Health and education are the two sectors most affected by structural adjustment policies in sub-Saharan Africa. Up to the 1980s, the paradigm of the welfare state largely dominated the public policies of post-independence African states. In the late 1940s, the Rassemblement Démocratique Africain claimed that one of the duties of the state was to provide free healthcare for citizens. During the years after independence, Africans grew accustomed to free medical care. However, as the states fell into debt, their ability to finance public services declined, on the one hand, while demand continued to increase, on the other. Against a background characterised by a reduction in national budgets and the aim of international financial institutions to minimise the role of the state, public healthcare has been in constant decline. Nevertheless, healthcare had to be financed by the state because one of its duties is to protect its citizens. Thus, mechanisms for the self-financing of public health facilities became well established (in accordance with the Bamako Initiative). In order to achieve this, however, it was essential that all national territory be served by viable health centres; in other words, structures in the most peripheral and remote areas should not be jeopardised by “deregulation.”

Thus, the sub-Saharan Africa health services were particularly affected by the changes in the modalities of governance. After the “all state” period and the subsequent “less state” period, from the early 1990s the need emerged for a degree of regulation and the planned organisation (or “rationalisation” to use the specific term) of the provision of medical care on national territory. One of the main instruments of this rationalisation was decentralisation, which took the form of the division of the national territory into health-administration sectors. Like many other sub-Saharan African countries, with the support of bilateral and multilateral donors, Cameroon undertook a reform of its

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health system in the 1990s, in compliance with various international directives, i.e. the Bamako Initiative and the resolutions of the Harare Conference, in particular.

Among other measures, the reform consisted in the establishment of a new health map, one of the main tools for the management of the health system. Very broadly, the health map is used to verify the available equipment and personnel requirements of the health system. Thus, it is also a planning instrument used, for example, to identify remote areas where health centres need to be built, to assist the teams that supervise the practices of health personnel and in the refurbishment of existing centres. Thus, this management instrument organises the health sector in accordance with the technical standards of public health. It necessitates territorial division on the basis of the hierarchised provision of care; however any new territorial division is likely to generate conflicts and negotiations, in particular when the political rationales adopted at local and national levels do not match the technical recommendations supported by the foreign aid donors.

The three case studies presented below, which were conducted in urban and rural areas in Cameroon, demonstrate that, given the actual methods of decentralisation and externalisation of development used at the local level, the dynamics of decentralisation underlying the drawing up of a new health map can lead paradoxically to the reinforcement of the central administration and, therefore, of the state. We start by describing the nature of the model on which the reform of the health system in Cameroon is based. We then analyse some concrete cases which illustrate the extent to which the negotiations at local level triggered by a reform of this kind are generally resolved at the highest level of the central administration.

The reform of the health system in Cameroon

The model

Since the Harare Conference in 1988, according to the World Health Organization, the health district has been considered as the cornerstone

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1 The data presented here was collected in 2001 as part of a research programme entitled “The local organisation of the health systems in Central Africa.” The research was financed by the Research Department of the French Ministry of Employment and Solidarity (Research, Studies, Evaluation & Statistics Dept).

2 For a more detailed presentation of these examples, see Gruénais (2002).