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British Commercialization of Healthcare in Southern Cameroons 1922-1961: Post-Colonial Impact on Healthcare and Cross-border Trade

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Abstract: *It is an established fact that healthcare practices existed in what later became Southern Cameroons before Western intrusion. Colonization and partition led to the introduction of Western biomedicine. Its introduction and sustenance was accompanied by a financial/monetized aspect and this was inherited by the administration of West Cameroon at independence. Using British Southern Cameroons as the theatre, this paper sets out to evaluate the impact of monetized commercialization of healthcare services on trade and healthcare sector after colonialism. The paper was informed by both primary and secondary sources. Archival information and oral interviews made up the primary sources while books, published articles and dissertations constituted the secondary sources. The descriptive historical approach was employed in the analysis of the work. The study submits that; the introduction of monetized commodification in healthcare services during the British mandate was a pace setter for illicit trade and poor healthcare practices after independence. The administration of Southern Cameroons as an appendage to British Nigeria while introducing financial charges on healthcare services eased neocolonial ills and threatened the quality and affordability of healthcare in the territory.*

Keywords: *Cross border crime, biomedicine, colonization, Southern Cameroon, Nigeria.*

1. INTRODUCTION

African healthcare practices preceded European intrusion in Cameroon. The German annexation of Cameroon opened the territory up to western influences amongst which was biomedicine. The outbreak of the First World War and the eventual defeat of the Germans in 1916 set the pace for a change of colonial authorities in the territory. The German defeat led to the convening of the Paris Peace conference which resulted to the creation of the League of Nations and the official partition of Cameroon. This decision of the League gave 1/5 of the former German protectorate to the British and 4/5 to the French. Article II of the British Mandate agreement gave Britain the task of ensuring the wellbeing of the colonized. It was in line with this article II and the British undeclared economic agenda that Britain began imposing Western biomedicine on Southern Cameroonians (Ngoh 2019, 14). To achieve her conspired goal of extending the tentacles of colonialism through the mandate, she aligned with article 9 of the mandate commission which gave her the option of administering the mandated territory as part of her colonies in the continent. To this effect, Britain administered Southern Cameroons as part of Nigeria. In 1924, as an extension from its British Nigerian colony, Britain through her Resident in Cameroon introduced hospital fee in colonial medical facilities. The introduction of financial charges for healthcare services was a new concept to Southern Cameroonians who were accustomed to their tested traditional practices that relied entirely on compensations in kinds. The administration of Southern Cameroons as an appendage to British Nigeria rejuvenated cultural ties/affinities that existed in the pre-colonial era and this served as catalysts for trade between Southern Cameroonians and British Nigeria. When both territories gained independence in 1961 and 1960 respectively, the law of territorial integrity, sovereignty and the notion of physical boundaries set in between these states (Fanso 2017, 243).At independence, the state of the Cameroon-Nigerian border through Ekok was porous principally because of the interconnectedness of these territories

during the Mandate and Trusteeship periods. This was an exciting avenue for smuggling and clandestine sales of pharmaceutical drugs and equipment. The availability of these drugs at the disposal of the local population and the presidential decree authorizing the creation of private hospitals further threatened the healthcare sector as it became a business for profit and not a service to ensure quality human capital in the country (Mougbakuo, 2018, 72). The introduction of financial charges for medical services in Southern Cameroons impacted the health sector and international trade between Nigeria and former Southern Cameroons in diverse ways. The key question here remains how Britain administered Southern Cameroons especially the health sector?

2. British Administration of Southern Cameroons Health Sector

The League of Nations Mandate Agreement in part, instructed Britain to improve on the health of Southern Cameroonians. This same mandate agreement in its 9th article made provisions for the administration of Southern Cameroons as part of British Nigeria and consequently, the territory was administratively attached to Nigeria. The implication of this was that all administrative services in Southern Cameroons were connected with similar services in neighboring Nigeria. The colonial government was organized into sections such as; educational, agricultural, and medical sectors amongst others. The organizational structure of the medical department in Southern Cameroons was determined from Nigeria as the health sector in Southern Cameroons was answerable to the Director of Medical and Sanitary Services(DMSS) in Nigeria. (Ngwa and Asongwe, 2020, 638).Decisions on the provision of healthcare and other welfare services in Southern Cameroons were the preserve of the DMSS in Nigeria. Through medical doctors and Divisional medical officers, healthcare services were extended to Southern Cameroons (Forkusam 1978, 36). When British Nigeria gained independence on October 1st 1960, Southern Cameroons was given the option in 1961 to gain her own independence either by joining the independent Republic of Cameroon or the Federal Republic of Nigeria. British Southern Cameroonians opted for independence by reunifying with the independent Republic of Cameroon. The administration of the health sector in Southern Cameroons did not go void of financial expenses that were to be provided by the natives. The administering ties between Southern Cameroons that existed during the mandate and trusteeship periods made it challenging for the trade routes that existed between both states to be easily cut off consequently, post-colonial repercussions.

3. Introduction of Hospital Fees in Southern Cameroons a Base for Commercialization

The part of Cameroon that later became Southern Cameroons had a well-structured healthcare system that cared for sick persons and pregnant women through herbalists, traditional birth attendants and ritualists. Within this healthcare system, healthcare providers were compensated in kinds. In some instances humanism characterized the services of herbalists and traditional midwives (Andeck, 2019). With the colonization of Cameroon by the Germans and the later partition of the territory as a result of the First World War, the territory felt under the control of Britain and France.1/5 of the territory was given to Britain as a mandate of the League of Nations under a mandate agreement. Article Two of the British Mandate agreement in part required Britain to ensure the social wellbeing of the population. In fulfilling this Clause of the mandate agreement, Western biomedical healthcare practices were extended to the territory (Asongwe,2017, 26).With the extension of western biomedical services to Southern Cameroons, the British colonial government later introduced medical fees. In 1924, the British Resident in Cameroon Arnett introduced a medical fee for all services provided at the different health facilities. This fee was later suspended in 1928 and in 1932 during his second mandate as British Resident in Cameroons, a medical fee was reintroduced (Ngoh 2019, 153-154). The reintroduction of medical fees in Southern Cameroons was inspired by the British decision to introduce medical fee for all services rendered by expatriates in Nigeria[1]. Southern Cameroons being administered as a province under British Nigeria, this decision was extended to the territory. Medical fee levied on patients and expectant mothers varied in the territory per division. By 1941, the fees for medical services were as follows. In the Victoria and Kumba Divisions, out patients paid 6 pence weekly for medical care while in the Mamfe and Bamenda Divisions, patients paid 2-4 pence

[1] Nigerian Gazette, No 57, vol.19, November 24th 1932, 875-876)

depending on the number of times the patient visited the hospital. The fees for in-patients were higher as they paid 5shielings (Ngoh 2019, 153-154). By 1951, the hospital fee had included women and children. Men were classified according totheir tax rates before being charged for medical services offered to them[2]. This was followed by the decision of the Cameroon Development Corporation (CDC) in May 1956 to introduce a medical fee for employees and their dependents whilst in CDC hospitals and health Aid posts[3]. With the very poor sanitary and health conditions in the different plantations, workers resorted to traditional healing practices due to very low wage rates that could not permit them support cost of living and cost of healthcare. By 1959, the British Government had passed the Hospital fee Ordinance which clearly stipulated the charges levied for the different services at the hospital and maternity centers. Maternity and childcare care fee stood at 5pounds while other out-patients cases were at 5-10 pounds and in-patients varied depending on the duration of the patient in the health unit or hospital. When expatriate medical officers had to treat cases that could not reach the hospital, the patient had to cover the total cost of the expenses[4].It is a constituted fact that the economy of British Southern Cameroons was financed with income generated from within the territory through court fines, taxes amongst others. Conscious of this economic pressure on the local population, the introduction and progressive increase in charges for medical care in the territory was therefore a strategy of trade to the interest of the colonialist/healthcare provider(Lang, 2019, 104).With the careful shift from direct administration (colonialism) to indirect administration (Neo-colonialism), the later deepened the situation as there was a dual interest, being that of the partway to neocolonialism (political Leaders) and the neocolonialists[5].

4. THE STATE OF HEALTHCARE AFTER INDEPENDENCE

After independence in 1961, there was continuity in the health sector in west Cameroon. In 1966, the parliament voted law N°66/DF/311 of July 10th 1966 which laid down the principles for the practice of medicine in the territory. According to this law, hospital fees were maintained in all hospitals and the federal government was in charge of subsidizing medical care in the state[6].With the fall in cocoa and coffee prices in the world market in the mid-1980s, resources became scarce in Cameroon to finance state projects such as the health and general administration. During this time, farmers and planters slumped into poverty and the economy of Cameroon fell into an economic crisis. This new environment characterized by cash problems compelled the country to acquiesce to the joint request of the International Monetary Fund (IMF) and the World Bank (WB) through the structural adjustment programs (SAPs). This program had as intention to revamp the economies of formal African colonies that were faced with economic crisis. In order to fully benefit from the masked Structural Adjustment Program, the Cameroon Government had to ratify the Bamako Initiative. By the ratification of the Bamako initiative, the government of Cameroon agreed to reduce all forms of temporary or permanent exclusion in health services (Moungbakou 2018, 72).The unexpected outcome of the Structural Adjustment Program was a further indebtedness of the Cameroon government. By the mid-1990s, Cameroon became part of the Heavily Indebted Poor Country initiative schemes of the World Bank. This scheme loaned money to some African countries on extremely high interest rates to the detriment of economic growth in these countries. To further sustain basic state economic management, the government of Cameroon in 1990 enacted a law authorizing the creation of private health facilities in Cameroon. This was followed by a reduction in the salaries of civil servants in 1994 and a devaluation of the franc CFA. Medical doctors were highly affected and the healthcare sector as well as trade in pharmaceutical products felt the impact of the commercialization of healthcare services introduced during British rule in Southern Cameroons.

[2] Buea National Archives (BNA)Sc/a/1953/5, Maternity and dispensary fee
[3] CDC, central archives, annual reports for the Cameroon Development Corporation for the year 1965.
[4] Southern Cameroons Gazette, no.27, 5th November 1959.
[5] The dual interest referred to here is the benefits the former colonizers had to get from healthcare services and the share to be gotten by the political leaders in Cameroon. Neocolonialism created avenues for the administration of former colonies to remained glued to Western direction and manipulation for western economic gains.
[6] Buea National Archives (BNA) Sc/a/1966/2, presidential decree of ethics for general duties of the medical doctors in the Federal Republic of Cameroon 1966.

5. Impact of the commercialization of health Care in post-colonial Cameroon on the healthcare sector

The transfer of healthcare management from the community to the administration during the British mandate in Southern Cameroons opened up the territory to auto medication. When the economic crisis set-in in the mid-1980s, subsidies were withdrawn from the healthcare sector. This was followed by the authorization of private health units in the territory which had profit at the center of their activities. Egbe Philip a healthcare provider in the present North West Region asserted that; "the clinic is my business… as long as I want to treat people; I am concerned with my profit"[7]Most healthcare providers levied financial charges for healthcare services that the local population found it costly above their income levels. These private hospitals were easily accessible but ironically were accessed only by the minority rich population who could afford the cost of healthcare in these centers. The majority population that could not afford the cost of these healthcare centers resorted to auto medication. With the poverty that stroke farmers, there were fewer resources to assure healthcare in the territory. A greater proportion of the population resorted to over-the-counter drugs. Most of these drugs were shipped by unauthorized suppliers. This happened since former employees who were laid off due to the economic crisis found the sales of pharmaceuticals as a profitable business that could sustain livelihood. Once a community member had symptoms of a disease or infection and was treated in the hospital, any other family or friend who had such symptoms was immediately given same medication without diagnoses. Unskilled roadside vendors equally prescribed drugs to sick persons. The consumption of some of these drugs led to death of individuals and termination of pregnancies that cost the life of the expectant mother (Geest 2002, 80).

To add, the commercialization of healthcare services introduced during British rule in Southern Cameroons brought into the health sector neglect on the part of the healthcare providers. In contrast to the provisions of the 1990 law authorizing the creation of private health centers and prohibiting state contracted doctors from practicing their profession in the private space, most state contracted medical doctors got involved in operating private clinics. According to section 13 of the law authorizing the practice of private medicine, medical doctors contracted by the state were not permitted to operate private health facilities[8]. Contrary to this law and due to the salary reductions that took place nation-wide in 1994, most medical doctors operated private health centers and some on illegal basis. To gain income to meet up with their daily expenses, medical doctors deserted their duty posts to gain extra income from their private health centers. Patients waited for medical doctors for very long hours at state hospitals and some who travelled over very long distances slept on benches in hospitals with the hope of meeting medical doctors. While others lost their lives attempting to receive treatment from government hospitals that were relatively affordable, part of the local population relied on road side vendors and traditional healers for their health challenges. Some medical doctors who were assigned in rural communities failed to assume duty but rather remained in township working in private clinics. Nurses in these hospitals where doctors were absent from their duty post resorted to the clandestine sales of drugs and other pharmaceuticals[9].Some nurses levied extra charges to the clients before they could receive medical attention.

Tribalism and nepotism characterized most government hospitals. Patients preferred visiting hospitals where they had acquaintances and their natives who could provide healthcare to them on the bases of "*Man- Know- Man*". This consequently increased the chances of resilience of traditional medicine as most natives preferred their herbalists, ritualists and traditional birth attendants who were readily available to provide the necessary care and at very affordable and comfortable conditions.

The commercialization of health care in British Southern Cameroons brought to light incompetent healthcare provider. The authorization of private health facilities created the need for more nurses and midwives to serve in these health units. With the financial benefits involved in health care delivery, numerous institutions surfaced with the said task of training healthcare personnel. Most of those trained in these unauthorized and clandestine schools were recruited to serve in private health facilities with very low qualifications and incompetence in the practice of Western biomedicine. With

[7] Interview with Egbe Philip E,N, Bamenda 08 July 2023
[8] Law No.90-036 0f 10th august 1990 relating to the organization and practice of private medicine.
[9] Interview with Alota Grace, Bamenda 20 August 2023

the high unemployment rates in Cameroon (7.81%) during the 1990s, many of these poorly trained nurses and midwives resorted to the creation of roadside medicine stores where they enhanced local resilience of 'over-the–counter' drugs and auto medication. Prescriptions were done to patients and pregnant women without prior medical examination. Most of these roadside vendors were known and described as "Doctors"[10]This greatly improved the rates of unsafe abortions and the consumption of restricted drugs as the interest of the vendors remained the economic benefits they received from their activities. These health challenges did not go without the different trade routes created by the British administration of Southern Cameroons as a Province under British Nigeria.

The commercialization of healthcare services in Southern Cameroons during the Mandate and trusteeship periods gave room for traditional medicine to survive (Lueong and Ngwa, 2023, 1536). Before the partition of German Cameroon in 1916, healthcare services were provided in the territory and payments were generally in kinds. In some cases, humanism characterized the provision of healthcare services and it was at the discretion of the patient to decide on how to compensate the healthcare provider. When Britain took over the territory and transformed the system of compensation to monetary terms, a greater proportion of the population resorted to traditional medicine which was accessible and affordable. This was coupled with the fact that most health centers and medical units were found in urban areas and entailed that the local population cover a long distance to access these services which were also costly. The introduction of medical fees added to the communication challenges that prevailed in the territory further scared many natives who resorted to traditional medicine

6. Impact of British Commercialization of healthcare services on post-colonial trade

During the British administration of Cameroon, port facilities were created and developed in Victoria and Tiko to ease the transportation of raw materials from the territory and plantation firms (Fanso, 2017, 242). Beaches were developed in some parts of Kumba and Mamfe Divisions of Southern Cameroons to ensure communication ease between Southern Cameroons and British Nigeria. Added to these were seasonal roads that linked the Mamfe and Nkambe Divisions of Southern Cameroons to Nigeria. After independence, trade continued between Cameroon and Nigeria through the trade routes established during the Mandate and Trusteeship periods. This was with great ease as the local population mastered the trade routes due to the policy of Indirect Rule which gave them access to the management of their affairs amongst which was trade.

The outbreak of the economic crisis in Cameroon in the mid-1980s, the national salary cuts, currency devaluation and the liberty laws that gave way to private individuals to operate health facilities served as a gateway for the smuggling of pharmaceuticals. The improvement in transport and communication network eased the illicit movement of goods particularly pharmaceuticals. There were entries that linked former Southern Cameroons with British Nigeria. For example Abongshie in the Nkambe Division and Ekok in the Mamfe Division of former Southern Cameroons had trade routes that linked the present day Taraba (Abong) and Cross River states (Ikom) in Nigeria respectively. Due to the profitable nature of healthcare services thanks to its commercialization, traders and unskilled health provider made use of these routes shaped by colonialism to make entry with drugs and other pharmaceutical products and equipment unnoticed. Traders who supplied contraband and poor quality drugs made use of these entry points to satisfy clients who were mostly roadside vendors and illegal healthcare centers. (Magaret, 2000,54,62). The rampant consumption of drugs especially in school milieus gained grounds from these vendors. Youths and other minors gained access to hard drugs because the interest of the vendors was the profit they made from their business and not the effects it had on the communities.

The commercialization of healthcare during British administering rule in Cameroon gave way to the supply of unauthorized and poor quality pharmaceuticals and medical equipment. Technological advancement and the liberalization of the Nigerian economy created entrepreneurs whose areas of entrepreneurship was in the importation of pharmaceutical products and medical equipments. Most of these entrepreneurs were Nigerians and Cameroonians who mastered colonial trade routes and

[10]Interview with Alota Grace, Bamenda 20 August 2023

employed them in the illegal importation and supply of these products. These traders in most cases were unlicensed and the few who had licenses used illegal trade routes in order to evade custom duties. To further increase chances of high profits and turnovers, where custom duties had to be applied, traders and entrepreneurs employed other techniques to ensure the products reached their destinations which were often the local populace. Some transported these drugs through automobile tyres, masked containers and through state agents. To a greater extent, the success of these unauthorized supplies in the markets was the complicity of custom officials. Most traders in pharmaceuticals succeeded in meeting their targets due to the corrupt nature of custom officials. Some of the unauthorized suppliers were intercepted by the custom officials and through bribes; the products were left to reach the targeted population through roadside vendors. Of all the border entries into former Southern Cameroons, the Ikom-Ekok corridor was the most fluid and witnessed a high percentage of smuggling in pharmaceuticals and other products. On this border, the Mfum Bridge was the only bridge that linked the two countries. It was on the two sides of the bridge that customs controlled movements of goods and persons. Logically with the existence of this single bridge, the transportation of illegal and illicit goods was supposed to be at minimal. According to Ndeh, (2017, 35), there were more than 10 illegal cross points between Ikom and Ekok. In these illegal cross points like Ekang, informal trade was done without the regular checks of custom officials. This gave way for the smuggling of pharmaceuticals into Cameroon. Apart from the use of bush paths these smugglers used the main roads but offered bribes to security officials and custom officials who were usually more interested in getting "settlement"(Magaret, 53, 59). Bribery encouraged by government officials played an important role in the smuggling of pharmaceuticals. When the smugglers successfully crossed into the country, they easily made their way to their destinations due to the bribes they offered to security officials on road checkpoints.

The smuggling of pharmaceuticals into Cameroon had serious repercussion on national security. This included social security and health security. On the health plan the smuggling into the country of pharmaceuticals led to the sale of drugs whose qualities were doubtful. Some of the drugs were not stored under the appropriate conditions and temperatures. Most street vendors exposed the drugs to sun and thus they became dangerous and posed a health hazard to the gullible population that consumed them. The smuggling of pharmaceuticals encouraged the phenomenon of auto-medication by the population. The drugs were usually cheaper than what was sold in standard pharmacies and the procedure of getting the drugs was less cumbersome and thus attracted more clients. Poverty or economic hardship was a major factor that pulled people to getting the drugs[11]. The administration of drugs without proper diagnosis equally rendered the health of the population insecured.

The smuggling of pharmaceuticals equally promoted the creation of unauthorized health facilities in different neighborhoods of the study locale. The creation of these facilities was easier because the unlicensed or quark practitioners or personnel had easy access to drugs. This practice had negative effect on the health security of the local population. Most of the practitioners in these facilities indulged into other illegal activities such as criminal abortion which in most cases were poorly done and led to death or other health complications[12]. On the social aspect, the smuggling of pharmaceuticals led to the illicit consumption of drugs by youths. The societies witnessed an upsurge in the consumption of some drugs without prescription. The principal drug consumed in this case was tramadol. This was done by youths and school children who abused the intake of the drug. Most of these drugs were sold by the roadside vendors and those who operated health facilities that were unauthorized. Due to the fact that their interest was to get money they sold such drugs to whoever was ready to buy. The abuse of the drugs by youths and students radicalized them and as such they indulged into other crimes like vandalism in the school milieu, prostitution theft and assault amongst other. This phenomenon made the society to be more insecure since many armed men and other notorious youths were easily radicalized by the drugs.

7. CONCLUSION

The colonization of Cameroon by the Germans in 1884 was a takeoff point for western influence in the territory especially in the field of healthcare. An outcome of the annexation of Cameroon was the extension of the First World War to Cameroon. As a result, there was a partitioning of the territory

[11] Interview with Enoch Ngwani Bamenda 28th August 2023
[12] Interview with Kennedy Chefor Bamenda July 14th 2023

which gave what later became known as Southern Cameroons to the British under the supervision of the League of Nations Mandate. In designing the task of the British over the Mandate, the League of Nations charged her to ensure the social wellbeing of the Population of the mandated territory. Hidden in the colonial agenda was the hope to spread western cultures and ways of live as well as gain chances of economic exploitation. To achieve the masked economic agenda, healthcare was provided to ensure a healthy workforce. In the provision of healthcare, the colonizers did not make provisions for the services and therefore relied on funds from the colonies to provide the basic healthcare. In realizing this objective, medical fees were introduced in the territory. The fee progressively increased as the years passed by. At independence, the territories inherited Western biomedical healthcare practices without a great mastery of its operation. The decision to inherit this healthcare system and other colonial practices resulted to an economic crisis that negatively affected government expenditures. Consequently, the health sector faced challenges such as auto medication, neglect, poor quality providers, interest oriented healthcare providers. Smuggling and sales of unauthorized pharmaceuticals and medical equipments characterized the health sector. Contrary to eurocentrist who believe colonialism came to civilize Southern Cameroons, it is clear here that colonialism intended economic exploitation and cultural differentiations for continuous domination and suppression of the African race.

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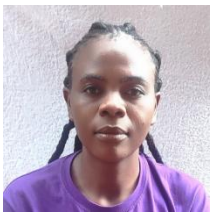

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