has therefore been able to adapt to different contexts.

4.1 Generally acclaimed positives

The relevance of this approach has been unanimously welcomed in the assessments:

- “*The community-based general practitioner is a concept that renews and reinforces primary health care*” (INSPC, Antananarivo, 2007);
- “*Medicalization is a relevant response to the health needs of isolated rural populations*” (WHO, 2008).

The assessments confirm high satisfaction rates among the beneficiary populations and among doctors, both newcomers and their more senior colleagues – as a significant number of the latter are still working at their original site. They appreciated the opportunity presented by a project that enabled them to exercise their vocation, to benefit from a support system

– AFD. 2010. Projet d'appui au développement de la médecine générale communautaire à Madagascar ex-post des projets ONG financés par le MAEE France.

– OMS 2008. Evaluation du programme d'appui à la médicalisation des aires de santé rurales au Mali (in French). Online.

www.who.int/hrh/resources/case_mali/fr/index.html

– Cabinet COEF Ressources. 2008. Etude sur l'appui à l'installation de médecins privés en zones rurales à Madagascar (in French). For the Malagasy Health Ministry upon financial support. AFD.

– Institut National de Santé Publique et Communautaire (INSPC). 2007. Evaluation à mi-parcours du projet Santé Sud Madagascar (in French).

– Balique H. 1998. L'expérience des médecins de campagne au Mali. Etude sur 32 installations (in French). Report Santé Sud/ORSTOM.

⁵ Evaluation

that gave them confidence in themselves, and to be integrated into a professional solidarity network. Most of them feel valued by being able to earn a living with a sense of being useful and performing a service for their host community, to which they feel close.

The average length of service has been assessed at 4 years and 8 months in Mali (WHO) and over 5 years in Madagascar (COEF Ressources). These retention rates are twice the average for other doctors (public or private) working in outlying areas.

On the monetary level, CBGPs are paid exclusively from community financial contributions, either directly, when the doctor sets up in independent practice, or indirectly, when the doctor works for a health center run by a community association (as in Mali). The standard contract for the latter provides for a guaranteed minimum (an average of CFA 100,000 per month) to which is added a variable part based on the center's revenue (25%), excluding medication costs.

The strictly private doctors apply a pricing schedule close to that of the community health care centers, affordable by the great majority of the population (consultation fees of €0.60 in Madagascar and €1.5 in Mali and Benin; average prescription charge of €1.2 in Madagascar and €2 in Mali and Benin). The option of credit (impossible in public health care centers) is widely appreciated, especially during lean periods.

Overall, the assessments show that CBGPs are relatively satisfied with their levels of income, which range between 1 and 3 times the average starting salary for a public-sector doctor. There is significant variation, the doctor's "personality quotient" being a determining factor: his or her qualities, empathy, and sense of vocation remain key criteria that influence the level of business.

4.2 Non-negligible risks and uncertainties

The WHO assessment for Mali states that "*the introduction of doctors into rural health centers has renewed local populations' confidence in the health system and has restored its credibility*", but also notes that it is hard to measure the impact of this change in terms of attendance rates and health indicators. The same observation is found in all of the assessments, due to a lack of reliable statistical data: the figures from medical centers are amalgamated with those of all the health districts and then reinterpreted at regional level before being reported up to national level. A comparative assessment of medical and non-medical structures would require a long and costly protocol that it has not yet been possible to conduct in a rigorous manner.

Additionally, despite the interest aroused by this progressive extension of medical coverage or "medicalization" of rural areas, we are yet to see a real groundswell of support at the institutional level, i.e. from the ministries or universities (though, as we shall see, there are some differences between countries). The assessments underline this insufficient take-up of a strategy that therefore continues to depend on an NGO, and on the uncertain funding that it has difficulty raising. A genuine "scaling up" calls for a more assertive political strategy, in the continuation of the decentralizing administrative reforms, tied in with the creation of new municipalities and framed by a public-private partnership with allocated funding.

This situation accounts for the sense of insecurity felt by the doctors who, for the most part, see this mode of practice as a way of gaining experience while waiting for other opportunities, believing that it offers no prospects for lack of effective recognition (no qualifying training, no equivalences for access to specializations or to channels such as the civil service entrance examinations). Their commitment to performing public health actions in their area, without any allocation of funding from the state so far, generates legitimate doubts about the government's intentions. Since the conditions for community-based private medical practice are not sufficiently acknowledged at the institutional level, it cannot be guaranteed to endure without the supervision currently provided by the local teams from *Santé Sud*.

5 Main difficulties encountered

Initially, there was some skepticism, stemming from two arguments:

- 1 Doctors will not go to – or stay in – rural areas because of the living conditions and the isolation;
- 2 Rural populations will not pay for their services, because they are not solvent.

Neither of these affirmations was borne out, whereas our hypothesis was indeed validated, namely:

- A significant number of young doctors are willing to practice in deprived areas, when a certain number of conditions are met;
- Rural populations have resources that they can and do mobilize when the service is appreciated and corresponds to their expectations.

The main difficulties came from the state-administered public health service: the first community-based private doctors were looked upon as competitors setting up purely to make a profit⁶. They were a threat to the hierarchical vision and executive function of the healthcare provider. A number of serious conflicts arose, but relationships evolved over the course of time. In some health districts, in Mali and Madagascar, the collaboration has become so close that some district chief doctors actively call for the installation of young community-based private doctors in order to improve primary health care coverage. In Benin, the initiative is still recent, but it stems from an explicit request by the Ministry of Health and the new Faculty of Medicine in Parakou, created to improve medical access in North Benin. This institutional commitment should facilitate the adoption of the concept and mechanism for introducing CBGPs.

Over time, seeing the problems of adaptation faced by young graduates on the ground, it became clear that additional training was required in order to prepare them better for their future role as clinicians in isolated areas, so that they could plan preventive and curative actions, organize teamwork,

⁶ Coulibaly S., Desplats D., Kone Y., Nimaga K., Dugas S., Farnarier G., Sy M., Balique H., Doumbo O., Van Dormael M. 2007. Une médecine rurale de proximité : l'expérience des médecins de campagne au Mali (in French). *Education for Health*, 20 (2): 1-9.

manage supplies of essential medicines, use the health information system, and communicate with health authorities, local government representatives and communities – none of which they learned at medical school. It was at this point – in 2003 in Mali, then in 2007 in Madagascar – that we became aware of the difficulties of implementing this type of training, given the yawning gap between hospital-centric university training, with its focus on specializations, and the real needs of the country's health care system. The design of an orientation program for rural doctors saw the light of day in Mali thanks to a collaboration with the Antwerp Institute of Tropical Medicine⁷, followed by partnership with the Antananarivo INSPC in Madagascar, with the participation of several national academics who were interested in the field implementation issues. The universities, however, remain skeptical, and their courses continue, by and large, to be modeled on those of Northern hemisphere, industrialized countries. Only the Faculty of Parakou has shown an interest in integrating community-based general practice as a specialization.

6 Discussion

In the light of our current experience, three aspects of the feasibility of setting up community-based private practices call for further discussion: the impact, the financial costs, and the take-up of the professional mechanism.

6.1 Impact

Although the real impact, in terms of quantified indicators, has not been sufficiently documented, there is some indirect data to suggest that the presence of a medical practitioner at the front line does increase health center attendance and the use of the curative and preventive arsenal, for example:

- Better delivery of curative care, extending as far as *“the treatment of chronic diseases in a prevention/treatment/follow-up continuum, and the implementation of promotion and prevention actions”* (WHO assessment);
- The frequently-observed attractiveness of centers with doctors, which receive many patients from outside the health area;
- The testimony of village chiefs, who observe that there have been fewer deaths (particularly among children) since the doctor arrived (INSPC assessment);
- An increase in revenues and the recruitment of additional staff at medical health centers (WHO assessment).

The numerous tutoring missions (44 to date) performed by French general practitioners in the three countries concerned to initiate CBGPs in the practice of “family medicine” also confirmed a high level of activity: queues, out-of-hours and

continuity of care, versatility, advanced strategies, home visits, etc. The social role of the community doctor should also be underlined: as the only people, in many localities, with a university-level education, many of them play an important role in dealings with the authorities, local representatives, and development agencies.

That being said, encouraging doctors to set up in remote areas is not sufficient in itself. The individual profile remains essential; some – especially if the support measures prove inadequate – might make do with perfunctory routine practices, as has been well documented by anthropologists⁸.

6.2 Financial costs

The cost of setting up in practice varies according to how it is done: it can be low if taking over a senior colleagues' community practice, or working under contract to a community health care center, and far more expensive if the CBGP sets up on his or her own, as an independent or within a framework negotiated with a community. In the latter instance (Madagascar, Benin), the complete equipment (medical devices, furniture, initial stock of medication, solar panels, motorbike) costs about 12,000 euros. Renovating an existing construction, or building a village health center with community participation, requires additional funding, which varies depending on the situation, but averages about 10,000 euros.

The assessment conducted by the INSPC in Madagascar showed that the investment cost was 4 to 6 times lower than for a public structure of the same level (depending on Basic Health Center (BHC) type, BHC1 or BHC2). On top of which, the operating expenses, being covered by the doctor, cost the state nothing! It is reasonable to conclude, therefore, that there is a cost involved in installing a community-based private doctor, but it is a very low price to pay for the service rendered, compared with a state structure of the same level.

Once in place, CBGPs make a living from their work, and cover all their own operating costs. Contractual arrangements with the community may alleviate these costs; for example, the municipality might decide to pay for a security guard or a healthcare assistant. On the whole, the operation is more likely to be financially viable where the doctor has come to an agreement with the host community on pricing and on the other modalities of the community-based medical practice or healthcare center.

6.3 Acceptance and extension of the professional mechanism

The question of acceptance is problematic; it arises in countries that have historically been marked by an administrative culture in which care is provided by public health systems and where the GP's function is devolved to non-doctors. For this reason, general practice, for young doctors and their families, is seen as a lower-grade occupation, the typical ideal being represented by the hospital specialist or the doctor

⁷ M. Van Dormael, S. Dugas, Y. Kone, S. Coulibaly, M. Sy, B. Marchal, D. Desplats. 2008. Appropriate training and retention of community doctors in rural areas: a case study from Mali. *Human Resources for Health*, 6:25.

⁸ Jaffre Y, Olivier De Sardan J.P. 2003. Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales de l'Afrique de l'Ouest (in French). Karthala (Ed). Paris.

whose career in public health is spent in government service. A recent study conducted in Madagascar by the International Health Unit of the University of Montreal revealed that almost a quarter of the country's GPs work in the offices of the Ministry of Health Administration.

Community-based general practice represents a real innovation both for doctors and the administration. For young doctors, it means investing in a risky career path, poorly recognized and with an uncertain future. For the administration, it is seen as a new link in the chain, questioning the validity of the health care pyramid, the dogma of the medical station head nurse, and the almost military hierarchical vision of the health system. The medical schools, meanwhile, remain in a kind of ivory tower, preoccupied with trying to manage overwhelming numbers of students, and increasingly unable to provide research supervision, with rural internships often disappearing for lack of resources.

The acceptance process, in this fairly widespread context, can only happen slowly; it requires nothing less than a change of mindset to bring about strategic innovations in training and in the organization of health care. In the countries studied, there are perceptible changes on the three levels concerned by this new approach:

- Local populations are increasingly demanding access to high-quality local care: with decentralization, local representatives and mayors, channeling the concerns of their constituents, are pressing for the presence of general practitioners and seeking to make it easier for them to set up practice;
- The doctors themselves, with the creation of their own professional associations, are gradually building up a collective identity capable of defending their status and of organizing a number of promotional activities such as participation in basic training (internship supervisors), continuing training networks, and solidarity between senior and junior colleagues;
- The authorities are facing up to the limits of the state as sole health care provider: with the obligation to cap civil service recruitment, the search for alternative solutions is becoming an increasingly obvious necessity. The government of Madagascar, for example, has committed itself to a public/private partnership (3P) policy, which has created a specific operating framework for community-based private doctors that enables them to be associated by contract with the public health system.

These changes should facilitate the acceptance of the professional mechanism put in place by *Santé Sud*, especially as the NGO's local delegations consist entirely of nationals. A mixed body, leaving the management of the professional mechanism to the doctors themselves and the power of regulation to the state, as part of its sector policy, would probably be a satisfactory solution, with allocated funding being supervised by the International Health Partnership (IHP+).

Three comments to round off this discussion:

- The first concerns the limits of extension: community-based doctors can provide a valuable service in many isolated or under-medicalized areas, but it is the responsibility of government to ensure care for non-viable zones (very sparsely populated and/or very poor areas), either through public-sector structures or by subsidizing service providers;
- The second concerns the currently fashionable policy of free health care. Apart from the fact that such policies have a significant downside (decline in quality, over-bureaucratization, dependence on external assistance), they represent a real threat to community-based private practitioners, who will be unable to make a living or will abandon their ethical and social goals for more lucrative practices reserved for an unsatisfied but solvent minority;
- Finally, it should be noted that some countries, for a variety of reasons, do not have sufficient medical resources to envisage such a change. Cameroon, for example, limits its production of doctors to the number required for the public sector, generating a large diaspora of students – with distinctly limited prospects – in the medical schools of neighboring countries.

7 Conclusions

The feasibility of setting up community-based private doctors to serve the large vulnerable populations that live in rural or periurban areas has now been demonstrated. It is possible under certain conditions, which we have described⁹, but it is not a solution for situations where community-based private practice is not viable – in such situations the state must assume its responsibilities.

The “medicalization” of front line care by non-public-sector doctors must be viewed in a spirit of complementarity, rather than competition, with the public health system. This fundamental requirement calls for a clear statement of political will, embodied in appropriate contractual arrangements.

As for young doctors, they will engage upon this new path if they are given a satisfactory practice environment, one that enables them to place their professional skills at the service of their patients and their patients' families.

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⁹ Desplats D, Razakarison C. 2011. Le Guide du médecin généraliste communautaire en Afrique et à Madagascar. Concept, organisation, pratiques (in French). 320p. Online. www.santesud.org