

Retaining Human Resources for Health in Remote Rural Areas in Cameroon

Executive Summary

This policy brief was prepared by the Centre for the Development of Best Practices in Health, a research unit within the Evidence Informed Policy Networks (EVIPNet) Branch in Cameroon

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For Best Practices in Health

CDBPS-H

Pour des Bonnes Pratiques en Santé

Who is this policy brief for?

Policymakers, their support staff, and other stakeholders with an interest in the problem addressed by this policy brief

Why was this policy brief prepared?

To **inform deliberations** about health policies and programmes by **summarising the best available evidence** about the problem and viable solutions

What is an evidence-based policy brief?

Evidence-based policy briefs bring together **global research evidence** (from systematic reviews*) and **local evidence** to inform deliberations about health policies and programmes

***Systematic review:** A summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise the relevant research, and to collect and analyse data from this research

The Problem

Background

This policy brief was prepared at the request of the Human Resources Directorate of the Ministry of Public Health to inform the deliberations leading to the development of the national strategic plan for the health workforce. It describes the magnitude, the consequences and the underlying factors of the desertion of rural Integrated Health Centres (IHC), District Health Centres (DHC) and some district hospitals considered "difficult areas" by health care staff. It offers three evidence-based options and related implementation considerations to improve access to the priority minimum package of primary health care. This is part of health service delivery for the districts and contributes to the fight against rampant poverty (55% of the population) in rural areas.

"Difficult" rural areas are remote or landlocked health areas, subdivisions and health districts underserved by modern amenities where health services are provided by low-skilled professionals and poorly equipped in health technology. Typically, it is a rural area located between 80 and 400 km or between 1-4 hour drive in good weather from the first referral hospital as these delays make it impossible to guarantee a continuity of care. The ten regions of Cameroon have difficult rural areas, but Adamawa, East, the Far North and North and the areas reassigned after the resolution of the Cameroon-Nigeria border dispute have the largest number of IHC and DHC deserted by health staff.

The magnitude of the problem

Retention of health workers and ensuring the supply of quality healthcare services in isolated rural areas is a challenge in many settings. Quantitative and qualitative shortages plus unequal distribution of health workers at the expense of rural areas characterize sub Saharan countries. In Cameroon, the population/caregiver ratios - 9.245/medical doctor and 1.806/nurse – deemed acceptable mask an uneven regional distribution: 3.657/MD in the Centre vs 61.873/MD in the Far North; 2.036/nurse in the West vs 7700 /nurse in the Far North. 59.75% of the workforce is concentrated in the richest regions - Central, Littoral and West – and serves 42.14% of the population. The high urban concentration of healthworkers contrasts with the severe shortage in rural areas, exacerbating unequal access of citizens to a basic public service: 25% of doctors and 38% of nurses serving 46% of the population and fuelling the vicious circle of poverty.

The response of the Government and development partners since 2006 involved a priority recruitment of 2331 fix term staff in most deprived areas under the HIPC funding opportunity and 150 additional staff under C2D funding in 2007 with contracts to work in targeted districts of Adamawa, Far North and North followed by further recruitment in 2009 and 2011. Decentralized management of contract staff and retaining them in their recruitment workplace has not always been efficient with over 12 month-delay for the first salary, wages not paid regularly, regional devolution of management not extended to the payroll, multiple migrations.

The consequences of the problem

The desertion of rural health facilities undermines the national health system: (a) dozens of health centers built and equipped at great expense to improve geographical access to health facilities remain closed and abandoned; (b) health services in the health districts are compromised because dozens of health areas are excluded from offering the minimum package of priority health interventions and (c) the instability of health workers in rural areas

undermines Cameroon's chances to achieving the health MDGs related to maternal and child health and endemic diseases control thus impoverishing the rural populations.

The loss of public confidence vis-à-vis public health facilities leads to the low utilization rate of public health facilities and leads to the expansion of informal healthcare centres. These include street medicine vendors and other charlatans and together collect almost 30% of national health expenditure.

The routine immunization coverage rate amongst children, the immunization coverage against tetanus and the PMTCT coverage amongst women of childbearing age are lower in rural areas. The four poorest regions and most deprived in human resources account for more than three quarters of 4500 maternal deaths recorded annually. The skilled birth attendance rate is on average 29.3% in the three northern regions against 71.9% in the Centre Region. The rates of maternal morbidity and mortality are inversely proportional to health workforce. The same applies to the appropriate treatment of diarrhea, respiratory infections and malaria in children. In terms of access to free vaccination, 64% of children aged 12-23 months living in the urban areas against 52% in rural areas have received all eight routine vaccines of the Expanded Programme on Immunization. Receiving appropriate antimalarial treatment within 24 hours is poorer in rural (29%) than urban (53%) areas.

The underlying factors of the problem

Poor management of the health map leads to the creation of new DHC and IHC while existing are under or not staffed. Some of these newly created facilities compete unhealthily with long-established not-for-profit dispensaries, clinics and hospitals subsidized by the state under contract agreements for the provision of primary health care services.

The administrative approach compared to the managerial approach of health workforce translates to the absence of effective monitoring and evaluation of personnel distribution, mobility and individual professional development. There is no code of procedures governing the recruitment, placement, training and professional development. Politics governs the recruitment and placement decisions. Procedures lack transparency and participation thus leaving little room for employees' desires and expectations. The hardship of some duty station is neither defined nor formally accepted within the civil services. Under the presidential Decree No. 2002/042 of 4 February 2002, health providers are entitled to three allowances - technical, public health and duty allowances. There is no mention of hardship of the duty station and support staff who are not health professionals are excluded from receiving these allowances. There is a strong perception of a flawed assignment system marked by favoritism and corruption. For example it has been stated that - "some urban workstations are purchased because they are deemed lucrative" and this is the breeding ground for frustration, de-motivation and demobilization of care providers posted to remote rural areas. An extended length of stay in these duty stations by these health workers leads inexorably to desertion. Approximate monitoring of absenteeism fuels the vicious circle; deserters continue to receive their salaries while they are working in urban private formal and informal health centers. Centralized payroll management prevents the immediate line manager in the district to punish truants. The procedures to suspend deserter's salary are too long and very few are completed and enforced. Procedures to access continuing professional development opportunities lack clarity and transparency.

Cameroonian health workers are identical to their colleagues in other settings in relation to the determinants and factors of individual [de] motivation. Positive or negative influences on motivation are among others: (i) the level of earned income, (ii) the characteristics of the duty station - home, school, work for the spouse (s), cost of living, access to basic amenities and transport infrastructure, (iii) relationships with colleagues and the administrative hierarchy in

relation to discipline and career management, (iv) compliance with the local community, (v) external obligations, and (v) the personal sense of professional vocation. Identified triggers for desertion are the poor environment, low wages, poor working conditions and limited opportunities for professional development. While nurses are primarily frustrated by low wages, doctors are frustrated by opaque and non participatory decision-making. Living conditions are deemed essential by the female staff whose proportion is growing in Cameroon - 46% of the total staff of the Ministry of health and more than 54% of nurses. In Ghana, for example, motives for refusal to serve in rural areas include the lack of housing and schools and qualified teachers for children, uncertain access to safe drinking water, lack of electrical energy, poor road infrastructure and lack of transportation.

The unavailability of basic infrastructure and equipment in health centers makes it difficult to practice in isolated rural areas. Indeed, 30.9% of health centers do not have a medical analysis laboratory and 83% do not have room for minor surgery. 45.7% of IHC have no access to electricity while 70% have no tap water. The unequal distribution of health workforce generates professional burn out and degrades the technical conditions of practice. Poor governance and poor management of health services also worsen the working conditions and strengthen the sense of injustice as it reduces the amount of bonuses paid to caregivers from user fees. The injustice felt by those stationed in the villages stems from the lack of transparent criteria for placement and retention in these duty stations. Feelings of isolation and abandonment are reinforced by the lack of supportive supervision and the lack of attractive opportunities for professional development. A survey in 2009 found a national average of three annual supervisory visits to district hospitals, six to DHC and five to IHC.

In total, the desertion of rural health is rooted in the low level of rural development, administrative rather than managerial approach to workforce, overlooking of the factors that affect [de] motivation of health professionals in poorly regulated and increasingly commercialized healthcare services.

Policy Options

These options result from contextualized evidence synthesis from systematic reviews and discussions with officials from the Human Resources Directorate of the Ministry of Public Health at two workshops in May and December 2011. The three combinations of interventions proposed hereafter aim at addressing the multiplicity and the interconnection of the underlying factors of the desertion of health personnel in remote rural health facilities. If the level and the quality of evidence for single interventions are variable, there is no documented evidence of the effectiveness of multifaceted interventions. The selection of one or more of the options for action will therefore require resources for a rigorous monitoring and evaluation of the effects.

Option 1: Governance arrangements: Fixing health workforce management to introduce participatory mechanisms accounting individual and organizational determinants of [de] motivation.

This is a mutation from the administrative approach towards a managerial approach revising the regulatory framework for health workforce to improve governance in particular by introducing more humanity, fairness, transparency, participation, discipline and fighting against impunity, favoritism and corruption. This could be an inter-ministerial decree governing: (1) the decentralized management of health workforce including the payroll, (2) the clarity of the pathways to continuing professional development, (3) the description of duty stations including quality of life and living conditions for the family to account for the increasingly feminization of the workforce, (4) the limitation of the length of stay and the rotation to remote rural duty stations, (5) the recruitment and placement procedures to integrate individual choice and objective criteria, (6) the contracting of not-for-profit health centres and the public-private collaboration to enhance the management of the district health map and improve the efficiency of healthcare provision, and (7) the practice in private clinics by civil servants.

Evidence rated as moderate to strong exists on the incentives for practicing in remote rural areas in developed countries. Some of the selection criteria for the recruitment and deployment in rural areas are: (i) the rural origin of the candidate or spouse, (ii) the male gender, and (iii) the student intent to practice in rural areas at the time of enrolment into training school. Such evidence is relevant to Cameroon despite differences in the level of rural development, lack of health insurance and the highly attractive urban centers associated with the perception that urban professional practice is more lucrative because of the loose regulation of private practice for civil servants and city dwellers considered wealthier than villagers. The costs to consider relate to the consultation and expertise for drafting the ministerial decree, its dissemination, and training of teams for its implementation and monitoring and evaluation.

Option 2: Financial arrangements: establish financial and non financial compensatory measures for practicing in remote rural areas.

This would be a decree establishing financial and special equipment allowances such as: (i) hardship allowance for remote rural practice to offset the additional costs of living, (ii) education allowance for children unable to pursue their studies in the locality of assignment of the parents, (iii) right to adequate duty housing, (iv) right to a suitable means of transport, and (v) conditional return grants for service in rural remote duty stations. The current program of construction and equipment of staff duty houses should be continued and intensified.

Findings from systematic reviews suggest that financial incentives are essential but not sufficient to retain health workers in remote areas. Retention is increased when financial incentives are accompanied by other measures such as improving the working and living environment and

conditions, the allocation of duty houses and means of transport, a system of recognition and valuing such as the right to career advancement or promotion after serving in remote rural areas. The effectiveness of incentives depends on their relevance to the real costs of living in remote areas and a workforce friendly environment marked by good governance. The absence of modern infrastructure and amenities often bypass the incentives. Poorly regulated private practice by civil servants and the rapidly increasing commercialization of healthcare services are threats to the effectiveness of financial and material incentives as the market dynamics of employment in health services exceed the principles and values governing population health such as universality and equity. Additional expected benefits are: (i) the reduction of coping and silent corruption whose "justification" is low wages, (ii) improvement of living conditions and monetary poverty reduction; (iii) improved utilization of health services and higher coverage indicators of priority health services.

Option 3: Delivery arrangements: introduce and sustain integrated supportive supervision in the districts by regional teams and specialist outreach

This option aims to correct the sense of abandonment and isolation of staff in rural areas. This will also strengthen the skills of health personnel as part of continuing education and professional development and may increase the healthcare supply to rural areas thus reducing inequalities of access to medical care.

Integrated supportive supervision includes working with the provider to set goals, monitor performance, identify and correct problems in order to allow professional development through proactive improvement of individual performance and the quality of services in an holistic approach. It acts on two components of the Kanfer model of individual motivation: the "Can do" - set of measures to effectively mobilize the individual worker's resources in order to achieve common goals - and the "Will do" - package of measures to align the worker to the objectives of the organization. As a communication instrument, it affects the "Will do" component by accounting the objectives and purposes of the supervisee.

If well conducted, the supervision allows the supervisee to feel supported, appreciated, recognized, valued and respected, especially important for health personnel in remote rural areas. The supervisee is aware that the periodic evaluation of his performance could either lead to career advancement or expose him/her to sanctions. Integrated supportive supervision may be an extra motivation for retention in remote duty stations because of the improved quality of care and subsequent appreciation of the beneficiary community. It should be noted however that the level of evidence is low regarding the effect of supervision on the quality of primary health care. Integrated supportive supervision is likely to accentuate the relationship of subordination between the supervisor and the supervisee or generate frustration of the supervisee when the supervisor is incompetent.

Doctors outreach clinics bring specialist closer to the vulnerable populations and reduce professional isolation of staff working in rural areas as well. The beneficial effects of mobile teams focus on reducing inequalities of access to specialized medical care and household transportation expenditures to consult a doctor. Access to physicians by villagers is increased and the interaction between doctors and staff serving in rural areas is improved. The effects on quality of care are positive when outreach activities include strengthening the referral system and continuing education activities. However, there are no cost-effectiveness or cost-benefit analyses of this intervention available in the African context. Implementing this option will therefore require a robust monitoring and evaluation framework. The costs relate to the preparation and implementation of integrated supportive supervision (expert design, content and tools validation, effective implementation) and the provision of logistical and financial resources for operating outreach clinics.

Implementation considerations

The table summarizes barriers foreseen during implementation and suggested strategies to counter those. The evidence on the effectiveness of the strategies is of poor quality.

<i>Options</i>	<i>Barriers</i>	<i>Strategies</i>
1. Governance arrangements	<i>Fixing health workforce management to introduce participatory mechanisms accounting for individual and organizational determinants of [de] motivation including the consistency of the health map, the humanization of assignments considering personal choice and expectations, decentralized payroll management, effective monitoring and evaluation of the health workforce and greater legibility of routes for professional development.</i>	
	Resistance to change	IEC and capacity building
	Inappropriate capacities	IEC and capacity building
	Corruption and favouritism	IEC and punish offenders
	Bureaucracy and poor collaboration between Ministries of Health, Public Services and Finance	IEC and Harmonization of tools and procedures around a single decision-making body
	Laissez-faire, non-compliance by ignorance and indiscipline	IEC and punish offenders
2. Financial arrangements	<i>Establish financial and non financial compensatory measures for practicing in remote rural areas in the form of hardship allowance for the extra cost of living, education allowance for children and material benefits – duty housing and appropriate means of transport, telemedicine, solar energy and water supply in health facilities.</i>	
	Resistance to change	IEC and capacity building
	Corruption and favouritism	IEC and punish offenders
	Lack of financial resources	Advocacy for resources mobilization from regional and local authorities and performance based financing
3. Delivery arrangements	<i>Introduce and sustain integrated supportive supervision in the districts by regional teams and specialist outreach clinics to district hospitals and DHC and general practitioner outreach clinics to IHC</i>	
	Unclear administrative will	Advocacy and IEC
	Shortage of human, material and financial resources	Advocacy for resource mobilization and community support - regional and local authorities
	Corruption and favouritism	IEC and punish offenders

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Internal Merit Review Process

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Competing interests

None known.

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