HOW CAN THE LOCAL LEVEL EXIST? THE CASE OF THE DECENTRALISATION OF THE HEALTH SYSTEM IN CAMEROON

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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,[1] 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.[2]

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

[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).

of the reorganisation of health systems.[3] The district is supposed to constitute the interface between the norms and strategies defined by the central level, on the one hand, and the demands of the community and the local authorities, on the other. The most important co-operation agencies, including the World Bank, have adopted this approach and have cooperated with many countries to create sustainable health districts. When developing countries choose to reform their health systems, the health districts then become the main target for donors and nongovernmental organisations (NGOs).[4]

The health district is supposed to correspond to a given administrative area and cover a specific population; its scope can, of course, vary, depending on the country and region.[5] It constitutes the smallest urban or rural unit for primary healthcare programmes. In theory, the health district is an autonomous component within the national health system; all of the institutions and individuals that provide healthcare (including private providers and traditional practitioners) are regarded as actors within the district health system. In theory, the district has a local administration, which was assigned tasks by the central health administration. It is under the responsibility of a district health committee, which is part of the district development committee and is in charge of implementing health objectives with the support of the district health team. The district, which has decision-making powers, must be able to manage its own financial resources. The district management team, which is led by a district medical officer, is responsible for the supervision of the health facilities, the collection of medical data and the coordination of the activities of all medical staff in the district. This team constitutes the link between the peripheral and the superior (i.e. provincial or regional) levels. Usually the district medical officer is not the director of the district hospital: the former must work in a public health capacity with all of the health actors in his

[3] See, for example, Monekosso (1989).

[4] For a complete analysis of the implementation of health districts, see Grodos (2004).

[5] The population admissible for a rural district is between 50,000 and 75,000 inhabitants, and 100,000 to 150,000 inhabitants in an urban area. However, the population numbers in the health districts, in which we worked in Cameroon, tend to demonstrate that theses norms can vary: there were 90,000 and 210,000 inhabitants in two contiguous rural districts in the extreme north of the country, 77,500 people in a rural district of the central region and the urban health district of Yaoundé which is dealt with below had 315,000 inhabitants in 1999.

district and hospital doctors do not always receive the training necessary for this task.

The health district should be composed of two levels of reference: the health centres, and the reference hospital or "hospital of first reference," which is usually called the "district hospital."

Each health centre serves a community belonging to a "health area" and all of these areas together make up the health district. The health centre is on the first level of the medical pyramid; this is where the medical staff, patients and the community are supposed to interact. These health centres offer primary care.[6] The services are provided by a range of health professionals, i.e. nurses and auxiliaries. The health centre is not supposed to benefit from the services of a doctor, the latter works at the level of the district hospital. The "community" is invited to participate in the management of the health centre which must have a board of management. The latter is made up of staff of the centre as well as representatives of the community, one of whom is generally responsible for the organisation of the centre's supplies, in particular of generic drugs. The health centre's board of management is accountable to the health committee and made up of representatives of the health area who collaborate with the staff of the centre to take specific—in particular preventive—action. The health centres are financially independent due, in part, to the receipt of payments from the community (in reality the centre's "customers") for the services provided and based on a cost-recovery policy implemented in accordance with the Bamako Initiative (1987).

Thus, in theory:

- the rural and urban populations set up the community health initiatives for the benefit of individuals, households and communities;
- the state provides the district management teams and the staff of the health facilities;
- the community and the health centres present medical problems to the medical district team;
- patients who cannot be treated in the health centres are transferred to the district hospital of first reference and, in very serious cases, possibly evacuated to regional or national hospitals; when discharged,

[6] Maternal and child health, family planning, treatment of illnesses and current injuries (curative care), the prevention and control of local endemic diseases.

these patients must be referred back to the health centres for follow-up visits.

The hierarchy of the health system—from the top to the bottom of the pyramid—is organised as shown in Table 1. Whether they involve the management of medical problems in general (medical information or monitoring, management of epidemics etc.) or the treatment of the patients, transfers must only be carried out in an upward direction to the next highest level (i.e. from the health centre to the district hospital, from the district hospital to provincial level, from provincial level to central level) or, in the case of back referrals, down to the next lowest level.

Table 1: Theoretical health pyramid.

Levels	Administrative structures	Competencies	Healthcare structures
Central	Central services of the Ministry of Health	Policy making and strategy definition	National reference hospitals University hospitals
Intermediate	Provincial delegations	Provision of technical support to the districts and programmes	Provincial hospitals
Peripheral	Health districts Health areas	Setting up of programmes	District hospitals Health centres

Comparing the model with the system inherited from the past

In accordance with this model, Cameroon has tried to limit the number of levels in the pyramid. However, because of choices made prior to the reform, some health structures located at levels that are not even defined in this model had to be preserved. This concerns, in particular, the case of the *centres médicaux d'arrondissement* (CMA). Prior to the reform, these health units were linked to administrative divisions called "*arrondissements*." Several *arrondissement* hospitals were built from 1980 with the aim of improving access to healthcare. However, the economic crisis forced the Ministry of Health to abandon this type of investment from 1985. With the advent of the health reform some of these establishments became district hospitals, others have disappeared.

However, the population and local authorities saw in these *arrondissement* hospitals an indicator of how the state treats their region, and gifts to the *arrondissement* hospital served the local populations as a yardstick of the true level of interest a candidate in the legislative elections took in them. Thus, it was necessary to maintain these intermediate health units (between the health centre and the district hospital) in some districts although it was clearly known that, as they constituted facilities located at an ambiguous level within the system to be established, these hospitals interrupted the continuity of the organisation of healthcare as planned by the reform.

In 2000 Cameroon had 143 health districts, divided in turn into 1388 health areas. The table below presents the number of health structures located at the different levels of the health pyramid.

Table 2: Health structures in Cameroon.[7]

Structure Type	Number
District hospitals	130
Other hospitals	67
Arrondissement health centres	92
Private and public health centres	1698

This table highlights, in particular, the gap that exists between the number of district hospitals and the number of districts created. In addition, even though there are more health centres than health areas, there are still 412 health areas that do not have a health centre. This kind of situation clearly opens the door to all kinds of competition and challenges the demarcation of the area served by health facilities located in the same region—i.e. their legitimacy or lack thereof, in offering services to nearby areas that do not, however, belong to their official "territory." This simple quantifiable observation reveals conditions that promote conflicts which, as we shall see, are further amplified by the discrepancy between the health and political-administrative divisions.

In administrative terms, Cameroon is divided into provinces, *départements*, and *arrondissements* and, in the case of some *départements*, admin-

[7] Source: Health map of Cameroon, Ministry of Public Health/AEDES (Belgium), 2001. "Other hospitals" refers to religious hospitals of national reference, and private or parapublic hospitals (for example, the National Social Insurance hospital); "Other health centres" refers to religious centres and also to structures belonging to companies.

istrative districts. The administrative district, which is the smallest administrative unit in the country, and the health district are defined on the basis of completely different criteria and often do not coincide. The country currently has ten administrative provinces, 58 *départements*, 269 *arrondissements* and 53 administrative districts. Whereas the definition of the administrative divisions is dictated by political rules, the definition of the divisions in the health system is dictated by a rationalisation of the public health system, whose primary concern is the viability of a health centre on the basis of its potential number of customers.

Local elites desperately seeking health centres

The two selected examples presented below, which are located in two very different areas of Cameroon, i.e. one in the centre of the country and the other in the extreme north, clearly illustrate the kind of local issues that have emerged as a result of the implementation of the new health map.

The first example concerns a *département* in the province of the centre, the *arrondissement* of A, which is named after the city that became its "capital." When this administrative unit was created, the worthies of A found themselves embroiled in a serious conflict with those of the locality of B concerning the location of the capital of the *arrondissement*. The creation of an *arrondissement* is an important matter: established by presidential decree, the *arrondissement* involves the simultaneous designation of a capital city which then becomes the main beneficiary of public investment and enjoys a privileged connection to the central administrative services. Given the size of their agglomeration and its advantageous geographical location at the crossroads of two provinces and four *arrondissements*, the population of locality B believed that the capital city of the new *arrondissement* should be theirs. However, some of the regime's influential figures came from the other city and managed to have A nominated as the capital city of the *arrondissement*, which therefore became the *arrondissement* of A on the new administrative map.

In order to compensate for the injury they had suffered when they lost the *arrondissement* capital, when new health centres had to be created as part of the implementation of the new health map, the worthies of locality B put pressure on both the French NGO, which was responsible for the establishment of the health system in this region, and the sub-prefect of the region to have a new health centre built in locality B. Given that this area already benefited from the services of an

efficient Catholic health centre, there was no justification whatsoever for such a project. However, as one of the managers of the French NGO stated, the population of locality B "did not listen to our explanations about the minimum population size necessary for the operation of a health centre or of the pointless competition it would generate with a centre which had been taking good care of them for a long time. I got the feeling that it was not the medical centre that they wanted, but a public institution in locality B by way of consolation for their previous administrative misadventure." Thus, in the end, the managers of the French NGO and the sub-prefect had to agree to the establishment of a public health centre in locality B just one kilometre away from the Catholic medical centre.

This example reveals the difficulties encountered on the ground when applying norms that originally took only the technical aspects of the model into account. In a context of scarce resources, the individual in charge of implementing the health reform in this area was forced to establish a medical centre that had no justification other than the appeasement of a local political conflict. In this example, the conflict relating to the local implementation of a national reform was resolved by the intervention of locally represented national actors in reaction to the pressure exerted on a foreign NGO, which was forced to make concessions that contradicted the technical rationale of its appointed task. It was clearly necessary for the NGO to make these concessions to ensure the continuation of the entire project. In other cases, the solution to a local problem can be found directly at national level, as illustrated by the following example involving a health facility in a northern province of the country.

A health district had been recently created in an area already served by a Catholic hospital. It was not long before the establishment of a public health system at local level within the framework of the health reform resulted in competition between public and private sectors. Moreover, it took shape against the background of a conflict between Catholics and Muslims, the latter constituting the administrative and political elite of this predominantly Fulbe region. The second most important person in the Cameroonian state and President of the National Assembly, a Muslim and native of the village in which the Catholic hospital existed, had long been presenting himself as a firm supporter of the development of the public service and supported the project of building a public district hospital near the Catholic one. This project was implemented by the provincial medical officer of the

time who was described by some as a "Muslim fundamentalist." In this conflict situation between the public and the private Catholic sector, the chief medical officer of the new medical district came into open conflict with the head doctor at the Catholic hospital. Based on the new health map, which assigned a specific area and population to each unit, the former ordered the latter to respect the limits of his territory and refrain from dispatching his "itinerant health workers" all over the region. The Catholic hospital refused to give in to this administrative order, stating *inter alia* that a large population spread beyond the boundaries of the area assigned to the Catholic hospital had been accustomed to Catholic medical care for thirty years. Therefore, according to the latter, the population of the area would refuse to be served by public health facilities which, moreover, would be incapable of taking good care of them and was likely to cause a medical disaster. As for the local authorities, they complied with the technical provisions of the new public health map, according to which the Catholic private hospital did not have any status or any particular position, thus justifying the existence of a public district hospital. In addition, the local health and administrative authorities accused the Catholic health service of proselytism through its hospital and of choosing the villages it served on the basis of their populations' observation of Christian values.[8]

In reality, however, the state did not have the resources to back up its policy and several years after it had been built, the public district hospital still had no doctor,[9] received less than ten patients per day, in some months facilitated no childbirths and, above all, was still being renovated. According to its staff, this public district hospital only provided services to non-local civil servants living in the area and the natives all used the nearby Catholic hospital which had three doctors, 130 beds, radiology and ultrasound equipment, surgery services etc. In the end, the provincial medical officer (and reputedly "fundamentalist Muslim") was replaced by a Christian doctor, which by common accord enabled a significant improvement in the dialogue between the local authorities and the Catholic health service. The President of the

[8] This region of north Cameroon, and most particularly its towns, was definitively dominated by Islamised Fulbe in the 19th century. However, so-called "pagan" populations, who were reputedly more receptive to Christian values and beliefs remained, in particular in the rural areas (see Schilder 1991).

[9] In fact, the district medical officer also held the role of district hospital doctor thus fulfilling two, if not three positions as one of these doctors also worked at the Catholic hospital.

National Assembly and the head doctor of the Catholic hospital reconciled in the capital, Yaoundé, and the Catholic hospital became the hospital of first reference for the district. The public district hospital, which had been built against the wishes of the Catholics, became a basic health centre.

In both of these cases, the technical rationale that dictated the demarcation of the health districts was challenged by local political issues, from which the main actors—be they the state authorities, the Catholic Church or a French NGO—drew their legitimacy in a reference framework that was quite external to the local situation. As demonstrated by the third example involving the implementation of health districts in the city of Yaoundé presented below, this type of local situation sometimes brings not only national actors or private western institutions (e.g. NGOs, churches), but also international institutional actors, such as the World Bank, into play.

Negotiating the local level with the central and international authorities in an urban context

Due to the spatial heterogeneity (ranging from the town centre to semi-rural peri-urban areas), the multiplicity of healthcare services on offer and the difficulties in mobilising very different populations, who find it easier to express their disagreement than in rural areas, the demarcation of health districts in cities appears to be an even more complicated matter than in rural areas. This heterogeneity does not facilitate the organisation or grouping of people from a neighbourhood in one and the same health centre. Moreover, the greater purchasing power of some city dwellers makes it possible for them to use private clinics and select their health services independently of any health map. The constraints specific to the urban environment undoubtedly explain the lack of commitment on the part of some donors to become involved in urban health projects.

The solution originally adopted for the establishment of urban districts was to base their delimitation on the existing administrative divisions. The World Bank had tried to establish a pilot urban health district as early as 1987, selecting the *arrondissement* as the corresponding administrative division. Thus, the health districts created thereafter matched the four administrative *arrondissements* in Yaoundé at the time. The process continued to the level of the health areas, where the demarcation again respected the existing division in administrative

areas. This correlation of health districts and administrative units made it possible to contain the difficulties posed by administrative coordination in a generalised context of decentralisation.

Initially, four health districts corresponded to the four urban *arrondissements* of Yaoundé. Nevertheless, the overlap between the health districts and the pre-existent administrative divisions could not be maintained when the number of *arrondissements* in Yaoundé increased from four to six in 1994. There were various reasons for this administrative development. President Biya's regime increased the number of administrative divisions during the transitional period from 1983 to 1987. Based on the age-old "divide and rule" maxim, this strategy made it possible to weaken some political strongholds: more administrative units meant the availability of more administrative posts and, therefore, more applicants representing potential political clients indebted to the established regime. However, technical structures are not as dynamic and flexible as political-administrative entities. Increasing the number of health districts to match with the six *arrondissements* of Yaoundé was considered as a possible solution; however this proposal met with reservations on the part of the World Bank. The World Bank, the main donor behind the reform of the health system, rejected the revision of its plan as the establishment of the four health districts in Yaoundé had already been organised and financed. Thus, the city now has four health districts for its six *arrondissements* whereby two of the health districts each cover two *arrondissements* as opposed to one.

According to the medical officers involved, the reporting of their activities to their superiors (i.e. to the two sub-prefects of the *arrondissements* corresponding to their health district) does not pose any particular problems. The two sub-prefects collaborate if necessary, even if, in the words of our informants, it is easier "to manage one sub-prefect than two." The chief medical officers of the district health units simply refer to one or other sub-prefect, depending on the location of the issue at stake.

Nevertheless, juggling between two sub-prefects does raise issues regarding the clear identification of the relevant administrative representative, i.e. when the district medical officer needs to request a meeting with the administrative authority which sub-prefect should he ask? The health districts in Douala which straddle contiguous *arrondissements*, i.e. the opposite situation of the health districts of Yaoundé, present a particularly striking example of the difficulties that can arise in such a situation. In this case, each sub-prefect has to deal with two district

medical officers, whose respective districts also come under the authority of another sub-prefect. This type of situation obviously raises problems of representation for the district medical officer who must attend the meetings organised by all the sub-prefects, to whom his district is subject administratively. The situation can be problematic, for example if the district medical officer has the technical authority to organise meetings, but does not have the administrative authority to convene the community representatives of the *arrondissement*, a prerogative of the *arrondissement* sub-prefect and the provincial governor. Furthermore, problems of precedence between the two sub-prefects can arise on the occasion of official ceremonies, thus the health service has no other choice than to refer to a higher, more central authority, i.e. the prefect. In the case of one of the two medical districts of Yaoundé, which is divided between two *arrondissements*, the history of their creation made it possible to alleviate such problems: the *arrondissement* of Yaoundé VI emerged from the partition of the *arrondissement* of Yaoundé III, the sub-prefect of "big Yaoundé III" remained sub-prefect of the new smaller district of Yaoundé III and his relationship with the sub-prefect of Yaoundé VI has been described as akin to that between an older and younger brother, a qualification further substantiated by the fact that the latter is, in fact, younger than the former.[10] As a matter of fact, due to the heterogeneity of their demarcations, the decrees that created the *arrondissements* did not specify which authorities should supervise the health districts, thus creating a legal gap on this level.

Nevertheless, these arrangements, which result in the prioritisation of the most central levels under a reform that was intended to promote decentralisation, cannot resolve all of the problems. The sub-prefectures employ and manage some of the healthcare workers, in particular the ancillary staff of the health centres (maintenance staff, nursing auxiliaries). When, for technical or accessibility reasons, the demarcation of the health areas further dissects the administrative boundaries, the management of the healthcare workers becomes an impossible task. This situation arose, in particular, in a health centre that served a health area located in the *arrondissement* of Yaoundé VI, but had been built

[10] In January 2002, this district was finally divided in two at the very end of the project financed by the World Bank; If the state wishes to comply with the dynamics of the health map, it will have to find the funds necessary to establish a new district hospital, and the existing medical areas will have to be re-organised to facilitate the definition of the health centres' reference structures.

in a neighbourhood belonging to Yaoundé III and resulted in certain problems with regard to personnel management: it was unclear which administrative authority was responsible for the assignment and assessment of staff employed by the territorial administration in a medical centre that was "not in the right place." This administrative dispute could only be settled by closing the medical centre and re-establishing it "in the right place."

Thus, in order to avoid delays and red-tape frustrations, if they live in the capital city, the actors on the most peripheral levels of the new districts prefer to go directly to the most central level, i.e. the Ministry of Health, and circumvent the intermediate level, i.e. the district. Therefore, the health instance that is supposed to constitute the very basis of the reform of the health system is denied its function.

Autonomy or marginalisation of the peri-urban area?

In fact, the question arises as to the extent to which this reform of the health system, which is supposed to grant a greater autonomy to the peripheral structures in a general context of decentralisation, is likely to result in the marginalisation of this periphery and abandon it to fulfil tasks that are neither rewarding, nor attractive or lucrative.

Indeed, the first-line healthcare units and the establishments to which patients are initially referred (health centres and district hospitals) are the least well equipped, have the least qualified and skilled staff and provide the least specialised care. They are sometimes situated in locations which are rather inconvenient for staffs who are accustomed to the living conditions of the major urban centres where they studied and trained for relatively long periods. The various corrupt practices, which are known to be widespread among the employees of African health facilities seeking to compensate for their low salaries,[11] are not widely pursued in these centres. Healthcare workers occupying positions that could, in theory, provide opportunities for misappropriation actually fail accumulate significant illicit gains because the equipment in the district health centres is not very specialised and, thus, relatively inexpensive, primary medical care is provided at a low cost to a poor population and the stocks of medical products held by the centres is

[11] The corruption practised by the health staff in Africa has been observed in almost all countries; for a recent description of these practices, cf. Olivier de Sardan (2001).

limited. In addition, since the financial administration remains highly centralised and since there is no banking network, the staff must travel to the main town of the province or even to the capital to receive their wages or to obtain the public funds allocated to them. Considering the difficulties always faced when dealing with the financial administration (lengthy procedures, bribes to be paid at each stage) many simply give up on the attempt to obtain their funding,[12] and this contributes to the further deterioration of services.

In fact, the financial autonomy now granted to the healthcare structures as a result of the implementation of the Bamako Initiative mainly benefits the main central establishments. In contrast with the situation in the previous structures, the significant role of the pharmacy, the cost of the equipment and the fees charged to the "rich" population living in the urban centres for specialist consultations make the handling of significant sums of money necessary, thus making it more likely that situations will be created that could provide lucrative opportunities for the misappropriation of funds. Moreover, the proximity between the medical care structure and the central administration makes it possible to resolve problems more quickly and to ensure that salaries and allocated funding are paid. For example, the increased revenue enables central hospitals to recruit personnel themselves who are not financially dependent on the central administration but on the health facility in question. As a result of this autonomy, the central healthcare facilities are less vulnerable to the whims of the central administration when it comes to the allocation of staff. Moreover, the staffs who work in facilities located at the top of the healthcare pyramid in an urban environment tend to be more satisfied with their assigned locations.

It should be noted, therefore, that general healthcare, which is the prerogative of the peripheral structures, is less and less likely to receive the support it requires.[13] Indeed, a desire to achieve greater visibility

[12] This is one of the reasons for the very low rate of execution of public budgets which is often confirmed in the health sector.

[13] Cf. preamble to the final declaration of the "Healthcare for All" conference, Anvers, Institute of Tropical Medicine, October 2001, which was staged under the aegis of the Belgian Presidency of the EU, which states that "During its EU-presidency in 2001, Belgium will focus the international agenda on the unacceptable state of health in large parts of the world. While reinforcing the political momentum for the fight against AIDS, TBC and malaria, it will in particular draw attention to the need to develop and strengthen accessible and efficient healthcare services, as a basic human right, as the cornerstone for sustainable health systems, and as an essential element in the renewed world-wide efforts to reduce the burden of infectious and poverty-related diseases". A

(for the donors, states, experts and technicians involved in these programmes) combined with a certain ideology originating from the pervasive sense of the urgency of the fight against the main diseases (in particular AIDS, tuberculosis and malaria) explains the rise of vertical programmes, as demonstrated by the creation of the Global Fund To Fight AIDS, Tuberculosis and Malaria. However, it is a known fact that it is very difficult to integrate the initiatives of these vertical programmes, which require very specialised and targeted action, with the general medical activities implemented at the level of the first line structures.[14] Moreover, the national directors of these vertical programmes, who negotiate the financing of their programme directly with the bilateral and multilateral donors, may use decentralisation as a pretext for preventing the flow of their funds down to peripheral structures, which are supposedly autonomous and should have the same competencies as central structures for the implementation of activities to fight specific pathologies. The national programme against AIDS in Congo Brazzaville in the 1990s, which considered that there was no need for the national programme to continue its support of the regional programmes, represents a particularly good example of this phenomenon. However, at the same time, the national programme continued to position itself as the sole partner of the foreign institutions (if only because of the practical difficulties posed by direct communication with the peripheral authorities), and remained the manager of all national AIDS projects which could only be implemented at central level.[15]

Thus, in a context of this nature, associations that could be expected to act as centrifugal forces have, in fact, little room for manoeuvre. In the case of Congo Brazzaville and the fight against AIDS, given that the national programme alone could give the *imprimatur* for any project involving its area of activity, and given the ties of dependency, and even clientelism, that bind the central authority to the associations engaged in the fight against AIDS,[16] the national programme came to be in a position to decide which associations could exist and were, therefore, likely to obtain external funding for the implementation of activities at local level. In Cameroon, however, as if to anticipate this risk of being

complete report of this conference can be found in the special issue of *The International Journal of Health Planning and Management*, n° 18, Oct.–Dec. 2003.

[14] Cf. Van Lerberghe & de Bethune (1998).

[15] Gruénais (2001).

[16] Delaunay (1998).

marginalised, as soon as they had become established on the periphery, most of the officially registered associations (i.e. 51 out of 66) engaged in the fight against AIDS based themselves in Yaoundé.[17]

However, even if an association is based on the periphery, it does not necessarily follow that the main frame of reference for its activities will be situation at local level. A decision of the Ministry of Health of Cameroon of April 14, 1999 "defining the framework of collaboration between the Ministry of Public Health, the associations and the NGOs" stipulates that an association wishing to collaborate with the local health authorities must obtain approval from the Ministry of Health. This approval can be obtained on the submission of a file at the Provincial Health Office which must transmit the file "together with a well-founded position" to the Minister. Article 5 of this decision specifies that "the Minister in charge of Public Health has a period of 30 days from the date of receipt of the file to decide on the application. Once this period has lapsed, its silence is an expression of approval of the collaboration." According to Article 6 of the same decision, "the association or organisation must obtain the prior approval of the Minister of Public Health for any change in its area of intervention." Thus, in the final analysis, as pointed out by a provincial medical officer, the central authorities alone decide which association will receive the approval necessary for collaboration with the local health authorities. The local representative of the Ministry must provide a "well-founded position" on the matter but can be ignored by the Ministry, i.e. if the provincial medical officer's opinion of the potential collaboration is negative, but the Minister still does not reply, the association will be approved all the same. The aforementioned medical officer stated in less diplomatic terms that a direct relation could now be established between the heads of the local associations and the Minister, disregarding the intermediate level, i.e. the provincial medical officer. However, in view of the fact that these local development associations are usually run by members of the elite, i.e. members of the government or Parliament who come from the areas in which the associations in questions are active, it is clear that this regulatory text officialises a privileged relationship between a central political authority and its stronghold, a relationship often accompanied by strategies for obtaining the resources allocated for development.

[17] Eboko (2002).

To conclude, it emerges clearly from the case study presented here that the implementation of a new health map intended—in the minds of the people who conceived it—to reinforce the peripheral level by granting it greater autonomy, can in fact lead to the reinforcement of the central level and the development of clientelism due, in part, to a lack of any real political will to support this peripheral level and, in particular, to the imposition of a model of organisation on areas that are under-administered to a very significant extent. As a result, the peripheral levels of the health pyramid sometimes only have a purely formal and potentially conflictive existence which enables the regular reaffirmation of the complete power of the centre, the only level that is capable of resolving these conflicts.

It should be noted that these findings on the Cameroonian health system confirm observations made in other developing countries, particularly in Latin America where it could be noted that "...decentralization may be viewed as both product and determinant of political conflict... In Latin America, decentralization to municipal government can strengthen the hand of dominant groups."[18] It should not, however, be concluded that these situations are specific to the developing countries. For example, in relation to the management of health issues by the municipalities in the Bordeaux region of France, J. C. Guyot states that "Basically, since the 1980s, decentralisation has barely changed the rules of the game, health policy remains a matter of the state or the national social welfare organisations."[19] In fact, in this field, in Cameroon as elsewhere and, undoubtedly, in many fields of public action and development, "apart from some rare exceptions, developers tend to disregard politics... [and] decentralisation is reduced to basically technocratic approaches."[20] However, politics cannot always be easily disregarded, even in the health sector: in practice, decentralisation can help to reassert the project of a unified state against local centrifugal forces.[21] In fact, given the knowledge that neither decentralisation measures nor the existence of associations and NGOs are determining factors, the entire situation would prompt one to question the real conditions surrounding the existence of a public policy at local level.

[18] Collins (1989: 168–171).
[19] Guyot (1995: 51).
[20] Lemarchand (1998: 11).
[21] This was also acknowledged in quite a different context concerning the measures taken by the Senegalese state in relation to the Casamance region (cf. H. Dramé 1998).

For the time being, it is above all the worthies of the governing regimes who end up negotiating the role of the state at local level. The local entities created in the course of decentralisation appear to have some autonomy from a formal and administrative point of view, but the rules of the game played by the local state are ultimately defined by central state actors. Moreover, the mechanisms established as part of the decentralisation process create new channels for intervention by these actors.

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