THE POLITICS OF SATISFYING BASIC NEEDS IN THE HEALTH SECTOR: THE ROLE OF THE W.H.O. IN THE PROMOTION OF ORAL REHYDRATION THERAPY (ORT) IN NIGERIA

BY

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DEDICATION

This Thesis is dedicated to my father who never had the chance to see his daughter grow up. To my mother who still struggles to keep us surviving; with all the love in my heart.

DECLARATION

I hereby declare that this thesis has been written by myself and that it is a record of my own research work. It has not been submitted to any other university for examination. All references in the work have also been dully acknowledged.

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CERTIFICATION

This thesis entitled: "The Politics of Satisfying Basic Needs in the Health Sector: The Role of the W.H.O. in the Promotion of Oral Rehydration Therapy (ORT) in Nigeria needs the regulations governing the award of the degree of M.Sc. (Political Science) of Ahmadu Bello University and is approved for its contribution to knowledge and literary presentation.

Chairman, Supervisory Committee	Date
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ABSTRACT

This study examines the relationship between the Nigerian state and external forces such as the WHO and Multi-National Corporations (MNC) and how they shape Nigeria's health policy.

The state-centric approach was used as the tool of analysis of public health policy. The study concluded that the marxist conception of the state and public policy was more appropriate for the understanding of the nature of Nigeria's health policy.

The relationship between the World Health Organization (WHO) and the Medical Industry was made the nature of this relationship examined and how it influences Nigeria's health policy.

The study also looked at the nature of Nigeria's health policy from the colonial era till date and the evolution of Nigeria's health services. It was shown that Nigeria's health services evolved from the activities of missionaries and colonial military. The colonial health policy was characterised by an urban based medical set up which neglected the rural population, a maldistributions which is seen in Nigeria's present health care delivery

system.

The influence of the WHO in Nigeria's health policy is seen in the policy making and implementation of the primary Health CAre (PHC), Oral Rehydration Therapy (ORT) promotion in Nigeria. The case study of ORT demonstrated that such externally directed policies are not solely for the benefit of the Nigerian populace but actually are in the interest of the dominant class in society who recognise and accumulate international capital. In a capitalist society the pursuit of health is no different the pursuit of profit. The state apparatus is used in the pursuance of this interest which runs contrary to the interest of the generality of the population. The study concludes with the fact that it is only by the replacement of this state apparatus with a proletarian state, the state policies will be more people directed.

TABLE OF CONTENTS

Chapter		Page
	Dedication	ii
	Declaration	iii
	Certification	iv
	Acknowledgement	v
	Abstract	vii
	List of Tables	xii
	List of Figures	xiv
	Definitions	xv
	Abbreviations	xvii
1.0	INTRODUCTION	3
1.1	Research Problem and Purpose of Study	3
1.2	Justification	13
1.3	Hypothesis	14
1.4	Methodology	15
1.5	Limitations of study	17
1.8	Scope of study	17
1.7	LITERATURE REVIEW STATE AND PUBLIC POLICY:	19
1.7.1	Liberal-pluralist view of the state and public policy in capitalist societies	20
1.7.2	The marxist view of the state and public policy	23
1.7.3	The state in post-colonial societies	26

Chapter		Page
1.7.4	The capitalist state and Health	30
	Footnotes	33
2.0	THE WHO AND THE MEDICAL INDUSTRIAL COMPLEX (MIC)	37
2.1	Introduction	37
2.2	The World Health Organization (WHO)	37
2.3	The Medical Industry and the Third World ..	44
2.4	The Medical Industrial Complex (MIC) and Third World Health Policy	46
2.5	The WHO, Medical Industry and the Third World	54
	Footnotes	60
3.0	THE HISTORY OF NIGERIA'S HEALTH SERVICES AND THE ACTIVITIES OF THE WHO	61
3.1	Introduction	61
3.2	Pre-colonial Nigeria and Medicine	61
3.3	Medical Missionary Activities"in Nigeria ..	64
3.4	The colonial state and Nigeria's Health Service	69
3.5	The world wars and the colonial health policy	73
3.6	British Colonial Assistance	74
3.7	Assistance from International Organizations ..	76
3.8	WHO Activities in Nigeria	79
3.9	The merging of the modern and traditional medical systems	81
	Footnotes	89
4.0	A CASE STUDY OF THE PROMOTION OF ORT IN NIGERIA	90
4.1	Introduction	90
4.2	PHC in Nigeria an Alternative Strategy?	90

Chapter		Page
4.3	The Promotion of ORT in Nigeria	95
4.4	International Agencies and ORT in Nigeria ..	103
4.5	Public Reaction to the simple solution	108
4.6	Politics of ORT	122
4.7	Pharmacies, Chemist and Pharmaceutical Manufacturers in the promotion of ORT in Nigeria	124
4.8	Health and Food Policy in Nigeria	129
4.9	Basic Health care for whose benefit	134
	Footnotes	137
5.0	SUMMARY AND CONCLUSION	141
	Footnotes	155
	BIBLIOGRAPHY	157
	APPENDIX A	167

LIST OF TABLES

Table		Page
1.1	Federal Ministry of Health 1981-1985 (1988 Fourth Plan Projects and Programmes	8
1.2	Federal Ministry of Health capital expenditure before, during and after the second Republic	9
2.1	Pharmaceutical Production (1977-1985)	47
3.1	The distribution of Missionaries and Health facilities according to Regions of Nigeria 1897-1960)	67
4.1	Primary Health care Expenditure for 1988 ..	94
4.2	Reported cases of deaths from diarrhoea in Nigeria ORT return 1985-1987	102
4.3	Respondents reaction to diarrhoea in children (mild and servere cases)	115
4.4	Respondents source of knowledge of ORT	117
4.5	Cross tabulation of age and knowledge attitude and practice (KAP) of ORT	118
4.6	Cross tabulation of educational level and KAP of ORT	119
4.7	Cross tabulation of occupation of respondents and KAP of ORT	120
4.8	Cross tabulation of occupation of spouse and KAP of ORT	121
4.9	Diarrhoeal Morbidity, Treatment and Availability of SSS ingredients and utensils survey ..	128
4.10	Dangi Pharmacy and General Enterprises Co. Ltd. Sale of Diarrhoeal Drugs 1988	131

LIST OF FIGURES

Figure		Page
4.1	Number of facilities supervised for ORT number of units reporting 1987	102
4.2	Global supply of (ORS) 1982-1985	104a
4.3	Pie chart showing KAP study Age of Respondents	109
4.4	Educational level of respondents	109
4.5	Occupation of respondents	110
4.6	Occupation of spouse of respondents	110

DEFINITIONS

Dehydration: Loss of water and dissolved salts from the body, occurring, for instance, as a result of diarrhoea.

Rehydration: The correction of dehydration.

Oral rehydration therapy (ORT): The administration of fluid by mouth to prevent or correct the dehydration that is a consequence of diarrhoea.

Oral rehydration salts (ORS): Specifically, the standard WHO/UNICEF recommended formula, which consists of four constituents:

1. Sodium chloride .. .. 3.5 grams
2. Trisodium citrate, dihydrate .. .. .. 2.9 grams

   or

   Sodium hydrogen carbonate (Sodium bicarbonate) .. .. 2.5 grams
3. Potassium chloride .. .. 1.5 grams
4. Glucose .. .. 20.0 grams

to be dissolved in one litre of clean drinking water

ORS is generally provided pre-packaged in a dry form to be reconstituted when required.

Salt and sugar solutions (SSS): consisting of white sugar (sucrose) and cooking salt (sodium chloride).

Source: The Management of diarrhoea and use of oral rehydration Therapy. Second edition WHO/UNICEF statement WHO Geneva 1985.

ABBREVIATIONS

A.B.U. - Ahmadu Bello University

C.D.D. - Control of dirrhoeal diseases

EDI - Expanded Immunization Programme

HFA/2000 - Health for all by the year 2000

IMF - International Monetary Fund

MIC - Medical Industrial Complex

MNC - Multi National Corporation

ORS - Oral Rehydration Salts

ORT - Oral Rehydration Therapy

PHC - Primary Health Care

SSS - Salt Sugar Solution

UN - United Nations

UNFPA - United Nations Fund for Population Activities

UNIDO - United Nations Industrial Development Organisation

UNICEF - United Nations Childrens Fund Emergency Fund

USAID - United States Agency for International Development

WHO - World Health Organization.

Chapter 1

1.0 INTRODUCTION

One of the major problems underdeveloped countries like Nigeria are faced with is that of health and health care delivery. Underdeveloped countries like Nigeria have been made to assume that western medicine provides the best tool for coping with health problems. They have been handed policy after policy which essentially aims at reproducing a western style model of health care delivery.

Third world countries have geared health expenditure towards the provision of large hospitals, high technology and high level personnel, neglecting the preventive aspects of medicine. Despite this massive expenditure on health the health situation of third world countries seems to be worsening. The current economic crisis with which they are faced and various Structural Adjustment Programmes (SAP) aimed at correcting it has only served to worsen their situations further.

The inability of western medicine to cater for Third World health problems has caused scholars like Lesley Doyal and Imogen Pennel to question its being appropriate for Third World countries. They argue that:

> Thus while the application of western medical treatment under third world conditions may have extremely beneficial short term consequences for the individual patient, it cannot reduce the high incidence of disease nor raise the general level of health.[1]

This clearly shows that the health problems of Third World countries can be attributed to socio-economic factors, which no hospital-based health policy can tackle.

The enormous benefits behind the exportation of western medicine to the third world by the industrialized west has resulted in the commoditization of health and health care. Countries like Nigeria spend large amounts of their budget on the improvement of health services which do not really cater for the health problems of its people.

The group of organized medicine which is involved in profiteering called the Medical Industrial Complex (MIC) has gone a long way in shaping WHO and Third Worlds health policies which emphasizes on the importation of drugs from foreign pharmaceutical firms, the construction of large urban base hospitals and their equiping with the latest gadgets. All this has continued to sap these third world countries of their scarce foreign exchange.

Recently, Third World countries like Nigeria have experienced a sudden shift from this more urban model of health care to a more rural based programme called Primary

Health Care (PHC). The PHC was spearheaded by the WHO and the United Nations Children Fund (UNICEF), and a host of other international institutions. The PHC is a rural based health programme which is supposed to cater for the majority of the population of the Third World. A WHO strategy for the achievement of "Health for all by the year 2000".

This study examines the health policies of the Nigerian State. It takes an in-depth look at the activities of the WHO and Transnational Corporations (TNC) involved in medicine and how they influence health policy in Higeria. A historical account is given of the health care service in Nigeria since pre-independence to date. A case study is made or ORT in Nigeria.

1.1 Research Problems and Purpose Study:

Nigeria's health policy has had a tendency towards a more curative type of medicine. As Nigeria's oil wealth boomed, such large hospital which were capital intensive were indeed welcome from the WHO and World Bank. According to Alkasum Abba et al

In almost all states, health policy was pre-occupied with hospital construction, hospital equipping and hospital maintenance. The construction of health centres and health clinics, which had been initiated during the military

regime, was a poor second with less funds allocated to it.[2]

This massive expenditure changed somewhat as harsh economic realities of recession and oil glut hit Nigeria. Along with this was the steady decline in the standards of living of the population, economic stabilization measures were implemented right from the Shagari era:

> The economic stabilisation policies of Shagari of April 1982 basically amounted to an attempt to review the economy by cutting down public expenditure, restructuring imports, attempting to diversify exports.[3]

These measures sum up the famous international Monetary Fund (IMF) and World Bank structural adjustment package for third world countries with debut crisis. The Nigerian economy is still on the throes of the economic crisis perpetrated in the Second Republic by oil glut. As export earnings and fiscal revenue shrank, the levels of expenditure generated in the 1970s and early 1980s could not be sustained; and there was a great need to cut down budget expenditure and conserve foreign exchange for the purpose of debt servicing.

The steady drop in oil revenue worsened the situation. The SAP recently implemented by the military administration can be seen as another attempt at rectifying the situations, by the military regime in accordance with World Bank

directives. The country is caused to "cut its coat according to its size."[4]

The various measures adopted in the streamlining process include massive retrenchment, cut down in budget size and expenditure particularly in the social sector, imposition of taxes, levies which has served to worsen the plight of the majority of Nigerians whose standards of living seems to fall every moment.

In the past national plants, health and other social services like education and housing are accorded very low priority terms of budgetary allocation and actual expenditure in relation to planned estimates. For instance the health sector suffered a sharp cut in the second national plan, the government accorded the highest priority to agriculture and industry, transportation and manpower development, while health occupied the third position.[5]

The health sector experienced a further demotion in the fourth national plan, health and housing came fourth position in the line of priorities after agriculture, education and economic infrastructure. This shows the importance the Federal Government places on health budget and allocation along side the more lucratice areas of the economy which generate more income.

Apart from the actual allocation accorded the health

sector a very important feature which must be noted is the over-emphasis placed on the more expensive curative aspects of health. Despite the government declared its intentions which seem positive towards the promotion of preventive medicine; it has tended to remain merely at rhetorics. This can be illustrated from the fact that in the 1970-1974 second national plan curative medicine received the lion share of 72%, while 16.7% went to the preventive services, 8.6% went to training and 3.2% was allocated to drugs.[6]

The 1975-1980 development plan saw a slight shift as curative medicine received 58.48% and preventive 25.84%. This can be we attributed to the fact that it was this same budget year that the Federal Basic Health Care Scheme (FBHCS) was launched. It was also an attempt by the government to redress the imbalance in the provision of health services for the urban and rural areas. The BHCS was aimed for the promotion of preventive health services to the rural dwellers. [7]

The Federal Government in executing this project which was quite ambitious like most of her projects spent over ₦110 million from 1975 is 1980[8] which is 8.3% of the budget for health. The project if taken to its conclusion, would provide 4000 health care units, for both rural and urban population.[9] Like most large government projects, the intent is always different from what is executed. Despite the

large sum spent in implementation of the FBHCS it did not yield desired results.

The Primary health care has taken over by the FBHCS, and received enormous publicity from the government. It is also one of the issues the government used to impress the masses in their times of hardship to gain favouratism. It can be seen from table 1.1 that despite the fact that only 29.0% of the plan provision of the 1981-1985 fourth national plan spent there was a definite bias towards PHC. PHC received (90.5%) of the plan provision; communicable diseases control received (16.4%), while the development of teaching hospitals and special hospitals received (38.7%), Training of health, which is aimed at cutting manpower development received (44.6%).[10] This illustrates further the sudden emphasis placed on rural health aimed at cutting down expenditure on health as prescribed by the WHO and the World Bank.

Looking at table 1.2 it can be seen that the cumulative actual expenditure of ₦1,097,345,085 by the end of 1987 financial year amounted to ₦224,037,0009 (20.42%) during the 1975-1979 military era, ₦528,128,499 (48.13%) during the Second Republic and ₦345,199,577 (31.4%) during 1984-1987 post Second Republic military administration. In comparison PHC/Communicable diseases control accounted for (25.05%) of the capital expenditure during the Second Republic and

Table 1.1: Federal Ministry of Health 1981-85 (To 1988)
Fourth Plan Projects And Programmes 1981-85
Health Plan Allocation Compared With Actual
Capital Expenditure

Item Of Expenditure	1981-85 Plan Allocation	1981-85 Actual Capital Expenditure	
		Amount	% Plan Allocation
	₦	₦	
1. Development of Teaching and Special Hospitals	862,400,000	333,476,168	38.7
2. Primary Health Care scheme.	101,000,000	91,419,914	90.5
3. Communicable Diseases control group.	77,100,000	12,674,014	16.4
4. Manufacturing & Supplies (Blood, Drugs & Vaccines).	66,000,000	7,822,564	11.9
5. Diagnostic & Quality Assurance facilities.	56,500,000	5,416,138	9.6
6. Training (Allied Health Manpower Development).	37,000,000	16,491,021	44.6
7. Policy and Management.	-	166,975	-
Total	1,200,000,000	467,466,397	39.0

Table 1.2: Federal Ministry of Health Capital Experience Before, During the After the Second Republic By December, 1987

Item of Expenditure	1975-1979 Pre- 2nd Republic(s)	1979-1983 2nd Rep. (₦)	1984-86 post 2nd Rep. (₦)	Cumulative exp. 1975-87 (₦)
1. Development of Teaching & Specialist Hospitals	135,380,368	371,162,327	181,587,857	689,010,552
- % total Exp.	60.87	70.28	52.59	62.80
2. Primary Health Care/Communica-Disease control	66,270,678	20,710,019	10,037,934	300,953,579
- % Total Exp.	29.58	25.05	28.98	27.2
3. Training	3,569,655	14,824,669	9,739,679	28,134,003
- % Total Exp.	1.59	2.81	2.82	2.56
4. Diagnostic and Quality Assurance facilities.	2,932,845	5,454,120	2,757,170	11,144,135
- % Total exp.	1.31	1.03	0.80	1.02
5. Manufacturing and Supplies	324,370	3,694,719	30,651,453	34,670,542
- % Total Exp.	0.15	0.70	8.88	3.16
6. Policy Management,	-	-	343,736	343,736
- % Total Exp.	-	-	0.10	0.003
7. Other Project Items	14,559,093	689,112	19,780,338	35,028,543
- % Total Exp.	6.50	0.13	5.73	3.19
Total	224,047,009	528,128,499	345,179,577	1,097,345,085

(29.08%) during the post second Republic military administration.

As for curative medicine the development of teaching and specialist hospitals accounted for (70.2%) in the Second Republic compared to (52.59%) in the post Second Republic military administration.[11] This goes to bolster our argument that PHC has come to play a very important part in Nigeria's health policy, particularly in the post Second Republic military era with its economic crises and SAP.

The sudden change in policy stance in the area of health which awards PHC such great emphasis, can be associated to the activities of international institutions like the WHO, UNICEF and the World Bank. Third World debt problems have warranted the involvement of such organisations who are begining to show more concern with the impact of the debt and adjustment policies on the populace of the debtor nations.

A recent study was done to that effect by Giovanni Andrea Cornia the socio-economic advisor of UNICEF's Programme Development Planning Division, where articulate UNICEF's involvement in adjustment issues, he goes further to outline some basic ways debtor nations can go about SAP with a 'human face'.[12]

An important issue which this study raises is that of

the involvement of WHO in Nigeria's health programmes. The WHO is seen as having influenced in no small way the policy stance of the Federal Government on health issues. Not just recently but even in the past. Nigeria has embarked some large capital intensive projects, on part of the ongoing PHC programme. This is done with the encouragement, technical advice from the WHO and financial support of the World Bank.

Rently the Federal Government in pursuance of PHC as part of its project launched an Essential Drug Programme in collaboration with WHO. It is presently negotiating for a loan from the World Bank of 7 million. The loan is to be used for the procurement of drugs from pharmaceutical firms abroad, drugs which are considered essential for any modern health system in a developing country like Nigeria.[13]

This bring us to the area of pharmaceutical manufacturers an area which this study touches upon. Apart from the WHO, there is that organized institution which profits from ill health and health called the medical Industrial Complex (MIC). The western MIC is a very powerful organization with tentacles all over the world. The MIC has vested interest in health policies of the Third World. In line with that it has a great interest in the nature of policies in the WHO which relates to these same countries in question. The MIC goes a long way to influence policy in the WHO in order to protect its interest which is in line

with the accummulation of capital. The second world war saw the development in the chemical and drug industry. This helped shape in no small way the ideology of the WHO:

> A fragmented and primarily technical response to health problems has dominated WHO policy ever since, and an early rhetorical commitment to public health and rural development has never been translated into practical strategies.[14]

The WHO's technical response to health issues can be seen clearly in her occupation with eradication campaigns for instance, the popular malaria campaign which intensify with the discovery of miracle DDT. The WHO malaria campaign received alot of corporate support for example the Rockefeller Foundation. Dr. Paul Russel of the Rockeffeler Foundation argued that:

> Although malaria is no longer a problem in the US it is of tremendous importance to the American businessmen as 60 per cent of imports come from and 40 per cent of our exports go to countries in which it is a problem ... a malaria eradication campaign was a dramatic undertaking that would penetrate to the homes of people and would benefit the US politically and financially.[15]

As earlier mentioned the WHO has moved to the area of community based project that have less technology This is a mere reflection of the changes in the nature of Third World and developed countries relations. Even these community based strategies for health have their underlying political implications for developing countries which can not be

ignored.

On the whole this study tries to throw more light on the nature of health problems in Third World countries like Nigeria and the role of external forces like the WHO and MIC in their health policy directions. The PHC, ORT promotion is used as a case study of the health programmes of the Federal Government which the WHO is very much involved in Nigeria's health policy.

1.2 Justification:

Health problems have continued to plague Third World countries like Nigeria. Few attempts have been made to examine the relationship between health and the nature of the state and her relationship with external forces.

The increasing ill health of the Third World populace is attributed to lack of development of Third World countries and the nature of the climate and demography. Some attribute it to the lack of modern technology and enough hospitals. To such the introduction of modern medicine has gone a long way in improving the health problems of the less privileged nations of the world.

This kind of view emphasizes the role of medicine in health and underplays the activities of external capitalist

forces on Third World health problems. However, the study looks at this in-depth and helps bring out the true dynamics of the health problems of Third World countries like Nigeria.

The promotion of ORT in Nigeria have been chosen in order to give a clearer picture of the programme implemented by the Nigerian state in collaboration with the WHO and other international bodies.

1.3 Hypothesis:

The main hypothesis this study is concerned with can be summarized as follows: Given the manner in which the Nigerian State was incorporated into the world capitalist system our suppositions that:

1. There is in existence a triangular relationship between the Nigerian State, the WHO and the MIC which encourages the pursuance of health policy in the interest of international capital.
2. The ORT though a laudable policy somewhat is in fact a diversionary strategy of the state which shy away from the real problem.
3. The ORT has failed to achieve the desired results in Nigeria because Nigeria's health care delivery system militates against that possibility.

1.4 Methodology:

The following methods and techniques of data collection used in this study are the consultation of secondary sources and a survey research.

The study consulted the existing literature on the state, international institutions like the WHO and TNC's in relation to the Third World in particular and the world at large. Data is used from official publications, such as federal health statistical reports, WHO and UNICEF publications, etc.

Secondly survey research is then used for the purpose of getting first hand information. Informed oral interviews have been conducted with Ministry officials, WHO and UNICEF officials. Additionally, oral interviews have also been conducted with a few doctors and nurses in public hospitals and health centres. A few pharmacies, chemist and pharmaceutical firms were visited and officials interviewed.

Apart from the oral interview, structured questionnaires have been used with close-ended questions. The study took a sample size of 200, respondents. It was conducted at the Paediatric Out-patient unit of the A.B.U. Teaching Hospital, Zaria. Simple random sampling method was used with no special criteria was used in the choice of respondents. The mothers who brought their children to the out-

patient unit were chosen for the interview.

The A.B.U. Teaching Hospital Paediatric Unit was chosen because of the existence of an CRT Unit in the Paediatric ward. It is assumed that mothers visiting the hospital stand a better chance of finding out about CRT and the preparation of the Sugar Salt Solution (SSS) home mix than mothers who resides in the village without any access to a health establishment or some sort.

The questionnaire is divided into two sections, the first part is concerned with personnel data, the age, educational level, and occupation of the spouse as the respondent. This was required to help in assessing their income

levels.

The second part was aimed at determining the extent mothers know about CRT and the SSS home mix and how they appreciate it in relation to the management of dehydration Win children caused by diarrhoea at home.

The questionnaires were administered over a span of seven consecutive days from Tuesday to Monday from the 12-18 June, 1988. We took a minimum of 28 and a maximum of 30 respondents each day. This was to enable us get a good sample considering some mothers would find some days of the week more convenient than others to come to the hospital.

1.5 Limitation of Study:

Certain limitations in this study must be taken note of. Limitations which we tried to overcome.

A major problem was that found with the official data. In some areas overlapping was found in the figures, which pose problems in determining the most reliable figures. Apart from that of the figures we have also cognizance of the fact that certain data do not represent reality, this can be attributed to certain facts which could be political. In view of this great care have been taken to handle such information with careful analysis.

In the survey research the problem of respondents who are inhibited pose problems; hampering their ability to answer questions freely. Some officials were reluctant to give out information or discuss certain issues. In an attempt to overcome this problem we employed subtle probing and prompting questions which served to encourage the respondents to reply more freely. Secondary data helped to achieve some balance where interviews were not forthcoming and vice versa.

1.6 Scope of Study:

Although references are made to rural health policies of the Nigerian governmental and international Agencies

directed at the population, the main focus of this study is on the ORT.

> Oral Rehydration therapy has been recognized as a strategy for Child Survival and Development Revelution (CSDR), in many countries with a high incidence of diarrhoea diseases.[17]

The OCRT is part of the National Diarrheoeal Diseases Control programme, which is aimed at cutting the cost in the treatment of dehydration caused by diarrhoea in children. This programme did not yield desired result, as expected. It would seem that the less privileged who would benefit from such a policy are in fact out of touch with it. Those that do not seem to understand its use and do not bother about it.

Despite the fact that the sugar salt solution, home mix is to enable mothers treat their children at home, mothers residing in the urban areas still prefer to rush their children to public hospitals for treatment of even the mildest cases of diarhhoea. People continue to insist on treatment in government hospitals which are in an appalling state, they lack drugs, even when they are available they must be bought at prizes that very few can afford.

The ORT is part of a health programme aimed in the less privileged in the society. The promotion of CRT is aimed towards shifting responsibilities of health from the

state to the people. Additionally, people are made to feel they are in fact the cause of their health problems and can solve them themselves. Most Health problems can in fact be attributed to their living standard. The populace live in such squalor where poverty prevails, no adequate good water supply sanitation coupled with poor nutrition. All these contribute to poor health causing diarrhoea and other associated diseases.

1.7 Literature Review:

In order to arrive to a more comprehensive and dynamic understanding of how international institution like the WHO influence the policy directions in Nigeria, the state centric approach is employed in this study. The approach enable us to study the phenomena within the framework of the state and its activities in the area of policy making.

There are basically two schools of thought of the state public policy: The liberal pluralist view and the Marxist view. Generally though, "A theory of state basically encompasses a look at society and the distribution or power in the society."[18]

1.7.1 The Liberal Pluralist View of the State and Public Policy in A Capitalist Society:

The pluralist view of the state is premised on the idea that society is fragmental and made up of various organized groups with conflicting interest. Professor Dahl has noted that pluralist

> suggest that there are a number of loci for arriving at political decisions, that businessmen, trade unions, politicians, consumers, farmers, voters and many other aggregates all have an impact on policy outcomes, that none of these aggregates is homogenous for all purposes; but weak over many others and that, the power to reject undesired alternatives is more common than the power to dominate over outcomes directly.[19]

Pluralist see state power as being diffused amongst units, that no group dominates the other. They assert that there is no dominant class only competing interest blocks whose activities are monitored by the state. So that there exist different elite groups who lack cohesion and this goes to ensure the diffusion of state power in society.

Michael Goldsmith, in his book Politics Planning and The City, while analysing the above position recognise the fact that not all people are prepared to participate in the policy making process; he goes further to say that those who do not partake in policy making do so in a manner which causes the passive majority to worry as to whether their

interest is catered for.

> The exercise of power by the active majority in this model is thus seen as authoritative or acceptable by the mass: the process of policy making is seen as legitimate and acceptable; Because those who take decisions are responsible to the changing needs of the majority, the openness of the political system ensuring that these changes are quickly provided by the decision makers.21

Pluralist confer to state the role of an impartial umpire which reconcile the conflicting interest of various groups. But Polsby opines that these varying interest groups with their "over-lapping membership" and "widely diffused power basis" use a multiplicity of techniques to influence the policy making process to say decision in their favour.[22]

Another pluralist whose argument must be taken note of is Schottle, he shares the views of the others and sees the state as capable of making policy in the interest of the generality of the society.[23] In line with this argument public policy is seen to serve the interest of the public and not just the privilege few. On the whole pluralist see the state as the only institution capable of withstanding pressures like economic, political and social through public policy.

In the area of health policy, the pluralist argue that the state formulates health policies like any other social policy in the interest of both the privileged and the less

privileged in society. So that no one interest group dominates the other. This view of the state has been criticized by scholars, it is seen as abstracting the state from society imbuing it with divine authority, which robs it of its true dynamics.[24]

George and Wilding have also argued that,

> the state ... can not be seen as impartial and neutral this is not possible in a society where classes exist and dominate each other.[25]

Certain public policies might seem in the interest of the whole society, but in actual fact lean towards a particular class for instance the recent move towards PHC, pluralist would claim that their aim is solely to satisfy the needs of the generality of the Nigerian population who are rural based. Not only does the PHC aim at that but it also helps the state cut down drastically on budget expenditure on the provision of social services like health for debt servicing. In the long run what, obtains is in fact health policies made supposedly in the interest of the masses, but in actual fact it is for the benefit of those who have ties with international capital, that is the dominant class. This runs in contradiction with the puluralist argument which sees public policy as being formulated in the interest the whole society..

1.7.2 The Marxist View of the State and Public Policy:

The Marxist view of the state stems from the writings of Marx. In Ralph Miliband's article "Marx and the state" he opines that Marx has basically two views of the state which he developed. The first is that which is found in the Communist Manifesto where Marx (in collaboration with Engles) makes the contention that "the executive of the modern state is but a committee for managing the common affairs of the whole bourgeoisie".[26]

Marx's second view on the state Miliband argues can be traced to analysis of the state and class in The Eighteenth Brumaire of Louis Bonaparte. He argues that the state is above all social classes and is the dominant force of society and not just an instrument of a class.[27]

Marxist see the pluralist view of the state as elitist in nature. Its emphasis on stability and consensus and support for the status quo is highly criticized. Contrary to this view Marxist recognise the existence of class and class struggle in society. Within the Marxist framework of analysis, the state is in charge of policy making and such holders of power in turn represent the interest of the dominant class. National interest becomes illusive and public policies somewhat private policy for the privileged few in society.

There are some scholars that argue it is possible for the state to make public policy in the interest of certain groups in society like the working class. Kirk argues that in Britain which is a welfare state this is obtained and can be seen in the way the state provided social services for the working class.[28]

The social workers of a capitalist state like Britain Marxist argue should not be idealized. As contradictions in capitalist societies intensify,

> Class conflict sometimes impel the bourgeoisies to make certain concessions and resort to political manoeuvring. While glossing over the contradictions inherent in capitalism, the ruling elite tries to moderate class conflict by mitigating the effect of economic crisis, reducing unemployment and inflation, etc.[29]

This essentially means that the actual benefits of such public policies are felt by the privileged few in society. In Britain for instance where medical care is organized by the state, it still remains an important source of profit: science equipment and drugs continue to be purchased from private pharmaceutical firms while state hospital are constructed by private firms.[30]

Another issue which must be stressed is the role of the state in maintaining the capitalist economic system through its involvement in the production process. The state is the largest customer of the private sector, and

some major industries could not survive in the private sector without the state customs, the credits, subsidies and benefactors which it dispenses.[31]

Apart from this obvious involvement in the economy which promotes the interest of international capital, the state is also engaged in public policy which enhances this interest and that of those who own the means of production. It is in line with this that the Nigerian state has had a tendency to pursue health policies in the interest of the MIC.

In the final analysis decisions about allocation on health, education, housing and other welfare benefits are all involve in the conflict amongst competing interest, with the resolution of such conflict as generally being in the favour of the dominant class in society.

In sharp contrast with the afore discussed a non-capitalist state is of a different dimension to a capitalist. The socialist state emerges as a result of a socialist revolution which transforms the mode of production and puts the state power in the hands of the proletariat. This idea of the dictatorship of the proletariat was first advanced by Marx and Englels in 1848 in the Communist Manifesto, which mentions the proletariat organized into a ruling class.[32]

Once in power the state of the proletariat dictatorship begins its transformation into a state of the whole people as soon as the building of socialism is completed.[33] The socialist state represents the interest of the whole society. This essentially means that the socialist health policy is aimed at the provision of medical care for the whole society. It applies not just to the health sector but other public services like education, housing are easily accessible to the populace.

In China a non-capitalist society have been able to come up with a health policy which caters for the whole society with its rural based majority like Nigeria. The Chinese "barefoot doctors" are famous for the way they have been able to cope with the health problems of rural majority of China. Attempts to import the barefoot doctor concept to other Third World countries have not been successful. This can be attributed to the fact that the state in the non-capitalist societies and capitalist differ which influences the nature of their policies in the area of health.[34]

1.7.3 The State in Post Colonial Societies

The issue of the state in post colonial societies has attracted alot of attention, various scholars have attempted the analysis of the nature of the state in past colonial societies. The central argument of the debate is that the

state in the Third World possesses certain peculiar features which make it somewhat different from the state in advanced capitalist societies.[35]

Major contributions to this debate can be seen in the works of Alavi (1979), Sau (1974), Bala (1982), Asobie (1987), Leys (1978), Jibrin Bala argues that the main problem with the contributions to the post colonial debate is that most scholars start from the analysis or the class character of the state, making categorizations which are somewhat abstract, 'metropolitan bourgeoisie', petty bourgeoisie, indegenous borgeoisie, landed bourgeoisie, etc., are linked to state power. The state power is seen as operating in the interest of one class against the interest of the other in the final analysis.

He maintained that the flaw with the above discussion on the state is in the restricting 'class theoretical determination of the state which has achieved justification in the elaborate framework provided by Nicos Poulantazas.

> Like in the Poulantzas problematic, none of the main contributors to the post colonial debate deems in necessary to analyse the relationship between the developments in the process of accumulation and its contradictions, and the state.[36]

The central argument of Asobie is that the state in the Third World is essentially a bourgeois state (i.e. a capitalist state, what makes it different from the developed

states of the West is the peculiarities found in the process of articulation of the mode of production. On the whole the 'post colonial state is simply a type of bourgeois state whose underlying structures is undergoing a transition from feudalism or communal feudal mode of production to capitalist mode of production.[37]

To bring the issue of the state in post colonial societies closer home with reference to Nigeria Sam Oyovbaire puts forth the position that:

> while the Nigerian state is much more than simply a collection of government institutions, mediating between individuals, groups and ethnic interests, it is in its present phase of development certainly less than a simple product or committee of capitalist interests.[38]

It is in his view the Nigerian state serves the interest of contradictory groups, and to look at just the issue of either, class or ethnicity is reductionist in nature as the factors can be seen to overlap depending on the historical context and particular issue at stake.[39]

Another major contribution to the study of the state is that of Bjorn Beckman, he is of the view that while the state organ services as an instrument for the penetration of international capital it cannot be overlooked, that in doing so it also aids the emancipation of the bourgeois class.[40] The state pursue policies which enhance the position of

international capital in Nigeria and also serves to better their own position vis-a-vis foreign capital.

> This is a class whose historic mission was to participate in the rapid exploitation of the resources and labour of the people as junior partners to the imperialist bourgeoisie.[41]

Those that are in possession of the state apparatus thus formulate policies which will serve the interest of that class in society which is dominant as a result of its position in the relations of reduction. In line with this assertion one sees the Nigerian state in the pursuit of public policies like that of health in the interest of the dominant class. it is also found that these health policies have an external orientation that invariably help strengthen the state ties with the capitalist west. There is a clear manifestation of this in nature of Nigeria's health policies which places emphasis on curative medicine which is fundamentally a modern urban based health service and operates at the expense of the silent majority who are rural dwellers.

> Modern medicine is very expensive and its production and distribution are controlled almost entirely by a small number of giant companies owned mostly by the U.S.A., West Germany and Switzerland.[42]

What obtains in Nigeria therefore is that health policies of the state are actually influenced by their relationship with international bodies like the WHO and MNC who are involved

in the production of pharmaceuticals. The Nigerian state is left with residual powers so to say over decision making as it continues to collaborate with foreign capital, whose interest conflicts with the majority of the population.

However, we cannot forget that the Nigerian state does in fact share a common interest with foreign capital and strives to improve its position. It is in the pursuance of this interest that even the so called policies which are beneficial to the public are in fact more beneficial to the national bourgeoisie. The recent move towards PHC and the promotion of ORT is aimed at solving rural health policies, by and large the state cuts down health expenditure which enables her spend more in the more lucrative sectors of the economy where private capital can flourish.

1.7.5 The Capitalist State and Health:

Under capitalism the primary role of the state according to Marxist is the reproduction of class relations, in a social formation where the hegemony of the bourgeois prevails. Vicente Navarro in "The crisis of the WEstern system of Medicine in contemporary capitalism" argues that it is the state which establishes its composition along with its role and the nature and type of policies it pursues within the health sector and elsewhere. It is this defined role of the state that explains the intrinsic bias capita-

list states response in favour of capital and against labour.[43]

Navurro goes on to point out that the state is aimed at maintaining the status quo and excludes any alternatives which threaten such a balance. He cites examples of the fact that,

> the overwhelming dominance of bourgeois ideology in the top corridors of power of major health research institutions explains the heavy emphasis on individual etiology-habit, diet and the like as the subject of research, rather than environment factors pollutants, carcinogens, etc.[44]

In line with this view Lesley Doyal and Imogen Pennel opine that health problems can reach to a considerable extent and be determined only by the existence of a particular type of mode of production. Under capitalism there is a contradiction between the pursuit of health and the accummulation of capital.[45] In their view any attempt at the control of ill health would interfere with the capitalist accummulation. In that health and health care is commoditized in capitalist societies.[46]

According to Okello Oculi, political power which is determined by the ownership of the means of production goes a long way in determining the 'health and non-health' of society.[47] From this we can conclude that as long as the Nigerian state is a capitalist state with the ties of inter-

national capital it will continue to pursue health policies which serve that interest. International bodies like the WHO where the hegemony of the vs and the capitalist West prevails will in this line continue to encourage the Nigerian state to pursue such health policies which serve to maintain capitalist relations in the world.

FOOTNOTES

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10. Exrtracts from comments by Dr. B. A. A. Dada Chief consultant (Medical statistician) on the Financial Situation as at 31 December August, 1988, p. 1.

11. Ibid, p. 2.

12. For a concise discussion see Cornia, Grovanni Andrea (UNICEF). "The Adjustment Stalemate: Conventional Approaches and New Ideas." NGES/Geneva Occasional papers No. 3 U.N. Non-Governmental Laison Service Geneva. April, 1987.

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Chapter 2

2.0 WHO AND THE MEDICAL INDUSTRIAL COMPLEX

2.1 Introduction

In the previous chapter we discussed the role of the state, the Liberal - Pluralist conception and the Marxist conception of the state and public policy.

This chapter examines the activities of the WHO and the pharmaceutical industries. It will further attempt to make a connection between them and how they both influence Third World health policy.

2.2 The World Health Organisation (WHO):

The post-world war period created great tension in Europe. Which led the United States and Western Europe have growing fear about the spread of communism in Europe.

> The U.S. States Department feared post-war economic chaos would lead to a repetition of what happened after the first world war. Cordell Hull Assistant Secretary of State regarded the United Nations as a political instrument which by universality of membership would compel the members to adopt the principle of free trade and respect for property.1

In essence there was a great need to maintain capitalist activities and revive the war devasted countries of Europe, and as a result of this the Marshall Aid Programme was put in motion by the U.S. and various relief organizations. This Marshall Plan and the U.N. were seen as attempts to create a bloc against Soviet Communism, thereby making it possible for U.S. dominance to prevail.

The attempt was seen by Roosevelte as a tool for U.S. foreign policy. The U.N. was to become a sort of world government in which the U.S. would dominate and pursue her non-isolationist policy. He argued strongly against isolationism and sought support for an active American role in post-world war activities.[2] According to Franz Schurman, Roosevelte did not envisage America joining a new League of Nations, but that nations join her in the U.N. as conceived by the U.S. on American soil.[3]

The concern of this study is not with the U.N., but one of her specialized agencies the WHO which is charged with the responsibility of health. The WHO was the first specialised agency created by the U.N. organization. At the Economic and Social Councils first session, a committee was appointed on the issue of health, and the WHO was founded. It's constitution was signed on July 1946 and ratified in 1948.[4]

The WHO played a crucial role as an international Red

Cross for Europe after the Second World War.

> The more fortunate nations began to feel a sense of responsibility for the crucial health problems. At first it took the form of health aid to war devasted countries i.e. as part of the Allied Relief Reconstruction Programme.[5]

Western nations realized that the restoration of good health was essential to the resumption of economic life. Thus, the WHO was created to cater for the health problems of western Europe. The activities of the organization expanded after sometimes into the catering for the health problems of colonies of these same European countries, and as they achieved independence the colonies also gained full membership of the world health body.

The main organ of the WHO is the World Health Assembly which is the supreme body that meets annually, it is composed of delegations of the organizations members based on their professional character. The World Health Assembly is responsible for determining the policies of the WHO.

The Executive Board of the WHO is the technical organ which makes proposals for deliberations by the World Health Assembly. It is made of 31 persons designated by members of the World Health Assembly. They represent supposedly the interest of the organization and not their individual states.

The WHO has 40-50 panels of experts involved in a wide range of activities.

> from air pollution to zonoses for example nutrition, anti-biotics, rabies, food additives tuberculosis and malaria and other diseases of such type.[6]

Members of these panels are responsible for recommendations made by various expert committees set up by the WHO. They are also involved in the setting of international standards and bodies, like the code for the marketing for breast milk substitutes.[7]

A unique feature of the WHO which sets it apart from other U.N. specialized agencies is its decentralized nature it has six regional organizations each constituting a regional committee and regional offices headed by a regional director. The seats of the regional offices are Alexandria (Eastern Mediterranean Region), Brazzaville (Africa Region) and Washington (Region of the Americas).

The WHO secretariat consist of the technical and field staffs who are charged with running the organization and executing projects and programmes. The secretariat staff are supposedly internationally representative, and receive no instructions from any external body other than the WHO. The technical and administrative head of the secretariat is the Director General who is appointed by the World Health Assembly.[9]

Like most international organizations membership is optional i.e. open to all states, any state joining the U.N. and receiving the WHO constitution automatically become member of the WHO. There are some states like Switzerland, who claim neutrality and does not belong to the U.N. they possess associate membership. As of 30 June 1985, the WHO had 164 members and one associate member.[10]

As for financing, the members of the organization are responsible for its regular budget. WHO's budget for 1984-1985 was $529.1 million. This figure includes the Pan American Health Organizations (PAHO) with which the WHO is merged.[11] The WHO receives funds from the United Nations Development Programme (UNDP). It reliefs heavily on the contributions from governments, individuals, and voluntary agencies. TNC have been known to make some generous contributions in kind and money. The organization when possible collaborates with such bodies in the implementation of health programmes and projects.

Decision making in the WHO is supposed to be the job of internationally minded individuals who represent the interest of the world. This however is not the case, hence a very powerful body within the institution which is active in policy making is that group which Vicente Navarro calls the Development Establishment. According to him this body

is active in major aid agencies like the WHO and champions within Western circles, they push the views of the dominant class. The capitalist class he argues continue to play a vital role in organizing the world capitalist system. It is this class the development establishments represent.[12]

The top decision making body of the WHO that is the World Health Assembly is merely a figure head. By and large the position of the dominant class prevails. This can be seen in the ideological content of many of her declarations, for instance the Alma Ata Declaration. The issues raised and recommendations made within the Alma ATa report are not new. For instance changes of priorities within the health care services, emphasis on PHC, shift from low to high technology; self-care and self-reliance and the encouragement of community participation in the implementation of programmes.[13]

> In 1972 the office of Health Economics (18) (The industry) and in 1975. The World Bank (19) produced reports on the state of health and medicine in the under developed world that closely resembles the Alma Ata recommendations. Indeed they are part of the "conventional wisdom" within the development establishment.[14]

The WHO is a non-governmental organization, whatever activities it is engaged in it does through the collaboration with state governments and their ministries of health or its equivalent. The global strategy for HEA/1000 draws attention to the role of ministries of health and their

collaboration with WHO in the stimulation and coordination of the PHC programme.[15]

The WHO is involved in a wide scope of activities all in the aid of attaining WHO's objective that is, "the attainment by all people of the highest possible level of health." The WHO to name just a few of its functions is involved in the strengthening of national health services and in giving technical assistance to governments on their request, it maintains epidemiological and statistical services, it stimulates the eradication of epidemics and other diseases, it promotes the prevention of accidental injuries and a host of other things.[16]

Since the second world war and the unprecedented internationalization of capital which followed, there was a shift in the provision of aid on a multi-lateral basis.[17] It can therefore be seen that it is not just Third World governments and their colonial powers that influence health policies, but also other international institutions like the WHO and World Bank feature quite prominently.

It is important to note that the WHO has had a bias for a technical response to health problems of the third world. The Malaria Campaigns she embarked upon are a clear indications of her inexpensive and ineffective strategies of "search and destroy."[18] A stregy which has not yielded

considerable success in tackling Third World health problems.

Recently, the WHO and other international agencies have made a major shift from the technical medicine policies to a community based one. Both the WHO and the World Bank realize that the health problems of the Third World are better solved in this manner and so they have made great steps in the promotion of the cost effective policies.

> Clearly it is not in the interest of international capital to waste resources in the Third World either through investment in economic projects which may be undermined by endemic disease.[19]

Recommendations have been towards the shifting of priorities within health care services to PHC, the use of less sophisticated technology like the ORT, emphasizes on self-care, self-reliance and community participation.[20]

2.3 The Medical Industry and the Third World:

A perfect example of the commoditization of health and medicine is provided by the TNC, who are involved in the manufacture of pharmaceuticals. Yet there is an acute shortage of drugs in the Third World. It is in view this, that the Western Medical Industries have succeeded in capturing Third World markets for the sale of their products. This resulted to the fact that:

> Although overall medical expenditure on drugs is proportionately very much greater. Whereas drugs account for about eleven percent of NHS spending, they represent roughly twenty percent of the health budget in most African countries, and in some Third World countries, they absorb as much as forty percent of total health expenditure.[21]

This can be explained by the fact that these developing nations depend on the importation of these pharmaceuticals from the industrialized countries. They also pay considerably more than European countries for pharmaceutical products, and this in no small way helps drain their much needed foreign exchange. This is aggrevated further by the fact that local production is almost negligible. For instance in Nigeria there are 27 pharmaceutical manufacturers and these manufacturers specialize mainly on antimalarials, analgesics, simple cough and vitamins.[22] Available data has shown that over 75% of Nigeria's drug needs is supplied from foreign pharmaceutical firms.[23] Even local production relies heavily on the importation of the basic materials for production with the exception of water. Out of the 27 major pharmaceutical firms operating in Nigeria as at the end of 1981, it was discovered that only 5 were actually indigenous.[24]

The drug market is dominated by a few powerful firms who wield enormous power over the developing countries. In a study conducted by Sanjay Lall, it was discovered that the oligopolistic nature of the industry with relatively few

large companies dominating international production, trade and innovation lends considerable market power to large firms. The use of this market power entails a number of economic and social costs for the Third World countries who rely heavily on the drug system.[25]

From Table 2.1 it is evident that local production of pharmaceuticals in Africa is indeed lower than the rest of the world and can not cater for their needs. What is more alarming is the fact that Egypt alone produces 80% of its domestic needs.[26]

2.4 The Medical Industrial Complex (MIC) And Third World Health Policy:

The dominance of the foreign pharmaceutical firms over Third World countries is also seen in their unethical methods of drug promotion in developing countries.

> A survey was conducted on the promotion of 28 prescription drugs in the form of 40 different products marketed in the U.S. and Latin America companies. Striking differences we found in the manner in which the identical drugs marketed by identical companies or its foreign affiliates was described to physicians in the U.S. and to physicians in Latin America.[27]

The medical industry has for quite sometimes been dominated by U.S. corporations, these corporations have become diversified in their operations. Apart from supplying

Table 2.1: Pharmaceutical Production (1977-1985)

in US $ Million

	Estimate		
	1977	1980	1985
Developed Countries	57,143	73,970	119,110
Share Of World Total (%)	88	88	87
Developing Countries			
Africa	364	470	820
Asia (Excluding China)	3,621	4,690	8.260
Latin America	3,391	4,400	7,750
Share Of World Total (%)	12	12	13
World Total	64,325	83,530	135,840

Source: The Nigerian Journal of Pharmacy, Vol. ?? No. ??, September/October 1964.

capital goods they have also become involved in marketing hospital management services and medical professionals on international basis. Some of these corporations are capable of processing entire hospital project from its construction to the administration.[28]

The development of modern medicine has provided the basis for the expansion of the health care industry. Notably amongst them is MIC, that institution of organized medicine and technology which makes profit of billions annually. MIC is made up of corporations in the medical business, medical researchers, physicians and federal governments.[29] The large corporations involved in the medical industry range from hospital construction companies, architectural firms, laboratories, conglomerates of nursing homes, and computer electronics declares. This group has a mutually dependent relationship with a vested interest in the medical care profits of the world at large.[30]

A feature of the MIC which can not be overlooked is its rapid expansion in instrumentation, as the complexity of instrumentation increases so does the cost of health care. For example an X-ray machine once costing $75.00. Now, with the image intensifiers, rotational exposures and so forth, the new (IAT) machine costs up to $500.00.[31]

With the development of such sophisticated equipments,

so also there must be the training of highly skilled personnel to man them. This increases even more the cost of medical care. Modern technology is fast changing because what is useful today becomes obsolete tomorrow. Moreover, modern medicine requires that you keep abreast of the latest developments in modern medical technology. In the U.S. the MIC and hospital corporations which exemplify the proprietary hospital are moving into the building of hospitals solely for the making of profit. These hospitals are designed to make large returns to the stockholders. Similarly, in the Third World there is a wave in the construction of private clinics, aimed at profit making. These Clinics where the privileged in society can receive modern medical treatment at expensive prices which only they themselves can afford.

What obtains in most major American drug companies is that the director and top official management no longer come from the traditional disciplines of drugs development and medicine. They now consist of representatives from banks and investment firms.[32]

There is an existence interrelationship between pharmaceutical firms and universities which turns universities into corporate laboratories. An example of this can be seen in the 25 billion dollar grant given to Harvard in 1975 from Monasanto Chemical Company for a period of 12 years towards research for a cure for cancer.[23] This is one of

the avenues the MIC use to perpetuate its present structure of activities.

These corporate bodies also engaged in funding of medical education. Brown, in his article titled "He who pays the piper: foundation, the medical profession and medical education reforms." Talks about U.S. medical education, having received corporate support from the Rockefellers as far back as 1910. He draws attention of the dominant capitalist class and the powerful institutional instruments as to what they use in moulding modern medicine, the use of their enormous wealth to force specific reforms in medical education aimed at serving the interest of capitalism rather than the mass of the people. In the earlier part of the 20th century John O. Rockefeller and Andrew Carnage published the flexner report attacking the medical system seeking reform to enhance their capitalist interests.[34]

These big businesses are not only capable of buying up smaller firms but they are also able to buy up the university medical research elite. For example, the multi-million dollar complex weilds a very powerful lobby. Consequently the preservation of the present system lies in the coordinated political power of the large pharmaceutical firms with their influence over health policies of the state using the state machinery to push their own interest.

> Close working relationships between the corporate elites and national economist planning bureaus in the executive breach often mean that long term economic planning is carried out int he interest of corporations rather than public interests.[35]

Corporate influence on government policies have direct and indirect effects on the health care delivery service. By the preservation of the present economic system with its unequal distribution of wealth and poverty the overall social inequalities are preserved along side of health and ill health in society.[36]

The state pursue policies which are in the interest of the MIC for instance, providing money for medical research, and creating laws for appropriation under older ones. The multinational firms are encouraged to pursue their interest abroad in the developing world; Third world countries have proven to be quite lucrative. Thus in view of the lack of sufficient funds in developing countries, the developed countries of the West engage in the provision of programmes of assistance sponsored by national governments as well as supra national development agencies. Robin Murray describes this kind of assistance, to what he calls foreign aid as an overseas extension of the states functions vis-a-vis private capital.[37]

The provision of aid in the post war years became a very important tool for capitalist expansion in the health

sector, it helped establish policies which would create conditions for the perpetuation of capitalist relations between the developed and underdeveloped countries of the world. For instance, the institutional concern of developed countries for the population problems of developing countries resulted into massive inflows of 'medical aid' for the control of fertility. Along with the aid the recipient country is handed a kind of population policy. It is important to note however that, like most of the aid given to developing countries there are strings attached.

Organisations like the Rockefeller, the International Planned Parenthood Foundation (IPPF) and the Ford Foundation have been actively involved with the cooperation of the WHO population programmes in the Third World. However, such policies have some negative effects on the countries they are implemented.

In a study of the population programmes of India. Baneriji argues that the programmes divert from the country's basic problems of poverty, social injustice, ill-health, unemployment illiteracy. In an attempt to bring about a decline in the birth rate through an extensive birth control campaign yet other social and economic development programmes were neglected resulting in some considerable damage.[38]

Medical aid programmes are very much a part of Third

World health planning. Attempts are made for strengthening health services which are of no real benefit to the under developed nations of the world. Aid plays a very significant role to Industrialized Nations since they are the donor countries. For instance.

> In the British case aid is important in promoting export of British goods and services, in fostering dependence on British scientific expertise, and in reinforcing the general dominance of the western medical paradigm.[39]

It is this kind of aid according to Vicente Navarro which is centred on the provision of teaching and specialist hospitals all aimed at the perpetuation of the pattern of production that benefits the consumption of the donor country and of the groups in the recipient country which. Frank refers to as the Lumpen bourgeoisie.[40]

On the whole the perpetuation of the Western medical pattern in developing countries can be traced to the system of medical education and the health care system in general. Those in control of the means of production, control the consumption in the health sector, that is the capitalist class. The capitalist class of the Third World desire the same kind of health care system found in the industrialized countries.[41] Unfortunately this pattern does not cater for the interest of the majority of the population that reside in the rural areas of most developing countries in the

world.

2.5 The WHO Medical Industry And The Third World

A study was conducted by Catherine Stenzl on the U.N. system and its concern with medicine policies. Catherine discovered that WHO's concern with medicine policies was initially with quality control, safety and standardization. It was not until the 1960 Thalidomine episode that discussions on drug safety and efficacy turned to actions.[42]

The Director General was asked to consider the creation of a system for the collection and dissemination of information on results of safety and effectiveness, trials of new drugs, and their registration in countries having necessary facilities, so that these data might possibly be used by the health authorities of countries importing pharmaceutical products.[43]

This move towards the integration of the issue of pharmaceutical quality control, safety and efficacy represented a new trend within the WHO. This new approach is a reflection of WHO's move away from the too technical approach of focusing on eradication of specific disease to move to a more dynamic one that sees health problems not only from a medical perspective but within a social and economic context.

This chance in the WHO strategies also saw a change in the organizations priorities. More attention was to be given to the developing world.

> Economic considerations began to appear in the texts and the reports on WHO's work in 1970 (official records, 180, in planning the establishment of pharmaceutical industries in developing countries ...[44]

Such production of drugs locally is to be done with the needs of the local populations in mind. It is from this angle therefore that the Assembly's drug policy was to be designed, taking cognizance of the needs of developing countries. In 1977, the WHO with it's export committee formed a new drug for developing countries. They came to the conclusion that about 200 drugs and vaccines were required for the health systems of developing countries.[45]

Member countries were encouraged to adopt the essential drug programmes as part of their PHC programmes, tailoring a model list to suit the needs of their country. Nigeria recently set in motion a national Essential Drug Policy with a list of 200 drugs. Representatives of the Ministry of Health, WHO and members of the Management Sciences for Health Boston, met to develop a specific 1987 work schedule for the preparation of the National programme. On the basis of the schedule established, local and international consultants subsequently make measurement of used

proposals to strengthen the drug supply logistics. All in aid of a comprehensive programme for selection, procurement and use of the drugs.[46] Along with this as mentioned earlier in Nigeria's negotiation for a 7 million dollar loan from the World Bank. This loan is to be given on the insistence of the World Bank that Nigeria abides strictly to WHO guide lines.[47]

There is a growing concern by the pharmaceutical industry with WHO policies. This was because there have been some serious allegations that the pharmaceutical industries have a committee of six operating in Geneva whose sole responsibility is the infiltration of every international institution to prevent mandatory legislation against the activities of multinational pharmaceutical firms.[48]

This shows that the MIC has vested interest in the activities of the WHO and it goes to all lengths to protect that interest. From lobbying of government officials to the bribing of physicians. A good example of where U.S. corporate interest has run contrary to the interest of the health and well being of the Third World can be seen in the unethical promotion of infant formulae. The WHO and UNICEF International Code for the marketing of infant formulae received alot of opposition from companies like Nestle which is based in the U.S., It was revealed in a secret memo that Nestle had no plans to change its marketing strategies for the sale

of infant formulaes to the Third World. The Nestle plan was to counter boycott of its products with an expensive and sophisticated public relations campaign.[49]

In 1978, a study was done on the activities of TNC in the U.N. system. It revealed documents that showed that the main demands of the West in the U.N. were actually formulated by their representatives.[50] This shows that there is in fact a link between the decision making bodies of the WHO and the medical industry who share a common interest in the preservation of capitalist relations.

There is in existence a catalogue titled World Aid, it is a supplement for U.N. development business. It is distributed throughout the world to key individuals involved in supply, planning and procurement on Aid financed projects in 89 Third World countries, plus the U.S., Canada and 19 European countries. World Aid has a market of over 24 billion dollars.[51] Companies like Ciba-Geigy, has an establishment fund in aid of the WHO leprosy programme advertised in the catalogue. Other companies include Medimpex, Hungary Moore and Co. Medical supplies London, Syntex dental products. England, Astra Pins West Germany, Sandoz Ltd. Switzerland and a host of other pharmaceutical firms.[52] Additionally, WHO is involved in research collaboration with many industries. In view of the high priority being given to the development of vaccines anti-diarrhoeal drugs and

diagnostic test; a close collaboration has been maintained with companies like Pfizer research on cholera, Brisotor Meyers (USA), Bio Merieux (France), all in the research of cholera.[53] This goes along the way to illustrate the fact that there does exist some kind of relation between the WHO and the MIC. This relationship manifests itself in the kind of policies pursued by the WHO, which serves to protect the interest of capital and influences Third World health policy in no small way.

Finally, the idea that western medicine is value free is quite doubtful after the following analysis of the activities of the MIC and the WHO. Medical technology is not only the logical consequence of scientific programmes, but rather the product of a particular injunctions of social economic and political forces.[54]

Medical technology is not always capable of curing ill health. There are situations been its therapeutic value is lost, as can be seen in the case of Third World countries. Nevertheless, there is that powerful body which has a vested interest in the promotion of medical policies that ensure costly expenditure. This corporate body activities in the Third World is quite harmful, studies have shown that most surgical procedures and drugs have little or no efficacy. Quite often technology used in industrialized countries are inappropriate for the developing world.

Developing countries within the World Health Assembly possess a large majority. They are increasingly using that power to articulate their needs. WHO has come to recognize this along with other factors which have been mentioned. There is the PHC programme which is to cater for the vast majority of Third World countries. The move towards self-reliance and a New International Economic Order are manifestations of the attempt by the bourgois of the Third World to assert themselves in relation to international capital.

The adoption of a resolution by the World Health Assembly like most U.N. assemblies is with the problem of implementation. The realization of proposals depends to a large extent on the willingness of the industrialized countries. Considering the fact that they provide the bulk of the funds for execution of health programmes and projects, U.S. emphasis on the provision of bilateral aid as opposed to multilateral aid for the financing of projects can be seen as an attempt by the U.S. to regain her lost influence as a result of the voting patterns of the General Assemblies of the U.N. system, where the majority has the power and the Third World form a formidable bloc. The WHO while being a specialized agency of the U.N. also has its political dimensions which must not be overlooked. The organization represents the interest of the development establishment and reproduces that political position which aims at the reproduction of capitalist special relations.

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Chapter 3

3.0 THE HISTORY OF NIGERIA'S HEALTH SERVICE AND THE ACTIVITIES OF WHO

3.1 Introduction

The second chapter centred on the WHO and the MIC. The activities of both institution were examined vis-a-vis how they relate to each other. The chapter also looked at how the WHO and MIC influence Third World health policy.

This chapter deals with the history of medical services in Nigeria and the activities of WHO. The study is divided into four sections: Pre-colonial Nigeria and medicine, the activities of Missionaries in the field of health, the colonial state and health services, international institutions like the WHO and Nigeria's health services.

3.2 Pre-Colonial Nigeria and Medicine

Before the advent of colonial rule, what is today known as Nigeria was made up of various parts at different stages of development. There were the powerful kingdoms of Ife and Yoruba land in the southern region and the Kanem Bornu Empire in the North. These kingdoms were richly

endowed with prosperous economies."[1] Traditional African economies are usually called subsistence economies, because most of the people were engaged in agriculture while there were communities who solely engaged in commerce."[2]

As the economic of the African states prospered, it necessitated division of labour and specialization. In Nigeria for instance, some members of the communities began to acquire skills in the art of medicine and healing.

> Apart from elderly women charged with the safe delivery of babies, there were herbalists, diviners, babers, surgeons, sooth sayers, religious teachers of Islamic faith who were recognized healers as well as indigenous psychiatrist.[3]

The manner in which these traditional practitioners operated depended on the nature of a patient's sickness. The serious cases had the practitioners undivided attention, for example, cases of mental derangement and leprosy. In Tiv land, for instance such patients were accommodated in rooms called <u>styumhe oruange</u> (sick man's house).[4]

The practitioners also made house calls, and birth attendants had the responsibility of going out to deliver babies. Minor cases of stomach ache, cough and cold, a simple prescriptions of some herbal concoctions from the practitioners was sufficient.

Medical practitioners were also sometimes engaged in

cult activities. So "in addition individuals received treatment (group therapy) as members of deity (such as the orisa cults, among the Yorubas) cults."[5] These traditional practitioners were considered as being vested with the societies guidance; blessed with powers to diagnose patient's illness from their cultural, social and physical causes. This makes their practice quite unique to the other forms of medicine which are only able to assess the physical causes of a patients illness.

The traditional health system was culturally non-disruptive, it was developed by the cultures of the local peoples. The training process of persons involved in medical delivery was understood by the people since it occurred within the milieu of the local village.[6]

To top it all the pre-cononial medical system was within easy reach of the community, this obtains even today in African societies and most of the Third World.

> In the Nigerian pre-capitalist economy the art of healing was not an avenue to get wealthy, cultural norms were a safety value that limited the possibility of ordained healers to go into practice.7

These communities were quite organized, and were able to provide sufficient health services for its members unlike the present set up where you have mal-distribution of health services. They were also able to provide the health

services on a continuous basis. The learning process was on the job training system, the skills are handed down from one generation to the other. To prevent extinction the sons and daughters of these practitioners are trained to take over when they die or retire.

It should be noted that pre-colonial Nigeria did have classes. With the development of ruling groups the society became stratified and classes developed. Where there are powerful groups in any society some dominate others and pre-colonial Nigeria was no exception.[8] The domineering group had the privilege of requesting for expensive treatments from medical practitioners, like charms for wealth. Nevertheless. the pre-colonial Nigerian medical service was extended to every member of the community.

3.3 Medical Missionary Activities in Nigeria:

The activities of Missionaries in Nigeria brought along with it western medicine. The arrival of Christian Missionaries in Nigeria during the first half of the 19th century brought not only the Bible, but also the modest introduction of the art of healing from the West.

These Missionaries were primarily occupied with the task of fostering Christianity and establishing their 'civilising influence' among Africans. According to Michael

Crowther, "The early Missionaries in West Africa had a dual purpose, to promote legitimate trade between Africans and Europeans and convert Africans to their own religion.[9]

The practise of medicine was only a subordinate assignment which had an Evangelic undertone to it. Moreover the main concern of the Missionaries was with the health of the, missionary community. This was the period that Africa acquired it's legendary name the "white man's grave". European morality rate was quite high hence the need for medical care while they were in Africa.

Along with this, the missionaries found that their community based medical care helped save the way for their Evangelical duties. Their medical activities elicitated feelings of confidence in the peoples they were converting. So they were bent on creating a place suitable for spreading the word of God. According to Ralph Schram, the missionaries were to a greater extent better than any that have been mentioned among the men and women who brought modern medicine care to Nigeria.[10]

The christian Missionaries might have been the first to introduce modern medicine to Nigeria, but they played a minor role in the provision of health services in Nigeria. One of the first hospitals to be built is the St. Thomas Island hospital and no other was established again until the Sacred Heart Hospital Abeokuta built in 1865 by the Roman

Catholic Mission 11 (RCM).

The christian missionaries were responsible for the establishment of more than 89 health facilities with 352 doctors and 7,241 beds between the year 1897-1960 in Nigeria. There was however an over concentration of these in the East and the Mid-Western regions . Table 3.1 illustrates the distribution of health facilities through out Nigeria from the period 1897-1960 and the missionary societies responsible for them.[12]

There have been a number of historical accounts of the medical missionaries. A famous one is that by Adelola Adeloye "The Nigerian Pioneers of Modern Medicine." This is an account of some of the first African medical doctors to have practised such as Samuel Ajayi Crowther. He established a dispensary in Abeokuta in 1892. Other early missionaries involved in medical activities in Nigeria are Mr. Van Cohen, from the British Guyana, who came to Abeokuta also in 1850. Another public health figure is Reverend Hope Masterson.[13]

Missionary activities intensified as colonial rule was established, in fact the christian missionaries assisted in providing medical and public health facilities even where the government felt unable to take the initiative.[14] This was as expected considering the fact that the christian

Table 3.1: The Distribution of Missions and Health Facilities According to Regions of Nigeria 1897-1960

Missions	No of Hospital 1980	No of Doctors 1980	No of Beds 1980	Regions
Basal Mission	-	-	30	North
Church of Brethren Mission	3	10	226	North
Church Missionery Society	7	49	622	East, West, North
Church of Scotland	4	32	328	East, West
Lutherian Mission	1	4	137	East
Methodist Missionary Society	7	26	634	East, West
Nigerian Baptist Mission	5	27	327	All regions
Qua Ibo Mission	5	11	267	East
Roman Catholic Mission	38	73	2839	All regions
Sudan Interior Mission	12	20	595	North
Sudan United Mission	12	73	975	North
Seventh Day Adventist	3	14	137	East, West
United Mission Society	1	4	69	
Total	89	352	7,241	4

Source: Ityavyar, Dennis. "Background to the Development of Health services in Nigeria." In Social Sciences Medicine Vol. 24, No. 6 p.490.

missionaries were on a "Goldly mission".

The humanitarian godly mission of the missionaries was not quite welcomed in the North as in the South because the Northern region had at that time embraced Islam. As a result christian missionary activities were confirmed to social activities of health and education. By the end of 1960, SIM and SUM had a total of 25 hospitals, dispensaries and leprosariums; 93 doctors and many nurses and midwives in various parts of Northern Nigeria.[15]

The Christian Missionary activities also extended to the area of health manpower development. Training centres were set up for medical personnel like nurses, mid-wives and paramedicals who manned these health facilities. The first African doctors were in fact trained at Fourah Bay College, Sierra Leoon, established by the (CMS) for the training of Evangelists.[16]

In general, the activities of the Christian Missionaries can not be overlooked. Considering the fact that they dealt more with the African peoples than the colonial administration, they can be considered as the pioneers of western medicine in Nigeria.

3.4 The Colonial State and Nigeria's Health Services:

The global expansion of Europe between the 1760s and the 1970s saw the spread of European trade across most of the West African region. There was a change of strategy as well as the quest for empire-building by the colonial world. They became not only buyers of raw materials but searched for markets for their finished products in the developing world.

Nigeria experienced a great influx of trading companies, seeking lucrative markets for their businessess. It was thus necessary to provide some form of health care for their employees. The medical services provided by these commercial bodies considerably became one of the first organized medical services of some sort in Nigeria.

Nigeria's medical services also have some of it's roots in the military. For according to Adelola Adeloye;

> An organized medical service in Nigeria had its roots in the arrangements made in 1862 by Harry Standrope Freeman, who was the first Governor and commander in chief of the settlement in Lagos.17

Part of the example within the West African medical service was the emergence of medicare from a military background. In Nigeria "a centralized health services at first military, and then colonial in structure, gave birth

to a uniform medical and sanitary service.[18]

The first hospital was a conversion from a centre of sickness of the Royal Navy in 1871. Two years later, the colonial hospital was shifted to a temporary location because a detachment of the West Indian Regiment was occupying the hospital as a Barrack. As colonial activities moved northwards under the command of George Goldie, small military hospitals were created at Lokoja, Jebba, Sungeru and Zaria by the beginning of 1900.[19]

The nature of colonial expansion can be seen as having contributed to the inequality in social services between the north and south, health services being one of them. Apart from the regions, the fact that most of these health facilities were located in the major towns which paved way for the unequal distribution of health services as well. The colonial health policy as its first task, made the preservation of the European population residing in these towns where other social amenities were at their disposal. Keeping the African labour force healthy was of no major importance, and where economic interests existed attempts were made to provide some rudimentary medical care.

Medical facilities originally meant for the European population were later extended to a few privileged Nigerians who were in the employment of the British Army or the civil

service, those that came in close contact with the Europeans. Africans were considered as carriers of diseases like the malaria parasite. The colonial health policy thus in order to prevent the spread of epidemics came up with a number of segregative policies aimed at keeping the various groups in separate living areas

> British expatriates sometimes referred explicitly to their quarters as 'sanitary districts. By contrast, there was a systematic denial of public health provision to the non-white population which naturally resulted in the high incidence of disease.[20]

Ikoyi and Lagos for example were distinctly different in their inhabitants. In 1929 Lord Lugard went to the extent of cautioning the European population that the natives were carriers of malaria and yellow fever and that whites would do better to keep away from them.[21]

The colonial health policy had a very negative attitude towards the health problems of the Africans. In a study of British rule in the Sokoto caliphate by Dr. Mahmud Modibo Tukur, it was found that epidemics like cerebro spinal meningitis a killer disease was of no consequence to the authorities as they were not even reputed. Dr. Mahmud Tukur pointed out:

> That it was not reported should not be surprising since there was little point in reporting unless it was merely to warn the British and those in their service to take precautionary measures.[22]

Despite the enormous amount of money the colonial administration made from its exploitative taxes only a meagre amount was spent on the provision of social welfare for the African population. The surplus were sent abroad to fatten the British Empire, New Zealand and Australia. The British supported very few social services.

> Thus, for example the Borno Native Authority maintained two leper settlements for a few years. In 1911 the Yola Native Authority maintained one Native hospital of a single room in Yola; as well as a leper settlement with 21 inmates near the town ...[23]

The colonial health policy even in the periods of crisis like epidemics did nothing to alleviate the suffering of the African population. The British neglected the health of the population grossly. They were rather more concerned with the maximization of profit and exploitation and expropriation of surplus from their colonies.

> State of the colonial economy was measured not by the welfare, of African peasants producers, manufacturers, consumers, businessmen tax payers, but solely by the increasing of exports and imports and the proportion of this trade that was conducted in the ruling country.[24]

The benefits which they were supposed to have brought to Africa to borrow from Walter Rodney were questionable. The only reason for social services were in fact to make things easier for the colonialist for instant, in Ibadan

there were only 50 Europeans before the Second World war, who had access to a segregated hospital with 11 beds. Mean while half a million blacks were given only 34 beds. This situation obtains in other areas as well. In the 1930s, 4,000 Europeans in Nigeria had 12 modern hospitals at their disposal, while the Africans with a population of 40 million had to make do with 52 beds.[25]

The colonial administration had her priorities and the social welfare of the Africans was not one of them. The 1931-1932 colonial budget while spending ₦694,904 on police, military and prisons; it spent only ₦271,712 on education and ₦441,589 on medical and public health out of a total expenditure of ₦8,063,142.[26] This can be attributed to the fact that colonial domination encountered resistance from the Africans and the military and police were the instruments of coercion to quell such resistance from the Africans to colonial rule.

3.5 The World Wars and the Colonial Health Policy:

The world wars had a terrible effect on the medical situation in Nigeria. There was a sharp reduction in the medical staff as they were drafted to the battle fronts to treat the Royal Army. Because the war consumed alot of funds, money for the construction of hospitals was not

available.

The existing hospitals deteriorated due to lack of maintainance. Of the 36 medical officers who went to the war front, 26 died creating serious crisis of shortage in the hospitals in Nigeria. To compound the situation, it was during the war years that Nigeria experienced one of her worst epidemics. Diseases spread across West Africa and brought about a very high mortality rates among the Africans. These diseases, which spread across West Africa brought about a very high mortality rate among the Africans. The ex-service men also brought with them from the war front deadly diseases like syphilis, gonorrhoea and influenza.[27]

3.6 British Colonial Assistance"

The post-war years saw the growth of assisted development policies in the colonies. Bilateral aid was provided through the successive Development and Welfare Acts. The 1940s and 1950s can be seen as a period of the growth of state interventionist policies in the metropolitan economies. What obtained was that British aid was only aimed at the development of infrastructures which enhanced expropriation in the colonies. There were however some pressures on Britain to review her neglected social and medical services.[29]

Nigeria for a considerable period of the war had problems of inadequate manpower. The British colonial health policy did not cater sufficiently for the training of indigenous medical staff. Even as late as 1958 there was not a single African doctor in the mission medical service.

However, some form of aid was made available to the colonies by the British Government. This was done under the colonial development Act of 1929. ₦1 million was to be given a year, which included monies for medical work. The amount was increased by the colonial development and welfare Act of 1940 to ₦5 million for ten years and ₦500,000 for medical research. By 1959 only ₦24.6 million had been spent by health and Britain on medical and health services, and ₦3.5 million on medical research. In Nigeria alone ₦2.5 spent on public , ₦1.3 million on rural health water supplies in the East and North.[30]

These figures are quite impressive but in actual fact the African population did not really benefit from the expenditure on health and other social services. For the majority of the population the existing rural dispenseries were the only source of modern medical attention they got; that was if they were within their reach:

> These dispensaries were grossly inadequate since they were still locally funded by impoverised Native Authorities while central government revenues were allocated to hospitals and other curative facilities in the urban areas.[31]

All in all the colonial health policy was strengthened by the programmes of assistance. Yet there was a widening inequality in the distribution of health services. According to Changula and Tarimo this did not happen by chance. Three official documents which appeared between 1947-1956, stressed the appalling rural health situation and at the same time appealed to hospitals which could do but little to alleviate the existing situation.[32]

This system of Medicare being designed to cater for a privileged few in society, was inappropriate in catering for the health needs of an African country like Nigeria, where more than three quarters of her population reside in the rural areas, who are suffering from diseases like malaria and diarrhoea. These diseases caused by their standards of living, is a condition brought about by the exploitative colonial system.

3.7 Assistance From International Organisation:

The acute shortage of medical staff led to an over-reliance on expatriate personnel. Local training did not yield much as the University College Ibadan only graduated its first class in 1960, while Lagos was still at its planning stages. After independence the picture of assistance changed somewhat, various international agencies offered

some form of assistance such organizations like the WHO, the Peace Corps, the Agency for International Development (AID), and the British Department of Technical Co-operation.[28]

The end of the Second World war saw the expansion of international medical aid in Nigeria. The technical assistance structure which replaced the colonial one allowed for more bodies to contribute aid to Nigeria's health service development. There were contributions from private and public organizations all over the world. Bodies like the Ahmadu Memorial Foundation Inc., Ford Foundation, Rockefeller and Nuffield are examples.

3.8 WHO Activities in Nigeria:

The WHO and UNICEF have been involved in a number of activities in Nigeria prior to independence. The kind of policies they pursued in the country illustrates the fact mentioned earlier of their tendency towards a technical response to health problems.[33]

WHO was involved in malaria control in Africa in 1955, and changed her strategy from free control to that of eradiation. This was not an easy task at all, considering the difficulties of tropical Africa. Nevertheless, they were quite optimistic with the discovery of residual insecticide and anti-malarials. They were however, not successful

because signs of improvement were temporary. In Ilaro for instance, an experiment was conducted from 1949 to 1953 in an area with residents totaling 2,500 were sprayed. The mosquitoes reduced but only for a shortwhile.[34]

The eradication of malarial proved to be a difficult task in Nigeria and Africa in general. WHO establish Medical Field Units (MFU) for combating diseases like cerebro spinal meningitis, small pox, paws and other epidemics. By 1960 there were six MFU in the Northern region, three in the West and three in the East, all engaged in some disease control programmes. The MFU's were however not quite above to cope with the scale of epidemics that ravaged Nigeria.[35]

There were epidemics on such a large scale which wiped out large population. Nevertheless, the WHO had some success with the yaws campaign which it had wiped out literally in Nigeria. There were others like the small pox campaign which like the yaws campaign received attention with the immunization campaigns of 1957. The yellow fever laboratories received assistance from the Rockefeller.

The involvement of the Rockefeller Foundation in Nigeria's yellow fever programme indicated that corporate bodies (like the Rockefeller) do have a vested interest in Third World health programmes. These interests though can

not be seen purely within humanitarian considerations, particularly as the discovery of different kinds of drugs needed markets. Medical corporations have been known to use the Third World as markets for the sale of drugs like contraceptives they cannot sell in their home countries.[37]

The Federal Ministry of health has received assistance from WHO in disease control and development of national health services in the years after independence, as part and parcel of her development plans. For instance, in the 1962-1968 Development plan the Ministry of health received continued assistance from the UNICEF and WHO in her epidemic control programmes of sleeping sickness, malaria, small pox and cerebro spinal meningitis.[38]

Nigeria has benefited from WHO through offers of fellowships in the quest for the development of health manpower. The problem though was the fact that a number of the courses offered at universities and other institutes of health were inappropriate to the Nigerian context. The University of London's Institute of Education was criticised for offering courses which lacked practical field training, out of context and irrelevant for Nigeria.[39]

This illustrates the manner in which a health system unsuitable for Nigeria was pertuated through the system of education for health manpower. For WHO's assistance to Nigeria in developing her health service after independence,

an expert committee was sent to Nigeria for this sole purpose. They dealt with training and the monitoring of the health system.[40]

WHO in Nigeria is presently co-operating with the Federal Ministry of Health in an effort to help improve its national health system. It gives technical assistance supporting training and managerial responsibilities. It assists the FMOH in the development and monitor of a PHC which is Nigeria's current strategy for 'Health for all by the year 2,000 (HFA/2,200). The WHO is presently involved in the training of personnel in six states.[41]

The WHO have involved in a similar rural health programme in Nigeria in the Federal Basic Health Care Scheme of the 70s.[42] It gave assistance of the Fedral Ministry of health for the provision of an integrated health service for the community.[43] This is a positive move, but unfortunately its implementation did not live up to expectations.

The present PHC programme emphasizes evaluation and monitoring. Attempts are being made with WHO's assistance to set up a uniform reporting system as well as with the provision of managerial courses. The university of Benin's Institute of Public Health has been identified as a national centre for co-ordinating the managerial courses with the collaboration of the WHO and the National Directorate of the

FMOH.[44]

Additionally, the WHO is involved with a number of other U.N. specialized agencies like the UNICEF and the UNFPA (all in collaboration with the Federal Ministry of health) in the execution of the PHC programme in Nigeria. The WHO involvement can be seen in maternal and child care plus family planning programmes, Health manpower development for PHC. Essential drug programme and health education all under the PHC. The WHO is also playing a very active role in the Control of Diarrhoel Disease Programme (CDD) which ORT is a part of.[45]

3.9 The Merging of the Traditional & Modern Medical Systems

This chapter covers the history of Nigeria's health care service and the activities of the WHO but it will not be complete without the mention of the indigenous medical system in relation to Nigeria's quest for HFA/2000. Nigeria's indigenous medical system has a fairly long history. It is the first form of medical practice known to Nigeria. Thus, it is fairly embedded in the culture of the various ethnic groups in this country. Inspite of governmental neglect, traditional medical system thrives the continuous patronage of the people. In the rural areas it remains the main source of health care, as well as in the

urban areas it also enjoys the patronage of the low and high income groups.[46]

The Nigerian indigenous medical system has enormous potentials which have been left untapped by the quest for HFA/2000. According to C. A. Erinosho,

> lately concerned researchers policy makers and bodies such as the World Health Organization began to call attention as well as highlight the role which traditional medicine in our developing countries might play in the management of patients.[47]

The move to the direction of a rural health policy by various states of the developing world and international agencies like the WHO involves the great desire to move cost on health care.[48] The argument is based on the idea that in view of the source resource available in Third World countries more effort should be made in determining which aspect of the health sector can be invested in for "maximum health impact."[49]

The call for the involvement of indigenous medical practitioners in Nigeria's health care delivery system has resulted in a protracted debate on the merits and demerits of the incorporation of these traditional healing in the western therapeutic system. There are various arguments for and against the integration of such a health system.[50] There are those who feel strongly about any form of integration, for instance. In Nigeria Asum (a psychiatrist), has

pointed out that many practitioners feel that not enough is known about indigenous practitioners to warrant integration. He remain unimpressed by the success of Yoruba healers in the fields of surgery, of thamology, neurology and pathology. He goes further to argue that contrary to what people think it is the traditional practitioners that are wary of integration for fear of competition and not vice versa.[51]

This view is shared by quite a few western trained practitioners. There has not been a formalized move towards integration of any sort in Nigeria. What obtained in the late 60s was the establishment of certain organizations, the Nigerian Association of Medical Herbalist, the Nigerian Union of Medical Herbalist and the Nigerian Union of Traditional Medical Practitioners. They were responsible licensing of medical practitioners and the likes.[52]

In recent times the attitudes of the government has been that of an informal recognition of these traditional practitioners. There has been no official structures created for the development of an integrated system. The 1975 FBHCS which was targeted at the rural population sought the use of middle cadre health personnel. That is health aids and health assistants to health workers, but nothing was done in the area of the integration of traditional medical practitioners in the scheme as such.[53]

1979 however, saw the growing interest in the collaboration of the two medical systems. In April, 1975 a conference sponsored by the Federal Ministry of Health was held to that effect. Suggestions were made for the training and a syllabus drafted for traditional medical practitioners as well as the understanding of their activities as a whole.[54] This was seen as an attempt to curtail the activities of these medical practitioners by the medical system whose interest was seen to be in jeopardy.

As maintained earlier the late 70s saw the growing involvement of the WHO in the health problems of developing countries and the move towards a more rural health policy. There was also their involvement and that of other international agencies in the development of various indigenous medical systems in developing countries. In 1977, a resolution was passed by the World Health Assembly, this resolution was aimed for the promotion, development training and regulation of traditional medical systems. It also sought to consider appropriate financing of these activities.[55]

A similar commitment was made at the Alma Ata declaration on PHC in 1978, taking into consideration the existence of traditional medical practitioners in various communities. There was indeed a possibility of the involvement of traditional medical practitioners in the PHC and their training accordingly. Other donor agencies have

stated similar policies towards the provision of grants and loans to such health programmes embarked on by states in the developing world. The World Bank and USAID help to provide financial support to rural health programmes which draw upon the resources of traditional health practitioners.[56]

The involvement of international agencies in the development of traditional medical system seems quite impressive, however such policies have tended to focus solely on Traditional Birth Attendants (TBA). This led to the neglect of other traditional practitioners who are completely forgotten. The neglect have been attributed to the fact that TBA are more technically inclined and not in line with the modern health services though they lack the necessary hygiene conditions for practice. The reason is that traditional medical practitioners are engaged in unscientific processes or supernatural and other belief systems which modern medicine can not quantify.[57]

Western trained medical practitioners have a negative attitude towards the issue of integration of the two systems of health. Tolu Pearce, conducted a study on the professional interest and attitude of university trained Nigerian physicians to the integration of the western and traditional medical systems. His result are quite revealing. The overall impression is that of tolerance, but not a serious acceptance. Tolu Pearce, attributes the rea-

sons to the idea of professional dominance. He says,

> Those engaged in the process of creating communication and applying knowledge are identified and identify themselves with recognisable increasingly organized occupational groups. It is likely that this group of professionals would rather not share his area of control with any other groups.[58]

Others like S. K. Bonsi, see the reluctance as a result of the historical and political development of their profession. Medical historians have observed that these orthodox physicians have become 'chosen' as legitimate because of their social and commercial work and the enormous support they receive from the dominant class in possession of state power.[59]

U. A. Ugun, also believes that the reluctance to accord traditional medical practioners equal status with western medical practitioners cannot be unrelated to the selfish interest of the western trained health professionals who advise government on health matters and from whom are chosen those who manage the ministry of health and health management boards of the federation.[60] This group continue to serve that interest and the accordance of equal status to traditional medicine which would pose as a competition is seen as some sort of threat to their interest.

Western medicine continue to enjoy enormous legal, financial and political support from the state. It is in

the light of this that one can comprehend the quest to minimise the competition which traditional medicine would pose to western medicine. Western medical professionals do not welcome any form of integration, they go to lengths to discredit traditional medicine by dwelling on its so called unscientific nature and lack of hygiene. And when they show interest it is in the quantifiable aspects of traditional medicine like the chemical components of herbs, while they overlook the others.

So far this chapter has tried to trace the evolution of Nigeria's health service. It has also looked at the activities of the WHO in Nigeria prior to independence to date, and the part of traditional medicine in the health care delivery system. The study examined the unequal nature of the Nigerian health service development during the colonial era where emphasis was placed only on urban based hospitals. This shows the negligence of the rural majority, who have to rely on few dispensaries for modern medicine. The colonial system did nothing in the area of developing traditional medicine, instead they used its existence as a way of minimizing expenditure on health and leaving the health of the population to be catered by the existing traditional system.

Finally, the activities of the WHO was in motion before independence, its presence is felt even more today

with the PHC. Part of the task of PHC is that of child health care programme which the ORT is an integral a part of. The next chapter will take take a look at the promotion of ORT in Nigeria and the role of the WHO.

FOOTNOTES

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12. Ibid, p. 490.

13. See Adeloye Adelola, The Nigerian Pioneers of modern medicine; Selective writings. Ibadan Universities Press, 1977, For study of some early medical missioneries in Nigeria.

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15. Itayavyar Dennis, A., op. cit, p. 491.

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23. Ibid, p. 726.

24. Crowther, M., op. cit, p. 249.

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26. Offiong, Daniel A., Imperialism and Dependence Fourth Dimension publishers, Nigeria, 1980, p.114.

27. Schram, R., op. cit, pp. 181-215.

28. Ibid, p. 287.

29. Doyal Lesley. op. cit, p. 254.

30. Schram, R., op. cit, p. 315.

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33. See Chapter one for discussions on the tendency toward a technical response of the WHO.

34. Schram, R., op. cit, pp. 320-321.

35. Ibid, pp. 320-321.

36. Ibid, pp. 321-324.

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38. National Archives. Ministry of Health file URB (305) Health Planning Development Plan, 1962-68 Kaduna Archives.

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43. WHO Special Action Plan document, op. cit, Introductory Chapter for details.

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Chapter 4

4.0 A CASE STUDY OF THE PROMOTION OF ORT IN NIGERIA

4.1 Introduction:

This chapter will examine the PHC, and the promotion of ORT in Nigeria. It will be mainly concerned with the implementation of the programme, the role the Nigerian Government played as well as that of the WHO and UNICEF in its implementation. (UNICEF is mentioned here because it is an active collaboration with the WHO on this programme as it deals with children).

This will include also a brief look at the involvement of other aid organizations and the pharmaceutical industry in the promotion of ORT in Nigeria. A report will be made of our findings on the use of ORT and Salt Sugar Solution (SSS) by a selected group of mothers.

4.2. PHC In Nigerian Alternative STrategy:

Nigeria, being a member of the WHO and UNICEF, has adopted strategies aimed at HFA/2000, in this view the provision of PHC is seen as central to the strategy and the

achievement of HFA/2000. Inherent in the PHC concept is the quest for an alternative health care strategy. The need for an alternative is as a result of the shortage of fund for a more expensive health care programme which will require enormous resources for hospital construction, training of personnel, and for sophisticated equipments. These are the sort of demands sought by the western model, which Nigeria has adopted in the past.[1]

Nigeria's health system like that of most developing nations is shaped along the western model. This bias for the curative type of medicine is seen in her budget allocations and expenditure for health which shows a definite bias for the development of teaching hospitals.[2]

Recently there has been emphasis in official policy and the media on the inclusion of preventive medicine within Nigeria's health policy strategies. In order to give impetus to the implementation, the President of the Federal Republic launched the National PHC system on Monday 7th August 1987.[3]

PHC encompasses a great deal and involves the following essential elements:

1. Education concerning the prevailing health problems and methods of preventing and controlling them; this centres around the fact that it is the individuals who

decides to be healthy or not healthy, to accept health measures all aimed at creating a healthy environment. Hence Education and information must be that which leads to a situation where people who want to be healthy, know how to go about it and do just that collectively or individually.

2. Promotion of food supply and proper nutrition; the importance of nutrition in health cannot be overemphasized. This has been recognized within the PHC programme, the objectives of the nutritional component include the promotion of activities geared at the improvement of good supply and nutritional family level.

3. Adequate supply of safe water and basic sanitation; the main objective of this particular PHC component are the prevention of disease and the improvement of the quality of life and well-being by the promotion of personal and communical hygiene, thereby ensuring availability of safe water supply and sanitation as all part of the move towards HFA/2000.

4. The Maternal and Child Health, Family Planning components of PHC aimed at the promotion and protection of the health of children, and women of child bearing age; all aimed at ensuring all children have the possibility for healthy growth and development so that women would have a healthier reproductive life.

5. Immunization against major infectious diseases; this particular component seeks the reduction of morbidity and mortality by the provision of immunization against the major killer diseases. In the third world priority is usually given to the following six diseases: diptherra, whooping cough, tetanus, measles, phomyelitis and tuberculosis.

6. The prevention and control of locally endemic diseases notably malaria and hypertension; in the developing world malaria remains the number one disease. The malaria control strategy of the PHC programme have to be fashioned to the epidemological and socio-economic conditions in those countries.

7. Appropriate treatment of common diseases and injuries such as diarrhoea and accidents at home; this particular component is the prevention of death and resulting from common diseases and injuries; to enable all children have the possibility for healthy growth and development.

8. The provision of essential drugs is aimed at the regulation of both the production or purchasing of drugs and the prescription or usage practices at all levels for both the improvement of cost effectiveness and the safety of drug management.[4]

Table 4.1 shows the 1988 expenditure on the PHC

Table 4.1: Primary Health Care Expenditure For 1988

Item	Amount (₦)
1. Training of community health officers (12 at ₦60,000)	720,000.00
2. Running cost of comprehensive health centres, 14 few functional out of 24 (rate ₦100,000 p.a.)	1,400,000.00
3. Training of tutors for PHC 2 x 60,000 Kaduna and Ibadan)	720,000.00
4. Contribution to UNICEF for water sanitarion for health facilities	800,000.00
5. Contribution of WORLD BANK on Sokoto health project	1,6000,000.00
6. National Maternal and child health and planning with UNFPA	50,000.00
7. Woman in health (with WHO collaborations in Nigeria continued)	50,000.00
8. Establishment of a running costs of zonal officers (4 zones at ₦432,106.40 each)	1,728,425.00
9. Running cost of the headquarters units support, health education monitoring and evaluation family health.	300,000.00
10. Allocation be EPl/ORT unit, Onikan	600,000.00
11. Assistant to societies and association for PHC activities	100,000.00
12. Implementation of programme work PHC 1988	1,880,000.00
Total	9,948,425.00

Source: Federal Ministry of Health accounts department, 1988.

programme. A total of ₦56,670,000.00 was spend out of which ₦600,000.00 was allocated to EPI/ORT unit headquarters Onikan. The main focus of this study is on the promotion of ORT in Nigeria which falls within the "appropriate treatment of common disease", and diarrhoea disease happens to be one of them. We will now take a closer look at ORT in Nigeria.

4.3 The Promotion of ORT in Nigeria

> In 1978, responses to the rising concern of member states of the WHO and UNICEF resulted in their commitment to PHC and their launching the diarrhoea disease control programme (CDD).5

As a main objective the CDD seeks to reduce diarhoeal diseases that are related to mortality and malnutrition in children through the implementation of the ORT and improved feeding practices.

A trend of some sort was thus inevitably set as more and more nations in the third world made commitments to a child servile revelation, which places great emphasis on the ORT programme. This can be traced to the fact that ORt is considered a low cost public health weapon, above to fight the illness which is responsible for more than half the world's child deaths today.[7]

Despite all the advances of modern medicine and

medical technology children of the Third World have continued to die of preventable diseases like diarrhoea. This can be attributed however to inappropriate planning which puts emphasis on curative services to the neglect of child health and social preventive health care.

Medical science has been able to achieve some positive results in the use of ORT in both children and adults. It is in the light of this that the WHO took the initiative to develop the oral rehydration salts (ORS), which has helped open awareness for the promotion of the ORT for children's diarrhoeal diseases. The method is quite beneficial in terms of efficiency and safety. It helps reduce the risk attributed to intravaneous therapy injections such as thrombdite and ciruclatory overload.

ORT is not a new thing to Nigeria. Nigeria was infact one of the pioneers of a national ORT programme.

> In the 1960's and the 1970's a number of medical personnel and primary health care projects experimented with ORT. Since the mid 1970's over 10,000 trainees in schools of technology have received some instruction in the preparation and use of sugar salt solution.9

In 1978 the WHO launched the National CDD programme and the ORT campaign was a central part of it. Moves were made to start a CDD service in Nigeria and in 1981 and 1982 studies were conducted to that effect. Universities were involved in the testing for the afficacy and acceptability of ORS as

recommended by the WHO and UNICEF in the treatment of dehydration in children due to diarrhoea. The study showed positive results as over 70% of the children were treated successfully with ORT. Despite this the national CDD has not yielded the desired result.

A similar survey was conducted by the Federal Ministry of Health (FMOH) and the UNICEF in 1984. It was hoped that the ORT programme would receive the same response the EPI received. This was not to be as there was a non-acceptance of ORT by health professionals who had been schooled in the western model. These professionals insist that the use of Intravaneous fluids, anti-diarrhoeal drugs and antibiotics to handle even the mildest case of diarrhoea was the best way. This has proved an obstacle in the promotion of ORT in Nigeria.

The ORT campaign was officially launched by the President in December 1984, and in his speech he declared:

> Our country takes seriously the challenge it has set for itself to reach 80% of our children with full immunization by the year 1990. As this programme expands vigorous promotion of oral Rehydration Therapy (ORT) and other elements of primary Health care will be integrated with it.11

This move towards an ORT was most welcomed in Nigeria where 20% of the population (as at mid-year 1985) are children under age of five. Deaths from diarrhoeal diseases

happens to be a major source of their mortality.

> Nigeria's mortality rate in infants and children which is 110 per 1000 is death from dehydration within an established 120,000 to 180,000 deaths per year.12

This can be attributed to the low standard of living prevalent in the rural areas where there exist poor environmental sanitation, inadequate safe drinking water, coupled with low level of personal hygiene and poor eating habits. All these go a long way in creating a suitable condition for disease, which is detrimental to the health of children and the whole population in general.

The treatment for diarrhoea, with the use of ORT is a short term measure, which just cope with the immediate impending disaster when a child is suffering from dehydration caused by diarrhoea. It is in fact not a cure for diarrhoea. ORT can only help to reduce deaths caused by dehydration due to diarrhoea. In Nigeria alone ORT has the potential to reduce at least half the deaths from rehydration.[13]

Nigeria CDD programme is directed at children 0-5 years. Using ORT sub-programme as its initial strategy is simple and an effective approach to diarrhoeal management. Though this is not a cue, but it is within the economic means of Nigerians at the household level and within the

nations health system. The Nigerian ORT programme to even cut further costs encourage the use of the SSS.

Due to the large population and the size of the country, problems are encountered in the supply of ORS to every household. If every case of diarrhoea in children is to be treated with the ORS, it is estimated that millions of packets of the solution have to be distributed on a daily basis. What even worsen this, is the fact that over 70% of the Nigerian population reside in the rural areas with little or no access to roads at all.

> A survey in the country by Dr. Quick of USAID (United Agency for International Development) revealed that at least 9 million packets of ORS will be needed in the country yearly if ORS is to get to every household.14

In view of the problems associated with the use of the ORS packets for the time being, have been limited for use only in health centres. They are being used by health workers and other health professionals in the treatment of dehydration caused by diarrhoea in children. In 1985 the FMOH in co-operation with the Paedratics Association of Nigeria (PAN) and UNICEF, drew up guidelines for a standard formulae for the preparation of the SSS home mix, using measures available in most Nigerian homes, for instance a 3ml spoon and a 600ml beer bottle or 2,300ml soft drink bottles.[16]

The standardized formulae base on the above measures in Nigeria is as follows:

1. 1 beer bottle or 2 soft drink bottles of water (600mls).
2. 1 level tea spoon of salt -(3ml) 1.8 - 2.49.
3. 10 level teaspoons (or 5 cubes) of sugar - 25.09.

Emphasis is placed on the levelling on the tea spoons.[17]

A comprehensive campaign for the promotion of the ORT programme was designed in 1984 to combat diarrhoeal diseases. It was in 1985 that a National ORT plan was drafted by some prominent paedistricians of the federation in collaboration with UNICEF. The ORT message and the manner the programme was to be promoted were all defined in the document.

In February 1985 with the assistance of UNICEF the first ORT demonstration unit was established at the Massey street childrens Hospital Lagos. Since the commencement of the programme in the hospital, there has been a reduction in the diarrhoeal case fatalities. The chief consultant of the hospital estimated the savings from alternative treatment[18] costs in the range of $6,000 per month. Other model ORT units were set up in four states in April and May. Prior to the programme diarrhoea record was poor, so that data on diarrhoea was incomplete, recently the records are

quite accurate after assessing the programme.

Table 4.2 shows the impact of ORT in diarrhoea case fatality and the admission rate in some health establishment with ORT units around the country. The table shows a decrease in the rate of diarrhoea case fatality and admission. 1.847 diarrhoeal deaths were reported in 1987 which is a mere 0.34% of all case reported, down from 0.41% in 1985-1986. This is a significant reduction from pre-ORT reported hospital case fatality rates which were quite high from between 2-15%.[19]

The ORT plan of action had a target of 300 units in each local government by 1986. Each ORT unit costs from between ₦200-₦1000 ($300-$1,500), depending on which part of the country it is situated. UNICEF have been quite active in the provision of equipment used for the establishment of such ORT units like cups, spoons, buckets and ORS packets for use by health officials.

> In 1985 - 86,200 units were submitted returns. In calendar year 1987, approximately 1,300 units submitted returns, which showed a total of 537,870 cases treated of which only 1.6% required intravenous therapy.21

See Figure 4.1 for illustrations of the above. The figures show how the ORT can go a long way in cutting cost in purchasing of intravenous fluids used in rehydration of children suffering from dehydration (caused by diarrhoea) in

.462077

Table 4.2

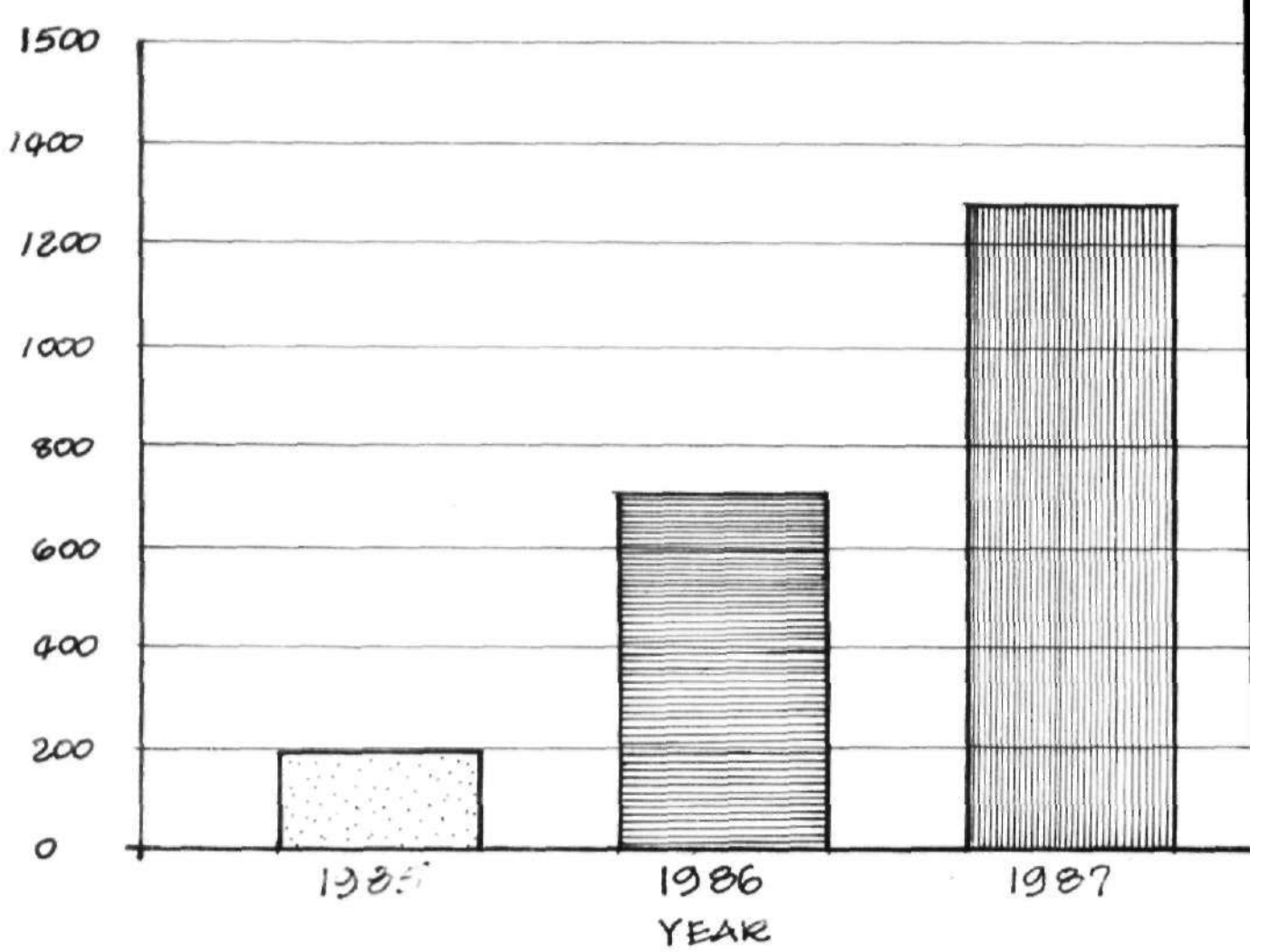
REPORTED CASES AND DEATHS FROM DIARRHOEA.
NIGERIA ORT RETURNS 1985-87

	NUMBER UNITS REPORTING	NUMBER CASES REPORTED	NUMBER TREATED W/ IV	% TREATED W/ IV	NUMBER REFERRED ADMITTED	% REFERRED ADMITTED	NUMBER OF DEATHS	% OF DEATHS	NUMBER ORS SACH USED	NUMBER SACH CASE
TOTAL JAN-DEC 87	1288	537870	8714	1162	17681	3·29	1847	0·34	234864	0·44
TOTAL 7/85-6/87	788	334704	5021	1150	19855	5·93	1381	0·41	122543	0·37
TOTAL 2/85-6/86	187	185820	1893	1102	4139	2·23	769	0·43	20948	0·11

Figure 4.1

NUMBER OF FACILITIES SUPERVISED FOR ORT

Number of Units Reporting



SOURCE: FMN/UNICEF NIGERIA MID-TERM PROGRAMME.

government facilities.

4.4 International Agencies and the ORT in Nigeria:

The activities of International agencies like the WHO, UNICEF and USAID cannot be over emphasized when we look at the ORT programme in Nigeria. Assistance from the WHO has been primarily through the CDD, which is now receiving priority from the WHO. In 1978 a technical advisory committee was established to work out short and long term objectives and to review evaluated and help implement the CDD.[22] WHO encourage states to set up their own national programmes.

In line with this objective the national CDD programmes sprang up. By 1985, 55 countries had designed their CDD's. This they did with assistance from the WHO and UNICEF which collaborates with their various ministries of health.[23]

The WHO and UNICEF have been actively involved in the research and field trials of ORT.

> "WHO funding for diarrhoeal disease research has increased sharply rising from about 12.5 million (US) in fiscal year 1982-1983 to $19.6 million in 1984-1985.24

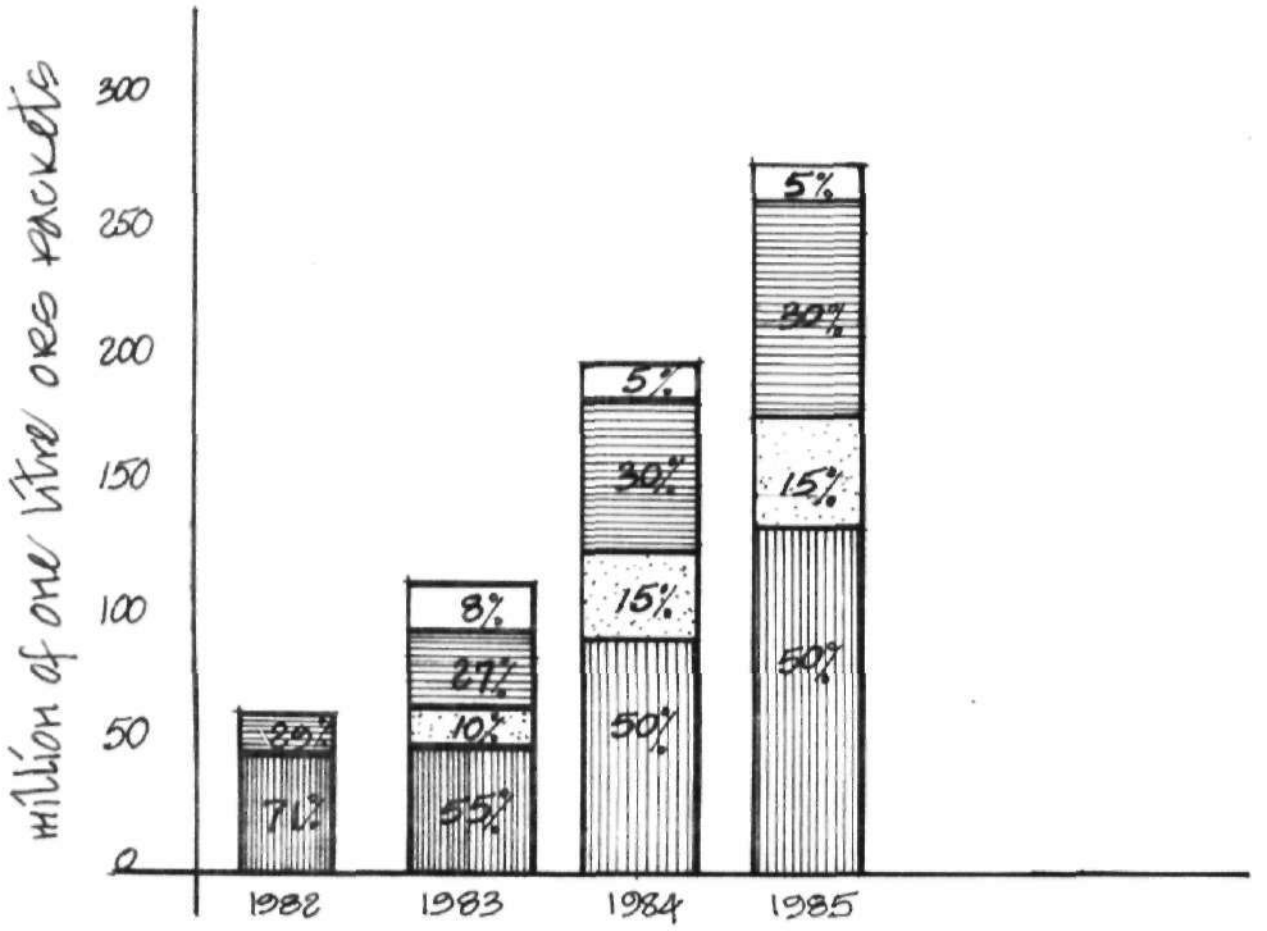
UNICEF has also been responsible for the provision of the ORS packets for the national ORT programme. In 1984 UNICEF purchased about 75 million packets as a competitive bid basis at the cost of 4 US cents. "The ORS packets were distributed to various ministries of health engaged in the ORT programmes. Other WHO sponsored programmes receive some packets. The WHO regional offices located in Washington, Brazaville, Copenhagen, New Delhi, Alexandria and Manila also received the supply of ORS packets for emergencies.[26]

Figure 4.2 illustrates the global supply of ORS packets between the period 1982-1985. It shows a noticeable increase in the number of packets supplied to the world. There is a steady climb from 60 million packets in 1985 and it is still climbing. There is also an indication of the growth of local production of ORS packets.

As earlier mentioned, there are a number of problems associated with the use of ORS packets in the implementation of the ORT programme on a national level. To ensure that supply is not hampered the WHO level. To ensure that supply is not hampered the WHO and UNICEF encouraged developing countries to engage in the local production of CRS packets. There is however, a heavy reliance on the importation of the ORS packets for local promotion of ORT. In Nigeria for instance UNICEF procured a total of 2.5 million sachets of ORS from 1986 to the present. 1.3 million of these have

GLOBAL Supply of (ORS) 1982-1985

FIG 4.2



legend

- local prod
- comm. imports
- provisional bumicet
- provision by other donors

SOURCE: The state of the world children 1987
UNICEF 1987

been distributed to the states. UNICEF has also distributed 500,000 plastic 3ml teaspoons to be given to mothers trained on ORT.[27]

The Federal Government is engaged in the joint procurement of CRS packets with UNICEF, of the 2.5 million packets procured the cost was borne equally by the Federal Government and UNICEF. A sum of $140,000 (which is $70,000 each) was spent by both parties in the purchase of the CRS packets.[28]

WHO and UNICEF have been involved in helping countries set up their own local sources of ORS. They have assisted over 40 countries with technical assistance, plant machinery and packaging.

Another international agency which has become increasingly involved in the promotion of CRT in the developing countries is USAID. The USAID has given enormous assistance to the WHO/UNICEF CDD programme. It has been responsible for the funding of a number of conferences on ORT, the second of which was held from December 10-13, 1985 in Washington DC. The USAID's main concern there was to bolster local production.[30] An enormous shift in fact was recorded according to USAID in the productionof ORS from developed to developing countries. To support this shift, in the production of CRS from industrialized to the developing world USAID launched its support, supply, pro-

duction and promotion of ORT. The scheme is aimed at providing loans and technical assistance to interested private Companies for the production of ORS locally.[31]

The AID also uses marketing experties to assist in pricing, advertising and improving distribution systems for the maximization of profit. That is the main reason for the interest of pharmaceutical industries in taking into consideration in this avenue of the promotion of ORT. Presently:

> According to 1983 WHO reports, Oral Rehydration salts are being produced in 30 developing countries, either for the government or for commercial sales. These countries include one in Africa (Lesotho) 14 in Asia, 3 in the Middle East and North Africa and 2 in Latin America.[32]

In the case of Nigeria the Kaduna Astra Arewa has been responsible for supplying the Federal Government with packets directly. These packets are in turn sent to government health facilities throughout the Federation.

On the whole the FMOH in close co-operation with the WHO and UNICEF have been actively involved in the implementation of the ORT programmes, as well as the coordination of the activities, of international agencies involved in the promotion of ORT in Nigeria. The various states of the Federation have received, support for their ORT efforts from these bodies (like USAID). In the area of training health manpower over 8,000 health professionals of different areas

have been trained in ORT. The training has been on the job or and/or inservice nature. With emphasis being placed on the monitoring, evaluation and the supervision of the CDD hence the need to train health professionals who will be capable of managing the ORT units.[33]

However, ORT is not a cure to diarrhoeal diseases, it is only aimed at correcting dehydration caused by diarrhoea. The health programme merely gives an impression of tackling the health problem. We we shall now see the public reaction to such a strategy.

4.5 Public Reaction to the Simple Solution:

The manner in which Nigeria's health service was evolved has in small way helped in shaping the attitude of the people towards health and medicine. The Western oriented and inhereited health system which emphasize urban based sophisticated hospitals with drugs, heavy equipment and Personnel only serve to inculcate attitudes which go against the spriit of such programmes as the ORT, which encourage low technology. However, an interesting discovery was made at the A.B.U. teaching hospital in the course of this study, which will help bolster our argument.

The following data have been collated from the paediatric out patient unit of the A.B.U. Teaching Hospital Zaria.

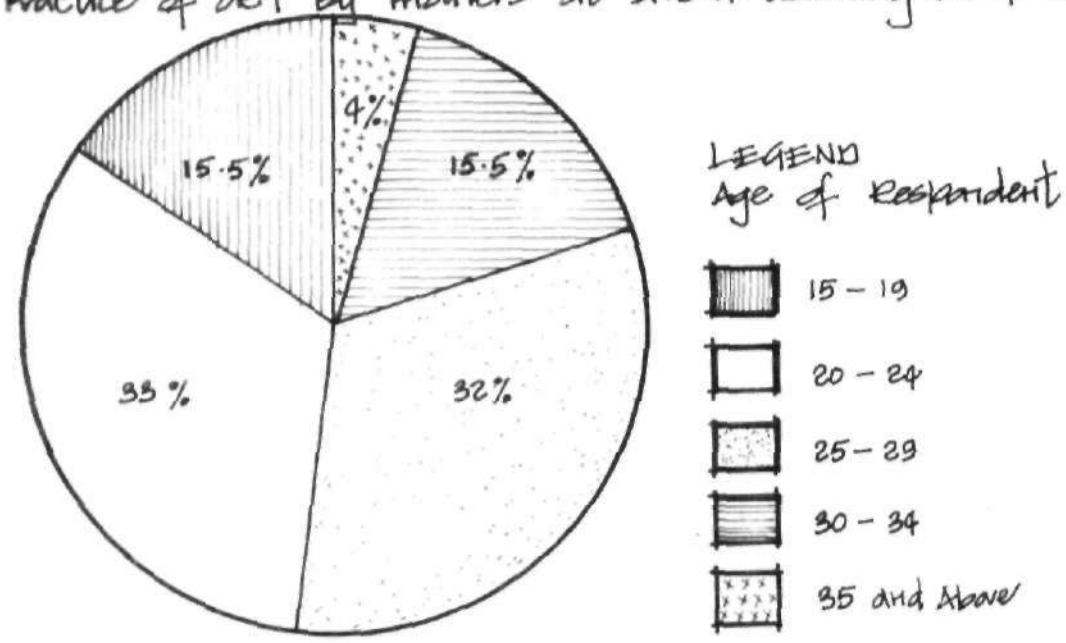
With respect to the demographic characteristics of the 200 mothers interviewed figure. Table 4.3 illustrates that the majority of the mothers fall within the age group of 20-24 which is 66 or (33%): another 31 mothers fell within the ages of 30-34 (15.5%) while only 8 admitted being either 35 or above (4%).

As expected the majority 67.5% had no any formal (modern) education, about 34,(17.%) of the mothers had primary education, 27,(13.%) had gone as far as secondary school, while 4 that is (2.%) had reached a higher institution of some sort (see Figure 4.4).

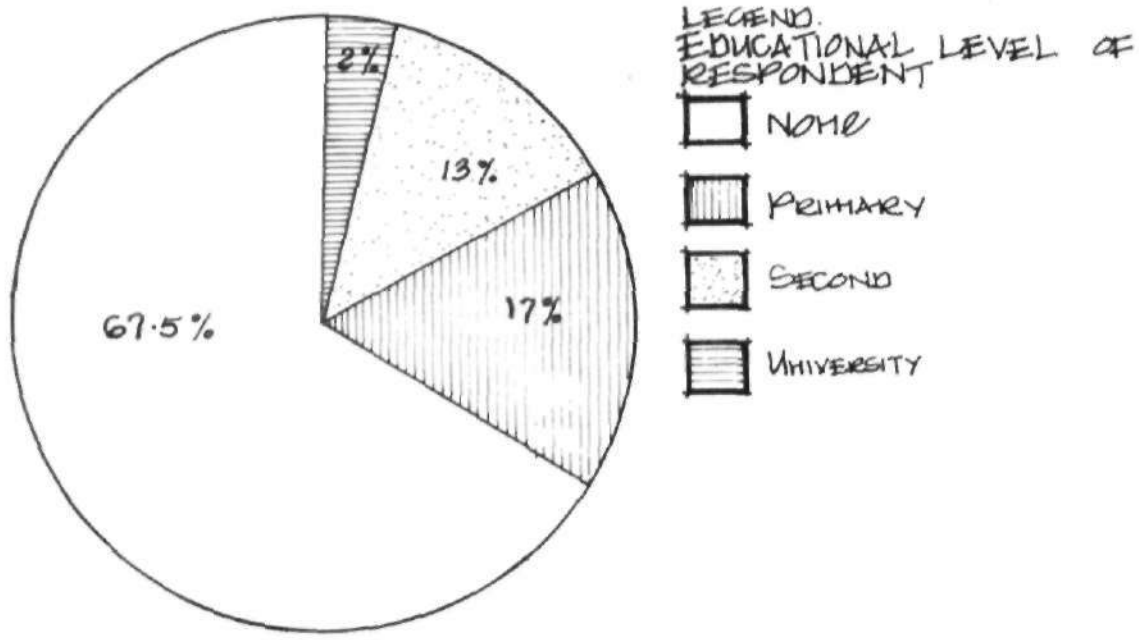
It can be gathered from Figure 4.5 that over 56.% were fulltime housewives, 47 (23.5% petty traders, 18 (9.%) tailors, 10 (5.%) teachers, while the rest 12 (6.%) consisted of either hair dressers, or household helpers and the like.

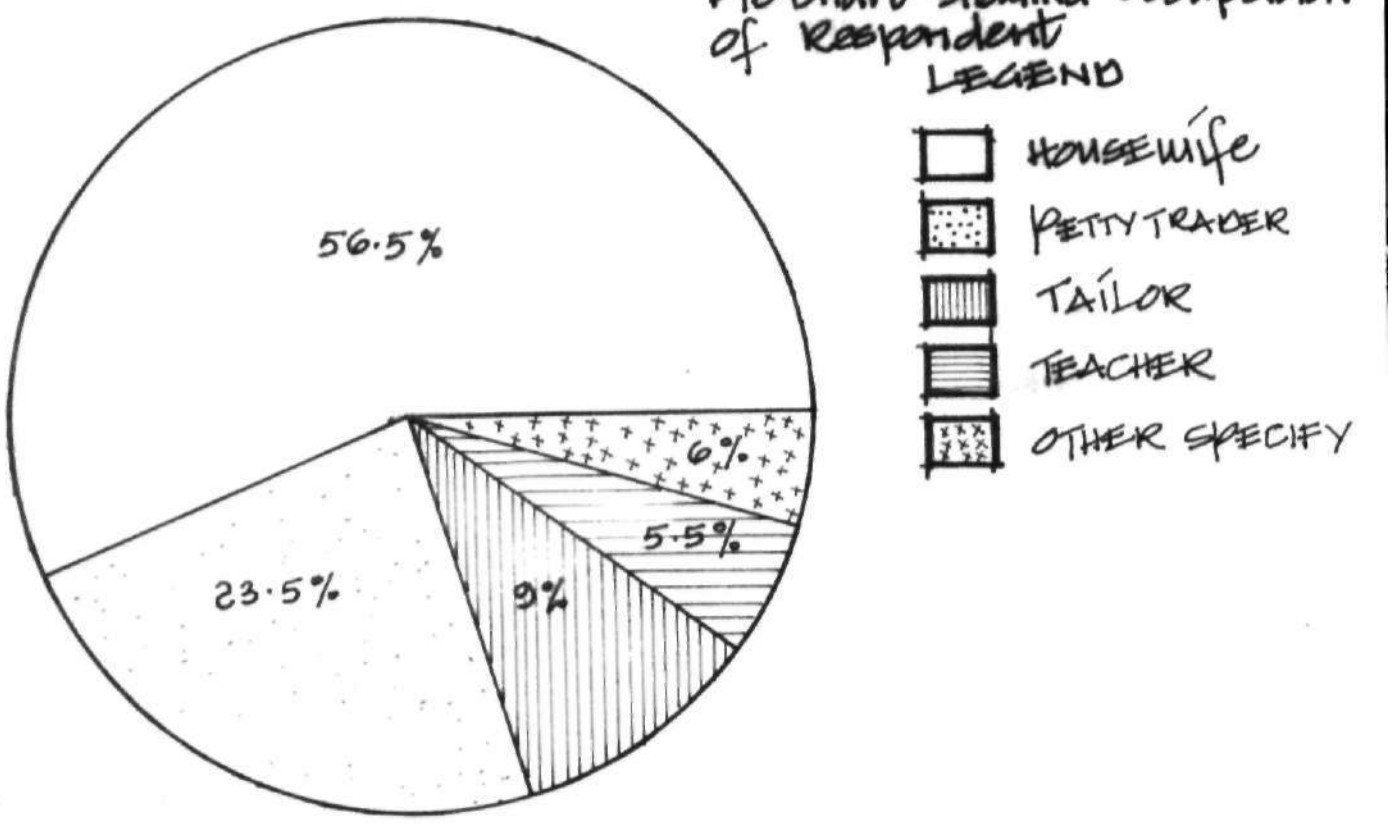
The Figure 4.6 shows an indication that as far as the occupation of a spouse concerned, questioning is necessary in order to be able to determine somehow the level of income of our respondents. 52 of the spouse of the respondents that is (29.%) are office workers (Clerks, Messangers), 51 or 25.5% were Artisans (Carpenters, Mechanics, etc.). There are 38 farmers (19.%), 31 are petty traders (15.5%), 21 (10.5%) of the spouse, consisted of high officials (senior civil) servants, bank Managers, etc.).

Pie Chart Showing study of the Knowledge, attitude and Practice of ORT By mothers at A.B.U. teaching Hospital

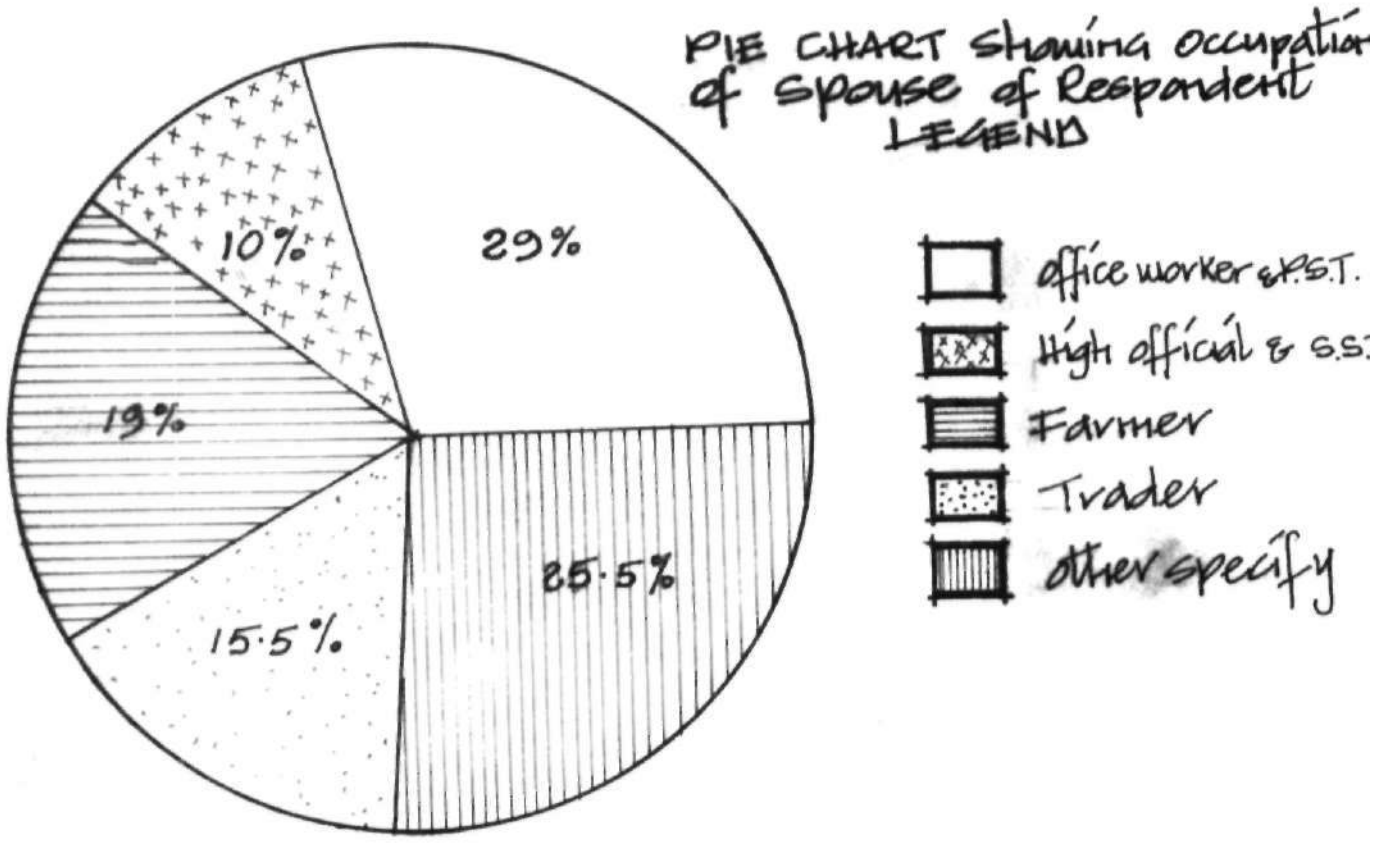


pie chart showing Educational Level of Respondent





Pie chart showing occupation of Respondent



PIE CHART Showing occupation of Spouse of Respondent

From the above we can deduce that the majority of the respondents falls within the low level income group. This can be explained by the fact that those privileged do not patronize public hospitals. Those that can afford prefer to patronize expensive private clinics. The chart shows only 10.5% of the respondents spouse fall within this group.

It can be seen as Table 4.3 indicates that out of the 200 mothers interviewed with mild cases, 90 of the mothers (45%) less than half, resorted to the ORT method, 33 (16%) choose public hospitals, 37 (18.5%) of the mothers prefer the Chemists, 30 (18%) of the mothers rely on other traditional remedies while only 49 that is 2% of the mothers resorted to with-holding food and water.

With almost 3/4's of the mothers who resort to the hospital and 14.5% who still prefer the Chemist, it would appear that in the severe cases of diarrhoea where ORT would be most appropriate for managing diarrhoea, mothers do not apply the ORT method. They rather prefer the modern hospitial or pharmacies and chemists. Where they can purchase drugs, a habit they acquired over the years.

This is even more appalling when one consider the fact that 92% of the mothers have actually heard about the ORT method. As expected among their main sources of information medical personnel account for (16.5%), 13.5% from friends, 5% from the Tv and radio and 10% from other sources (see

Table 4.3: Respondents Reaction to Diarrhoea In Children (Mild and Severe Cases)

Reaction to Diarrhoea In Children	Mild Cases		Severe Cases	
	Number	Percentage	Number	Percentage
Withheld Food and Water	4	2.0%	1	0.5%
ORT	90	45.0%	9	4.5%
Hospital	33	16.0%	148	74%
Chemist	37	18.5%	29	14.5%
Others	36	18.0%	12	6.0%
	N-200		N-200	

Source: Paediatric out-patient Department, A.B.U. Teaching Hospital, Zaria.

table 4.4. With regards to knowledge of preparation it was found that as much as 82 (41%) knew the correct formulae or the home based SSS.

Table 4.5, 6,7 and 8 show cross tablulations of age, educational level, occupation, respondent and of spouse of 200 respondents which are cross tablulated with their knowledge, attitude and practice of ORT.

In Table 4.5 it can be seen that there exist a pattern where in mild cases, the younger they are the more likely they are to resort to ORT. It can be seen that mothers of under 19 have (61.3%) rate of resorting to ORT and those between the ages of 20-24 have 53.0%, 25-29 have 42.2%, 30-34 is 25.8% and 35 and above have the rate of 12.5%. From these figures, one can easily see the steady steady decrease in percentage of those who resort to ORT as they grow older. This can be attributed to the fact that the younger ones are more susceptible to new ideas.

In the more severe cases of diarrhoea in children the opposite is the case. The younger mothers have a tendency to rush to the public hospital for treatment which is probably as a result of their inexeperience. About 96.8% of the mothers under 19 rush to the hospital, between 20-24 that is 77.3% do that. Consequently, there is a drop to 65.6% in the age group of those who fall between 25-29; with a slight

Table 4.4: Source of Knowledge of ORT

Medi-Personnel	129	64.5
Friends	27	13.5
Radio/TV	10	5.0
Others	20	10.0
-	14	7.0
-	200	

Source: Paediatric Out-Patient Department, A.B.U. Teaching Hospital, Zaria

Table 4.5: Cross Tabulation of age of respondent and the knowledge attitude and practice of ORT

Age		Knowledge of ORT		Knowledge of Correct SS Formulae		Reaction to Diarrhoea in children (Mild and Severe Cases)				
		Yes	No	Yes	No	With-hold waters food	ORT	Pub-lic Hospi-tal	Che-mist	Others
Under 19	M						61.3	22.6	9.7	6.5
		100.0	-	54.8	4.9	-				
Number 31	S							96.8		3.2
20-24	M					1.5	53.0	12.1	15.2	18.2
		93.9	6.0	4.70	33.0					
Number 66	S						1.5	77.3	16.7	4.3
25-29	M					4.7	42.2	15.6	21.9	15.6
		96.9	3.1	38.9	64.1					
Number 67	S					1.5	9.4	65.6	21.9	1
30-34	M						25.8	22.6	29.0	22.6
		80.6	19.4	29.0	71.0					
Number 31	S						6.5	77.4	3.2	12.9
35 & Above	M						12.5	12.5	12.5	62.5
		50.0	50.0	15.0	85.0					
number 8	S							25.0	12.5	62.5
		X2 = 38.3 DF = 10		X2 = 1472 DP = 10		MM:X2 = 30.26 DF = 20				Sign = .0657
		Sign = .0000		Sign = .1424		S:X2 = 64.72 DF = 20				Sign = .000.

Source: Paediatric Out-Patient Department, A.B.U., Teaching Hospital, Zaria

Table 4.6: Cross Tabulation of the Educational Level of Respondent and the Knowledge attitude and practice of ORT

Educational Level			Knowledge of ORT		Knowledge of correct SSS Formulae		Reaction to Diarrhoea in Children (Mild & severe Cases)				
			Yes	No	Yes	No	With-Hold Water & Food	ORT	Public Hospi-tal	Che-mist	Others
None		M	88.9	11.1	31.9	6.81	2.2	36.3	17.8	20.0	23.7
Number	185	S					-	3.7	72.6	15.5	8.1
Primary		M	100.0	-	61.8	38.2	-	61.8	11.8	20.6	5.9
Number	34	S					-	2.9	82.4	11.8	2.9
Secondary		M	96.3	3.7	51.9	48.1	-	62.7	18.8	7.4	7.4
Number	27	S					3.7	7.4	74.1	14.8	-
Higher Institution		M	100.0	-	75.0	25.0	25.0	50.0	-	25.0	-
Number	4	S					-	25.0	75.0	-	-

X2 = 14.09 DF = 6 Sign = .0286 X2 = 14.23 DF = 6 Sign = .0272 M:X^2 = 30.13 DF = 12 Sign = .0027 S:X^2 = 15.66 DF = 12 Sign = .2072

Source: Paediatric Out-Patient Department, A.B.U. Teaching Hospital, Zaria

Table 4.7: Cross Tabulation of Occupation of Respondent and the Knowledge attitute and Practice of ORT

Occupation			Knowledge of ORT		Knowledge of correct SSS Formulae		Reaction to Diarrhoea in Children (Mild & severe Cases)				
			Yes	No	Yes	No	With-Hold Water & Food	ORT	Public Hospital	Chemist	Others
House wife		M	89.4	10.8	39.8	61.2	2.7	46.9	16.8	17.?	15.9
Number	113	S					.9	4.4	73.5	13.?	8.0
Petty Trader		M	93.80	6.4	34.0	65.9	38.3	19.3	27.?	27.3	5.9
Number	47	S					-	4.3	76.6	12.8	6.4
Tailor		M	100.0	-	38.9	61.1	-	33.3	16.7	22.2	27.8
Number	18	S					-	-	77.8	22.2	-
Teacher		M	100.0	-	70.0	30.0	60.0	10.0	30.0	-	-
Number	10	S					-	30.0	60.0	20.2	-
Others		M	91.70	8.3	50.0	50.0	8.30	58.3	8.30	-	25.0
Number		S					-	-	83.3	16.?	-

X^2 = 4.00 DF = 8 Sign = .8568

X^2 = 7.99 DF = 8 Sign = .4339

$M:X^2$ = 14.11 DF = 16 Sign = .5903

$S:S^2$ = 12.68 DF = 16 Sign = .7241

Source: Paediatric out-patient Department, A.B.U. Teaching Hospital.

Table 4.8: Cross Tabulation of Occupation Space of Respondent and the Knowledge attitude and Practice of ORT

Occupation of Spouces			Knowledge of ORT		Knowledge of correct SSS Formulae		Reaction to Diarrhoea in Children (Mild & severe Cases)				
			Yes	No	Yes	No	Withhold Water & Food	ORT	Public Hospital	Chemist	Others
Higher Official (Senior Civil Servant, Manager)		M	90.5	9.5	42.85	57.14	4.8	61.9	19.0	9.5	4.8
Number	21	S						14.2	76.19	9.5	
Office Worker (Messenger, Clerk)		M	94.8	5.0	44.8	55.17	1.7	53.4	24.18	15.5	5.17
Number	53	S					1.7	3.4	84.4	6.8	3.4
Artisans		M	100.0	-	38.46	61.53	-	42.3	15.4	26.9	15.4
Number	52	S						1.9	86.5	13.46	3.8
Trader		M	90.3	9.7	41.93	58.0	3.2	35.5	9.7	29.0	44.7
Number	31	S					-	3.2	64.5	25.8	6.5
Teachers		M	78.9	21.1	34.21	65.78	2.6	34.2	10.5	7.9	22.6
Number	38	S					-	5.3	57.9	21.1	15.8

$X^2 = 37.12$ Sign = .0007 $X^2 = 3.06$ DF = 14 Sign = .8857 $M:X^2 = 46.57$ DF = 28 Sign = .0152 $S:X^2 = 84.23$ DF = 28 Sign = .0000.

Source: Paediatric out-patient Department, A.B.U. Teaching Hospital.

increase for those who fall between 30-34, there is a drop again for those who are 35 and above, because they are more likely to resort to their old traditional method of treating diarrhoea.

It has been found that as they grow older their knowledge of ORT decrease. As can be seen where 100% of those under 19 have heard of ORT, only 50% know it at 35 and above age group.

A similar pattern can be seen with those respondents who know the correct formulae. For the younger they are the better knowledge of it they have. For instance, over 54% of those under 19 know the correct preparation, while among those over 35 only 15% know it. Thus we see a steady decline in Table 4.5 as they older.

In Table 4.6 a similar situation is obtained where the more educated the respondent are the more likely they are to use ORT in mild cases, as well as and know the correct formulae for SSS. However, education played a significant role in determining their knowledge of ORT and its use in the more severe cases of diarrhoea.

As for the occupation of the respodnent it can be seen from Table 4.7 that there is no significant link between it and the attitude of the respondent to ORT. The same thing can be seen in the occupation of the spouse as illustrated

in Table 4.8. From the facts mentioned above, it can be seen that artisans, farmers, and traders tended to use the chemist and other traditional methods more than the others. On the whole there exists no real pattern with regards to the occupations of both the respondent and their spouse, and their knowledge as regards to the attitude and practice of ORT.

It is remarkable that a high percentage of the respondents still place so much confidence in a health established centre, which paradoxically is in an appalling state. The A.B.U. Teaching Hospitals, like most hospitals in the Federation lacks up to date equipments, drugs and medical personnel. But nevertheless, the mothers come as early as five oclock a.m. and spend the whole morning there hoping they will be attended to. In the paediatric out-patient, what obtains is that the doctors see a limited number each day, from a minimum of 70 and a maximum of 100 patients. This makes things difficult for mothers who bring their children, since many patients come each day. It then means that queueing up does not necessarily mean you will be attended to by a doctor.

Despite this difficulty and the fact that those that are lucky enough must pay for needles, bottles etc. used for their tests in hosptial laboratories and for the drugs, which most of them cannot afford, but patients still flock

to the hospitals. There are so many pathetic cases of those left to die simply because they cannot afford to pay for the "public" hospital services. One wonders then, why the promotion of ORT which is aimed at cutting costs for the less privileged is not as successful as expected for mothers. Quite a few mothers are knowledgeable about ORT and the correct preparation of the SSS (home based mix) manage diarrhoea at home. But do not seem to appreciate it and so they are not convinced of its efficacy to use it in the more severe cases of diarrhoea.

This supposedly 'people empowering' health programme as David Warner calls it, is quite laudable a programme but its implementation is somewhat lax and is not achieving desired results. According to the staff nurse in charge of the nations first ORT unit of the Massey Childrens Hospital Lagos, mothers who are given prescription of the ORT mix by doctors are most reluctant to use it, they prefer drugs.[35]

4.6 Politics of ORT:

As was earlier mentioned a number of studies have been conducted over the years to assess the efficacy of the ORT in Nigeria some of them have yielded some impressive results:

> In the months following the estblishment of the ORT unit, the Massey street hospital was able to achieve a 50% reduction in diarrhoeal case fatalities, and the chief consultant estimated a savings on alternative costs in the range of $6,000 per month.[36]

The ORT is considered the answer to Third World diarrhoeal dehdration problems. But like other policies ORT has far reaching political implications. According to David Werner.

> Any such technology can be empowering, in ways which are either "people espowering or prople debilitating in terms of helping overcome or perpetuate the underlying causes of poor health.[37]

Such a health programme like ORT can, if implemented wrongly serve to further entrench social injustice and inequalities that perpetuate poverty and health. There are various arguments as to how ORT should be promoted. The non-governmental have tended to adopt a people centred approach which de-emphasizes the use of ORS and leans towards the use of SSS and other home mix to manage dehydration in children caused by diarrhoeas.[38]

The relative advantage of the SSS discussed earlier have been noted by Ngieria which has adopted the de-emphasis of ORS in her national ORT campaign in order to cut cost in health expenditure.[39] Politically however, the two sides are diametrically opposed. The use of the packets keeps the control of diarrhoea medicalized, institutionalized, mysti-

fied and creates a dependency. The source of the packets becomes glorified so to say. Distributon of the packets involves a long chain of bureaucrats profiteer, and pre-fessionals. It is such that a breakdown in the chain of supply could wreck havoc on the population who are dependent on the ORS.

On the other hand it can be seen that with the use of the home mix, medicine becomes some what demystified and the people are independent of outside source except for initial education of the SSS method.[41] This method helps give people the conference to save their children from death.

The WHO has as usual adopted the technical scientific approach. In that WHO, most health ministries and other large national and international agencies are "packeteers".[42] This approach is detrimental to the move towards self-sufficiency and self-reliance health wise in developing countries like Nigeria. UNICEF has in the past promoted ORT policy which emphasised ORS. However, the UNICEF has moved progressively in the direction of promoting the home mix approach to ORT.[43] This is the approach the Federal Government shaped for her national CDD programmes. Nevertheless she encourages pharmaceutical firms to engage in local production of ORS to maintain supplies at the health centres.

Our study took cognizance of the SSS approach in the National ORT campaign. A similar survey was conducted by the ORT unit headquarters in Lagos in 1986. To sum up, the Federal Governments survey was community-based and done in the 19 states of the federation. Table 4.9 illustrates the findings of this survey. The findings revealed that there was a definite bias of the use of modern medicines in the federation with a median of 64.5%; as per the use of ORS and SSS it was 10.5% and 19.7% respectively.

The survey also looked at the availability of ingredients and utensils for the preparation of SSS in the homes of respondents. Reports show that there was a mdeium of 77.8% for the availability of sugar, 98.6% for salt, 84.1% for 3ml teaspoons and 94.1% of 650ml beer bottles or soft drink bottles. This goes a long way to illustrate the fact that despite the fact that these ingredients and utensils are available, the SSS approach has had a minimum impact on the population.

4.7 Pharmacies, Chemist and Pharmaceutical Manufacturers in the Promotion of ORT in Nigeria:

From the investigation conducted in a few pharmacies (some of whom wished to remain anoymous), it was discovered that quite a few did not stock COS packets or if they did

Table 4.9: Diarrhoeal Morbidity, Treatment And Availability Of (SSS) Salt Sugar Solution Ingredients And Utensils Survey

State	LGA	Sample size	Date	Incidence		Treatment Rate						SSS Ingredients & Utensils Availability			
				2 wks. Prevalence Rate %	*Annual Episode/ Child	ORS %	SSS %	Other Home fluid %	IV %	Traditional Medicine %	Other Medicine %	Sugar %	Salt %	3 ml tea spoon %	(650 ml) Beer or soft drink bottle
Anambra	Enugu	1200	Sept. 1986	10.7	2.8	18	18	16.4	0	2.3	62.5	80.2	99.2	74.4	94.8
Bauchi	Bauchi	1220	Sept. 1986	24.2	6.2	4.5	31.4	3.4	3.1	13.8	64.8	77.9	99.8	84.6	89.3
Bendel	Oredo	1200	Sept. 1986	9.4	2.4	19.5	13.3	3.0	17.0	13.3	54.0	67.3	98.4	91.8	96.3
Benue	Makurdi	1208	Sept. 1986	20.8	5.4	0.8	6.4	1.6	0	7.2	53.8	66.7	96.2	62.0	93.0
Borno	Maiduguri	1200	Sept. 1986	31.7	8.2	10.0	9.5	50.5	6	2.4	72.6	75.2	88.3	48.8	67.6
Cross River	Calabar	1230	Sept. 1986	12.0	3.1	12.2	27.0	25.0	1.3	7.4	67.6	96.5	99.0	91.5	98.2
Gongola	Yola	1200	Sept. 1986	36.5	9.5	8.4	32.4	29.2	1.5	18.5	39.5	75.6	99.3	53.9	94.1
Imo	Owerri	1200	Sept. 1986	11.0	3.0	4.3	12.9	13.6	0	8.6	60.0	52.9	97.0	85.3	92.6
Kaduna	Kaduna	1200	Sept. 1986	17.3	4.5	12.1	28.0	32.8	0	5.8	66.7	80.2	96.4	30.1	86.0
Kano	Kano	1216	Sept. 1986	32.0	8.3	9.0	10.8	6.7	0.5	10.5	63.5	32.0	94.5	49.2	77.0
Kwara	Ilorin	1199	Sept. 1986	9.0	2.3	11.1	17.6	7.4	0.9	15.7	73.1	91.2	99.6	89.9	95.0
Lagos	Lagos	1200	Sept. 1986	9.8	2.5	33.3	41.9	1.7	0.9	5.1	60.7	91.5	99.9	57.4	94.1
Niger	Changhaga	1200	Sept. 1986	20.8	5.4	7.6	52.2	12.0	1.6	8.8	61.0	84.8	95.3	87.8	89.4
Ondo	Akure	1200	Sept. 1986	12.0	3.1	22.9	47.2	14.6	0	5.6	50.7	70.8	98.5	93.6	94.2
Ondo	Owo	1202	Sept. 1986	7.6	2.0	11.0	71.4	1.1	0	3.3	83.5	69.5	98.7	90.2	96.8
Ogun	Abeokuta	1200	Sept. 1986	11.3	2.8	8.1	11,1	9.6	2.2	19.2	65.2	81.0	99.2	65.6	95.7
Oyo	Ibadan	1214	Sept. 1986	13.8	3.6	15.5	26.8	7.1	0.6	0	59.6	77.8	97.3	71.4	92.0
Plateau	Jos	1230	Sept. 1986	19.0	4.9	12.9	14.5	20.1	1.3	6	87.2	74.4	98.7	83.6	94.1
Rivers	P/Harcourt	1200	Sept. 1986	15.8	4.1	5.8	17.4	20.0	3.7	6.3	75.8	86.2	98.7	90.4	95.5
Sokoto	Sokoto	1216	Sept. 1986	38.1	9.9	8.0	20.3	37.8	0.4	24.8	73.4	82.5	92.8	85.4	89.3
Range	Min.	Min.		7.6	2.0	0.8	6.4	1.1	0	0	39.5	32.0	88.3	30.1	67.6
	Max.	Max.		38.1	9.9	33.3	71.4	50.5	17.0	24.0	87.2	96.5	99.9	93.6	98.2
Median				14.8	3.8	10.5	19.7	14.1	0.9	7.3	64.5	77.8	98.6	84.1	94.1

*Mainland.

Source: Oral Rehydration Therapy Unit, Onikan. Federal Ministry of Health, Lagos.

they were very expensive. For instance, in "Depontus pharmaceutical chemist and stores Kaduna" a packet costs from ₦1.00 to ₦1.50. In another store "Cardiner Bros chemist" a packet of oralite powder costs ₦2.00 while orhesal costs ₦2.50. In a larger pharmacy "Danai pharmacy' the prices were much lower 80k, however it should be noted that at the time of the study the pharmacy did not have any ORS packets.

Even at 80k the ORS packet is not exactly sold at a token fee. Information gathered on the ORT give the impression that the packets cost much less than what is actually obtained at the stores. A case of diarrhoea which requires rehydration would need a minimum of mix packets; the maximum would depend on how severe the dehydration is.

It was also discovered that quite a few of the shops, stocked expired discoloured packets because of the low sales of ORS packets It was also found that these shops had what they called a steady sale of anti-diarrhoeal drugs, depending on the season. According to Mallam Yusuf Shehu, the Manager of "Dangi Pharmacy" Zaria, they have experienced no reduction in the sales of anti-diarrhoeal drugs, and antibiotics for diarrhoea since the commencement of the programme on ORT. This is not surprising considering the fact that the ORT method is not a cure for diarrhoea as such. One would still expect patients to require drugs to cure

their diarrhoea.

We were unable to get a detained table of the sales of anti-diarrhoeal drugs in chemist and pharmacies as they lacked comprehensive records. We were however able to get the list of sales of anti-diarrhoeal drugs for children, brought in three months July, August and September 1988. In Table 4.10 it can be seen that no real steady pattern exists; there are fluctuations depending on the product for instance, Diapec suspension which had a sale of ₦600.00 in July had an increase in sales in September to ₦1006.00; Kaomyuh which had a sale of ₦2000.00 in July dropped to ₦757.00 in September.

Other pharmaceutical firms did not produce ORS packets like Pfizer, Hoechart, May and Baker. At the time of this study we discovered from E. O. Oneworkaes, the Sales Manager (Pharmaceuticals) that the head offce of SCOA had in fact sent a team of experts to Nigeria to do a feasibility study for the production of ORS in Nigeria. The study concluded that, the establishment of such a firm was not profitable; considering the large sales of anti-diarrhoeal drugs and the emphasis on SSS.

What can be gathered from this is that pharmaceutical firms as well as pharmacies and chemists are profit-making institutions, hence they prefer avenues where they can make more and more profit. Additionally, they prefer to manufac-

Table 4.10: Dangi Pharmacy and Genent Co. Ltd. Sale of Diarrohea Drugs

Item Description		July	August	September	Retail Price
					N.K
1. Diapec tables	4x3's	599.00	500.00	1006.00	4.60
2. Guanmycin Syspension	150ml	374.00	855.00	411.00	8.76
3. Imodium Suspension	30ml	42.00	54.00	20.00	7.86
4. Kaomycin Syspension	60ml	1950.00	307.00	757.00	8.33
5. Medix Anti Diarrhoea	100ml	581.00	266.00	466.00	3.75
6. Mist kaolin Suspension	200ml	212.00	166.60	200.00	2.06
7. Mist kaolin Suspension	2 litres	107.00	88.00	41.00	4.42
8. Neopectin Suspension	100ml	58.00	40.00	40.00	18.00
9. Neopectin Suspension	2 litre	281.00	132.00	140.00	60.80

from animal dropings, terrace crop rotation and mixed farming and the development of iron implements.[45]

In cases of food crisis extra precautions were taken. In Northern Nigeria for instance where famine was not unknown, there were extensions in the line of consumption into the wider extended family, while reciprocal gift were encouraged. Apart from this there was the selection of drought resistent strains, crop combination all in an attempt to fight environmental flactuations.[46]

To bolster our argument further, it is clear that pre-colonial socieites in Africa were infact self-sufficient in food production. There are reports to the British Empire on the nature of the Pre-colonial economy which were quite impressive. For instance the third Report on Yola Province in December 1901 showed favourable conditions for British trade with the Africans, with large quantities of gum gutta production, the Africans were self-sufficient and the markets were well supplied with food and livestock.[47]

In Ghana the situation was similar. Nik Plange argues that,

> "The pre-colonial mode of production of Northern Ghana generally conformed with what has been described by Samir Amin as the African type. The important features of this mode of production included subsistence agriculture and trading. Commodities that were produced then formed part of domestic consumption and the surplus put into the trading circuit.[48]

Colonialism meant the systematic destruction of this self-sufficient food production, in African societies . The role of the colonial system in Third World countries like Nigeria in the process of accumulation and how this role influenced the nutritional conditions of those colonized societies can be seen in the fact that while malnutrition is associated with poverty colonialism only served to impoverish the colonized societies.[49]

Mahmud Tukur, in his thesis argues that,

> The extent of the damage that British economic and fiscal policies inflicted on the emirates can be grasped with even greater clarity if it is realised that at the time of the imposition of their domination of the emirates the economy of the emirates was based on indegenous agriculture as well as indigenous industry with imported goods playing little role and that as British policy started to be implemented with ever greater efficiency, this economy corrspondingly lost its indegenous industrial base, and had its agricultural base distorted with a growing emphasis on export crops for the benefit of the British metropolitan economy.50

There is alot of evidence which susggest that it was after the imposition of colonial rule that crisis set in. In Northern Nigerian for instance, the first six years of colonial rule there was a widespread of famine. In Yola province it was so severae that people took to pawning their children into slavery. Corn became scarce in the markets to the extent that the British administrators from 1902-1908

had to resort to the importation of grains from areas were the famine was less severe like Bauchi to ration amongst its troops and employees.[51]

Okello Oculi observes that there is a link between malnutrition and under-development. This can be seen in the emergence of what he calls an international division of labour in the agricultural sphere during colonialism. This saw colonizing countries and their settlers inclaves developing balanced production of food stuffs and protein sources. While on the other hand the colonized and exploited countries put much emphasis on the production of industrial crops, To neglect of food and protein sources for the Africans.[52]

This means that while the colonized countries produced cash crops at the expense of their food needs, the colonizing economies took no responsibility whatsoever for the food needs of these colonized states. Further worsening the condition of cash crops sold received very low prices and were subject to the fluctuations of the international market which put them at a great disadvantage vis-a-vis the colonizers.[53] It is from this angle that the dynamics of the present food crisis of the Third World in general and Nigeria in particular can be understood.

The Nigerian State despite its abundant human and natural resources is finding it increasingly difficult to

feed its population. This is in vigorous pursuit of agricultural policies that seek the involvement of private individuals, corporate capital and technology as opposed to family or communual holdings. To do this the state sought the institutional support of the Food and Agricultural Organization, (FAO) and the World Bank who provide capital and structural plans of production and distribution activities. They also involved other multinational firms engaged in agricultural business which supply the capital goods and technology in this more towards modern agricultgure which displaces the peasantry.

Part of the Nigerian state response to the food crisis has been the massive importation of food, which appears to be more of a substitute than complimentary to domestic efforts for increasing food output. Within just two decades of Nigerias post-indepencence experience 1962-1983 the food import bill increased by about 1,820:2 million i.e. from ₦47.0 in 1962 to ₦1,873.2 million in 1952 which signifies an increase of 3,987% in just two decases.[54] What makes the picture even more gloomy is the fact that, despite this massive importation of food the crisis is still far from being solved.

By and large Nigerian's response to the food crisis has been a strategy which serves to intensify dependence of Nigerian agriculture on agricultural products and technology

from developed capitalist nations. The state strategy is capital intensive and aims at the transfer of land from the peasants to large capitalist firms engaged in agricultre.

All this serves to worsen the food situation in Nigeria and the plight of the people who continue to suffer from hunger and starvation, the implications for health are far reaching especially for children who are our prime concern in this study.

> "In Nigeria, 40% of the under fives are estimated to be malnourished. An analysis of the statistics of Ruwan Sany Health Clinic - a pumay health care facility of the institute of health - showed that the proportionate morbidity due to malnutrition in under fives has risen from 9.4% in 1982 to 15.8% in 1987.[55]

The future of Nigerias children seems somewhat bleak under the present economic crisis which cause the serious deterioration in the quality of human life, malnutrition and disease has become part of life in Nigeria and most Third World countries in the world.

4.9 Basic Health Care For Whose Benefit:

The ORT campaign is aimed at satisfying the basic needs of the population in the health sector, in relation to diarrhoeal diseases in children the ORT can be viewed as a laudable programme whose implementation have not yielded

desired results. This can be attributed to several factors related to the structrure of the existing system of health care in the country.[56]

Our colonial heritage which has helped fasion health system towards the western Mic is not that which seeks to protect the global interest, moreover the interest of the MIC runs contrary to the interest of the masses. According to Vicente Navarro.

> There is the invasion of all sectors of our collective and personal lives including education, medicine, the arts, transportation, etc., by the process of capital accummulation in its search for profit.[57]

The past few years have seen Nigeria getting deeper and deeper into economic crisis resulting in austerity measures and structural adjustment programmes of one kind or another. All these have taken their toll on the generality of the population whose standards of living only appear to be worsening, despite the many sacrifices they have made. The government has continued to squeeze the national budget cutting down its expenditure in social services for the people and the removal of subsidies. The WHO and UNICEF have evolved strategies to lesson the blows of economic crisis. They convince the government that PHC, instead of building expensive hospitals is the answer. The PHC programme is inexpensive and hence will reduce government expenditure on health allowing for funds to be used in the

more lucrative sectors of the economy.

From the investigations carried out so far there exists a link between the activities of the World Bank, IMF, UNICEF and WHO in relation to Nigeria's sudden change in health policy direction. In some ways one cannot separate the ORT which is part of the PHC programmes from the economic recovery programmes of the World Bank and IMF in the Third World. There is perhaps more than sheer coincidence that the renewed campaign for basic health practices in the Third World came at a time when the harsh monetarist politics of the IMF and the World Bank are taking their toll on the people of Africa, Asia and Latin America. We see promotion of ORT like other PHC policies as some subsistence health care which allows people to use cheap means to remedy ailments, but do not tackle the structural economic relationships which cause this ill-health in the first place.

FOOTNOTES

1. Bichman, B., "Health care and traditional medicine - considering the beginnings of changing health care concepts in AFrica". In social science and medicine Vol. 13, 1979.

2. See Chapter three, for further discussion on bias for currative services.

3. "Imputs from the health sector for Mr. President's National Day Broadcast 1987," p.2. Federal Ministry of Health.

4. For details on the eight essenaitl elements of PHC see, "Analysis of contents of the eight essential elements of PHC". Final report to the HPC, HPC working group on PHC, 10 August 1981, p.ii.

5. Diarrhoeal Dialogue. No. 1 May 1980, AHRTAGH WHO hall centre p. 6 for details.

6. Ibid. p. 6.

7. State of the worlds children 1985 UNICEF 1985 p. 35.

8. Okehialam, T. C., "Expanded Programme on Immunization (EPI) and Orgal Dehydration Therapy (ORT): Strategies for child survival and development in Nigeria" In Student Doctor, Feb. 1987, p.16.

9. "National Plan Oral Rehydration Therapy promotion" 1985 Federal Ministry of Health 1985, p.2.

10. Okeh, C. Theodore, "Review of Oral Rehydration activities in Nigeria" in second EPI/ORT Federal Ministry of Health/UNICEF REview Workshop Kano 1986, p.3.

11. Ibid, p. 5.

12. National Plan op. cit. p. 2.

13. Ibid, p.2.

14. "National programme programme for control of Diarrhoeal Diseases" Federal Ministry of Health Lagos 1985 p. 4.

15. "Diarrhoeal Diseas control programme" Paper presented at the National CDD programme. Managers meeting, Bamako Mali 1-6 June 1987, p. 4.

16. FGN/UNICEF Nigeria mid-term programme Review 1987, p. 13.

17. National Plan op. cit. p. 4.

18. UNICEF/FGN country plan of Action 1986, p. 56.

19. Diarrhoeal Disease progamme op. cit. p. 5.

20. For further details see op. cit. National Programme for control of Diarrhoeal Diseases, p. 4.

21. FGN/UNICEF Nigeria op. cit. p. 27.

22. "Issues in World Health" In Population Reports No. 2, July August 1984, p. 22.

23. For a comprehensive picture see op. cit. National Programme fo control and Diarrhoeal Diseases op. cit. p. 22.

24. "Issues in World Health "opcit p. 62.

25. Ibid, p. 47.

26. For details on UNICEF distribution of ORS to Regional Offices see Ibid p. 47-48.

27. FGN/UNICEF Nigeria op. cit. p. 23.

28. See National Programme for control of Diarrhoea Diseases op cit., p. 6.

29. World Health magazine April 1986, p. 3.

30. For concise discussion see The proceedings of the second ICORT II. December 10-13 1985, p. 5.

31. Ibid, p. 5.

32. Issues in World health op. cit. p. 48.

33. Ibid, p. 48.

34. Diarrhoeal Disease Control Programme op. cit. p. 3.

35. Extracts From Oral interview with the staff Nurse Midwife Olaku at the Massey Childrens hospital Lagos 1988.

36. UNICEF.FGN op. cit. p. 56.

37. For deails see Werner D., "Public health ?? Poverty and empoverishment - a challenge" In Ifda dossier 56 May/June 1988, pp 3-9.

38. Extracts from a letter by David Werner to UNICEF officials pp 1-2.

39. See section ORT programme in Nigeria for details on the SSS approach.

40. Werner D. "Public health poverty and emproverishment" op. cit. p. 7.

41. Ibid, p. 8.

42. Ibid, p. 8.

43. Extracts from discussion with Alan Brody UNICEF official Lagos 1988.

44. Doyal Lesley, op. cit, p. 107.

45. Rodney Walter; op. cit, p. 48.

46. Shenton B. and Watts Mike, Capitalism and Hunger in Northern Nigeria. In Review of African Political Economy No. 15116.

47. Tukur Mahmud Modibo, op. cit. p. 165.

48. Plange Nii-K., Underdevelopment in Northern Ghana: National Crises or Colonial Capitalism. In Review of African Political Economy of op. cit. p. 6.

49. Oculi Okello, Political Economy of Mahutrition, Ahmadu Bello University Press, 1967.

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51. Ibid; p. 903.

52. Oculi Okello, Food and the African Revolution, Vanguard Printers and Publishers Ltd., 1986, p. 31.

53. Ibid, p. 32.

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55. Ejembi, C. L. and Bandipo, A. B., The Impact of Nigerians structural Adjustment Programmes (SAP) on the Health Care Delivery System. Paper Presented at the Conference on SAP and the Future of Nigeria organized by CSER, A.B.U., Zaria, March 28-30, 1989, p. 19.

56. See Chapter 3 for discussions on Nigeria's colonial health policy.

57. Navarro, Vicente, "The crisis of the WEstern System of Medicine in Contemporary capitalism" in International Journal of Health Services. Vol. 8, No. 2 1978, p. 187.

Chapter 5

5.0 *SUMMARY AND CONCLUSION*

The major aim of this thesis is to examine the relationship between the state, the WHO, and the activities of the MIC which is essential for the understanding of health policy in Nigeria and the Third World countries. To discuss this point we have sought the use of the Marxist conception of the state as an alternative approach, after finding the Liberal-Pluralist conception of the state that is lacking in its analysis of the state and public policy.

The liberal-pluralit view sees the state as neutral umpire whose sole role is the maintainance of order in a society which is made up of several conflicting groups. The state is responsible for the aggregation of these conflicting interests, and no one interest dominates the other. The Liberal-Pluralist conception delludes itself on the question of class and class contradictions and the fact that a dominant group does exist which controls public policy processes. It also fails to see the dynamic relationship between the state organ in its involvement in economic activities, which it engaged in.

This thesis maintains that the analysis of the state

and the role of the state in public policy is in fact incapable of understanding the issue of health policy in Nigeria. It is from this point that our study observes the analysis of the state from the marxist approach, which helps form the basis for understanding the dielectrical relationship between the state organ and outside forces in the formulation and implementation of public policy in Nigeria. The state does in fact represent the class interests of the dominant group in society, who dominate as a result of their ownership and control of the means of production.

The Nigerian state, as a result of the manner in which developing countries were incorporated into the world capitalist system is dependent on the bourgeoise of the industrialized world. The state is alligned to this foreign class whose sole purpose is to extract maximum profit from its relationship with the bourgeoisie of the Third World. The ruling class of the Third World, taking cognizance of their relationship with foreign capital are responsible for the formulation of policies which will serve to strengthen their relationship.

According to Franz Fanon:

> The national middle class which takes over power at the end of the colonial regime is an underdeveloped middle class. It has practically no economic power, and in any case it is no way commensurate with the bourgeoisie of the mother country which it hopes to replace.1

This class taken over from the colonialist are ready to enjoy the same privileges, but at the same time they continue to rely on these former colonialist for help in the management of their state affairs. Its action is somewhat limited and conditioned by its relationship with the global capitalist order. Hence it continues to pursue policies which will not conflict or challenge the global order.[2]

Eskor Toyo, asserts that this bourgeoise class seeks to develop itself through the promotion of capitalism in the country. However, frustrated as it is, it used state power for its self-development. He goes on to add that in fact, the imperialists are not forcing an alliance of the Third World, as scholars would have us believe. To the contrary, the Third World bourgeoisie of their own accord, consciously promote an alliance with international capital aimed at self-development. That it is in fact, the leadership who in their quest for self-development promote capitalist activities finding a useful ally in imperialism exploiting the people.[3]

Thus, within the world economic order major public policy are made by multinational institutions, while residual powers of decision-making on minor issues are with the indigenous ruling class, which desperately persist in collaborating with foreign capital whose interest run contrary to

public interest.[4]

Chapter two examined the MIC and its activities on the global level, particularly in relation to the Third World countries. It also looked at the activities of the WHO and the MIC influences on decision-making. However, Portray Asaf as the the MIC corporate body which has vested interestes type of policies pursued by the Third World, it is also in their interest to see the perpetuation of the policies. The MIC is a ruthless body with enourmous powers across the globe, Who are able to influence directly and through international institutions like the WHO. The WHO though a humanitarian organization who actually represents a certain interest of developing establishment, Yet her interest of international capital prevails under the cloak of assistance to the less privileged in the world. This link that exists between Third World health policy, and international capital, which is aimed at profit maximination is at the expense of the majority of the people from whom health services are out of reach.

From our study of the Nigerian health service in chapter three, we can deduce that the bias nature of health services in Nigeria which favour the urban elite can be attributed to the manner in which Nigeria's helath services envolved from inherited colonial set up. The colonial policy that comes with the sole objective of the exploita-

tion of Nigeria's natural resources.

From the initial stage, the colonial health policy as we earlier noted was aimed at the colonialist expatriates and Africans who were privileged enough to come in contact with them, hence it was urban based. The health policy and WHO assisted health programmes and projects centred around disease eradication campaigns with the help of Mobile Field Units which toured certain villages within reach. But the colonial health policy made no direct attempts at the creation of new health manpower at the rural level, nor did they establish hospitals and training centres African health professionals which the indigenous people would benefit from. Its emphasis was on the importation of expatriate health professionals to cater for the colonialist in Africa and a few privileged Africans.[5] Okello argues that;

> Health care in the rural sector ranging from child delivery by culturally-accepted midwives, treating wounds, setting bone-fractures to providing chemicals and psychological cures for various illness, were essentially subsidized under colonial capitalism by the autonomous subsistence medical personnel in the rural sector, thereby freeing the colonial state from this social service over head cost.[6]

All this created conditions are merely suitable for the maximum extraction and exploitation of the African colonies. Apart from the need to preserve the colonial labor force, the health of the African was of no real consequence to the colonialist. The activities of Missionaries which were

humanitarian were of a different dimension, but even then their roles were minimal.

The western oriented health system inherited from the colonialist was created in such a manner that it serves the continuous perpetuation of the system which enhances the position of the dominant class in society. The African western trained health professionals as a result of their training owe allegiance to a medical system which runs contrary to the interestes of the majority. This advocates for health policies which emphasize hospital construction and medical schools which cater for a privileged few. Its interest coincides with that of international capital, which opposes state policies that direct resources to internal developement for a more productive avenue that favours the activities of transnational corporations abroad.

What must be emphasized is the fact that the colonial state policy was such that even after independence the ruling class that came to power had been groomed to take over and help in the perpetuation of a system where the dominance of the ruling class prevails. The continuing dependence of Third World countries on the Industrialized nations is clearly illustrated in her health system which is western oriented. This health system ensures that a large amount of Nigeria's health budget is directed towards the importation of health equipment, drugs and health pro-

fessionals from abroad.

As earlier mentioned Table 1.2 illustrates the fact that Nigeria's health plans have placed a great priority on the preventive aspects of medicine to the neglect of curative aspects. In the 1975-1979 pre-second Republic period 29.58% was given to PHC and communicabnle diseases, in 1972-1983 29.95 was allocated and in the 1984-1986 period under the present Minister of Health Professor Olukoyi Ransome Kuti, 29.02% was allocated to PHC and communicable diseases. On the whole a total of just 27.2% as from 1975-1987 have been allocated to PHC and communicable disease. While more than 72.73% went to the curative aspects of medicine from the development of hospitals to the training of health professionals and provision of drugs.[7]

Third World countries like Nigeria, lack enough resources to maintain such a health system that will cater for the whole country. However, it is not just the lack of funds that can attribute to the inadequate provision of health services in Nigeria. The manner in which Nigeria was incorporated into the world system has also created social structures within the periphery which are responsive to the dynamics of western capitalism. In essence, it is this particular role of the state and dominant class in the Third World countries which determines the nature of policies.[8]

Thus, the sudden economic crisis facing Third World countries has forced a number of them to embark upon Structural Adjustment Programmes, which are wrecking havoc on them, emphasizes the reduction of the national budget for public expenditure, which goes a long way in worsening the predicament of the majority of the population. Institutions like the WHO and UNICEF come supposedly to the rescue of the populous with their own programmes, aimed at alleviating their suffering. All in the effort to give the Structural Adjustment Programmes a human face according to Givanni Andrea Cornia.[9]

The introduction of PHC rural based health policy, which incorporates the activities of traditional practitioners supposedly considered to be an effective and inexpensive health policy, is just what Third World countries require. From my own point of view, the state shifts the responsibility of health from itself to the people, who are barely able to survive the hardships of the times.

The state comes up with what we term a "subsistence health policy" aimed at preserving the health of its labour force. The health policy does not tackle the structural problems which are the root causes of misery. Our study focused on the promotion of ORT in Nigeria which is part of the PHC package implemented in Nigeria by the Federal Ministry of Health in collaboration with the WHO, UNICEF,

World Bank and a host of other international institutions yield nothing but to protect their vested interests in its implementation.

The ORT is only aimed at managing dehydration in children suffering from diarrhoea, but it is not a cure as such. This means that there is still the need for the use of anti-diarrhoeals in some cases. At the same time the causes, of diarrhoea which is associated with bad living conditions is left untabled by their diversionary policy as promoted by the WHO and other international institutions in Third World countries.

The ORT policy in Nigeria emphasizes the use of SSS at home by mothers, which is to help minimize the need for hospital treatment for children suffering from diarrhoea. Here we see a clear attempt by the government to give the people the impression that they are becoming self-reliant and self-sufficient. Self-sufficient in terms of being able to cope with one of their problems, when in reality they wish to cut off some of their expenditures on health, in order to divert funds to so called more productive ventures which coincidentally favour international capitalist interests.

The findings of this research showed that promoted ORT has in fact not yielded as positive a result as the FMOH had anticipated, because people still rely on government hospi-

tals for the treatment or their children suffering, even from the mildest cases of diarrhoea. Those who do not take to the formulae patronise chemists and other drug stores. This is as a result of the lack of drugs in government hospitals. The study also revealed that people seemed to lack confidence in the SSS, this we attribute to their orientation towards the western styled hospital services which provide drugs prescribed by doctors instead of the mix one can easily do by himself. In fact there has been no definite improvement in the conditions of the people, considering the promotion of ORT in Nigeria it has failed in that respect.

Despite the common pronouncements for HFA/2000, most countries are not engaged in any meaningful social reconstruction. Instead seem to be contended with the maintenance of a stratified socio-economic, as well as political structures which only benefit the privileged class. It is in the light of this that various scholars argued that the PHC efforts of Third World countries will not succeed, where it does seem to gain ground like the case of Guatala, it suffered strong opposition from the state. Guatemala promotive "salude", village health workers featured quite prominently in the PHC programme, whereby village health workers achieved through rural emancipation. However those workers, were not revolutionaries as such but their self help acti-

vities generated opposition from the government and they were crushed.[10]

H. K. Heggenbougen shares Hellandandu's view that PHC efforts will not succeed in a non-egalitarian society.[11] He asserts that:

> In any hierachical non-egalitarian society PHC efforts whether seen within a local or national context will be repressed when they begin to succeed, since success of necessity implies attack on existing socio-political economic structures.[12]

In Nigeria, this problem might not arise for the fact that health workers after receiving training return to the Ministries of Helah to man administrative posts. This was deplored by Mr. Adewole of the community medicine training centre A.B.U., Zaria, when he said they have had the problem over the years of their students not being deployed to rural areas, but rather getting promotions and serving in Ministries.

In an interview with Dr. Olufemi of the Essential Drug Programme FMOH Lagos we found that in the southern region the same problem is encountered but with slight difference, because there in the south the private clinics absorb these health workers for cheap labour.

To summarize, the human face programmes of the WHO and UNICEF as well as the promotion of ORT are not geared

towards the improvement of the standard of living in the society as they constitute no structural change with the promotion of ORT and other PHC projects. Even if it were possible to save some children from death; they would be condemned to live a life of virtual "living death," under the hostile living conditions which prevail in the country, a living condition which causes diseases.[13]

The implementation of WHO recommendations invitably means that the quality of life among the poor would remain incomparable to that of the rich and Medical complexes would continue to flourish with international assistance. "This pattern of growth can be summarized as less to the poor and more to the rich."[14] It would seem that HFA/2000 through PHC will mean that, the resources which should have gone to the rural areas will go towards the maintenance of health care of the dominant class in society. PHC will receive the left-overs from the hospital system and the gap between the development of the rural and urban area will contine to widen.[15]

The poor in society have no political power and do not make policy nor do they influecne policies made by the dominant class. One conclude that the interest of international capital is protected with the help of the Nigerian state, and the ruling class which is aimed at promoting her alliance with the metropolitan bourgeoisie pursue policies

that enhance capitalist development.

Furthermore, The ruling class set objectives which are incapable of fulfilling our strategies, thus they engage in deception and enticing the public who continue to live in a perpetual state of suspense. The word public policy is seen as mockery for in reality public policy is in fact private policy of the domiant class. Heinecke states that:

> According to public policy makers only certain impignments merit government recognition, while other such as hunger, malnutrition endemic disease and infact mortality are presumed unimportant.[17]

Where public policy is aimed at the people this can be explained by the class contradictions inherent in capitalism. Somehow concessions have to be made to the proletarist all in the effort to perpetuate the system. Strategies like the PHC and the promotion of ORT help the regime in power to some amount of legitimacy even though that may be short-lived. This gives people of feeling of being paid attention to which soon wear off the people come to realize that they are actually being handed a lopsided deal.

Beckman argues that to reduce the Nigerian state and its bourgeoisie to simple agents of foreign capital, underestimates the territorial base of the ruling, class. It also obstructs the extent to which the relationahip has gone. The interests shared by the domestic bourgeoisie and

international capital goes beyond that of a principle and agent. Both parties have a joint stake in the expansion of capitalism, they share the same world view of strategic occurences and have the same class orientation.[16]

The relationship between the Nigerian state and international capital goes a long way in explaining the class nature of Nigeria's health policy, because it is defined in the interest of the dominant class. Under such a health system policies like the PHC and the promotion of ORT should not be expected to perform some revolunationary task which will take the mass of the population out of their misery.

No matter how attractive PHC looks like, it would be too much to expect a revolutionized health care, but it is only through the removal of the existing set up that caters for the interest of the few and its replacement that the welfare of the people in Nigeria's health policy direction. Finally, the continuous relations with international capital and the state which helps to promote the MIC will only serve to entrench Nigeria more deeply into the world capitalist system, that neglects the majority of the population who suffer from deprivation and want.

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Appendix A: Department of Political Science, M.Sc. Project

QUESTIONNAIRE ON KNOWLEDGE, ATTITUDE AND PRACTICE OF ORAL REHYDRATION THERAPY (ORT)

Section A: Personal Data:

1. Age: 15-19 |__| 20-24 |__| 25-29 |__|
   30-34 |__| 35-39 |__| 40-44 |__|
2. Educational level: none |__| Primary |__|
   Secondary |__| Higher Institution |__|
3. Occupation: Housewife |__| Petty trader |__|
   Tailor |__| Teacher |__| Others |__|
4. Occupation of spouse:
   High official (senior civil servant, manager) |__|
   office worker (Messenger, Clerks) |__| Artisans |__|
   Petty trader |__| Farmer |__|

Section_B: Knowledge, Attitude And Practice of ORT:

5. What is your reaction when a child has diarrhoea ?

	Withhold food and water	give ORS Solution at home	hospital	chemist	dispensary	others specify
Mild:	☐	☐	☐	☐	☐	☐
Severe:	☐	☐	☐	☐	☐	☐

6. Have you heard of ORT? Yes ☐ No ☐

7. If yes, what is your source?

Personnel ☐ friends ☐ Radio, TV ☐

Others ☐

8. Do you know how to prepare SSS? Yes ☐ No ☐

9. If yes do you use it often when your child has diarrhoea? Yes ☐ No ☐

10. If yes, do you find it useful? Yes ☐ No ☐

Comments:
