Retaining Human Resources for Health in Remote Rural Areas in Cameroon

Executive Summary

December 2011

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 Department of the Ministry of Public Health to inform the deliberations leading to the development of the national strategic plan health workforce. It describes the magnitude, the consequences and causes of the desertion of rural landlocked 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 of the villagers to the priority minimum package of primary health care as part of the servicing of health districts and 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 are concerned, but Adamawa, East, the Far North and North concentrate the largest number of IHC and DHC deserted by health staff and it is the same for areas reassigned after the resolution of the Cameroon-Nigeria border dispute.

The magnitude of the problem
Retention of health workers and ensuring the supply of quality healthcare services in isolated rural areas are extremely important worldwide. Quantitative and qualitative shortages plus a screaming unequal distribution at the expense of rural areas characterize sub Saharan countries. In Cameroon, the population/caregiver ratios - 9.245/MD 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. The richest regions - Central, Littoral and West – concentrate 59.75% of the workforce to serve 42.14% of the population. The high urban concentration contrasts with the screaming 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 keeping them in their recruitment workplace has not always been diligent: 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 sustainably 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 in the bush; (b) servicing the health districts is compromised because dozens of health areas are excluded from offering the minimum package of priority health interventions and (c) the versatility 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 constitutes a breeding ground for the expansion of informal healthcare centres that collect nowadays almost 30% of national health expenditures including street medicines vendors and other charlatans.

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**

Approximate 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 rather administrative approach than managerial to health workforce translates in the absence of effective monitoring and evaluation of its 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 – without any mention to hardship of the duty station and non-caregivers are excluded from receiving these allowances. The strong perception of a flawed assignment system marked by favoritism and corruption - "some urban workstations are purchased because deemed lucrative" - is the breeding ground for frustration, de-motivation and demobilization of care providers posted to remote rural areas and extending the length of stay in these duty stations 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 do in relation to 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 and more than 54% of nurses. In Ghana, for example, motives of 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, overlook of the factors of [de] motivation of health professionals in poorly regulated and increasingly commercialized healthcare services.
Options

They are the result of evidence synthesis from systematic reviews and discussions with officials from the Human Resources Department of the Ministry of Public Health at two workshops in May and December 2011. Instead of single interventions proven effective, three combinations of interventions are proposed because of the multiplicity and the interconnection of causes. If the level and the quality of available evidence for single interventions are variable - low, moderate, strong, there is no evidence on the effectiveness of multifaceted interventions. The selection of one or more of the options for action will therefore require a rigorous monitoring and evaluation framework.

Option 1: Governance arrangements: Fixing health workforce management to introduce participatory mechanisms accounting 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 legibility of professional development pathways.

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 the fight 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 legibility of the pathways to continuing professional development, (3) clear description of duty stations including quality of life and living conditions for the family to account for the increasingly feminization of the workforce, (4) limiting the length of stay and the rotation to remote rural duty stations, (5) the recruitment and placement procedures to integrate individual choice and legible criteria, (6) strengthening 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 attracting factors and incentives for practicing in remote rural areas in developed countries. These are the selection criteria for the recruitment and deployment in rural areas such as: (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 high attractiveness of 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 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.

This would be a presidential decree establishing financial incentives and special equipment: (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.

Systematic reviews confirm 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 reducing poverty; (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 clinics to district hospitals and DHC and general practitioner outreach clinics to IHC

This option aims to correct the sense of abandonment and isolation of staff in rural areas, to strengthen the skills of such personnel as part of continuing education and professional development and to 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 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

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<td><strong>Option 1: Governance arrangements</strong></td>
<td>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.</td>
<td>Resistance to change, Inappropriate capacities, Corruption and favouritism, Bureaucracy and poor collaboration between Minsanté, Minfopra and Minfi, Laissez-faire and non-compliance by ignorance and indiscipline</td>
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| **Option 2: Financial arrangements:** | 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. | Resistance to change, Corruption and favouritism, Lack of financial resources | IEC and capacity building, IEC and punish offenders, Advocacy for resources mobilization from regional and local authorities and performance based financing |

| **Option 3: Delivery arrangements** | 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 | Unclear administrative will, Shortage of human and material resources and financial, Corruption and favouritism | Advocacy and IEC, Advocacy for resource mobilization and community support - regional and local authorities, IEC and punish offenders |
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Internal Merit Review Process
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Competing interests
None known.

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www.evipnet.org/sure

The Centre for Development of Best Practices in Health (CDBPH) is a research unit that was established in June 2008 at the Yaoundé Central Hospital. Its aim is to foster knowledge translation and exchange for better health in Africa. CDBPH is a knowledge brokerage unit designed to link health researchers with health decision makers. This initiative aims to assist researchers by collecting, synthesising, re-packaging, and communicating relevant evidence in user-friendly terms that stakeholders at many different levels can both understand and use effectively. The CDBPH also intends to serve health decision makers by providing capacity building opportunities, providing evidence summaries, and identifying needs and gaps related to Evidence to Practice. www.cdbph.org

The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available.

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