Public service reforms and their impact on health sector personnel

Case studies on Cameroon, Colombia, Jordan, Philippines, Poland, Uganda

International Labour Office

World Health Organization

Preface

Over the past decade many countries have undergone public service reforms of some kind, however the consequences for employment and working conditions in the health sector have hardly been documented. This gap in information needs to be addressed, as any public service reform should be judged in terms of its influence on various sectors. The health sector is in most countries predominantly a public sector and therefore influenced by public service reforms. Achievement and improvement in the health sector are crucially dependent on the performance of staff at all levels which, in turn, is intimately related to their general employment and working conditions.

In 1998 the International Labour Office (ILO) and the World Health Organization (WHO) therefore launched a joint research programme to document selected reform processes and detail their impact on health care personnel. The lessons drawn from the individual cases are designed to assist international advisers, governments and organizations of civil society to implement more effective health sector reforms. Six countries from different regions of the world were selected as the focus for this international research (Cameroon, Colombia, Jordan, the Philippines, Poland, Uganda) and studies on public service reforms and their impact on health sector personnel in these countries were carried out in 1998 and 1999. Colombia and Uganda served as pilot country studies in 1998 and the other country studies followed in 1999. They all were discussed at an international round table. The Public Administration Promotion Centre of the German Foundation for International Development (DSE), Public Services International (PSI) and the International Council of Nurses (ICN) together with their affiliates assisted this joint effort of WHO and ILO throughout the whole process by providing technical advice and information at national, regional and interregional levels. The reasons for ILO and WHO launching this programme had different origins, but led to the same interest in the theme for the joint programme.

The 1998 sectoral meeting on health services requested the ILO to facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers, workers and governments and to facilitate research activities on the impact of reform processes on the workforce. The joint programme with the WHO and the round table were a first response to these requests. For the ILO, this programme contributes to the follow-up of a series of sectoral meetings on reforms in both the health services and the public service sectors which concluded that "reforms are most likely to achieve their objectives of delivering efficient, effective and high-quality services when planned and implemented with the full participation of the public sector workers and their unions and consumers of public services at all stages of the decision-making process. Continuing dialogue between governments and the citizenry as a whole, including public sector workers, should be ensured" (1995) and that successful "health care reforms cannot be imposed from above and from outside" (1998).

For the WHO, the study of the impact of public sector reforms on health human resources is part of a programme to better understand the environment, factors and conditions that have an impact on health workers. With these data and information, discussion papers have been developed and disseminated to enable and increase debate on the key issues. These issues include: education and training, motivation of health care providers, policy development, planning, recruitment, retention and deployment. The research is intended to provide the basis from which policy options can be developed for use by decision-makers in different countries. The WHO's workplan in the area of health workforce, education, performance and policy includes:

- a review of the changing roles of health professionals in many countries, through a reprofiling of different methods of health provider mix under different institutional arrangements;

- strengthening national capacity to use existing computer-based tools for health workforce planning and management;

- development of a set of standards for quality in the education of health workers;

- development of a set of policy options for improving provider performance;

- direct country support in overall human resource policy development and more specifically in nursing educational issues.

The WHO is working with countries as well as bilateral and multilateral partners in forwarding this agenda.

At an international round table of experts hosted by the DSE in October 1999 in Berlin, the experiences documented in the country studies were analysed and complemented. This round table was attended by the authors of the country studies, representatives of governments, private employers' and workers' organizations from the countries, as well as by officials from the organizations cooperating in this programme. The result of the discussions was the formulation of critical questions which were meant to facilitate the design, implementation and evaluation of human resource policies in public service and in particular health sector reform. This set of "Critical questions for initiating and reviewing public service reforms" is published in the report of the round table in Berlin in October 1999 and can be obtained from the organizers. With the present working paper the ILO and the WHO make also available the full text of the country studies which were revised by the authors in the light of discussion at the round table in Berlin. The opinions expressed in the studies are those of the authors and not necessarily those of the ILO and the WHO. Working papers are preliminary documents circulated to stimulate discussion and obtain comments.

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Public service reforms and their impact on health sector personnel in Cameroon

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Executive summary

Cameroon is a central African State with a population of about 14 million inhabitants on a surface area of about 465,000 km^2. Her independence was acquired in 1960 and 1961 from the French and the British respectively in the francophone and the anglophone zones. It is a developing economy like most sub-Saharan African countries. The per capita income in 1998 was US$684.

After independence the Government began to set up post-colonial structures to comply with the state of independence and to adjust to the socio-cultural realities of the nation in all sectors. This led to progressive reforms in all sectors among which was the public service. Public service reforms in turn produced impact on the other sectors such as health, education, social affairs and public works.

This paper deals with the impact of public service reforms on health sector personnel in particular in Cameroon. Because of the iterative nature of reforms in general, it was attempted to treat the subject-matter as it has been observed and lived in the last decade and a half. This period was marked by intense economic upheavals due to the fall in prices of export products from developing countries and a generalized economic crisis. Liquidity deficits and poverty and unemployment on the obviously overpopulated civil service were the hallmarks of the epoch. The need to reduce public expenditure and to improve the efficiency and effectiveness of the public service gave birth to the reforms and the reforms produced impact on health personnel as in other sectors.

The objective of this study was to identify the reforms that had taken place in the public service and the impact produced on the health sector personnel during the past decade.

The methodology used was a review of relevant literature and texts published in the past ten to 15 years and structured interview of health personnel in various categories, in both the public and the private health subsectors in Yaoundé and Douala and their environs.

This paper is structured in three main parts as follows: part one deals with the origin, the context and the socio-economic background that gave birth to the reforms. It deals with the remarkable fall in public revenue from export products and petroleum and the complexity of the management of health sector personnel by three ministerial departments and the linkages between them in the development of human resources. It also defines the objective of the reforms as that of redefining the role of the State in the management of national resources including personnel for better output at a lower wage bill. Before defining the processes of the reforms the paper also states the strategies that were used to implement the reforms. The reduction of personnel population through operation ANTILOPE and the development of new public service regulations in 1994 are among the processes used to ensure the wage bill reduction. The major actors in the reform process are also identified as well as the role played by each one of them.

How far the reforms were implemented, the working conditions of the public sector, the achievements, constraints and failures in the implementation of the reforms are all revisited in this section of the paper.

Section two of the work highlights the impact of these reforms on the health sector personnel, starting with the policies for human resource management in the sector. It also provides an overview of the health system in Cameroon as characterized by three levels according to the three-phase scenario for the implementation of PHC and the categorization of health facilities in Cameroon. What is the weight of the public health sector as compared to the private for-profit and non-profit subsectors is also reviewed. The overall costs, the fiscal restraints, and the availability of resources for the implementation of the reforms is discussed in this section of the study. Before briefly describing the educational system with the various levels and certifications in a bicultural context, we also attempt to describe the intended and unintended staff movements consequential to the reform process. The education sector in Cameroon is a very large one with both public and private sectors making important inputs in the development of educational institutions from primary education to the universities. Levels of qualification required before admission into training schools for nursing or for medicine are also described.

In this section the different professional orders or associations in the health sector are described as well as their standards and the mechanisms involved in the registration into these organizations. The National Medical Association and the National Association for Paramedical Personnel are among the most active and prominent organizations of health sector personnel. The roles of these organizations in the assurance of quality services and the respect of professional ethics are also discussed. Labour relations and workforce, as well as gender issues are reviewed.

The reforms of the public service did bring about changing patterns of employment with a rise in the role of the community participation in employing and staffing health facilities in a context of the resort to cost recovery as the strategy for improving financial availability and sustainability of the services. It is also observed that career opportunities and training as well as staff mobility have been influenced by the reforms. We have also tried to review the working environment and its impact on the workforce's health and safety. Finally, in this section an attempt is made to analyse the reform effects on the public-private mix in the health sector.

In section three of this study an analysis is made of the lessons learned from Cameroon's public service reforms and their impact on the health sector personnel. Socio-economic and political lessons as well as the impact on personnel moral are discussed. Decentralization as a major strategy to ensure equity and social justice in health care delivery and as a step towards good governance is discussed. A comparative review of public service reforms in Ghana, the Democratic Republic of the Congo (former Zaire) and other sub-Saharan African countries is made. As far as transferability is concerned, it is asserted that this cannot be automatic, as there will always be need to consider each transferable process within the socio-economic context of the receiving country.

It is concluded that public service reforms constitute an iterative process that will continue for a long time as perfection is sought. In the past ten to 15 years the reforms have produced remarkable impact on health sector personnel, greatly impairing the performance of the personnel. Yet it does not all seem hopeless because the expected resumption of

growth in the economy of the nation is being realized. This being the case, it is hoped the positive impact on health personnel and the resultant improvement in the quality of health care are expected to occur as well in the years ahead. This is even more likely to be the case with the imminent implementation of the programme of good governance in Cameroon.

List of abbreviations

ADB	African Development Bank
DSE	German Foundation for International Development
FCFA	Francs CFA
GCE	General Certificate of Education
ILO	International Labour Office
IMF	International Monetary Fund
IMR	Infant mortality rate
MoPH	Ministry of Public Health
NGO	Non-governmental organization
PHC	Primary health care
PSFH	Provincial special funds for health
SAP	Structural adjustment plan
WHO	World Health Organization

1. Introduction

The Republic of Cameroon is a sub-Saharan country situated in the Central African region. Cameroon is bounded to the west by the Federal Republic of Nigeria, to the north by the Republic of Chad, to the east by the Central African Republic and to the south by the Atlantic Ocean, the Republic of Equatorial Guinea, the Republic of Gabon, and Congo. The surface area of this triangular nation is about 465,000 km^2 and the population is estimated at about 14 million inhabitants in 1999.

As in most developing countries, the economy of Cameroon is based essentially on the primary sector. In 1997-98 the per capita income was estimated at about US$684.*(1)* According to the Ministry of the Economy and Finance of Cameroon, the gross domestic product was projected at about FCFA5,433,000 million in the fiscal year 1997-98 (US$1=FCFA550).

In 1990 there was one doctor for 11,407 inhabitants but in 1997 this ratio fell to one doctor for 14,730 inhabitants. The infant mortality rate (IMR) is estimated at 77 per 1,000 live births; the maternal mortality is estimated at about 430 per 100,000 live births.*(1)*

Reforms are changes in systems and methods of work geared to improve the quality of service rendered to the population and to do so at the best cost effective rates within the context of the society in which the reforms are being carried out. Public service reforms have been ongoing in Cameroon since independence in the sixties, marked by creation of a public service commission and the corps of functionaries with the related regulations and career profile. For the purpose of this paper it seems realistic to deal in essence with the public service reforms that have taken place during the past ten to 15 years.

The impact of the reforms on the health personnel will deal in essence with personnel of the public sector, but as much as possible impact on private sector health personnel will also be discussed. The volume of both sectors in health care delivery in Cameroon will be discussed later in this paper.

2. Synthesis of public service reform in Cameroon

2.1. Origin, context, socio-economic background and framework of reform efforts

Cameroon is described as having been operating in a context of economic crisis since the 1980s. This economic crisis linked to the global economic recession of the same period has given rise to most of the reforms that will be discussed in this paper. The economic crisis in Cameroon was marked by the rapid fall of the economic growth of Cameroon, fall in the price of export products and petroleum revenue, and the depreciation of the value of

the US dollar.*(2)* One out of every two Cameroonians was considered to be at poverty level according to a household survey carried out in Cameroon in 1996. This means that 50 per cent of the people earned below FCFA148,000 per year per person.*(9, 13)*

In Cameroon public service workers, commonly called "civil servants" are generally managed by at least three ministries. In the health sector the Ministry of the Public Service and Administrative Reforms recruits civil service workers. They are paid their salaries through the Ministry of the Economy and Finance and they work effectively in the Ministry of Public Health (MoPH). In this circumstance, issues of professional and career progress are handled in the public service while those related to profession practice and ethics are handled in the MoPH. The Ministry of Finance addresses matters of salaries. The consequence of this situation is that reforms in any of these ministries invariably touch on the health personnel.

Budget expenditure in the social sector has evolved remarkably towards a fall over the past decade. For example, in 1992-93 the budget expenditure on education was 14.5 per cent of the national budget. In the same year 4.8 per cent and 0.5 per cent of the budget was spent on health and social welfare respectively and 1.9 per cent for higher education.*(10)* According to data from the Ministry of the Economy and Finance, the national budget was FCFA1,113 billion of which3.3 per cent was spent on health in 1996-97 and 5.8 per cent and 0.2 per cent was spent for education and social welfare respectively. In 1998-99 the national budget was FCFA1,230 billion of which 2.4 per cent was spent on health while 7.4 per cent was spent on education and 0.2 per cent on social welfare.*(11)*

2.2. Reform objectives and strategies

The Statement of Development Strategy and Economic Recovery of May 1989*(3)* clearly outlines the objectives and strategies of the public service reform that was carried out in order to cope with the economic crisis of the epoch.

The primary objective of the reform was to redefine the role of the State and improve personnel management. It was expected that this objective would result in improved control of the wage bill. This would be achieved through the following strategies:

- a recruitment policy limiting entry into the civil service, in particular, from vocational and administrative training schools;
- an early retirement scheme and the strict application of retirement regulations;
- the consolidation of existing systems of payroll management;
- the curtailment of travel allowances, in particular by reducing the movement of personnel;

- the review of the policy of social benefits (family allowances, housing allowances, government houses, etc.);

- the review of the organizational structures of ministries and the setting up of organizational and personnel plans defining clearly the roles of each ministry, taking care to avoid duplication of responsibilities. The review will define the exact staffing needs of the ministries and, where appropriate, identify existence of overstaffing. This should in turn enable the determination of operating budgets based on the mission and identified needs of each ministry;

- a policy of reduction of civil servants based, in particular, on voluntary departures and redeployment in the private sector.

The second objective concerned the increase of efficiency in the civil service. This would be achieved through the following strategies:

- the review of the legal and statutory framework of the civil service (general staff regulations, special rules and regulations, etc. to define a civil service policy based on enhancing career development and on increasing the motivation and duty consciousness of government employees; and particularly:

  – an inventory of skilled personnel in the administration, by level;

  – a new remuneration policy in the Civil Service which links the review of salaries, subsidiary allowances and benefits to the evaluation of individual performances;

  – the improvement and institutional reinforcement of personnel management (careers) and financial management (salaries), and the strengthening of institutional relations between ministries;

  – a vocational and continuing education policy adapted to the needs of the civil service.

A civil service commission would be set up to ensure that the abovementioned objectives were achieved.

2.3. Reform processes and actors

The processes. It is in the light of the abovementioned objectives that a major census of civil servants was carried out under the name “Operation ANTILOPE” carried out jointly by the Ministry of Public Services and the Ministry of Finance to identify “ghost” civil servants. Massive retirements were carried out for all civil servants who had worked for 30 years or had attained the age limit set for their category. The number of civil

servants passed from 188,000 in December 1990 to 165,000 in December 1994. Mention must be made here of the suspension of all promotions and advancement of civil servants and the salary reductions that were effected on their salaries twice in 1992-93.*(1)* The devaluation of the FCFA in 1994,*(4)* came to reduce the salaries of civil servants to less than one-third of real figures. Personnel of the health sector were not exempted from these cuts.

The new civil service regulations were published in 1994 and the new organizational structure of the MoPH was published in 1995.

Recruitment into the civil service has been suspended since then. In the MoPH in particular, only doctors trained in national faculty of medicine and biomedical sciences have been recruited. Paramedical training schools for nurses and laboratory technicians were closed for about five years and when they were reopened they trained personnel who could not be recruited into the civil service. Medical doctors and specialists trained abroad have not been able to find a place in the public service of Cameroon. Most of these personnel, when they have been able to find a place, it has been in the private sector comprising essentially the religious mission hospitals and other for-profit private health establishments which, in majority, own their private training schools for nurses and other paramedical staff.

The actors. The public service reforms discussed in this paper were made in response to an overall economic crisis in the nation. The major actors of the reform are:

(a) *The Government of the Republic of Cameroon* that was confronted with its incapacity to maintain a positive economic growth and uphold its macroeconomic indicators as marked by the depletion of internal and external reserves, a constantly increasing external debt and a significant growth of the internal debt as well.

(b) *The Bretton Woods institutions.* These comprise partners with whom the Government agreed to work out survival mechanisms for the improvement of the ailing economy of Cameroon. The International Monetary Fund (IMF) was involved in the stabilization programme of public finances through a FCFA24 billion budget aid to Cameroon signed in September 1988 to cover a period of 18 months. The IMF and the World Bank (WB) jointly carried out stabilization and structural adjustment programmes through policy framework agreements. The African Development Bank (ADB) was also partner to these arrangements.*(6)*

(c) *The people of Cameroon* can be considered as a major actor in this reform. They constitute the civil servants' population, which bore the burden of retrenchment, and salary cuts. The population tolerated all advantages and inconveniences of the structural adjustment plan (SAP).

(d) *Multilateral and bilateral cooperations* that provided support to health care in various parts of the country in accordance with the policy and the structural adjustment plan.

2.4. Focus and scope of reform implementation

As far as the public service is concerned the reforms were focused mainly on the personnel. Related variables such as number, duration of effective work in the civil service, salary level, allowances, housing, training, and working facilities were considered. Civil servants in the health sector were affected as much as those of other social sectors such as education and social and women's affairs. Security sectors such as the military and the police were little or not directly affected by these reforms. All categories of civil servants from category D to A [1] as well as contract workers from category 1 to 12 were touched by the reforms. Staff in diplomatic missions out of the national territory was not excluded except those in security positions in the missions.

Implementation of the reforms was "tolerated" by most Cameroonians including civil servants even though some are said to have gone on the streets to protest in 1994 and 1997.*(29)* All the measures cited above remain effective till the time of writing this study.

2.5. Working conditions and terms of employment in the public sector

Working conditions and terms of employment in the public sector in Cameroon are spelled out in the Constitution of the Republic of Cameroon,*(7)* revised in 1996 and in the Public Service Regulations*(8)* published in 1994 as part of the reforms. According to the Constitution, and concerning employment, the following is stated in the preamble: "Every man has the right and the duty to work." It also states in the same preamble that: "The State guarantees for all citizens, of one sex or the other, the rights and liberties enumerated in the preamble of the constitution."

The terms of employment in the public sector are stated in article 13 of the 133 article Presidential Decree No. 94/199 of 07 October 1994, which constitutes the New Public Service Statute of the State.*(8)* This document also stipulates clearly the conditions of work, the disciplinary measures and positive sanctions to which every civil servant is subject. This document however does not spell out the conditions of employment and the working conditions for workers subject to the Labour Code.

2.6. Overall achievements, constraints and failures

Under the double effect of the 1994 devaluation of the FCFA and the reform measures taken, Cameroon began to regain economic growth. The 1994-95 financial year ended with a growth rate of 3.3 per cent and is situated at about 5 per cent in the 1997-98 financial year.*(4)* The return to economic growth is marked by a considerable improvement in the standard of living of the population through a slight increase in the revenue and a rise in overall consumption within a context of reduced inflation. This resumption of

[1] Category A = doctors, pharmacists; B = state registered nurses; C = assistant nurses; D = nurse aides.

economic growth has improved public finance and enabled the Government to take actions such as to improve the conditions of living of the low-income as well as the most vulnerable groups. One such action in the health sector is the setting aside of 100 per cent of the revenue collected in public hospitals to be utilized in the hospitals where the revenue is so collected for improving the conditions of their wards and services and for motivating the staff to better production.

Constraints and failures have not been lacking in the whole of this process. Cameroon has had to deal with intense political activity within the implementation of the democratic process and its negative social externalities in a multi-tribal nation. Because the population was not prepared to pass from one party to multi-party politics, government messages were often misinterpreted with consequent blockage to the execution of programmes.*(10)* Another major constraint has been that of having to deal with a high degree of corruption within the public sector.

In the health sector it has not been easy to cope with the growing pandemic of HIV/AIDS as well as its associated re-emerging diseases such as tuberculosis and the frequent epidemics of meningitis and cholera in some parts of the country. The sero-prevalence of HIV has grown tenfold in the past ten years.

The reforms had no effect on the rate of unemployment, which has remained as high as 35 per cent within the active age group of 25 to 29 years in general, and 47 per cent among the female in this same age range.*(9)* Recruitment into the private sector is rare and persistently at a standstill in the public sector. Failure to improve or raise the salaries of civil servants has left a persistently unmotivated and demoralized public service with aggravation of corruption within the sector.

3. The impact of public service reforms on health sector employment and working conditions

3.1. Implications for human resources policies in the health sector

Like in all sectors of national development, human resources in the health sector remain the most important of the three major types of resources. It is the human resources that utilize the financial and material resources for the production of goods and services. Therefore all reforms related to human resources would invariably affect the performance of the sector. In order to ensure sustainability of health facilities and enhance capacity-building within the framework of the reforms, it became obvious that new policies had to be developed. Such policies needed to ensure the quality and mix of personnel at the various levels of the health care system and also improve the managerial capacities of the staff charged with the management of the facilities. This became even more pertinent in the face of the implementation of cost recovery in public health facilities. Doctors and nurses charged with such management needed to go beyond the clinical practice on to general resource management for the financial survival of the facilities.

Cost recovery began in Cameroon in 1990 within the implementation of the Bamako Initiative. Beginning with the payments for essential drugs, the cost recovery moved on to payment for consultation and for each procedure carried out in hospital especially in surgery. It became imperative to train personnel with a bias to bookkeeping and financial management, most health facilities having become micro business enterprises.

Major policy development was marked by the creation of the Directorate for Human Resources within the Ministry of Public Health and the implementation since 1995 of a process of rationalization of human resources.*(10)* The rationalization process envisaged the following:

- elaboration of a policy on personnel training;
- description of training profiles and plans for initial and continuous training;
- constitution of career plans;
- mastery and distribution of personnel according to predetermined standards in categories of health facilities and a complete census of health personnel in the private and public sectors. This would enable the Ministry of Health to determine the real needs in human resources;
- since 1995 there has been a process of revision of curricula for the training schools in order to be able to respond adequately to the new orientations.

However, these measures will still need to deal with the constraint of personnel being managed by three ministries (public service, finance, and health) which makes it sometimes difficult to take rapid and appropriate decisions on staff movement. The rationalization of human resources occurred essentially in the public sector on which the MoPH had direct impact. The private sector has been known for rational management of all its resources including personnel.

3.1.1. General organization of the health sector

After Alma Ata, the implementation of primary health care (PHC) in Cameroon was reoriented in order to make quality health care more accessible to the population. In order to do this the health sector was generally described in three levels according to the African scenario for implementation of PHC in three phases. The three levels are described in table 1.

Table 1. The health system of Cameroon

Level	Administrative structures	Role	Operational structures
Central	The Cabinet of the Minister of Health The General Secretariat The directorates	Conception and development of policies and strategies	Reference general hospitals Central hospitals University hospitals
Intermediate	Provincial delegations of public health	Technical support to programmes	Provincial hospitals
Peripheral	The health district The health area	Operational support	District hospitals Subdivisional medicalized health centres Integrated health centres

Modified from *WHO/OMS Profil-Pays Cameroun, 1995*, p. 44.

The health sector is divided into the public and private sectors. The public sector comprises government health facilities constituting about 60 per cent of all health facilities. The private health sector can be subdivided into the lucrative and the non-lucrative subsectors. About 38 per cent of the whole health sector is non-lucrative belonging to religious organizations in most part and the private lucrative accounts for about 2 per cent of health facilities.

From the operational point of view and in order to improve accessibility to health facilities for the population, the country has been carved out into 140 health districts comprising the peripheral level. Anywhere in Cameroon one would find himself within a health district. A health district in Cameroon is an operational unit for the implementation of primary health care comprising the following:

1. integrated health centres that provide quality health (comprehensive, continuous, integrated) care to a given population of about 5,000 to 10,000 inhabitants. A minimum package of care and technical level is defined for this zone known as the health area;

2. a district hospital that serves as first referral level for patients from the health centres;

3. a district health service, which is the administrative structure responsible for coordination and supervision;

4. dialogue structures comprising health committees and management committees representing the population in the promotion of community participation and partnership between the communities and the Government.

The reorganization of the referral system provides for referral and counter-referral between integrated health centres and district hospitals, on the one hand, and between district hospitals and provincial hospitals, on the other. The central and the general hospitals ensure the third level of referral. However, this does not hinder the patients' free will to choose the level at which treatment may be sought. Financial brakes (disincentives) enhance the process.

In this system the health facilities have been classified into six categories in order to define the responsibility of each facility in terms of the type of services that should be offered by which personnel and with what technical equipment. These six categories are as follows:

- 1st category: general hospitals;
- 2nd category: central hospitals;
- 3rd category: provincial hospitals;
- 4th category: district hospitals;
- 5th category: subdivisional medicalized health centres;
- 6th category: integrated health centres.

In Cameroon the health centre constitutes the interface between the population and the health services. In a health area one or more non-integrated health centres may support the integrated health centre. Also a district hospital may belong to the public or private non-lucrative sector.

The pharmaceutical subsector is defined by the adoption of the Essential Drug Policy based on generic formulae in order to improve the accessibility of drugs to the population. The organization of the Essential Drug System provides for creation of community pharmacies in health centres and hospitals as well as the creation of provincial centres for drug stockage and support to the districts. These provincial centres supply essential drugs to the peripheral facilities. At the central level there is a National Essential Drug Supply Centre charged with importation and distribution of essential drugs to the provincial centres without, however, having a monopoly of the business. The private for-profit pharmacies that deal in brand label pharmaceuticals complement the pharmaceutical subsector.

A quality control laboratory for the study of the quality of drugs has been set up in the capital.

The health system has been organized to support the financing of health care through cost recovery and community participation by way of donations in cash or kind.

The intermediate level of the health system comprises ten provincial delegations that represent the ministry and ensure technical support to districts through supervision, training and retraining and coordination of all subsectors of health.

The central level was reorganized in 1995 in order to promote the policies that will provide the basis for a quality care-driven system. There are five directorates and two divisions as follows:

- the Directorate of Human Resources;
- the Directorate of Financial Resources and Infrastructure;
- the Directorate of Pharmacy;
- the Directorate of Community Health;
- the Directorate of Hospital Medicine;
- the Division of Cooperation;
- the Division of Studies, Planning, Health Information and Computer Services.

Given these institutional changes and the organization of hospitals and clinics, it is necessary to review at this point the conditions under which health staff has worked especially as concerns regulations and benefits.

While it is noted that health sector personnel suffered the same effects of the structural adjustment plan as did the personnel of the public service in general, it is also observed that in terms of working conditions, those of the health personnel have often been more difficult. Public service personnel of the non-health sector has a practical working week of 40 hours but those of the health sector have 40 hours plus unlimited hours for calls and night duty risks. Conditions for annual leave and all other regulations are the same for all civil servants. In the sector of education teachers go on annual leave in addition to the holiday breaks.

In terms of benefits health personnel appear to be among the most disfavoured. While personnel in the education sector have benefited from an additional monthly technical allowance of about FCFA12,000, medical personnel of the same category, grade and class does not receive such an allowance. A technical allowance of FCFA3,000 was accorded to nurses more than 20 years ago while doctors and other senior health personnel have no technical allowance. Nevertheless, doctors benefited from *quote part* from consultation fees paid to the hospitals. About five years ago this *quote part* was also extended to other staff working in hospitals and shared on a sliding scale, leaving each staff member with a few francs only. Those working in preventive and community programmes never benefited from this incentive. No doubt then, most health personnel would prefer to work in a hospital rather than in preventive and promotional programmes.

In spite of the need for health personnel to reside in housing at proximity to the health facilities in order to ensure continuity of care, health personnel have no benefit of housing.

Claims of health personnel for free or reduced cost of medical attention for themselves, and their offspring, have received no response over the past decade.

3.1.2. Overall costs, fiscal restraints and availability of resources

Public service reforms in general imply effort that depends in great part on the scope, the coverage and the methodology by which the reforms were carried out. Each actor involved in the reform directly or indirectly bears part of the costs. Because public service reforms constituted part of the structural adjustment programme, it became obvious that there would be need for satisfactory qualitative and quantitative financing over a considerably long period to produce the desired effect. Externally generated funds needed to be complemented by mobilization of internal resources. The reform of the civil service, however, required logistic support in addition to the financial one. In financial terms and as an example mention is made of the budget aid offered to the Government of Cameroon to the tune of US$70 million (FCFA24 billion) in September 1988 and which expired in June 1990.*(2)* In 1989 negotiations were made with the World Bank for a US$9 million loan to Cameroon to support economic management.*(6)*

Other overall costs are those borne by civil servants in terms of losses such as in salary cuts and a reduction in travel allowances. Opportunity costs include the reduced quality of care to patients as a consequence of a demotivated civil service.

In terms of fiscal restraints it has been noted that the shortage of liquidity in the public treasury in general did not only induce the reform but also further deterred its implementation. In the already low budgetary allocation for the health sector (less than 5 per cent of the national budget in the last five years), approximately 80 per cent of it was spent on staff salaries leaving little for investment, maintenance and other running costs. Poor maintenance of equipment and lack of working material are deterrents to optimum performance of health personnel.

3.1.3. Intended and unintended staff movements

It has already been stated above that three ministerial departments manage civil servants in Cameroon. Staff movements are one of the variables highly affected by this tripartite management. These movements are further influenced by the Prime Minister's office, which has to approve the intended movements of senior officials such as directors, subdirectors and some regional service heads. Other personnel occupying very senior posts such as permanent secretary and inspector-general can only be moved under presidential appointments. In general all intended staff movements are initiated by the Ministry of Public Health and then presented to the higher services in the hierarchy for obtention of the required authorizations. In the absence of a career profile for health personnel, intended movements depend essentially on the good will of the person proposing appointments for posts of responsibility. Thus, discretion often prevails over merit and experience. The consequence of this is that it is not unusual to find for example, a less-experienced medical officer who is the boss of a much older and experienced one at a district or regional management position. This arrangement in a way promotes favouritism, tribalism, and corruption, as well as reducing effectiveness and motivation in the disfavoured group.

Because managerial posts are associated to special duty allowances, the appointed personnel is often motivated to work hard, even though sometimes ineffectively. In 1995 it was an intended movement to retrench a considerable number of non-technical (ward maids, drivers, clerks) staff.

Unintended movements of staff are those movements that are not the direct result of decision by the MoPH or its representatives to initiate transfers or promotions to posts of management responsibility. The new public service statutes of 1994*(8)* strongly promote marriage among civil servants and the need for them to live together as much as possible. The employing minister, in case the two (husband and wife) work in the same ministerial department or the two ministers where the husband and wife are in different ministries have the responsibility to see that the couple is not separated. The consequence of this situation is that wives often follow their husbands as they are transferred from one part of the country to another. Within the health sector this has been shown to account for the fact that health personnel are in plethora in the big cities of Yaoundé and Douala while the rural health services are in dire need of staff. More than 50 per cent of all health personnel is based in the ten provincial headquarters for a total population of less than 6 million inhabitants whereas the remaining 50 per cent is dispersed to cover the rest of the country with a population of about 8 million people.*(14)*

Other unintended movements of staff include the departure of 206 pharmacists from the public service into the private sector in 1989 and another 59 of them in 1990.*(10)*

Deaths and retirement have also accounted to movements of staff. Moreover, health workers are known to have migrated to *greener pastures* like other sectors such as education, as stated by the Resident Representative of the United Nations Economic Commission for Africa on addressing a seminar on the social impact of structural adjustment programmes*(30)* in 1995.

3.1.4. Educational systems

Since independence in 1960 the domain of education is one of those in which much progress has been made within the social sector in Cameroon. If there has been any progress in the overall development of the nation it has been importantly due to education of the people. This rapidly expanding sector has been based on two cultural colonial systems of education. The French system of education covers eight provinces with a population of about 10 million inhabitants while the British system covers two provinces with a population of approximately 4 million people. Corresponding levels have been established between the two systems. In terms of growth, between the 1995-96 and the 1996-97 academic years, the number of children in the nursery school grew by 13 per cent while in the primary and secondary general education these numbers grew by 1.8 per cent and 7 per cent respectively.*(9)*

Irrespective of the cultural background, the education sector is organized in three levels, all of which are sponsored by the State, private individuals and the religious missions. Educational establishments are created by state regulatory mechanisms. Such creation takes into consideration not only the national school map, but also the financial capacity of the prospective proprietor of the establishment. The three levels of education are as follows:

1. nursery and primary education;

2. secondary general and commercial education;

3. higher education.

Nursery and primary education is carried out in public as well as private missionary and non-missionary schools. This level is for children aged from 4 to 11 years approximately.

The State, private individuals and missions dispense secondary education. It may be both technical and commercial or purely general education.

These two levels are directly under the supervision of the Ministry of National Education that is responsible for authorizing the creation.

Higher education includes all universities and their affiliated institutions. At present there are six public universities and three private universities of which one has a regional coverage (Catholic University of Central Africa). With reference to health personnel, it is worth noting here that medical doctors and specialists in internal medicine, surgery, obstetrics and gynaecology as well as radiology are trained in the University of Yaoundé. Senior nurses are also trained in this university.

Table 2 illustrates the organization of education in Cameroon.

Table 2. Organization of education in Cameroon

Level	Entry age	Conditions of admission	Years of study	End of course certificate
Nursery	3-4	After third birthday	2-3	
Primary	5-6	After fifth birthday	6-7	FSLC (First School-Leaving Certificate)
Secondary general (1st cycle)	12-14	Competitive entrance examination	4-5	GCE Ordinary Level
Secondary general (2nd cycle)	16-18	GCE Ordinary Level	2-3	GCE Advanced Level
Technical commercial (1st cycle)	12-14	Competitive entrance examination	4-5	RSA or CAP
Technical commercial (2nd cycle)	16-18	Competitive entrance examination	2-3	RSA Stage III
Higher institution	>18	RSA Stage III	2-3	Higher Technical Diploma
First degree	>18	GCE Advance level	3	B.Sc. or B.A.
Second degree	>21	B.Sc. or B.A.	1-2	M.Sc. or M.A.
Third degree	>23	M.Sc. or M.A.	3-4	Ph.D.

Source: WHO/OMS *Profil-Pays Cameroun* (modified).

After the pre-service education such as described above and at varying levels Cameroonians can get into a profession of their choice including the medical professions. Entrance into professional schools for training in nursing and medicine is essentially through competitive examinations. General education in the sciences provides the basis for

participating in the entrance examinations. There are two major groups of professions in the health sector in Cameroon:

(a) Paramedical professions include nurse aides, which is the lowest grade of nurses. Above this class of personnel there are the assistant nurses, the state registered nurses, and the senior staff nurses in ascending order. Other paramedical professionals include the laboratory technicians and pharmacy technicians. Admission into the competitive entrance for nurses requires the obtention of the First School-Leaving Certificate for nurse aides and the General Certificate of Education Ordinary Level for assistant nurses. State registered nurses and senior staff nurses require the GCE Advance Level as a basis for competing. The laboratory technicians and pharmacy assistants require the GCE Ordinary and Advance Levels respectively for admission into the competitive entrance examination. However, within each professional class of nurses it is possible to rise from one class to the higher one through in-service training. A period of three years' practice in the field is required in order to qualify for competition into the higher professional class.

(b) Medical training is available in one of Cameroon's eight universities. Admission into medical school is through a competitive entrance examination for holders of GCE Advance Level. This is the general requirement for registration into university in the country. In-service training is available for practising general practitioners desiring to specialize in obstetrics and gynaecology, internal medicine, paediatrics, general surgery, and radiology. It is also possible to undergo in-service training abroad especially in the specialities not offered in the country such as neurology, gastro-enterology and other sub-specialities. No pharmacy school exists in the nation presently. All pharmacists have been and continue to be trained abroad.

Both the public and the private sector run training schools for nurses. Each sector trains for its system although the MoPH regulates and issues certification. In terms of continuing education and capacity-building, health personnel benefits from seminars and workshops organized periodically for both nurses and physicians. The National Medical Council of Cameroon organizes on a yearly basis a medical conference at which selected subjects are presented by colleagues and discussed. The medical conference also provides a space for presentation of scientific works. In general, staff involved in public health benefit from more frequent continuing education, this being commensurate with the community-geared health care delivery of developing countries. In the past two years the Ministry of Public Health developed a scheme for the training of graduating doctors from the faculty of medicine to provide them with attitudes for adapting to the health system. Above all, it is sought to provide these young doctors with a human face to their practice. This is, too, an effort to fight against corruption and to improve caretaking behaviour and empathy towards patients in future physicians.

3.1.5. Professional standards, registration, code and scope of practice

Health personnel are organized in professional associations or orders. These organizations play an important role in the promotion of ethics in the professions and oversee the quality of health care delivered by the personnel. Each organization has a code

of ethics that must be respected in practice. In an attempt to review some of these organizations, mention must be made of the following:

- The National Medical Association of Cameroon is the main organization of physicians in Cameroon. All medical doctors trained in Cameroon and abroad are expected to register in this order before practising medicine according to its Code of Medical Ethics. This code of ethics*(15)* written in 1983, treats such topics as the general obligations of the doctor, the obligation of the doctor towards the patient, duties of doctors with respect to social medicine, duties of doctors towards the fraternity of colleagues and towards other health personnel.

- The Association of Paramedical Personnel covers nurses, midwives, and laboratory technicians of all grades. This association established in 1989 is made of three organs: the general assembly, the executive of the order, and the provincial sections.*(16)* The code of ethics of this organization also stipulates the conduct of paramedical staff in the execution of their duties.

- Other professional associations include the Association of Pharmacists and the Association of Dental Surgeons. It is worth noting that in the past ten years there has been a proliferation of sub-speciality associations such as the Association of Obstetricians and Gynaecologists, and the Association of Surgeons and the Association of Paediatricians.

In all cases these organizations define the process of registration and the fees to be paid in so doing as well as the scope of practice.

3.1.6. Labour relations

Workers' unions were rare in Cameroon prior to the democratic era that began in 1991. There was one national workers' union that involved essentially the workers of the private sector and this union carried out all transactions and negotiations with employers.

Today, the situation is changed with the existence of several workers' unions in different fields including the health sector. The democratization and gradual decentralization have given rise to the development of unions with obvious and active workers' representation for collective negotiations and bargaining for conditions of work.

In the health sector, in particular, the professional associations have englobed the responsibility for negotiating with the Government on issues that are likely to influence the profession in general. For instance, the installation of a medical practitioner in private practice or the settling of a pharmacist in private practice requires approval from the corresponding professional organization before the Ministry of Public Health can give the final say. In addition to this, medical doctors and pharmacists as well as dental surgeons are expected to have put in at least five years of work under another experienced practitioner in order for the approval for setting up their own practice.

In the tertiary hospitals of the big cities there exist workers' unions within the institutions with workers' representatives democratically elected by their peers for negotiation and conflict resolution with the administration of the hospitals for the assurance of discipline and output and the award of incentives when they do exist. The institution of an annual award of prizes to the best nurses and doctors of some health establishments has gone a long way to motivate output and improve the quality of care.

Collective bargaining in the health sector is carried out through the negotiation between workers or staff representatives and the management of facilities. Such negotiations relate to conditions of work and planning of work schedules in some major facilities.(31) In the private health sector negotiations are often limited to the employer and the employee although Labour Code stipulations need to be taken into consideration. In the public sector salaries are predetermined according to qualifications, as already stated earlier in this paper. Another framework for collective negotiation is within the management committees of hospitals in which personnel are represented.

3.1.7. Gender policy and gender outcomes

The Constitution of the Republic of Cameroon*(7)* states in the preamble, that "[t]he State guarantees for all citizens of one sex or the other, the rights and liberties enumerated in the preamble of the constitution".

An earlier statement in the same document makes the precision that everyone has the right and the duty to work. It seems therefore obvious that in terms of policy, gender discrimination does not exist. According to P.N. Fonkwo and R. Meloni,*(17)* female personnel in the health field are not easily mobilized because, in a bid to protect the family, wives are supposed to stay at their husbands' place of posting. This contrasts with another observation, as Hilary Standing*(18)* pointed out: "Front-line health workers are disproportionately female." In Cameroon, the inability to mobilize this important group of personnel tends to aggravate the shortage of staff in the rural areas. Cameroon is nevertheless one of the few countries in which males work as "midwives", assuming duties of managing pregnancy and deliveries in health facilities in most part of the nation with the exemption of the Muslim zones. Recruitment into professional schools is open to candidates of both sexes and those who satisfy the conditions for admission are taken into the establishments on merit.

In terms of gender outcomes it is worth noting that women are beginning to play outstanding roles in the public sector in general and in the health sector in particular. At the central level of the MoPH the permanent secretary and two directors out of seven are women. The second technical adviser to the MoPH is also a woman. At the provincial and district levels, women occupy the posts of provincial chiefs and district medical officers without any inferiority in the outputs as compared to their male counterparts.

And yet, in the past ten years feminist organizations have become more vocal with increase in advocacy and lobbying in favour of female training, employment and empowerment in all sectors of the economy. There exists an association of female medical doctors, as there is one for female jurists.

3.2. Impact on the health workforce

The reforms of the public sector involved the suspension of recruitment into the civil service in addition to retrenchment of some personnel. Besides, many civil servants did resign their jobs following the salary reductions of 1993-94. To these must be added the further reduction of staff numbers due to deaths in the past ten years. The overall effect of these measures is the reduction in the numbers of staff in various categories. It is not unusual to find health centres run by one or two persons especially in the rural areas.

The impact of this situation is the increase in workload for personnel and the ensuing poor performance in the quality of care provided to service users. In the face of acute poverty and lack of incentives the personnel turns to survival mechanisms that have to be borne by patients through drug pilferage and parallel sales as well as under-the-table payment for care. The shortage of personnel has made it almost impossible to ensure continuity of care in many health facilities. Holistic care is almost totally compromised even in urban areas where there is an occasional plethora of staff. The nights are often poorly covered. The outcome of all this is the marked reduction in the utilization of services especially in the rural and suburban zones where the poor are predominant. In most public health centres in the rural areas, the utilization rates fell from approximately 0.6 new cases per inhabitant per year to approximately 0.2 new cases per inhabitant per year. An important factor that contributed to a reduction in the workforce is the brain drain of medical specialists who left the country because of low salaries.

Because the workers of the private sector did not suffer the primary effects of salary cuts (their salaries in some cases were even raised), the state of their motivation has been good. This accounts at least in part to the persistent overload of private hospitals such as those of the religious missions and the social insurance health services.

3.2.1. Changes in the pattern of employment

There is little data available on the magnitude of the private sector in terms of employment in relationship to the public sector or the total national employment load. However, it is known that in Cameroon the largest sector of public service employment is the education sector, followed by health. The private health sector accounts for approximately 40 per cent of the health sector facilities in Cameroon. This proportion is likely to be the same in terms of employee population.

In the public sector there has been little or no change in the pattern of employment that has prevailed in the past one and a half decades. Some medical doctors for public hospitals and clinics have continued to be employed by the Ministry of the Public Service that also follows the career development of all civil servants. However, with the emphasis on community participation in health development in recent years, some communities have been engaged in the recruitment of personnel at local level. These are community workers who have the required qualifications and satisfy all other conditions for employment. It is through this mechanism that some financially viable district hospitals have succeeded to circumscribe the problem of staff shortage and contribute to the employment of trained and unemployed nurses and doctors. In some hospitals, such as the Nylon District Hospital in Douala, approximately one-third of the staff is made up of community workers.*(19)*

In the private sector employment of health personnel is essentially through the National Employment Fund and through direct negotiations between employing organizations and suitable candidates. The National Employment Fund is a government parastatal that keeps registers of applicants of all fields and cross-matches candidates with available jobs. It also provides some training to some potential candidates in order to facilitate their insertion into service when employed eventually. All such employees of the private sector are subject to conditions of the National Social Insurance Fund to which employers are expected to subscribe and pay in pension savings for their workers.

Decentralization is an important component of good governance. In the past two years the Government of Cameroon has decentralized the use of funds collected in public hospitals to be used to face lift public hospitals. This process in some hospitals has included the recruitment of additional staff. The perception for employment in future in the public sector, if authorized, will be based on recruitment according to available vacancies. This will enable district authorities to be able to employ their own staff and so ensure staff presence and submission.

3.2.2. Legal status of staff

It is not superfluous to restate here that most of the health personnel (at least 60 per cent) in Cameroon belong to the public sector and are considered as public servants with all the rigidity involved in such a status. It is probably due to this status that the Government could afford to reduce the salaries of medical and paramedical personnel while maintaining the salaries of some personnel such as the forces of law and order and not withstanding the deleterious effects of such a decision on the health of the population. The health worker in Cameroon is generally looked upon as one whose job requires more of compensation in “kind” than in cash. It has been and remains forbidden for a civil servant still in function to set up a private practice. To do so the status must change from the civil servant to that of private practitioner. This is the same for all categories of health personnel from nurse aides to public health administrators.

In the past ten years Cameroon has reoriented its health policy to emphasize PHC to the disadvantage of hospital-based expensive health care. This has also been associated to emphasis on cost recovery and community participation. It is therefore not surprising that cost effectiveness, rationalization and accountability have become hallmarks in the management of the system. In this context it became obvious that management staff with commercial capacity and accounting skill were needed. This gave birth to the recruitment on a community basis of personnel with a non-civil service status. Their salaries are negotiated with employers even though minimum levels are indicated depending on qualification and experience. Most of them are on contract status.

Simultaneous to this reorientation of health care has been the liberalization of the economy in Cameroon and privatization of some public services and parastatals. The response to this liberalization has been the proliferation of private for-profit clinics and non-profit health mission hospitals. Personnel in these clinics work on negotiated conditions and are more disposed to change their posts as new avenues present themselves. Contractual arrangements link them to their employers. The only constraints to which employers are subjected are those imposed by the National Social Insurance Fund, to register their workers and make regular insurance schemes and pension deposits for these

workers. The liberalization of the economy of the nation also gave rise to the creation of training schools to provide the personnel as will be seen in the next section of this paper.

3.2.3. Training and retraining, career opportunities, and mobility

This is the moment to emphasize the impact of the public service reforms on the training, opportunities and the mobility of health personnel. Among the first effects of the reforms was the initial closure of the public training schools for paramedical staff. This closure led to the quasi extermination of some categories of personnel such as health administrators, psychiatric nurses and pharmacy technicians. Of all the public health administrators that were trained in the National School of Administration only a few are still in service in the central services of the MoPH. This category of staff was trained to manage and direct the hospitals but this role has been confided to medical doctors.

The implication here is that medical doctors will be given additional training in management of resources and in accounting. However, it became obvious that the skills for management could not be taken for granted as far as physicians are concerned. After initial training on administration and management, on leaving medical school, retraining has been organized in the form of seminars and workshops for these managers. Although some of these schools were reopened for the training of nurses, such personnel have been destined for the private sector in most part. Because the private non-profit religious organizations have their own training schools, those trained in government training institutions have the possibility of getting jobs only in private for-profit health establishments. There are also a number of private non-mission non-public training schools for nurses. The opportunities for this personnel will be discussed in the next paragraph, but before that let it be recalled that medical doctors have continued to be trained in the single school of medicine in the country since 1969. Since some ten years specialist training has been going on for a limited number of specialities.

In terms of opportunities, it is worth noting here that prior to the reforms all nurses and doctors admitted into the corresponding schools were considered as civil servants while still in training and so they received stipulated allowances.*(16)* They were automatically integrated into the public service on graduation. Today, it is the contrary. All candidates admitted into schools of nursing and into the faculty of medicine and biomedical sciences are charged fees. On graduation, while the medical doctors trained in the country have automatic integration into the public service, nurses have to seek jobs now extremely rare in the private sector. Doctors and pharmacists trained abroad also have to seek employment in the private sector. These professionals, however, may benefit from liberalization and proceed to the opening of private practices, with or without authorization, in order to earn a living. The national authorities thus have to deal not only with the paradoxical shortage of personnel in public sector health facilities, but also with a proliferating illegal practice that is often of questionable quality.

In view of the foregoing, one can guess the situation of mobility of personnel of the health sector. Public service reforms did not consider the career profile for health personnel. Hence it remains an uncertainty what a general practitioner will be in the next five to ten years since admission into specialization is not automatic. The most obvious rise up any ladder of professional service is that foreseen in the public service regulations. It

enables one to pass from class 3 medical doctor to a class 1 medical doctor after some ten to 15 years if disciplined and vigilant to request such promotions which are not automatic either.

3.2.4. Organizational change and participation of workforce

The health sector in Cameroon, like all other sectors and organizations, desires to see positive change in time and space. Because useful change depends markedly on personnel and the rational use of the other material and financial resources, strategies to ensure such change have had to be put in place. According to the action plan*(3)* for the implementation of civil service reforms, the establishment of management structures and the appropriate resources was supposed to have been in place since September 1989. Computerization of personnel management, establishment of new management systems, and the training of management were supposed to have been effective since 1990.

In the health sector human resources development was improved through the creation of a directorate specific for the management of human resources. Within the framework of its activities, supervision, a major strategy for continuing training and improved quality of work, was put in place. Supervision tools for personnel performance were established for all levels of the three-phase health scenario in Cameroon. According to this set-up, supervisors from central level supervise the regional staff twice a year. The regional team of supervisors in turn supervises the district personnel four times yearly while the district teams supervise the health centre personnel once a month. Accountability in health establishments of the public sector is of prime importance. This began since the introduction of cost recovery in these institutions in 1990. Effort to ensure such accountability depended essentially on controls and audits carried out in health establishments from time to time. These episodic checks are also reinforced by inspection of services at all levels. The results of these actions have, however, been mediocre as far as the public sector is concerned.

Like all other civil servants, the health personnel is subjected to 40 hours of work per week in theory. This is achieved in practice through eight-hour shifts each working day and a weekend call duty after which there is one day of rest. This presupposes at least four working teams such that while three are rotating one is doing the weekend call duties and rest. Because of the staff shortage already described earlier, the continuity of care is often compromised. In rural hospitals and health centres with considerable staff deficiency the doctors and nurses are invariably on permanent call day and night and weekends.

Part-time work does not exist in the public sector. However, in the private sector it is not unusual to find medical practitioners, specialist nurses and pharmacists from public facilities taking loci in various clinics following mutual agreements. This activity provides some degree of employment to the personnel without permanent employment posts. Like other civil servants, health personnel are entitled to 30 days' annual leave per year and 14 weeks' maternity leave for female workers in the public sector.*(8)* A man is entitled to three days' paternity leave when his wife gives birth. Although these terms are generally accepted, they are not the result of any negotiation or consensus. They are stipulated in the public service regulations of 1994.

3.2.5. Staff performance and remuneration

Staff performance between the public and private sector is like comparison between night and day, the latter being the day. This situation is commensurate with salary packages in the two sectors in addition to a better working environment in the private sector. In the past (prior to the reforms) the private sector personnel envied the civil servant but after the reforms the situation was reversed. While public service reforms induced a more than 50 per cent salary reduction and loss in most allowances, some private sector personnel saw their pay packages doubled after the devaluation of the FCFA in 1994. Some three years ago within the public sector salaries and allowances were increased for magistrates. The magistrate and the medical doctor are both category A.2 civil servants, but the salary of the doctor and allowances together are less than 60 per cent of that of the magistrate ceteris paribus. The nurses have continued to remain below category A.2 irrespective of high qualification and professional experience. This is believed to be contributory to poor remuneration of nurses as stated by P.E.N. Taminang.*(32)*

Housing and travel allowances were reduced by more than 50 per cent for health sector personnel of the public sector. The only incentive that the public sector health personnel benefits from is the *quote part* on fees collected through consultation and surgical procedures less than 50 per cent of which is shared according to stipulated proportions among all personnel working in the hospital. This means that personnel working mainly in preventive services will have nothing beyond her/his night allowance if she/he spends nights out of her/his home up to a limited number of days per year.

Retirement benefits are granted to all civil servants including health sector personnel according to grade at retirement. The percentage of the basic salary that constitutes the retirement benefit also depends upon the number of years put in and the grade attained. After more than five years of salary uncertainty in amount and regularity of payment, they became regular since two years ago, but remain at the reduced rates for public sector health personnel.

Discipline is rigorous in the private sector due to “hire and fire” practice, which is totally lacking in the public sector.

3.2.6. Work environment, staff perceptions, equal opportunities, attitudes, and absenteeism

The public service reforms came to aggravate an already unhealthy working environment in the public sector health services. Not only was the environment physically demanding as a result of dilapidated and poorly maintained structures and equipment, but the personnel was also irritable and frustrated by the ambient political and social agitation of a new born democratic era. The effect of the poverty factor on the working environment has been described at the beginning of this paper.

Staff perceptions of the reforms have not ceased to be those of some “punishment” inflicted on the nation by the IMF and the World Bank. Some categories of personnel that were most affected by the suspension of recruitment and retrenchment include state agents,

with resultant weakness of services that depended on these groups of the staff.*(20)* Such services include the kitchen, the laundry, the electrical and plumbing services. The personnel in these categories had the perception of having been particularly targeted by the reforms. When the training schools for nurses were reopened a few years ago, equal opportunities were given to all potential candidates through the competitive entrance examinations.

In general, the attitude to work has been that of laissez-faire at all levels of the health pyramid. Holistic care is no longer a subject of emphasis among health personnel as was the situation before the reforms. The consequence of this is the reduction of consultation time per patient, preceded by long queues and waits in front of consultation offices. Absenteeism has become a common phenomenon owing to the low salaries that have obliged most health workers to trek to their job sites rather than make use of public transportation. The same reason accounts for lateness at work and lack of assiduity and professional consciousness.

In a comparative assessment on the impact and result of civil service reform Abdel Salam, et al.*(28)* agree that unlike in Cameroon, absenteeism was one of the manifestations of overemployment in the Arab Republic of Egypt.

3.2.7. Workforce occupational safety and health

The revised public service statutes of 1994*(8)* give considerable importance to the civil servants' right to protection especially in the course of executing their functions. Articles 25 and 26 deal specifically with this issue of protection and security. It is in this sense that health personnel of the public service are protected. Article 25 of the statutes affirms that the State will ensure the protection of the civil servant from all threats, insults, violence, injuries or defamation to which the staff member may be victim in the course of executing his duties. The State will also evaluate all damages incurred by the personnel and carry out restitution of expenses and repair of damages. The State may also induce legal action against the aggressor of the civil servant. Article 26 emphasizes the civil responsibility of the State in substituting for a staff member fined in court for a personal fault committed against a third party while exercising his duties. A civil servant wrongly accused for technical or personal fault in the course of exercising his functions will also benefit from protection by the State.

Concerning the health of personnel, article 31 of the public service statutes makes it abundantly clear that in case of accident or disease not associated to service the State will participate, as need be, in paying for medical attention, drugs, evacuation, hospitalization, functional reductions of limbs and acquisition of appliances. This measure will also be applicable, not only to the civil servant, but also to wife or husband, legitimate children in accordance with modalities fixed by decree of the Prime Minister. The State also ensures the protection of civil servants against professional accidents and diseases. Although some risks (violence, road accidents) have not been documented as such in Cameroon, it is known that there is an increased risk of HIV infection in staff working in surgical units and in delivery rooms if the required precautions are not rigorously applied.

Health personnel of the private sector are covered by similar regulations implemented by their employers according to the National Social Insurance Fund principles and

procedures. This is the reason why it is compulsory for employers to have all their employees registered and subscriptions paid in respect of each of them.

3.3. Reform effects on public-private mix in the health sector

It has already been stated that the health system was reoriented in 1989 to lay more emphasis on primary health care and the involvement of communities in the co-financing and co-management of health facilities. It has also been stated that the private sector provides about 45 per cent of health coverage of the population of Cameroon. Because the economic crisis that gave rise to these reforms was a financial crisis in its essence, it became obvious that the private sector could not be left out in the Government's efforts to ensure quality care for the people. This was even more necessary owing to the high quality care known to be provided by the private sector, be it profit-making or non-profit-making.

The introduction of cost recovery in 1990 ushered in the important role of the population in financing health. But communities were called upon not only to finance but also to manage the health problems of their localities in conjunction with health personnel.

Community participation in the management of health involves the identification of health problems, their priority setting, implementation of identified strategies, allocation of resources generated locally, supervision and monitoring health activities and evaluation of programmes and their implementation. This has been made possible by the creation of health committees and management committees to oversee the implementation of health programmes. These committees include democratically elected representatives of the population according to health catchment areas and health districts. These dialogue structures, as they are called, are potent organs for community mobilization and promotion of local initiatives in health.*(22)* The creation of provincial special funds for health (PSFH) provides a provincial "super structure" constituted by representatives of health districts democratically elected to ensure the management of health problems in the province. The financial resources of the funds are derived from the districts contributing from their sales of essential drugs in their health facilities in accordance with the Bamako Initiative.*(21)* Most importantly the PSFH has an important role of promoting social justice and equity in health care in the health districts. The private sector is also represented in dialogue structures at all levels.

In the past five years there has been a proliferation of non-governmental organizations (NGOs) in the health sector. Local NGOs and international ones play a significant role in health promotion.*(21)* Management of health problems has ceased to be the preoccupation of government alone. The management and coverage of populations in some health districts has been passed on to mission health services in accordance with agreements between the MoPH and the missions. In these arrangements the State, through the MoPH, provides financial or material assistance to these organizations. In some cases government doctors and nurses have been seconded to the private sector health services as need be and in terms with contractual arrangements.

In this context the MoPH plays the major role of monitoring and supervision through the district health teams. Supervisors from the central services of the MoPH ensure

supervision of the provincial services and facilities. District health teams for the supervision of health areas include staff from the private sector.

4. Lessons learned: Comparison and transferability of reform experiences

4.1. Lessons learned

In the 1996 Meeting of the African Association for Public Administration and Management held in Cairo, Egypt, it was observed that there is yet to be determined the methods for measuring the cost and benefits of civil service reforms. The need to develop a framework for analysing the successes and failures of civil service reforms and for preparing Africa for the challenges of the future was underscored.*(23)* This assertion still holds true today considering the cyclical nature of the civil service reforms in the face of a persistent need to improve output and efficiency of the public service in Africa. This is the process through which Cameroon has been going since the beginning of the last decade. A number of lessons can be learned from it in as far as the health sector is concerned.

4.1.1. Socio-economic lessons (context of SAP)

In Cameroon's Declaration of the Strategy for the Fight Against Poverty, it is stated that in the fiscal year 1994-95 the real growth rate was 3.3 per cent and in the 1997-98 fiscal year this growth rate was more than 5 per cent.*(4)* This positive growth rate of the economy contrasts clearly with negative growth of 3-4 per cent between 1986-87 and 1993-94. This gives an indication that notwithstanding the austerity measures of the reforms, the nation has made and continues to make progress towards a once more flourishing economy. This is the first lesson that seems clear as a result of the structural adjustment programme although it is yet to be estimated how much the health sector per se has contributed to this growth.

4.1.2. Political lessons

The economic and socio-political crisis associated to democratization of Cameroon seems to have precipitated or enhanced the reforms. It is difficult to say whether or not the reforms preceded the advent of pluralistic politics in the Cameroon. All the reform programmes were politicized with a resultant inter-class conflict.

There was a need to skew down the pay bill of the State through salary reductions and the identification of ghost civil servants, yet to achieve this result the State had to receive budget aid from the IMF and the World Bank. So there was a need to invest money in order to solve the problem of overspending. Besides, there was a dire need to define a social dimension of the structural adjustment in order to reduce the effects of the austerity measures on high-risk groups such and women and children.

Personnel morale and performance

There was momentous negative impact on the morale, motivation and integrity of the civil service. There is a great need to describe strategies to circumscribe the impact of this poor morale of the staff. The quality of health care delivery dropped drastically following the onset of the reforms with incidental parallel drug sales and under-the-table payment for attention of low quality. It is worth noting here that reform goes beyond seeking to modernize the civil service skills and entails anticipating political, bureaucratic and attitudinal resistance to change.

Public-private sector relations

The public and private sectors of health services worked in quasi isolation prior to the reforms of the public service, each one seeking to cater for a population that was considered to be a property of the dominant sector. In the past five years the situation is changing considerably with emphasis on the principle of subsidiarity being implemented. This has also curbed the unhealthy competition that existed within the two sectors in the past. Today in Cameroon private non-profit confessional health facilities are committed to ensure health coverage for the population in the health districts that have been allocated to them under certain conditions. Personnel of both sectors work together in district health teams to ensure supervision of the health centres and other services in the area and to train and retrain the local staff within the principle of continuing professional training. It is within this frame that local and international NGOs have become important partners in the implementation of PHC.

Decentralization

Decentralization has received acclamation as an important tool for the empowerment of local communities. The district health system in Cameroon as in most countries in sub-Saharan Africa provides the ideal framework for the implementation of decentralization under the new public management as described by M. Moore.*(24)* The decentralization process in Cameroon, as part of the reforms, has provided the district health managers with responsibility to plan, implement and evaluate their action plans in conjunction with the population. In the last financial year more than 50 per cent of the running budget of the MoPH was delegated for use in the development of districts in Cameroon as against less than 30 per cent in the past years, even when there was enough to milk from the state cow. It is expected that this decentralization of funds to the districts will get close to 60 per cent in the current financial year, 1999-2000.

4.2. Comparison and transferability

Public sector reforms have gone on for several years in developed and developing countries. The purpose of these reforms has been the same in essence, to improve the efficiency and effectiveness of the civil service within an environment of ever-increasing transparency geared towards good governance. Whereas the target of reforms in the advanced economies has been to produce a modern civil service through the new public management (M. Moore*(24)*), the developing countries have done so targeting growth of

the economy and reduction of deficits while attempting to attain an overall goal of cost effectiveness in the management of increasingly rare resources.

4.2.1. Comparison

In sub-Saharan Africa public sector reforms in general have taken place in Ghana, Malawi, Mali, Nigeria, Sudan, Senegal, and Zambia among others. All these countries were characterized by the rapidly growing public sector as reported by O.A. Lindauer, et al.*(25)* Between 1975 and 1983 the growth rates of these countries varied from 2.6 per cent per annum in Sudan to 15 per cent in Ghana and Nigeria.

Also, it was observed that current expenditure on wages and salaries as a percentage of total expenditure and net lending in sub-Saharan Africa ranged from 13.2 per cent in the Democratic Republic of the Congo (former Zaire) to 50.7 per cent in Cameroon in 1992 as reported by the IMF *Government Finance Yearbook(26)* in 1994. In most of these African countries the reforms were executed through IMF and World Bank-induced structural adjustment programmes that involved the reduction in public expenditure, gradual elimination of budget deficits, reduction in the size of the civil service, privatization of public enterprises, elimination of subsidies and price controls, devaluation of currency, and liberalization of the economy.*(23)* These were short-term measures expected to be able to usher in long-term economic growth. Cameroon was no exception. The results of these measures on the public servants including health sector personnel were not much different from one country to another. Huge sums of money were put in to finance these reforms and by 1992 approximately US$660 million were disbursed as technical assistance loans. There has also been a remarkable effort to promote capacity-building in these African countries with varying results from one country to the another.

As M. Moore puts it*(24)*, "the idea that wholesale reform of the public service could be effected in developing countries was never very convincing. Recent experience suggests that change will be gradual, incremental, and probably very variable both between and within countries".

4.2.2. Transferability

The desire for public service improvement in performance and the need to reduce costs and reduce resource wastage cuts across all African countries, given the central role of this sector in the dynamism of national development. For some of these countries the need is more urgent than for others. To achieve the desired acceleration of public service reforms that will improve sector output in such sectors as health and education, there will be a need for transfer of know-how in human resource management from the more developed to the less developed. This will avoid any attempts to reinvent the wheel in the search for public service amelioration in general.

Yet transfer of what seems good in Cameroon may not just be possible in another country because of differences in socio-economic and cultural environment and other technical variables that are likely to influence change. This means that any attempt to transfer any strategy or technique from one country to another requires that each case be

considered on its merits rather than on sentiment. What is it that can be transferred from Cameroon and to where? Because it is difficult to associate the economic growth of Cameroon in the past three years to public sector reforms per se, it becomes almost impossible to clearly determine what can be exported from Cameroon with specific reference to health sector personnel.

It seems, however, that a few positive points of the reform process may be transferable where and whence this seems most applicable and plausible. For instance, the decentralization process of district health management to local level for better empowerment of the population is worth transfer. Closely associated to this is cost recovery in public health facilities which has provided additional resources for improving the hospital as a workplace and so improving the motivation of the personnel socially and financially.

Another aspect of the reform process or result area is in the promotion of collaboration between public and private sector health personnel in providing health care and promoting subsidiarity and equity. In the long run transferability must, however, be viewed with prudence.

4.3. Conclusion

Public service reforms have been going on in Cameroon since the post independence era and will continue as long as better performance for a more cost effective and transparent administration is required. The Government of Cameroon has been developing a programme for good governance that will soon be implemented. This programme which has important dimensions of public administration, civil society participation in development, decentralization, economic, financial and social development and Justice provides a positive and futuristic view of the development of public sector reforms.*(27)* The advent of this programme and the ensuing reforms will doubtlessly have impact on the health sector personnel.

As the economy of Cameroon continues to grow, it is hoped that the fruit of this growth will go a long way to improving the socio-economic status of the Cameroonian civil servant and so this will also promote the provision of quality health care to all Cameroonians. Only then will the health sector personnel be able to see the deleterious effects of the reforms as a matter of the past.

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