Strengthening Primary Health Care: A Prerequisite For Development In Cameroon

Cameroon – a sub-Saharan African country has set 2035 as the year in which it will become an emerging economy. Human capital has long been recognized as being indispensable to economic growth, but the lack of progress in health outcomes in Cameroon negatively affects its human capital while posing a serious threat to economic growth. Prioritizing improvements in healthcare delivery and access to the poorest segments of the Cameroonian population should be of major concern if solid progress towards lasting growth is to be achieved. Cameroon's health statistics oddly lag behind those of counterpart sub-Saharan African countries. According to the World Bank (2013), life expectancy for Cameroonians has decreased since 1990 by 2 years, contrasting the 5-year increase in sub-Saharan Africa. The under-five mortality rate,, currently standing at 122 deaths per 1000 live births in Cameroon has shown one of the smallest reductions in the world over the past two decades (World Bank 2013); malaria, pneumonia, and diarrhea are the main causes of the slow reduction in under-five mortality.

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In an editorial issue focusing on health in Cameroon, the World Bank (2013) described the health profile of Cameroon, using standardized health indicators. Statistics from this report show that Cameroon has a maternal mortality ratio that is higher than the average for sub-Saharan Africa and this ratio has increased substantially over the last decade. Pregnancy and childbirth are still major risk factors of mortality in women, with 1 woman dying every 2 hours from complications during pregnancy or childbirth; a significant 1 out of every 127 pregnancies is fatal. Uneven distribution of economic growth in Cameroon creates disparities which have health consequences. As a result, mortality levels are higher among the poor and especially in rural areas. For example, child mortality rates remain significantly higher in the North and Far North regions (191 deaths/1000 live births and 168 deaths/1000 live births respectively) of Cameroon with 20% of children dying before their 5th birthday (World Bank 2013). The same observations can be made with pregnancy-related deaths, which are also substantially higher in rural than urban areas, Immunization rates decrease from urban to rural areas. In the North West region, the proportion of children aged 12 – 23 months with full immunization stands at 82.5% compared to 30.9% in the Far North region (World Bank 2013).

Although health indicators in cities predominantly score better than in rural areas, the massive social and economic stratification within urban areas results in significant health inequities (WHO 2008). A good part of the urban population in Cameroon live in slums that lack durable housing and ample living area; characterized by poor sanitation and the unavailability of clean water and security. The inhabitants of these slums are unfairly exposed to pollution, accidents, violence, hazards, social incoherence and unhealthy lifestyles, thereby creating an environment that is extremely unfavorable for health. The unopposed exposure of these populations to risk factors of both infectious and non-communicable diseases not only increases the burden of overall disease, but also raises the frequency of an already markedly underestimated multi-morbidity.

The benefits of a healthy population cannot be overemphasized. A plethora of evidence exists that highlights the interwoven and directly proportional relationship between good health and economic development. The mechanisms by which good health affects economic development are straightforward. Good health increases the levels of school attendance and performance, hence improving the levels of education. Additionally, it increases workforce productivity by improving general physical and mental capabilities in the absence of illness. A combination of an educated and skilled healthy workforce with high levels of productivity culminates in raised human capital and an inevitable increase in economic growth rate. The idea of an entirely health population is utopian due to the constant presence of diseases. However, attaining and maintaining good health for a majority of the population can be achieved with a solid and effective primary health care (PHC) system. The main goal of PHC is to make universal health available to all populations. According to Sambala et al. (2010) PHC remains the only conventional health delivery service that can deal with resilient public health problems effectively. Out of all current systems, PHC has the most organised and sophisticated structure, theories and political principles to deal with the major issues that affect population health such as inequity, inequality and social injustice – issues that arise from uneven economic growth distribution and capitalist economic policies.

The PHC concept created by the 1978 WHO Alma Ata Declaration was based on the urgent need to protect and promote public health interests. This declaration defined PHC as – ***"…essential health care on practical, scientifically sound and socially acceptable methods, and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community or country could afford to maintain at every stage of their development in the spirit of self-reliance and self-determination"*** (Samabala et al. 2010). Based on this definition, PHC is the foundation of health systems and focuses on health promotion, disease prevention, healthy lifestyles and priority settings, providing health systems with the strength and support to attain the best health results. Therefore, health systems built on strong PHC are more resilient, efficient and equitable. By connecting people and families with trusted health workers and supportive systems throughout their lives; providing access to services ranging from family planning and routine immunizations to treatment of illness and management of chronic conditions, a high-performing PHC can enable a country to maximize the impact of its investments in programs to defeat infectious and non-communicable diseases (Ehlers and Mburu 2015).

The concept of PHC is the taproot for better health and can improve access to health services. However, achieving this requires an indispensable interplay among theoretical, political and sociological influences arising from economic, social, and political determinants of ill-health in this era of rapid globalization. Furthermore, to achieve an acceptable level of efficiency, the Alma Ata declaration outlines 8 core components which must be encompassed by PHC and together can guarantee the optimal functioning of any health system. These components include:

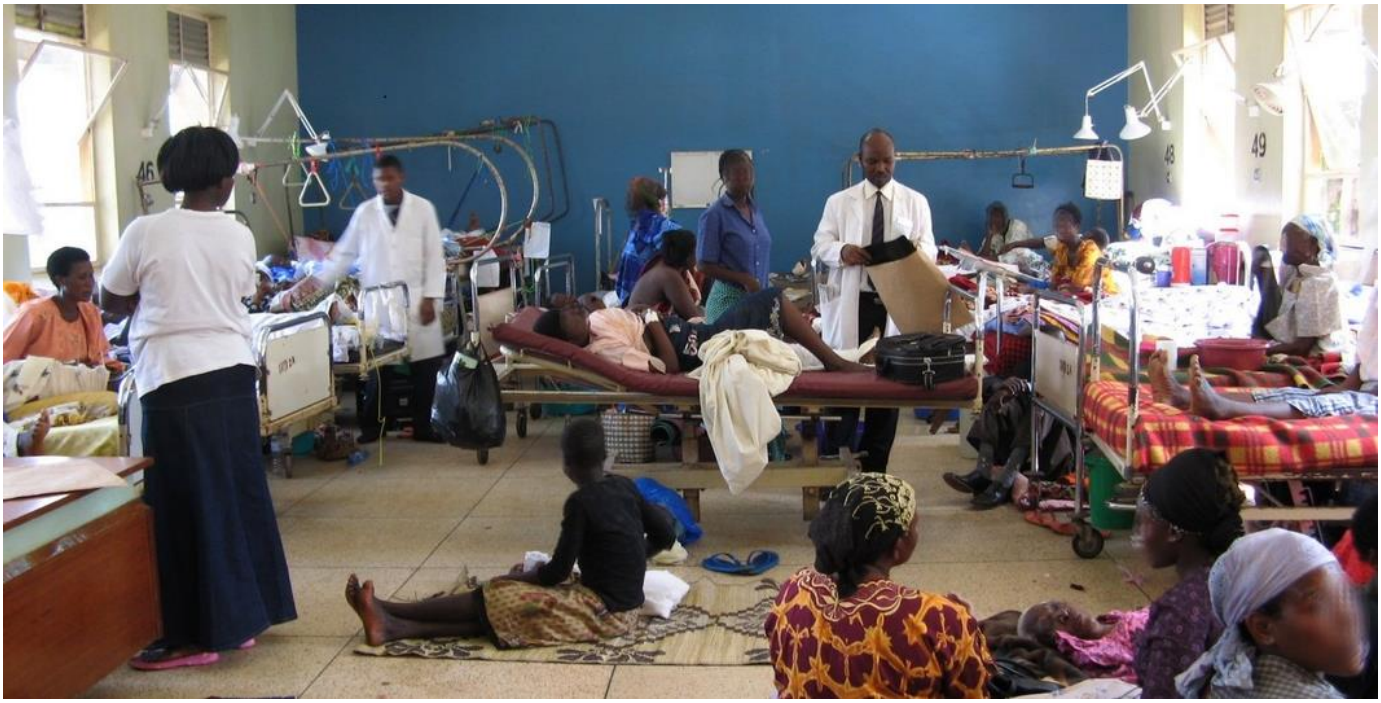
- Health education
- Promotion of good food and nutrition
- Provision of safe water and basic sanitation
- Maternal and child health
- Immunization against infectious diseases
- Treatment of common ailments and injuries
- Prevention and control of local endemic diseases
- Supply of essential drugs

PHC in Cameroon, as in most sub-Saharan African countries, is feeble. It is heavily characterized by limited public resources which, are not deployed to where they are most needed. Public health interventions, with the capacity to tackle the risk factors of most infectious and non-communicable diseases, are often neglected, even when they are cost-effective (WHO 2008). More so, care delivery in Cameroon is largely episodic and reactive to patient-initiated presentations. Over the last few decades, PHC has not sufficiently evolved to cope with the changes and demands of population health. Health authorities have demonstrated a poor track record in their ability to anticipate, prepare and adapt to these changes and demands, which have become an everyday reality. As well as their failure to adapt to and meet the needs of population health, health authorities have been largely incapable of influencing political developments and the allocation of resources towards health care; instead

allowing for the health sector to be labeled as an economic burden. Consequently, the weak state of PHC in Cameroon places a heavy burden on the nation's tertiary hospitals. Secondary care is also fragile and mostly provided by the primary sector;hence inverting the pyramidal distribution of patients such that the majority of patients receive care from the tertiary level.

The feeble state of PHC in Cameroon stems from several challenges it faces which limit its effectiveness. The first step towards strengthen PHC will be to understand the challenges or barriers it currently faces, since finding sustainable solutions to these challenges will unquestionably strengthen PHC. The major challenges are categorized and discussed below.

CHALLENGES TO PRIMARY HEALTH CARE IN CAMEROON



1) Health Expenditure and Access

Despite the poor performance of Cameroon's health indicators, overall the country spends more on health than most sub-Saharan countries (except South Africa). Health expenditure stands at approximately USD $61 per capita compared to the sub-Saharan average of USD $51 per capita (World Bank 2013). However, public spending in the health sector is still low despite the marginal increase in resources allocated to health over the last decade. Only 1.5% of the GDP is allocated to health, making it the lowest in Africa and far below the WHO recommendation of 10% (World Bank 2013). As a consequence of low public spending, the burden of health care costs is largely born by households. The seeming inexistence of risk-pooling mechanisms exacerbates the situation. In 2010, out of the USD $61 spent per Cameroonian on health just USD $17 was financed by the State, of which USD $8 of this USD $17 was provided by international donors. USD $44 was financed

by the population, making Cameroon a country with one of the highest levels of direct (out-of-pocket) payments from users, relative to total expenditure in sub-Saharan Africa (World Bank 2013). This more than corroborates the suggestion by WHO Commission on Macroeconomics and Health that most developing nations need to spend between USD $30-40 per person per year on health (Bryan et al. 2010)

Observations on access to, and uptake of, health services show a strong correlation between health statistics and revenue statistics. For example, the uptake of pre-natal health services is close to 100% for the richest quintile of the population while it is below 60% for the poorest (World Bank 2013). This implies that the richer you are, the higher the chances that you will benefit from delivery assisted by a qualified professional. Meanwhile, the poorest are most likely to be assisted by a traditional midwife or even a friend. Therefore, wealthy households and regions enjoy better access to health services than poorer households and regions.

2) Distribution of Health Workforce

Although Cameroon enjoys one the highest densities of nurses and doctors (1.9 doctors per 10,000 people) in sub-Saharan Africa, the distribution of this workforce across the country is skewed. The majority of doctors are based in urban areas with more than half employed in the Center, Littoral and West regions. A staggering 40% of doctors in the country practice in the Center region, which has 18% of the population, while only 8% of doctors practice in the Far North region which also has 18% of the country's population (World Bank 2013). The uneven distribution of the health workforce is further worsened by the massive migration of health professionals trained by the country to more developed countries where they can make a better living. This causes an acute shortage of doctors and nurses in most rural parts of the country, perpetuating the ineffectiveness of PHC.

3) Mind-set and Behaviour

Absenteeism of health staff especially in isolated rural areas is a major problem in Cameroon. According to the World Bank (2013), a study conducted in the Southwest region showed up to 32% of health centers were operating with a single staffer at each center.
In addition, there are few institutions for the training of health staff. As a result, the number of doctors and nurses produced by the nation is not sufficient to cope with the increasing population. There is also the problem of massive migration of trained health professionals either to urban areas or to other countries where they can make a better living. This migration is due to several factors such as: low salaries with delay in payments, lack of choice on initial postings,remote location of some health centers and the poor quality of most primary care facilities–lack of access to additional trainings. A consequence of having demoralized staff within PHC and, as the first point of contact, increases the tendency for them to be view as unmotivated, unaccountable and unskilled; inevitably leading to a loss of trust in the health care system. A poor perception of the healthcare system, in turn, causes a delay in seeking care on the part of the patient, or forces the patient to seek care from other alternatives at much higher costs (ie, private clinics).

4) Shortage of Health Surveillance Systems

The shortage of sophisticated health surveillance and disease monitoring systems in Cameroon is proving problematic. There is little standardization, collection, consolidation and analysis of health data, with very limited production of annual reports on health statistics on the part of the government. This heavily impacts the quantity and quality of health data that is collected –an important tool for research and decision-making. Assessing the effectiveness of health interventions and the performance of PHC relies on the monitoring and sharing of data. Furthermore, the availability of quality health data is crucial for the decision-making processes, with respect to health care spending. This absence of quality data means the government and international donors are forced to rely on ad-hoc and punctual surveys such as national household surveys or Demographic and Health Surveys (DHS); both prone to inaccuracy, to assess and measure the country's health outcomes (World Bank 2013). Closing the gaps and improving PHC requires better data, which will result in more effective planning and action within the health sector.

5) Health Care Is Not People-Centered

One of the founding fathers of modern medicine, William Osler, once said "it is much more important to know what sort of patient has a disease than what sort of disease a patient has." This statement highlights one of the major flaws with PHC in Cameroon – it is not people-centered. Cameroon has put less emphasis on making health services people-centered. Neglecting the needs and expectations of the people subsequently disconnects health services from the communities they are meant to serve (WHO 2008). The inadequate recognition of the human element in health, and the importance of tailoring health services to the specificity of each community or individual situation, represent major limitations in contemporary healthcare. The end results are not only inequity and poor social outcomes, but also reduction in health-outcome returns on the investment in health services (WHO 2008). In Cameroon, people-centered health services is a luxury and not a necessity.

6) Weak Management Practices

Weak management practices are increasing the fragility of PHC. The lack of information systems to support health care delivery hampers the effective functioning of PHC. Also, a lack of effective performance management tools means there is no accountability for underperformance by health professionals and workers. Weak managerial oversight and the lack of proper methods for tracking and managing inventory of medical supplies and drugs lead to poor procurement and distribution processes.
These challenges call for a reorganization of PHC such that it reflects the social values that are paramount for a strong and efficient PHC system. These social values and the reforms needed as prescribed by WHO (2008) include:

- Health equity, solidarity and social inclusion: Universal coverage reforms.

- People-centered care: Service delivery reforms.
- Communities where health is promoted and protected: Public policy reforms.
- Health authorities that can be relied on: Leadership reforms.

The reorganization needed is one that prescribes, clearly, that the quality of health care provided should ensure continuity by providing care from not only the beginning but to the end of the episode the patient is experiencing. The quality of health care must also ensure that the care provided should be comprehensive, focusing not only on treatment but also taking into consideration the physical, economic and social environment of the patient in order to tackle the determinants of ill-health, locally. A health service that provides entry-point ambulatory care for health-related problems should thus offer a comprehensive range of diagnostic, curative, rehabilitative and palliative services. Ultimately, the care delivered should be integrated by ensuring that curative, preventive and health promotional activities are carried out in the same place and time. This will also close the divide between preventive and curative medicine (World Bank 2013).

SOLUTIONS FOR IMPROVING CAMEROON'S PRIMARY HEALTH CARE SYSTEM

The problems plaguing PHC generally reinforce one another. Using the human resource problem as an example; low financing translates to low salaries and supply levels, which contributes to the low morale among staff that leads to low productivity and retention rates. Low productivity creates a poor perception of the health care system, causing patients to seek care from more expensive caregivers. This implies higher out-of-pocket fees, which negatively affects the income of the individual or family and, through other processes, can lead to more ill-health. This example reaffirms the need for holistic solutions for improving PHC.

In pursuance of an improvement of PHC, conventional services must be transformed and reorganized to ensure that they become easily and permanently accessible, provide effective and people-centered preventive and curative health care without excessive reliance on out-of-pocket payments, and provide social protection via universal coverage schemes. The solutions proposed should provide multiple benefits ranging from increased accessibility to health services, improved health staff productivity to more investment in PHC. These solutions are discussed in detail.

1) Improving Productivity and Morale of Health Staff

Human resources in health care are an indispensable input in the effective reformation and implementation of primary care reforms. Human resources, with respect to healthcare, are the personification of the values that define PHC. So far, a failure to provide a conducive environment for has driven either towards greater sub-specialization in tertiary care institutions or migration to larger cities and other countries (WHO 2008). Financial and performance-based incentives can be used to improve the productivity of the health workforce. In addition to increasing the base salary, performance-based bonuses can be paid to staff in an effort to motivate and enhance their performance.

Several measures could also be considered to solve the low staffing problem. These measures include: the creation of new kinds of workers that require shorter training, improving staff retention and increasing training capabilities. Health workers that require a shorter training period can be introduced into rural areas so as to supplement the ever shrinking numbers of health staff in these areas. This reduces the need for health workers that are willing to work in these rural areas.

Retention of health workers such as doctors and nurses in rural areas can be achieved by providing incentive packages and student grants which they could use to get further training, on the condition they return to serve in these rural areas. E-learning and active mentorship programs could also be introduced to improve ongoing training (Bryan et al. 2010). Furthermore, stronger commitment from local districts to improve and maintain the quality of healthcare facilities and services can play a role in increasing health worker retention rates.
In a bid to boost staff morale, hospitals can play a crucial role by expanding training programs, creating and delivering e-learning capabilities as well as developing new mentorship programs. They should also enhance their clinical leadership, performance-management and talent-management capacities, and form networks to establish more effective referral arrangements from primary care providers and among district, regional and tertiary hospitals (Bryan et al. 2010). These networks can deliver continuous medical education and increase collaboration among health facilities.

2) Improving Accessibility to Health Services

Increasing accessibility to care can be done by bringing care closer to people, especially in rural settings, and creating a direct relationship with these communities. Extending the reach of PHC and improving its performance will require the adoption of new delivery methods to improve access to care, a greater role for non-profit and private organizations in health service delivery, and introduction of performance-based incentives supported by the routine collection of operational data on the number of patients attended to and the conditions treated. Evidence shows that relocating the entry point into health systems from the specialized clinics, tertiary hospitals and emergency services to closer-to-client generalist primary care centers carries more measurable benefits in terms of relief from suffering, prevention of illness and even death, and an improved health equity (WHO 2008).

Relocating the entry point into the health system, so as to bring care closer to communities, can be accomplished by using the following innovative delivery models.

- Making use of community health care workers that can undertake health promotion activities within local communities and serve as liaisons to more highly-trained colleagues. If every village can have its own community healthcare worker, then the basics of healthcare delivery will be available to all. The presence of community health workers may help in changing the mindsets of the patients and their perception of the health system.
- Embracing mobile healthcare as a means of extending the reach of local dispensaries and health centers. Mobile health workers can regularly travel to distant unserved villages to provide medical supplies and communication tools to these communities.
- Introducing tele-health, via the creation of call centers staffed by nurses with oversight from doctors. These call centers will support both community and mobile health workers who can use mobile phones and other communication technologies to consult with the call center staff.

Expanding accessibility to health services can also be done by encouraging non-profit and private organizations to provide more primary care via dispensaries and health centers that are owner-operated or run through a social franchising model (Bryan et al. 2010).

3) Empowering Health Care Providers

Non-profit organizations and private entities that act as primary care providers can be empowered by giving them the responsibility for the health of a defined population in its entirety. Strengthening their role as coordinators of the inputs of care by giving them administrative and purchasing power will not only improve efficiency of the health services provided, but will make it easier to evaluate their performance and ensure accountability.

4) Improving Management Capabilities and Policies

The main responsibility of the Ministry of Health (MoH) and other public authorities is to make available the various building blocks needed to create a solid health system and set the mechanism required to meet the nation's health goals (WHO 2008). By opting for PHC, policies created by the MoH must be aligned with the reformation of primary care and universal coverage; implying there can be no half measures. Therefore, the MoH and district officials will need to improve their leadership capabilities and their ability to monitor the delivery and implementation of initiatives as well as guide the construction of the system.

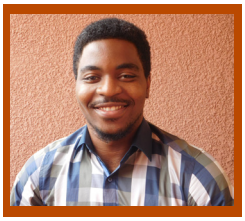
The power of information technology can be harnessed by using mobile phones; for example in the routine data collection of the demand for services, the deployment and productivity of staff, and the supply of drugs and equipment. Aggregating this data will provide better insight into the effectiveness of health interventions, the system's supply chain, spot emerging issues such as epidemics or reduction in number of staff, evaluating the performance of the health system as a whole and aid in the survey of health trends.

5) Increase Investment in Health Care

The WHO recommends that a country spend at least 10% of its GDP on healthcare However, less than 2% of Cameroon's GDP is spent on healthcare. This is a major reason for the underperformance of the current health system and the inability of the current PHC to cope with the increasing population and rising health issues the country is facing.

Increasing investment in healthcare will have positive effects on the long-term function of PHC and the health system, as a whole. These benefits include an improvement in the conditions of health facilities around the nation, an adequate supply of drugs and equipment, higher salaries for health staff which will discourage migration, a reduction in the cost of health care implying a decrease in out-of-pocket expenditure on health care, investment in modern medical technology and so much more.

PHC remains the only conventional health delivery service that can deal with the increasing and persistent health issues Cameroon is facing. Given the feeble nature of Cameroon's PHC system, strengthening PHC through the adoption of holistic solutions that tackle the everyday challenges it faces, remains the most assured option which guarantees an improvement in population health. Hence, an improvement on the current health statistics and population on health, as a whole, can only be guaranteed by a reformed and strengthened PHC. A healthy population is an indispensable platform required for Cameroon as it builds towards its 2035 vision for economic growth.



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