An Appraisal on the Evolution of Medicine in Cameroon

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Abstract.

The study is carried out to determine the evolution of medicine in Cameroon from pre-colonial till date. The specific aim of the study is to determine the extent to which the Cameroonian legislation has evolved within this period in the domain of medicine and health; It equally identifies the laws put in place by the Cameroonian legislature concerning the code of ethics medicine and provide recommendations: The study adopted a quantitative and qualitative method to arrive at our conclusion. The rights of patients have not been neglected equally in the International code of Ethics. This is because the dignity of the human person is at the center of the battle for Human Rights protection. In this configuration, medical practice is no stranger to this pursuit given that some standards must be observed by medical personnel in carrying out their duties. In fact, medical practice has attained a sufficient statute to the extent that principles of law are now relevant to it, notably with issues like dignity of the human person, regulation of medical profession, confidentiality of information between medical practitioners and the patient and consent. The study discovered that medicine has evolved and to an extent the Cameroonian legislature has to keep pace with the evolution of medicine.

Keywords: diseases; ethics; health; legislation; patient

1. INTRODUCTION

The dynamics of conventional medicine can be traced to the fifth and sixth century B.C when the father of modern medicine, Hippocrates, recognized the need for a code of conduct for medical practitioners in the art of healing.[1] Despite attempts at updating the Hippocratic Oath through the centuries, it is still substantially patient-oriented as it is entirely dedicated to the welfare of the sick-the patient. This is so notwithstanding the modifications the code has gone through with a view to aligning it with the practice and language of modern medicine. This exercise was carried out in 1948 by the General Assembly of the World Medical Association. In this endeavour, the original oath was replaced with the Geneva Declaration to read as follows:

> At the time of being admitted as a member of the medical profession, I solemnly pledge myself to consecrate my life to the service of humanity; I will give to my teachers the respect of gratitude that is their due: I will practise my profession with conscience and dignity; the health of my patient will be my consideration; I will respect the secret which are confided in me, even after the patient has died; I will maintain by all the means in my power, the honour and the noble traditions of the medical profession; my colleagues will be my sisters and brothers; I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity. I make these promises solemnly, freely and upon my honour.[2]

[1] *"I swear by Appolo Physician, by Aesculapius, Hygiea and Panacea and I take witness all the gods, all the goddesses to keep according to my ability and judgement the following oath. To consider dear to me as my parents who taught me this art; to live in common with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art if they desire to learn it - without fee and covenant - to give a share of precepts and oral instruction and all other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law but to no one else. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy. In purity and holiness, I will guard my life and my art. I will not use a knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work. Whatever house I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice of all mischief and in particular of sexual relation with both female and male persons, be they free or slaves. What I may see or hear at the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things harmful to be spoken about. If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot."*

[2] Umerah, B C., *Medical Practice and the Law in Nigeria*, Longman Nigeria Limited, 1989, p.9.

The Hippocratic Oath as retaken by the Geneva Declaration has gone one step further as it hinges on the commitment of the medical doctor to maintain the "noble profession of the medical tradition". Not only does it address the attitude of the medical doctor vis-à-vis the patient, but also the respect of dignity of the profession - medical ethics - and colleagues are emphasized. Also, the standard of treatment contained in the package of "noble profession of the medical tradition" as prescribed by the respectable body of medical opinion and which the medical doctor must comply with is ascertained. Failure to comply with the said standards will amount to working below the expected standard. Furthermore, in one of the provisions of the physicians' oath, the doctor pledges that "the health of my patient will be my first consideration". This phrase suggests that a reasonable doctor should always evaluate his or her conduct vis-à-vis the patient during the period of administering treatment.

Similarly, the medical doctor equally pledges to maintain utmost respect for human life from the time of conception, for even under threat, he/she will not use his/her medical knowledge against the laws of humanity. This is illustrative of the fact that the medical doctor owes a duty of care not only to the physical person but also to the unborn child called the foetus. The Hippocratic Oath is thus the fundamental source of law governing the liability of health professionals for medical negligence. The oath is a covenant that is recited by medical doctors before they start the practice of medicine. It equally establishes principles and standards that must be complied with by the health provider failing which they may be adjudged guilty of medical malpractice.

Despite the Geneva Declaration on the International Code of Ethics, other Declarations such as the Helsinki Declaration of 1964 came to redress some of the atrocities and beastly acts which were perpetrated during the Second World War at Nuremberg in Nazi Germany concerning medical research camps. The declaration provides the basic principles in clinical research; with clinical research combined with professional care and non-therapeutic clinical research.[3] Equally, the Oslo Declaration of 1970 on therapeutic abortion combined with the Tokyo Declaration of 1975 provides a guide to practitioners in their attitudes to torture and inhuman treatment. These therefore present some honest attempts made over the years by the medical profession to enthrone a moral code in the art of healing thus addressing issues related to the responsibility of medical doctors.

1.1 EVOLUTION OF MEDICINE IN CAMEROON

i) Pre-colonial and Colonial periods

Before Cameroon became a German protectorate, a number of tribes occupied the territorial space known as Cameroon today. The practice of medicine was non-conventional. In fact, this is generally referred to as traditional medicine as it is practised today but which has evolved tremendously. If someone fell sick, the first thing he or she did was to try to heal his or her self through the use of concoction from herbs and backs of trees that could be found in the surrounding area of the places where they lived. Then, if they could not cure themselves, they would first turn to a traditional healer nearby. They visited the house of the healer, bringing with them offerings in kind. Since ancient times, our human ancestors have tried to maintain their health through proper

[3] *Ibid*, p. 9.

diet and the use of herbal remedies aimed at maintaining the balance of "hot" and "cold" states of the body. At the same time they also tried to look for effective ways to cure sickness, to find and use the right medicines to treat those who were suffering from diseases.[4]

Traditional medicine is a holistic discipline involving indigenous herbalist and African spirituality, typically involving diviners, midwives, and herbalist.[5] Practitioners of traditional medicine in Cameroon during this era claimed to be able to cure various and diverse conditions such as cancers, psychiatric disorders, high blood pressure, cholera, most venereal diseases, epilepsy, asthma, eczema, fever, anxiety, depression, urinary tract infections, gout, and healing of wounds and burns.

Disease was perceived to have both natural and supernatural underpinnings. Ailments that were not serious like minor headache and cough were seen to have originated from natural etiological causes. However, more serious ailments were believed to have supernatural etiological causes. That is, they emanated from sorcery, witchcraft or ancestral spirits. One of the steps taken to resolve this was to consult a diviner for spiritual diagnosis. As such there was a general belief that illness or diseases have aetiological causes which require the services of a diviner who must mediate between the patient and the supernatural forces to explain the cause of the disease and the required remedy. People used divination in management of disease and once a person fell sick, the patient, relations or friends consulted oracles for supernatural diagnosis and etiology of the problem. Diagnosis was reached through spiritual means and a treatment was prescribed, usually consisting of herbal remedy that was considered to have not only healing abilities but also symbolic and spiritual significance.[6]

Before the establishment of science-based medicine, traditional medicine was the dominant medical system for the local people in Cameroon but the arrival of the Europeans was a noticeable turning point in the history of this ancient tradition and culture. Herbal medicine was generally not adequately researched, and was weakly regulated. There was a lack of the detailed documentation of the traditional knowledge, which was generally transferred orally. Serious adverse effect resulted from misidentification or misuse of healing plants.[7]

After the Berlin Conference in 1884, Germany declared Cameroon a German protectorate and this lasted until the World War I. Under the German colonial health system (1884-1916), traditional medicine was "weakened" and became informal due to stigmatization, discouragement, and repression by colonial and religious masters, even though their western health care system was only made of urban health structures with access initially limited to the latter. Traditional diviner-healers were outlawed because they were considered by the colonial master to be practitioners of witchcraft and magic, and declared illegal by the colonial authorities, creating a war against aspects

[4] Wayan Ariati, P., "*The Role of Traditional Healers and Traditional Medicine in Bali*", Abroad paper for the SIT Academic Director's Symposium, 2010, p. 2.

[5] Helwig, D., *"Traditional African medicine"* , Gale Encyclopedia of Alternative Medicine, 2005. Retrieved on the 24 April 2016.

[6] Abdullahi, A. A., *"Trend and Challenges of Traditional medicine in Africa"* African Journal of Traditional, Complementary and Alternative Medicines, 2011. p. 8. [7] *Ibid.* p. 8.

of the indigenous culture that were seen as witchcraft. During this time, attempts were also made to control the sale of herbal medicines. During this period, the environment was perceived as particularly hostile to the colonial masters due to high prevalence of tropical diseases, like malaria, sleeping sickness, which were common in the Gulf of Guinea and were a threat to the colonial masters to the extent that it was known as the " the grave of the white man".[7] Little was done to investigate the legitimacy of these practices, as many foreigners believed that the native medical practices were pagan and superstitious and could only be suitably fixed by inheriting Western methods. The indigenous populations was equally devastated by intestinal worms, leprosy, meningitis, and lungs infections to the point that the Germans believed that the local population will be eradicated in a hundred years' time.[8] As colonialism and Christianity spread through Cameroon, colonialists built general hospitals and Christian missionaries built private ones, with the hope of making headway against widespread diseases. During times of conflict, opposition was particularly vehement as people were more likely to call on the supernatural realm. Consequently, medical doctors and health practitioners have, in most cases, continued to shun traditional practitioners despite their contribution to meeting the basic health needs of the population. Science has, in the past, considered methods of traditional knowledge as primitive and backward.

Under the British administration, the Southern Cameroons generally referred to as "British Cameroon" was attached to Nigeria while the French Cameroon was administered by France from the country's capital, Yaoundé. Nigeria and Cameroon were made of tribes and kingdoms, with an either weak or strong feudal organization with growing economies relying more on agriculture and trade, and the surplus of food production was redistributed to nonproducers, including traditional healers. These traditional healers were already organized in such specialties as midwives, medicine men, diviners, magicians, transmitting knowledge in an initiating mode, without any record. Because there were few medical doctors at that time, traditional practitioners thus dominated in the practice of medicine.

I.I.I. COLONIAL HEALTH SYSTEM IN ''BRITISH AND FRENCH CAMEROONS''

After World War I, the League of Nations gave the British charged over the Cameroons under Article II of the Mandate Commission Act for the British to take:

> *The Responsibility for the peace, order and the good governance of the territory, and for promotion to the utmost, of the material and moral wellbeing and social progress of the inhabitants [...].*[9]

[7] Mveng, E., *Histoire de Cameroun* Paris: Présence Africaine, 1969. p.317. The expression was used by Lord Kimberly.
[8] *Ibid*. p. 317.
[9] Kale, P. M., *Political Evolution in the Cameroons* Buea: West Cameroon, Government Press, 1968, p. 8.

But when the British took over the territory, they passed over this responsibility to the Native Authorities to sponsor the training, to supply the services of Sanitary Inspectors, and to buy the equipment while the Government acted as a guide and adviser.[10]

The health situation in British Southern Cameroons was characterized by outbreaks of epidemics especially between 1916 and 1945. The most prevalent epidemics were small-pox, yaws, influenza, dysentery and chicken-pox with malaria being a common phenomenon. The head of the Medical Administration in Southern Cameroons was the Director of Medical and Sanitary Services who was resident at Enugu. Afterwards, the services were separated and two directors were appointed: the Director of Medical Services and the Director of Sanitary Services. These directors issued medical and health regulations and instructions to the resident in Buea who passed them to the divisional doctor. Both missionary doctors and the medical staff of native Authority were subjected to the government doctors of their divisions.

The indigenous population was responsible for the provision of health facilities and resources while the colonial administration acted as a guide and adviser. In British Southern Cameroons, the provision of health services was born by plantation owners in their population, by the Roman Catholic mission, the Basel Mission, the German-American Baptist mission and the Colonial Administration. In 1916, the British Colonial administration established hospitals in each of the four divisions in Southern Cameroons. Each division had a medical officer[11] i.e. Victoria, Bamenda, Buea, Mamfe and eventually Kumba division which had a medical doctor in 1925.[12]

British Cameroons lacked adequately qualified medical personnel. In 1938, after two years of British administration, Southern Cameroons had only six medical doctors (no indigenous medical doctor), one nursing sister, one sanitary superintendent, 25 male nurses, 6 female nurses, 6 dispensers, 5 sanitary inspectors (vaccinators), 23 other male Native Authority staff, and 3 other female Native Authority staff.[13] This meant that there were about 95 051 people per doctor in Southern Cameroons in 1938[14].

The Medical Department of Southern Cameroons was therefore short of medical personnel. The lack of government scholarships to deserving Southern Cameroonian students to pursue secondary education, the inability of qualified students to get scholarship elsewhere and the fact that most parents could not afford the high fees, made it difficult, if not impossible, for Southern

[10] Prosser, G., *Indirect Rule: Touchstone or Tombstone for Colonial Policy?* in Prosser, G. and Roger Loius, W. M., (eds), *Britain and Germany in Africa: Imperial Rivalry and Colonial Rule* (New Haven and London: Yale University Press, 1987), p.35.
[11] Ngoh, V. J., *Cameroon 1884-1985, A Hundred Years of History*, CEPER, Yaounde, 1990. p.173.
[12] *Ibid.* p. 173.
[13] Forkusam, A. L., "*The Evolution of Health Services in the Southern Cameroons under British Administration, 1915-1945*", DESS thesis, University of Yaounde, 1978, p. 48.
[14] *Ibid*, p. 48.

Cameroonians to be trained as medical doctors.[15] In 1938, the Director of Medical Services suggested that Native Authorities should train their own Medical Doctors in Nigeria at a reduced fee but the Native Authorities in Southern Cameroons found the fees too high. But nevertheless some few Cameroonian doctors finally underwent the training.

In 1924, the British Resident in Southern Cameroons, William Arnet, who was the British colonial administrator, introduced a payment of fees in government hospitals. According to Arnet and his supporters, the amount to be paid (1 to 3 Pence per day) by the patients was less than one tenth of the salary that Europeans budgeted for medical treatment. In addition, the proponents argued that the fees would drive away those who went to the hospitals to drink medicines whether they were not sick. Finally, the Arnet Group said that the payment of fees will reduce the number of patients and enable the doctors to concentrate on actual patients.[17] These reasons, notwithstanding, the decision was criticized by the Director of Medical and Sanitary Services as well as by the indigenous population and some doctors in the divisions.[16]

Many patients either refused going to hospitals or those in the Victoria Division went to Douala for treatment. Although the proposed Arnet fees was eventually abolished, it was later on decided that fees should be paid in government hospitals. In 1927, the Government, after supervising the situation instituted a Labour Ordinance. In order to concretise the Labour Ordinance of 1927, the Government passed a Labour Health Act in 1929. This document defined Government expectations in the provision of camp sanitation.

As from the 1930s the British colonial administration began withdrawing her financial and material aid from the medical services of the Native Authorities. The institution of hospital fees notwithstanding, government hospitals found it more and more difficult to meet with their increased cost. In 1941, despite objections from the medical doctors in Southern Cameroons, hospital fees were increased.[17] In addition to the increase in hospital fees, school pupils were no longer given free treatment except for diseases such as yaws, scabies, ring worms, syphilis and eye-trouble. Also, drugs were no longer given for use at home except in serious cases. The servants of African Civil Servants were no longer given free medical treatment, and free feeding in the hospitals was reserved solely for paupers.[18]

According to Ityavyar,[19] the British colonial administration, helped by the religious organizations, developed a comprehensive health system that was initially concentrated in urban and coastal areas, and later on extended to the inner country due to the health workforce development through

[15] Dr. Emmanuel L. Endeley was the first Southern Cameroonian Medical Doctor [17]
NAB, Sca/1928/3, Hospital fees: General correspondence 1928.
[16] Ngoh, V. J., *op cit.* p, 174.
[17] Ngoh, V. J., *op cit.* p, 174.
[18] *Ibid*, p. 176.
[19] Ityavyar, D. A., "*Background to the Development of Health Services in Nigeria"*, Social Science and Medicine, Vol 24(6), Elsevir Ltd, 1989 p, 487-499.

the creation of several training nursing, midwifery, pharmacists, and medical schools, with about 47% of existing hospitals in 1960 were mission-owned and enrolled 352 doctors.

In order to supply the growing colonial economy with healthy workforce, in 1946, the British colonial administration created a University College, a Faculty of Medicine, a School of pharmacy, a School of Dental Technology, a School of Dental Hygienists, a School of Radiography, a School of Medical Laboratory Technology, regional schools for nurses, midwives, sanitary inspectors, and health advisors.[20] This reform organized a three layer health system with central services coordinated by the Minister and his division officers, the regional body with the three medical divisions (Southern Cameroons was directly attached to the Federal Ministry), and the medical areas ruled by a medical officer working in a public hospital. The implementation of this strategic plan resulted in the improvement of life expectancy which, according to the United Nation's estimates, was between 31.3 and 36.5 years in the early 1950s. The principal causes of mortality and morbidity in 1959 in Southern Cameroons were malaria, accidental injuries, worm infestations, bronchitis, dysentery, and diseases of the eye and ear.[21] In 1956, the Southern Cameroons had 19 hospitals (6 public, 13 mission and private).

i) Colonial Health System in "French-speaking Cameroon"

The health policy in this part of the country was geared at building health infrastructures, reinforcing health regulation and reorganizing health services[22].The French colonial administration oriented its health strategy more toward hygiene and sanitation activities in urban settings, in addition to disease specific prevention interventions at community level**.**

The colonial masters saw in health policies a means to preserve their lives rather than an obligation towards the indigenous population[23]. In this light, G. Martin posits that the wisest and reasonable way to preserve the lives of the Europeans and their army was to offer healthcare, establish good sanitary conditions and curb epidemics.[24]

The first health system was instituted by order of 16 November 1916 "Le Service Medical" (The Medical Service) which comprised the central and the external services. The central service was made up of three services: a health service for the troops, the general health service (le service des établissements hospitaliers du service général) and the epidemics and sanitation services (les services de la police sanitaire, des épidemies, de l'hygiene et de la salubrité publique). The external

[20] WHO, *Health Bulletin*, 1959.
[21] *Ibid*, 1963.
[22] Kontchou, L. F, "*Evolution des politiques sanitaires au Cameroun (1919-2000) : approche historique*", Université de Yaoundé 1, Mémoire en vue de l'obtention d'un DEA, Année académique 2008-2009, P. 1.
[23] *Ibid*, p. 63.
[24] Martin, G., *L'Existence au Cameroun : études sociales, études médicales, études d'hygiene et prophylaxie*, Paris, Emile Laroze, 1921, P. 533.

services were comprised of medical posts (postes medicaux) installed in the 09 administrative units.

The mission of the medical Service (le Service Medical) was later elaborated[25] as dealing with healthcare and administrative or general control attributions[26]. Between 1916 and 1937, 04 decrees and 40 orders were enacted[27]. This was so because according to Governor Bonnacarrère "the black man was refractory to hygiene"[28]. According to the order of 7th September 1921, 'la prophiylaxie' or treatment of 'la variole', of leprosy and sleeping sickness was done in special sequence; to this effect the consumption of alcohol was prohibited[29].

Health activities in the French-speaking Cameroon were dominated by the prowess of Dr Eugene Jamot whose legacy is the Jamot hospital.[30] The main challenge of the colonial administration was the eradication of sleeping sickness. The other diseases included malaria, leprosy, measles and venereal diseases. To address these diseases, a modern hygiene institute and maternity were created in Yaoundé and Ebolowa in 1925 and 1928 respectively. A nursing training school was created in Ayos in 1933 by the French colonial masters. This school contributed immensely to the training of indigenous physicians. In 1939, French Cameroon had 150 medical centers and 50 doctors.[31] To fight sleeping sickness, a team lead by Eugene Jamot made up of 12 doctors, 22 nurses, 13 assistant, 24 health agents of European origin went through the contaminated regions.[32] Those regions were divided into seven sectors, Yaounde, Ayos, Abong Mbang, Bertoua, Bafia, Sangmalema and Logone-Birni. The sleeping sickness disease was eradicated totally in 1939.[33] Nurses before had to be trained in Senegal where the French colonial administration created a medical school, or in France, after their graduation from the nursing school.

In 1938, the Order of 7th June 1938 changed the Medical Service to the Health Service (Le Service de Santé). The central services were ruled (regis) by general and specific stipulations or dispositions. It created 09 central services and local entities.[34]

The central services comprised of the Department of Public Health, Hygiene and Prophylaxy or Treatment Service, Central Hospitals, the Central Pharmacy, the Hygiene and Microbiology Institute, the Ayos Learning Center, Europeans hospitals, the Douala and Yaoundé Indigenous Hospitals. In the various regions, regional centers and mobile units were put in place. They were

[25] Order of 2nd February 1917 Archives Nationales de Yaoundé
[26] Ndong O., "*Le Droit Camerounais à La Protection de la Santé et de la Salubrité Publique de 1916 à 1978*", tome 1 : les Administrations Sanitaires, P 13.
[27] It did not take into consideration Service Notes and Circulars.
[28] *Ibid*, p. 16-20, this was contained in his Circular of 17 December 1921.
[29] *Ibid*, p. 19.
[30] Tegna, E.M., "*Historique de Politique de Sante au Cameroun: De la Promotion Sanitaire Allemande au Politique Sectorielles Actuel*", p.145. Revue Scientifique De L'ecole Des Science De La Sante De L'Universite Catholique D'Afrique Central No. 4.
[31] Martin du Gard, M., *L'appel du Cameroun, Paris*: Flammarion, 1939, p. 71-72.
[32] *Ibid.* p. 71-72.
[33] Tegna, E.M., *op cit.* p.148.
[34] Tegna, E.M., *op cit.* p. 148.

managed by medical doctors. The doctor responsible for the regional centers had as prerogatives to fight against endemic diseases, control the procurement of medicine, ensure hygiene and sanitation and oversee the execution of legal instruments.[35] He was obliged to take both the verbal and the written oath. He was also obliged to send a technical report to the Director of the Health Service on the activities of the mobile units, death declarations (statistics and causes) and the supplying of the units in medicine.[3637] He also had to produce an annual report in three copies: one for the 'Commissaire de la République', another for the Director of the Health Service and the last for the archives. It presents the activities carried out within the region and establishes a nosological report (mortality causes, climatology and morbidity).[38] These reports were monitoring and policy tools for the central services. The Order obliged him to go round his administrative units in 120 days (faire les tournées).[40]

The medical doctor responsible for the Mobile Units was the deputy regional doctor. These Units had to ensure health education, control natality and mortality rate, fight against infectious diseases and provide healthcare to patients.[39] The Order obliged the units to carry out 240 days rounds.[40] The doctor/patient or nurse/patient ratio was very low; for example, there was one health center for 3300 inhabitants in public hospitals and one health center for 7500 in the private sector in 1956.[41]

Looking at the budget voted for the health sector, it is obvious that treatment and the supply of medicine were less important than building health infrastructure.[42]The management policy of medicine was an important component of the health policy put in place by the French Colonial administration. It was regulated by the Ministerial Instruction of 16 January 1905, applicable in Cameroon through the Order of 6 March 1930; the treatment of civil servants and auxiliary staff (purchasing of medicine) was partially paid by the Administration till 1930 although they were exempted from consultation and hospitalization fees.[43]To enable a greater access to medicine, imported medicines were exempted from custom duties.[44]

[35] Nationale Archives of Yaoundé, Health report sent to High Commissioner p. 15-18.
[36] Kontchou, Luc Fongang, *Evolution des politiques sanitaires au Cameroun (1961-2000) : Approche Historique*, p.
[37] .
[38] Nationale Archives of Yaoundé, Medical control missions to Cameroon Report on Public Health, 1950
[40]Kontchou, Luc Fongang, *op.cit*, pp. 70-71.
[39] *Ibid*, p. 71.
[40] Ndong O., *Le Droit Camerounais à la Protection de la santé et de la Salubrité Publique de 1916 à 1978*, tome 1 : Les Administrations Sanitaires, p. 30.
[41] French Report to the United Nations, p. 240.
[42] Kontchou, L.F, *op.cit*, p. 85.
[43] *Ibid*, p. 92.
[44] Decision No. 1191 of 20th March 1950.

In 1959, private doctors were also authorized to operate.[45] The supply of medicine to these doctors had to be done by pharmacies located in their region of operation; they had an obligation to inform the central services of the name and address of the pharmacy supplying the medicine to them.[46]

2. HEALTH SYSTEM IN CAMEROON FROM 1960 TO PRESENT DATE

Based on the studies provided in 1959 by a French contractor (Societe Generale d'Etudes et de Planifications), the government designed its first quinquennial plan for 1961-65, with the major health objectives being to reinforce preventive medicine and health promotion (school health, nutrition), health workforce, vertical and horizontal equity in the distribution of health services, and the development of vertical programmes for Malaria control, and maternal and child health.[47]

The health aspect of the plan had to be coordinated by the Commissioner-General of Public Health and Populations, WHO's public adviser, and a French Government specialist; however, this health plan [was not implemented and] served mainly as a precursor of the development of the second quinquennial plan.[48]

The Federal Minister of Health and Population created in 1961 became in 1965 the Commission-General of Public Health and Populations with a deputy assigned for WestCameroon; the Commissioner-General was assisted by a Director General of Public Health who had to coordinate seven departments which were: Endemic Diseases and Rural Health, Maternal and Child Health, Malaria eradication, Pharmaceutical Services, Medical and Hospital Surveys and Statistics, Public Hygiene and Environmental Sanitation, Nursing Care and Education.[49]

At the intermediate level, there were one hospital per department (staffed with a clinician doctor) and a departmental health center in charge of preventive medicine, including mobile units for immunization and patients-finding.[50] For service delivery, the country had 71 hospitals, 730 medical centers, and 34 Leprosaria, for a total of 13,499 beds (2.6/1,000 inhabitants); the out-patients service utilization rate was 29.4% (1.5million consultations for a total population of 5.1million inhabitant in 1965); and the major diseases included malaria, measles, whoopingcough, dysentery, yaws, pulmonary infection.[51]

[45] Law No. 10 of 23rd February 1959.
[46] *Ibid*, P. 95.
[47] WHO, *Health Bulletin*, 1967.
[48] *Ibid*.
[49] *Ibid.*
[50] *Ibid*.
[51] *Ibid*.

The health workforce in 1965 comprised 196 doctors (1/26,000 inhabitants) of whom 65% worked for the Government, 7 dentists, 79 midwifes,105 assistant nurses and for health financing, the Government spent 10% of its budget for health (368 CFA Francs per capita) in 1965. [52]

In fact, the first university and first faculty of medicine were created in Cameroon one year (1961) and nine years (1969) respectively after the country became independent.[55] At independence in 1960, the health workforce in 1960 comprised 159 doctors, 11 dentists, 46 pharmacists, 2184 nurses and nursing auxiliaries and 45 midwifes.[53]

3. CONCLUSION

Cameroon has developed its first health sector strategy since 2001 to 2015. Cameroon has a legislative and regulatory for governance of the health sector. This framework contains more than a dozen texts. A national governance programme attached to the service of the prime minister with ministerial division has been set up. [54] The legal frame work of the health system is characterized by a multitude of regulatory acts with sometimes competing, discordant and obsolete provisions. This is probably due to lack of respect for the legal system by health actor and the lack of awareness of existing legal institution.

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[52] *Ibid*.
[55] *Ibid.*
[53] Ngah, B.E., "*The Human Right Based Approrach to the Health of the Mother and Child in Cameroon"*, Masters Thesis, University of Dschang, 2014, p. 31.
[54] Order No. 0019/PM of February 13, 2003m indicates the whole organization with, ineralia the objectives to promote the partnership between public/.private sector and civil society and a culture of responsibility in the management of public affairs, improving the transparency of the state apparatus and combatting corruption.

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