Strengthening human resources for health through multisectoral approaches and leadership: the case of Cameroon

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Problem Cameroon has a severe shortage of human resources for health (HRH) and those that are available are concentrated in urban areas.
Approach As the result of a national emergency plan for the years 2006–2008, innovative strategies and a multisectoral partnership – led by the Ministry of Public Health and supported by diverse national and international organizations – were developed to address the shortages and maldistribution of HRH in Cameroon.
Local setting At the time that the emergency plan was developed, Cameroon had health services of poor quality, an imbalance between HRH training and employment, a maldistribution of HRH between urban and rural areas and a poor allocation of financial resources for HRH. It also lacked an accreditation system for use in the training of health workers.
Relevant changes Between 2007 and 2009, the number of active health workers in Cameroon increased by 36%, several new institutions for higher education in health care and training schools for paramedical staff and midwives were opened, and a national strategy for universal health coverage was developed.
Lessons learnt In the improvement of HRH, strong leadership is needed to ensure effective coordination and communication between the many different stakeholders. A national process of coordination and facilitation can produce a consensus-based view of the main HRH challenges. Once these challenges have been identified, the stakeholders can plan appropriate interventions that are coordinated, evidence-based and coherent.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Background

Although Cameroon has an acute shortage of human resources for health (HRH), it lacks the economic resources to support the mass recruitment of new health workers. Only 27% of the individuals who completed their training at nursing schools in Cameroon between 1990 and 2009 were recruited by the Ministry of Public Service.[1] The training in health care that does take place in Cameroon is also seldom matched with employment needs. In 2011, for example, severe staff shortages in the fields of mental health, ophthalmology and anaesthesia–resuscitation were known to exist, but almost all health science students at training schools in Cameroon were intending to work as nursing aids, state registered nurses or laboratory technicians in other fields of medicine. Approximately 66% of the health workers in Cameroon are employed in the public sector but more heath workers are needed in both the public and the private sectors (Table 1).[2]

Context

Much of the current HRH crisis in Cameroon can be attributed to low government spending on health – a mere 4.6% and 5.1% of the gross domestic product in 2000 and 2012, respectively[3] – and a lack of effective coordination between the key stakeholders. Poor coordination has led to the duplication of interventions, the use of conflicting procedures and a general waste of resources.

Substantial increases in the Cameroonian health budget are not likely to occur in the near future. The main strategy for reducing HRH problems in Cameroon is therefore to capitalize on the existing potential – primarily by improving the coordination and effectiveness of the key stakeholders' current efforts to improve the health system.

In response to the HRH crisis, the Cameroonian government developed an HRH emergency plan for the years 2006 to 2008. Implementation of this plan led to the recruitment of 5400 health workers, the opening of new training schools for health workers, the revision of the training curricula for paramedical staff, and a simplification of the process that contract or temporary workers need to follow to become permanent employees in the public sector. Between 2007 and 2010, Cameroonian HRH received increased financial support from external sponsors. Over this period, the International Monetary Fund and the World Bank – via the Heavily Indebted Poor Country initiative – and the French government – via the *Contrat de Désendettement et de Développement* – together contributed about 7359 million African Financial Community (CFA) francs towards the salaries of health workers in Cameroon.

The HRH emergency plan for 2006–2008 did not solve the maldistribution of HRH in Cameroon, where health care is concentrated in urban areas; the low allocation of financial resources for HRH, or the absence of an accreditation system for HRH training. External resources were therefore mobilized to develop new approaches to address these challenges. The mobilization process started in 2007, with a 2-day conference on HRH organized by the Global Health Workforce Alliance. This conference resulted in the Douala Plan of Action.[4] In 2010 – with financial support from the World Health Organization (WHO), the Global Health Workforce Alliance, the French Development Agency and the European Union – Cameroon's Ministry of Public Health formally adopted and implemented a "country coordination and facilitation" process. The aims were to clarify the main challenges to effective HRH in Cameroon and to subsequently create an integrated, participatory and comprehensive HRH-development strategy – for the years 2011–2015 – that would address these challenges.

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Table 1. **Supply and shortfall of human resources for health in Cameroon, 2011**

Sector	No. of individuals[a]		
	Needed	Registered	Shortfall
Public			
Health-care providers	36 728	17 334	19 394
Other workers[b]	12 388	7 849	3 894
Total	49 116	25 183	23 933
Private			
All workers	16 743	13 024	23 933
Entire health sector	65 859	38 207	27 652

[a] Estimates from an external evaluation (S Kingue and F Nissack, unpublished data, 2012).
[b] Health sector workers not involved directly in health care. This includes, for example, managers, statisticians and analysts.

The country coordination and facilitation process for HRH development was a catalytic force that ensured the mobilization and coordination of the key stakeholders. The stakeholders became jointly responsible for reviewing national HRH problems, setting strategic priorities and developing a national, strategic HRH plan. As part of the process undertaken to address the problem of HRH maldistribution, financial resources were mobilized, the extent of the maldistribution was evaluated and a retention policy for health workers was developed.[5] The main aim of the retention policy was to ensure the presence of health workers in rural areas of Cameroon that are difficult to access.[6]

To address the problem of poor stakeholder coordination, a meeting with over 200 participants was convened.[7] This meeting led to several recommendations, including the development of a multisectoral coordinating committee and a multisectoral technical working group for HRH in Cameroon. In 2010, these recommendations led the Cameroonian Ministry of Public Health to mobilize a national coordinating committee composed of representatives of all the key stakeholders. This committee currently acts as the umbrella organization for developing HRH, raising awareness of issues surrounding HRH and high-level HRH advocacy. It also manages an HRH technical working group, an HRH national observatory and a multidisciplinary HRH research group.[8] The members of the committee include 11 ministerial administrators and representatives of development partners ($n = 2$), the private sector ($n = 1$), decentralized local and regional authorities ($n = 1$), civil society organizations ($n = 1$), chambers of commerce ($n = 1$), professional associations ($n = 4$), trade unions ($n = 2$), medical and nursing schools ($n = 2$) and patient associations ($n = 1$), plus other experts on an as-needed basis. The committee meets twice a year routinely and ad hoc at other times. Before the country coordination and facilitation strategy was implemented, the committee responsible for HRH in Cameroon met relatively rarely and only on an as-needed basis.

The HRH technical working group in Cameroon is responsible for the development of HRH policies and strategic plans and the subsequent monitoring of their implementation. It meets four times per year to respond to the central HRH issues. Meetings of both the coordinating committee and the technical working group follow established agendas and focus on specific needs. For example, the committee's agenda includes creating synergy among the various ministries involved in health sector improvement; ensuring coherence among health sector activities, resources and actors; coordinating and informing the key HRH stakeholders; and seeking sustainable funding solutions with interested partners. The agenda of the technical working group includes creating synergy among the different activities aimed at health sector improvement by ensuring coherence in activities, resources and operators; harmonizing the various health sector interventions; coordinating and informing the actors responsible for implementing the interventions; following up on Cameroon's commitments to developing its health sector; encouraging multisectoral participation; ensuring coherence in the implementation of health sector strategies and other strategies, such as those to stimulate growth and employment; finding sustainable solutions to the problem of health financing in dialogue with all interested partners; following up the key indicators of the evolution of the health system; and coordinating and supervising health sector reviews.

Results

Since 2006, strong leadership has facilitated the process of moving to an evidence-based approach to HRH development in Cameroon. It has encouraged collaboration between the ministries involved in the Cameroonian health sector, fostered relevant discussion and dialogue, increased trust between the various stakeholders, and promoted a consensus view and approach. The nongovernmental organizations and national societies involved in health care in Cameroon have been able to expand their role, increase their visibility and improve their credibility with the national government and other stakeholders. Even health workers in remote areas have been able to contribute to the HRH planning process.

Implementation of the HRH emergency plan resulted in the recruitment of 6417 additional health workers in Cameroon between 2007 and 2009. Such recruitment increased the number of active health workers in the country from 11 528 in 2005 to 15 720 in 2009 – a 36% increase.[9] Over the same period the number of Cameroonian institutions for higher education in health sciences was increased from five to seven in a further attempt to address the shortfall in health workers in general and of specialist physicians and midwives in particular. Training at degree level has been expanded to cover an additional 14 medical specialties, bringing the total to 26, with the aim of more than doubling the number of specialist physicians active in Cameroon – to 130 – by 2014. The number of training schools for paramedical staff in Cameroon increased by 54% between 2007 and 2013 with the creation of 37 new schools, including 10 for the training of midwives. Over the same period, the number of paramedical workers active in Cameroon increased from 4000 to about 9000. The aim is to have 81 training schools for paramedical staff and at least 250 midwives trained per year by 2014.

Payment to health workers increased considerably too. Between 2007 and 2010, the monthly gross salaries of government-recruited assistant nurses, nurses and physicians had risen by a mean of 8.75% – to 102 540, 147 352 and 217 578 CFA francs, respectively.[1]

As a result of the implementation of the country coordination and facilitation

process, all HRH stakeholders are now involved in all strategic planning that relates to the national health system. The Cameroonian government is currently developing a strategy for universal health coverage that will include the development or expansion of social insurance for public sector workers and their families, private health insurance schemes and community-based health insurance schemes. The aim is to have at least 40% of the population of Cameroon covered by health insurance by 2015.[5]

An external evaluation of the country coordination and facilitation process was conducted in 2012 with funding from the European Union. The data collected in this evaluation indicated that the process had been successfully implemented in Cameroon. This success was largely attributed to precise methods that permitted – and still permit – stakeholders to be identified and then engaged on the basis of their specific interests and their potential contributions to solving the HRH crisis.[10] Several lessons can be learnt from the results of the external evaluation (Box 1). Investing in the country coordination and facilitation process and applying it appear to be cost-effective and sustainable ways to build stakeholder consensus on the actions needed to address HRH challenges. A return on investment can be demonstrated. Policies and legal frameworks to promote the retention of health workers and, in particular, to develop and scale up effective strategies for the retention of health workers in rural areas should help developing countries such as Cameroon to achieve universal health coverage and the health-related Millennium Development Goals by 2015. The education of potential health workers should follow competency-based curricula that are responsive to – and respectful of – population needs. ■

Box 1. **Summary of main lessons learnt**

- In the improvement of human resources for health, strong leadership is needed to ensure effective coordination and communication between the many different stakeholders.
- A national process of coordination and facilitation can produce a consensus-based view of the main challenges involved in the area of human resources for health.
- Once the main challenges have been identified, the stakeholders can plan appropriate interventions that are coordinated, evidence-based and coherent.

Competing interests: None declared.

ملخص

تعزيز الموارد البشرية الصحية من خلال القيادة والأساليب متعددة القطاعات: حالة الكاميرون

المشكلة تعاني الكاميرون من نقص حاد في الموارد البشرية الصحية وتتركز الموارد البشرية الصحية المتاحة في المناطق الحضرية.

الأسلوب نتيجة لخطة طوارئ وطنية للسنوات من 2006 إلى 2008، تم وضع استراتيجيات مبتكرة وشراكة متعددة القطاعات – بقيادة وزارة الصحة العمومية وبدعم من منظمات وطنية ودولية عديدة – للتعامل مع أوجه النقص وسوء التوزيع في الموارد البشرية الصحية في الكاميرون.

المواقع المحلية في الوقت الذي وضعت فيه خطة الطوارئ، كانت الخدمات الصحية في الكاميرون تعاني من سوء الجودة وعدم التوازن بين تدريب الموارد البشرية الصحية والتوظيف، وسوء توزيع الموارد البشرية الصحية بين المناطق الحضرية والريفية، وسوء تخصيص الموارد المالية للموارد البشرية الصحية. كما افتقرت كذلك إلى نظام اعتماد لاستخدامه في تدريب العاملين الصحيين.

التغيّرات ذات الصلة ازداد عدد العاملين الصحيين الفعالين في الكاميرون في الفترة من 2007 إلى 2009 بنسبة 36 ٪، وتم افتتاح عدة مؤسسات جديدة للتعليم العالي في مجال الرعاية الصحية ومدارس تدريب للمساعدين الطبيين والقابلات، وتم وضع استراتيجية وطنية من أجل التغطية الصحية الشاملة.

الدروس المستفادة ثمة حاجة إلى قيادة قوية في تحسين الموارد البشرية الصحية لضمان فعالية التنسيق والاتصال بين العديد من أصحاب المصلحة المختلفين. ومن الممكن أن تسفر عملية للتنسيق والتيسير على الصعيد الوطني عن رؤية تستند على توافق في الآراء حول تحديات الموارد البشرية الصحية الرئيسية. وبمجرد تحديد هذه التحديات، يستطيع أصحاب المصلحة تخطيط تدخلات ملائمة ومنسقة ومستندة على بيّنات ومتسقة.

摘要

通过多部门方法和领导强化卫生人力资源：喀麦隆的案例

问题 喀麦隆严重缺乏卫生人力资源（HRH）并且可用的资源都集中在城市地区。

方法 随着 2006－2008 年国家应急计划的推出，喀麦隆制定了创新战略和发展了多部门合作关系（由卫生部领导并得到不同国家和国际组织的支持）以解决该国 HRH 短缺和分配不合理的问题。

当地状况 在制定应急计划时，喀麦隆存在卫生服务质量差、HRH 培训和就业不均衡、城乡地区 HRH 分配不合理以及 HRH 财政资源配置不到位等问题。此外，它还缺乏供卫生工作者培训中采用的认可体系。

相关变化 在 2007 至 2009 年间，喀麦隆在岗卫生工作者数量增加 36%，新开办了数家卫生保健高等教育机构和辅助医疗人员和助产士培训学校，并制定了全民医保的国家战略。

经验教训 在 HRH 改进过程中，需要强有力的领导以确保多个不同利益相关者之间的有效协作和沟通。国家协调和推动进程可形成对主要 HRH 挑战的共识。在确认了这些挑战之后，利益相关者就可以规划出协调一致、基于证据并且连贯的适当干预措施。

Résumé

Renforcer les ressources humaines pour la santé à travers un leadership et des approches multisectorielles: le cas du Cameroun

Problème Le Cameroun souffre d'une grave pénurie de ressources humaines pour la santé (RHS) et le peu de personnel disponible se concentre dans les zones urbaines.

Approche Suite à un plan d'urgence national pour la période 2006–2008,

des stratégies novatrices et un partenariat multisectoriel – dirigé par le ministre de la Santé publique et soutenu par diverses organisations nationales et internationales – ont été développés pour faire face à la pénurie et à la mauvaise répartition des RHS au Cameroun.

Environnement local À l'époque où le plan d'urgence a été développé, le Cameroun souffrait de services de santé de mauvaise qualité, d'un déséquilibre entre la formation et l'emploi des RHS, d'une mauvaise répartition des RHS entre les zones urbaines et rurales et d'une affectation inadéquate des ressources financières des RHS. On manquait également d'un système d'homologation pouvant être utilisé dans la formation des agents de santé.

Changements significatifs Entre 2007 et 2009, le nombre d'agents de santé actifs au Cameroun a augmenté de 36%, plusieurs instituts supérieurs de formation en soins de santé et écoles de formation paramédicale et de sages-femmes ont vu le jour et une nouvelle stratégie a été développée pour la couverture sanitaire universelle.

Leçons tirées Dans l'amélioration des RSH, un leadership fort est nécessaire pour assurer une coordination et une communication efficaces entre les nombreux acteurs en place. Un processus national de coordination et de facilitation peut produire une approche consensuelle des principaux défis des RHS. Une fois ces défis identifiés, les acteurs clés peuvent planifier des interventions appropriées, coordonnées, cohérentes et fondées sur les faits.

Резюме

Укрепление кадровых ресурсов здравоохранения посредством многосекторальных подходов и руководства: на примере Камеруна

Проблема В Камеруне отмечается острая нехватка кадровых ресурсов здравоохранения (КРЗ), а существующие ресурсы в основном сосредоточены в городских районах.

Подход В результате принятия национального плана по борьбе с чрезвычайными ситуациями на 2006-2008 годы были разработаны новаторские стратегии и установлено межсекторальное партнерство под руководством министерства здравоохранения и при поддержке различных национальных и международных организаций с целью решения проблем нехватки и неравномерного распределения КРЗ в Камеруне.

Местные условия Когда разрабатывался данный план по борьбе с чрезвычайными ситуациями, качество услуг здравоохранения в Камеруне было низким, отмечался дисбаланс между профессиональной подготовкой и занятостью КРЗ, неравномерное распределение КРЗ между городскими и сельскими районами и плохое распределение финансовых ресурсов для КРЗ. Также отсутствовала система аккредитации в области профессиональной подготовки работников здравоохранения.

Осуществленные перемены С 2007 по 2009 год количество активных медицинских работников в Камеруне возросло на 36%, было открыто несколько новых институтов для получения высшего образования в сфере здравоохранения и учебных заведений для младшего медицинского персонала и акушерок, разработана национальная стратегия всеобщего охвата медико-санитарной помощью.

Выводы Для улучшения ситуации в КРЗ необходимо сильное руководство, способное обеспечить эффективную координацию и связь между множеством различных заинтересованных сторон. Национальный процесс координации и содействия может привести к консенсусу при решении основных проблем в области КРЗ. После выявления основных проблем заинтересованные стороны могут спланировать соответствующие мероприятия, которые будут являться скоординированными, научно обоснованными и последовательными.

Resumen

Reforzar los recursos humanos para la salud a través de enfoques multisectoriales y liderazgo: el caso de Camerún

Situación Camerún padece una escasez grave de recursos humanos para la salud (RHS) y los recursos disponibles se concentran en las zonas urbanas.

Enfoque Como resultado de un plan de emergencia nacional para los años 2006–2008, se desarrollaron estrategias novedosas y una asociación multisectorial, dirigida por el Ministerio de sanidad pública y respaldada por diversas organizaciones nacionales e internacionales a fin de hacer frente a la escasez y la mala distribución de los RHS en Camerún.

Marco regional La situación de Camerún cuando se desarrolló el plan de emergencia era la siguiente: servicios sanitarios de muy poca calidad, desequilibrio entre la formación y el empleo de los RHS, mala distribución de los RHS entre las zonas urbanas y rurales y una asignación irregular de los recursos financieros para los RHS. También carecía de un sistema de acreditación en la formación de personal sanitario.

Cambios importantes Entre 2007 y 2009, el número de trabajadores sanitarios activos en Camerún aumentó un 36%, se inauguraron numerosos centros de formación superior en el ámbito de la salud y de formación de personal paramédico y matronas y se desarrolló una estrategia nacional para una cobertura sanitaria universal.

Lecciones aprendidas Para conseguir mejorar los RHS es necesario un liderazgo fuerte que garantice una coordinación y comunicación eficaces entre las distintas partes interesadas. Un proceso de coordinación y asesoramiento nacional puede dar lugar a una visión de los principales desafíos de los RHS basada en el consenso. Una vez que se han identificado dichos desafíos, las partes interesadas pueden planificar intervenciones adecuadas, coordinadas, coherentes y basadas en las pruebas científicas.

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