THE UNDERDEVELOPMENT OF HEALTH CARE SERVICES IN NIGERIA

by

DENNIS ANONGO ITYAVYAR
B.Sc. (Hons) Zaria

A Thesis Submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF ARTS

IN

SOCIOLOGY

THE UNDERDEVELOPMENT OF HEALTH CARE SERVICES IN NIGERIA

BY

DENNIS ANONGO ITYAVYAR

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF ARTS

---- to
Ngowar
Tersoo and
Aseer
A team that monitors my emotions

Table of Contents

Page

LIST OF TABLES

Page

Acknowledgements

I wish to acknowledge the support of my thesis supervisory committee whose combined efforts contributed not only to producing a good piece of work but also to its early completion. The effective supervision and critical comments by my advisor Professor Alexander Segall are greatly reflected in the quality and style of this thesis. I am indebted to Professor G. Albert Kristjanson whose consistent support far surpassed my immediate academic concerns. His obvious interestin my welfare was most appreciated. My external examiner Professor Joe Kaufert must also be remembered for his invaluable role. His personal interest in the research topic coupled with his wide knowledge and experience in Third World countries were assets to me.

I extend my appreciation to the staff of Sociology Department who made useful suggestions to me. Among these Professor Douglas Rennie, Prof. Agnes Calliste and Prof. Raymond Currie deserve a special mention.

I am also greatly indebted by my darling wife Nancy N. Ityavyar for her invaluable support and personal sacrifice during our one year imperative seperation for the sake of this work. I also acknowledge my brother and friend Mr. James Zasha for his prayers, suggestions and encouragement. Lastly, I thank University of Jos, Nigeria, for sponsoring my graduate studies in Canada, Dr. & Mrs. Al Tamburi for financial assistance, Mr. & Mrs. D. Steenburg for moral support and Ms. Anita Gagnon for a very keen secretarial assistance.

Dennis A. Ityavyar
Sociology Department
University of Manitoba
Winnipeg

Abstract

This Study is an attempt to investigate the cause and consequences of underdevelopment of health care services in the Third World. Three main questions are addressed: Why are health care services underdeveloped? What are the obstacles to health care development? How can health care services become developed? The study focuses on one particular Third World country, that is Nigeria, on the assumption that the problem of underdevelopment in any country within the Third World will provide a basis for understanding similar problems facing other countries in the Third World.

The Study identifies a positive relationship between general underdevelopment of Third World countries and underdevelopment of the health care sector. While colonialism actually caused general underdevelopment of the Socio-political economy, neo-colonial forces work to sustain it. The diffusion of entrepreneural values (such as commidification of health, Capitalism) and the class interests of the indigenous bourgeoise are obstacles to the development of health care services.

The health care sector in Third World countries will become developed once certain entrepreneural values (such as Medicalization of health) are discouraged. The social structure of the health care delivery system must also be altered and the class interests of the indigenous bourgeoisie overriden by collective interests. This will affect the socio-policial economy, leading to general development and the emergence of a comprehensive health care delivery system. Such a system will emphasize preven-

tive services, which will develop along with other social services such as pipe-borne water, roads, sewage systems and housing. This will consequently raise the standard of living and will in turn improve the health status of people in Third World countries.

CHAPTER ONE

INTRODUCTION

(a) Statement of the Problem

The main problem of the Third World is underdevelopment. Underdevelopment has eaten deep into and left sterile the economic, political and social institutions of Third World countries. This manifests itself in many ways including: general poverty, illiteracy, widespread disease as well as inadequate and inefficient private and public services.

The underdevelopment of economic institutions in the Third World countries is manifested in inefficient technology and the predominance of human and animal power over inanimate power such as electricity or atomic energy. There is a low level of labour productivity, and the primary sector dominates the manufacturing sector of the economy, there being a relatively limited development of organized machine-based industries. The agricultural sector, in particular, is non-mechanized. Above all, the National per capita income of countries in the Third World is low compared to developed countries.

Politically, governments in Third World countries are very unstable, and are typically characterised by tribal and other internal conflicts, coups d'etat or other forms of violence.[1] Furthermore, most of the World's dictators are found in Third World countries.

The social institutions are equally underdeveloped. A low standard of living is reflected in insufficient food intake, poor housing and in-

adequate provision of private and public services such as pipe-born water, electricity and schools. This gives rise to a high rate of illiteracy, disease and poverty. Health care facilities are particularly inadequate, inefficient and unevenly distributed within these countries. Infrastructural facilities like roads, railways and ports are in deplorable conditions and in some places these are completely non-existant.[2]

The thrust of this research, then is to investigate the problem of underdevelopment in Third World countries. An investigation of all aspects of this problem is obviously beyond the scope of this study. Therefore, this analysis will focus on one particular Third World Country, that is Nigeria, and one sector of Nigerian society, that is the Health Care System, in an effort to understand the impact of underdevelopment. This selection is guided by the belief that, an analysis of the problems of underdevelopment in one country within the Third World will provide a basis for understanding similar problems facing other countries in the Third World. The underdevelopment of the health sector in Nigeria, will therefore be analysed with the aim of finding the source of this underdevelopment, the factors which sustain it, and the means by which it might be eliminated.

(b) Objectives of the Study

The Objective of this study is to identify and discuss the factors that influence the production, distribution and consumption of the available health services in Nigeria. An attempt will be made to present an historical account of the development of health care service in Nigeria

from its pre-independence era to the present. This will enable a comparism of the past with the present and will also assist in predicting the future of the health care system in Nigeria. This will further lead to a brief assessment of the effects of change and development on the health sector. Areas such as planning, distribution of facilities, financing and consumption patterns of health care services will be explored.

This study will also attempt to relate theories of social change and development to the study of the health care sector in the Third World. Several studies[3] in the area of Medical Sociology and community medicine have focused specifically on the health sector, neglecting the general problem of underdevelopment. But to "focus on forces or actors within medicine in order to understand its ideology; composition, function, production and distribution or whatever, is to ask the wrong questions and therefore cannot lead to the right answers."[4] Recently, Waitzkin and Waterman[5] called for contributions in Medical Sociology which would discuss problems of health care in broad theoretical perspectives. This study is aimed at making such a contribution.

Lastly, the analysis of the consequences of underdevelopment on health care in the Third World, and the policy recommendations advanced, would open an avenue of hope for the neglected rural millions of Nigerians and the residents of other Third World countries who need health care services but are unable to obtain them.

(c) Alternative Theoretical Approaches to Social Change and Development.

Both advanced industrial countries and non-industrial countries

have witnessed major changes since World War II. The epoch after the war ushered in an ambitious period in which newly independent countries such as Nigeria, Ghana, Peru, Sri Lanka and Bangladesh began making efforts to eliminate the legacy of imperialist domination. After their liberation, some of these countries e.g. Tanzania, and Mozambique took the path of socialist reconstruction while the majority of them (Nigeria, Ghana, Zambia, Uganda, Venezuela, Argentina, and India, etc.) took the Capitalist form of directed and planned change which is popularly known as a 'mixed-economy.' All these countries, regardless of their pattern of economic development have come to be known as "Third World" or "Under-developed societies." Recently some e.g. India, Venezuela, and Argentina have acquired the more respectable title of "Developing Societies."

Developing societies have many common attributes and characteristics. All of them at one time in their history were colonizied by European Imperialists. All of them currently suffer from the problem of underdevelopment. All of them desire to overcome poverty, illiteracy and disease i.e., they are striving for development and change from their present economic, political and social conditions. Finally, all of them are faced with the problem of <u>how</u> to develop and change in a way that will enable them to overcome underdevelopment.

Efforts have been made by various theorists in the social sciences to explain change and development in developing countries. The many existing theories of development and change may be categorised in a number of different ways.[6] For the purpose of this review, these theories

will be grouped under three major headings. Each of the three groups of theories will represent a different and distinct explanation of development and change in the Third World. These are:

I The Ideal-Type Approach

II The Diffusionist Approach

III The Conflict Approach

This review of alternative theoretical approaches is intended to situate the identified problem of underdevelopment within the broader context of the sociology of Change and Development, and to provide the basis for formulating the conceptual model to guide the present research. An attempt will be made to evaluate critically the relevance of each of these three theoretical approaches to the research problem to be examined in this study.

I The Ideal-Type Approach

This approach contains two different but related theories - Evolutionism and Functionalism. The basic idea underlying both theories is that of "Polar ideal types," one called developed and the other underdeveloped. The concept of development is based on a continuum with the developed societies at one end and underdeveloped societies at the other end of it. For development or change to occur, presumbaly the underdeveloped societies will have to move along the continuum towards the position presently occupied by the developed countries.

Although a generation of Anthropologists and Sociologists[7] had earlier provided theoretical explanations for this pattern of change in

developing societies, it was in the work of Parsons'[8] and Hoselitz[9] that this assumption was made methodologically explicit, by the use of pattern variables. Prior to Parson's contribution to structural functionalism, evolutionalism was the main social theory of development.

A. Theory of Evolution

Evolutionary theory gained popularity in the latter half of the 19th century due to Charles Darwin and his theory of biological evolution. Darwin's idea that man had evolved from a lower to a more complex form of life prompted many scientists such as Sumner, Maine and Henry Morgan to posit that human culture evolved in a similar fashion i.e. "man had progressed from a condition of simple, amoral savagery to a civilized state."[10] Theories of social change however do not owe their origins to Darwin but to August Comte and Herbert Spencer whose work on social change were published before Darwin. Both Comte and Spencer aimed at explaining the past, present and possibly predict future patterns of social evolution.[11]

Comte believed that social evolution is governed by a "natural law of progress, which flows from the law of human organization and, in its turn, becomes the Supreme law of all practical phenomena."[12] According to him, man is progressing towards a perfect society. To attain societal perfection, the human intellect would pass through three historical phases of sophistication - the theological, metaphysical and the positive. In the theological stage, the "imagination completely predominates over the observing faculty to which all right of inquiry

is denied."[13] People think inanimate objects are alive and have a will of their own.

In the metaphysical stage causality is explained in terms of abstract forces, and one great entity, nature prevails. It is a transitional stage where the society starts to acquire science and industry, but "has not become frankly industrial."[14] The positive stage refers to the era of science and industry where people develop explanations in terms of natural processes and laws. At this point in a society's development, it is possible to control human events. Each stage has a particular form of mental and material development.

Comte's evolutionism therefore implies that the Third World countries are still in the Metaphysical stage. The theory further implies that the evolution process of development has occured earlier in the Western world and will consequently occur in the Third World with time. The health care section also will not develop in the Third World ahead of this general pattern of development. The health sector is just a part of the society which is awaiting an evolutionary process of development.

To Anthropologist Morgan, societies could be ordered along an evolutionary continuum through which humans everywhere must pass. According to Morgan, the progress of human kind occurs in three main stages of evolution - Savagery, Barbarism and Civilization. The countries of the Third World are supposedly on the third stage of Barbarism and with time, they (developing countries) will move to the civilization stage.

Herbert Spencer posits that social evolution can be best under-

stood in terms of "a progression towards greater size, coherence, multiformity and definiteness."[15] He attributes the process of societal evolution to inexorable laws of nature which inevitably lead to progress and an increasingly desirable society. According to him a particular stage of social evolution (such as the present underdevelopment in the Third World) might seem oppressive and undesirable, but it could never be eliminated with legislation. The state should therefore play the smallest possible role in the regulation of society in order not to interfere with the natural evolutionary processes.[16] If Spencer's evolutionary theory were to apply in the Third World, health care and other sectors of the economy can not be planned by the government because doing so would interfere with this natural process.

By using concrete examples of communities, Tonnies has made the evolutionary theory of social change explicit. He describes the trend from what he calls Gemeinschaft to Gesellschaft as one in which:

> small, primitive; traditional; homogenous closely-knit communities are eradicated and replaced by a large, urbanized, industrial society where human relations are impersonal, formal contractual, utilitarian, realistic and specialised."[17]

Like Spencer, Tonnies views society as growing more and more complex in a linear process. Unlike Comte and Spencer, Tonnies does not expect progression to a perfect society. He states that a society has provided man with many new freedoms, with new dimensions of knowledge and with material affluence -- it has also brought alienation, atomization and impersonality."[18] The Third World is now embarked on the task of eradicating primitive and traditional society in order to achieve

development. Health Care services as implied by Tonnies cannot be developed until the task of eradicating traditionalism in underdeveloped countries is finished.

To Robert Redfield, development depends on whether a country is on the "folk" or "urban" side of a continuum. The folk community according to him is characteristically

> small, isolated and homogenous with a strong sense of growing solidarity. Ways of living are conventionalized into a coherent system called culture -- the economy is one of status rather than of market."[19]

He indicated that, simple societies will be more developed as they intensify their contact with other cultures such as Western culture. The contact will lead to heterogeneity and disorganization of the simple societies' homogeneous structures.[20]

The theories of Comte, Spencer and Tonnies imply the following characteristics of classical evolutionary theory: (1) evolution is unilinear - there is only one possible path of change (2) progress is seen in very positive terms - advanced societies are in all ways better than simple societies. (This change is usually from simple to more complex, but never from complex to simple) (3) Change is natural, inevitable and requires no explanation and (4) social evolution passes through a series of identifiable steps and stages.

Evolutionary theory has been criticized on many grounds by many theorists and especially by the School of Functionalism. Its concept of Unilinear change has been "rejected on the grounds that human history -- fails to display a general, encompassing trend towards higher

enlightment."[21] Various sectors within a society do not necessarily proceed at the same pace and in the same direction. For example, the development of the health sector in the Third World may be well ahead of the development of attitudes towards modern medicine.

Malinowski particularly argues that "We must first understand the nature of cultural phenomena, their function and form before we can intelligently speak of their coming to be."[22] The functionalists also attack the evolutionists' view of social change for not including a theory of persistence or order. Maybe it is a reaction to the Evolutionary School of thought that functionalists focus upon stabilizing and pattern - maintaining processes, arguing that order rather than change is the natural phenomenon in social life.

The implication of evolutionary theory for health care development is perhaps a conservative one. In the first place, evolutionists don't consider it necessary to explain change in this case - change is inevitable and it will occur only when it can i.e. it is natural. It is intended to predict the future, but the prediction is vague. Health care institutions (according to evlutionists) need not be planned, because these (health institutions) will inevitably change when the entire developing society moves to the next stage of development. The theory has also failed to explain why the countries of the West are higher up on the evolutionary stages. They also fail to explain adequately why the "natural process" of evolution resulted in development in the West and underdevelopment in the Third World.

Evolutionary theory can be criticised for basing its arguments on

propositions which are not testable. This creates a serious limitation for the scientific application of evolutionary theory in social science studies. The holistic nature of the theory makes it difficult to be used in small units like the health sector which is only a small sub-structure within the socio-political economy. The stages used by evolutionists implicitly show that, evolutionary theory cannot be adequately used in the study of small groups; for instance how can health care sector move from the theological to the metaphysical stage, or from savagery to Babarism or from Gemeinschaft to Gesellschaft? Evolutionists imply that change in the entire society affects all sub-units; but these sub-units cannot change on their own. Health care must therefore change as a side effect of changes in the entire society.

B Stages of Economic Growth

W. Rostow's description of the stages of economic growth could be regarded as a neo-evolutionary theory. Rostow, like Comte and Spencer, has outlined five stages to explain development. Unlike Comte and Spencer, Rostow focuses his theory on the developing countries. Rostow calls it "an economic theory of development."[23] He identifies all societies in their economic dimensions as falling within five stages - the traditional society, pre-conditions for take-off, take-off, drive to maturity and mass consumption age. A brief examination of each of these stages throws some light on Rostow's theory:

(i) The traditional Society:

According to Rostow, a traditional society is one whose structure

is developed "within limited production functions based on pre-Newtonian Science and technology and on pre-Newtonian attitudes towards the physical world."[24] There is a limit on the level of attainable output in the traditional society because the potentialities which flow from modern Science and technology "were either not available or not regularly and systemically applied."[25] Examples of traditional societies include the dynasties in China, the civilization of the Middle East and Medieval Europe. The post-Newtonian Societies (such as African Societies) for a time remained untouched or unmmoved by man's new capability for regularly manipulating his environment to his economic advantage.[26] Apart from very few societies in Africa, all societies have passed the traditional stage of development. Rostow further posits that, the characteristics of the traditional society such as its politics, social structure and its values as well as its economy still prevail in some parts of the world e.g. the developing countries.[27]

(ii) Pre-conditon for take-off

This is a transitional stage between the traditional society and the take-off. It takes time to transform a traditional society in the ways necessary for it to exploit the fruits of modern science. For instance, Western Europe was in this stage between the 17th and 18th centuries. Britain took-off first. As Rostow says:

> Among the Western European States, Britain, favoured by geography, natural resources, trading possibilities, social and political structure was the first to develop fully the pre-condition for take-off.[28]

All other countries after Britain such as the U.S.A. and Canada were nursed to the take-off stage by Britain. He contends that, in modern history, the stage of pre-condition arises "not indigenously but from some external intrusion by more advanced societies -- this intrusion sets in motion ideas and sentiments which initiate the process by which a modern alternative to the traditional society is constructed out of the old culture."[29]

The precondition stage is characterised by traditionally low productivity methods, by the old social structure and values, and by the regionally based political institutions that developed in conjunction with them. Rostow explicitly explains that the present underdeveloped countries are still in the stage of preconditions for take-off which countries in the West had passed a century or two ago. Colonialism and imperialism according to Rostow, are the necessary ways that would lead underdeveloped countries to the take-off stage.[30]

(iii) Take-off Stage

In this stage all the traditional elements and values are presumably overcome and dropped. The forces making for economic progress, and modern activity expand and come to dominate the society. Growth becomes its normal condition. This stage is characterised by technology, "build-up of social overhead capital and a surge of technological development in industry and agriculture -- and the emergence to political power of a group prepared to regard the modernization of the economy as serious, high-order political business."[31] Investments now rise from 5% of the national income to 10% or more. Industries in the take-off stage expand

rapidly and yield a lot of profit which is re-invested in new plants: These new industries, in turn stimulate through their rapidly expanding requirements for factory workers, the services to support them and other manufactured goods, a further expansion in urban areas and in other modern industrial plants. The agricultural sector becomes mechanized and commercialized and the "revolutionary changes in agricultural productivity are an essential condition for successful take-off. Rostow locates the take-off of Britain to the two decades after 1780, France and U.S.A. in 1860, and Germany, Japan, Russia and Canada in the later quarter of the 19th century. India and China and perhaps Argentina[32] are just launching their take-off stage. The majority of the Third World Countries are yet to reach this stage while a majority of Western countries like U.S.A., Britain, Canada and France have presumably passed this stage of development.

(iv) The Drive to Maturity

The drive to maturity stage is defined as "the stage in which an economy demonstrates the capacity to move beyond the original industries which powered its take-off and to absorb and to apply efficiently over a very wide range of its resources - the most advanced fruits of (then) modern technology."[33] This is the stage in which an economy demonstrates that is has the technological and entrepreneurial skills to produce not everything, but anything it chooses to produce. It may lack raw materials (like contemporary Sweden and Switzerland) to produce a given type of output economically, but its dependence is a matter of economic choice or political priority rather than a technological or institutional

restraint. About four decades are required (according to Rostow) for a nation to move from take-off stage to maturity. (e.g. Britain, Germany, France and U.S.A.).

(v) The age of high mass-consumption

In this stage, emphasis is shifted towards the production of durable goods and services such as automobiles. Rostow explains that when societies achieved maturity in the 20th century, real income per head rose to a point where a large number of persons gained a command over consumption which transcended basic food, shelter, and clothing. The structure of the working force changed in ways which increased not only the proportion of urban to total population, but also the proportion of the population working in offices or in skilled factory jobs - aware of and anxious to acquire the consumption fruits of a mature economy. The mass-consumption stage has also ceased to accept further extension of modern technology as an overriding objective (for example, the various demonstrations against nuclear warfare). In this stage, increased resources are allocated to social and security welfare. The United States reached the high mass-consumption development stage in the 1950's, after the second World War, followed shortly by Europe and Japan. Rostow points out too that the Soviet Union is technically ready for this stage.[34]

(vi) Beyond consumption

This is the final stage of development which only the U.S.A. is seen by Rostow to hold the potential of reaching in the near future. Rostow feels that it is impossible to predict adequately or even out-

line the characteristics of this stage since only the U.S.A. out of the developed countries has so far shown characteristics of reaching the "beyond consumption stage."

Rostow is more explicit in explaining the process of change from one stage of development to another than evolutionists like Tonnies and Redfield. His emphasis is on the rate of investment in each stage

> Get the investment rate up to the point where the increase in output outstrips the rate of population -- a rate of investment over 10% of national income - and the job is done.[35]

To Rostow, the difference between a traditional (underdeveloped) and a modern (developed) society is merely a question of whether its investment rate is low relative to population increase. Each development stage, according to him has a higher rate of investment.

To reach a 10% rate of investment, he contends, some persons in such a society must be prepared to "undergo the strain and risks of leadership in bringing the flow of available inventions and productivity into the capital stock; -- and lend their money on long terms and high risks to back the innovating entrepreneurs in modern industry."[36] Change of attitude is required so that, the general society will accept the technology prevalent in each stage. Lastly, Rostow believes that, the developed countries need to assist the Third World to take-off. Colonialism and neo-colonialism according to Rostow are necessary steps toward helping the developing countries take-off economically.

Critics such as Gunder Frank[37] are of the opinion that Rostow's stages of growth "do not correspond at all to the past or present reality of the underdeveloped countries whose development they are supposed

to guide." It is explicit in Rostow's work that underdevelopment is the original stage of what are supposedly traditional societies - that there were no stages prior to the present stage of development. It is further clear in Rostow's theory that, the now developed societies were once underdeveloped. This is quite contrary to fact. Rostow's entire approach

> attributes a history to the developed countries but denies all history to the underdeveloped ones. The countries that are today underdeveloped evidently have a history no less than have the developed ones.[38]

It might be accurate to affirm that none of the countries in the Third World today are the way they were even a century ago.

Rostow has perhaps failed to address adequately the issue of colonialism. His theory of development takes account neither of the history of the underdeveloped countries nor their crucial relations with the now developed ones over the several centuries past.[39]

Contact between Western and Third World countries is important in explaining the process of development. For instance, both Baran and Frank have indicated that the early contact between Europe and India resulted in the latter's underdevelopment. When Indian was colonized by Britain, all her industries and pattern of development were disturbed or destroyed. India was exploited. Instead of industrialization, the imperialists emphasized the production of raw materials which were often shipped to Europe. The country was left sterile before independence was attained. Jawaharlal Nehru has documented these facts in his book 'The discovery of India.'[40]

> nearly all our major problems today have grown up during British rule and as a direct result of British policy: the minority problem, various vested interests, lack of industry, neglect of agriculture, the extreme backwardness in social services, and, above all the tragic poverty of the people.

Ignoring these relevant historical factors makes Rostow's work deficient. In another distortion of history, he attributed the early economic take-off of Britain to its geography, natural resources, social and political structure and trading possiblities. It would appear that Rostow has refused to acknowledge the fact that Europe developed because of its ability to exploit the non-industrial societies.[41] Basil Davidson[42] and Walter Rodnay[43] have explained the British exploitation of Africa. In fact Rodney even calls his book How Europe underdeveloped Africa. Frank[44] and Navarro[45] have also debunked Rostow's thesis by explaining European exploitation of Latin America. The English Mercantalists such as Thomas Mun[46] also demonstrated how Europe depended on the colonies to develop. KarlMarx,[47] and Earl Hamilton[48] have also explained the source of European development as imperialism. These sources have made it clear and shown the crucial role played by the underdeveloped countries in financing the industrialization of the now developed countries. Frank expressed his bitterness to and disagreement with Rostow to the extent of making fun of the 'stages of economic growth' thesis as follows:

> If the now underdeveloped countries were really to follow the stages of growth of the now developed countries, they would have to find still other people to exploit into underdevelopment as the developed countries did before them.[49]

Rostow's stages are so static that no country, once underdeveloped, can be conceived as crossing the line to development. Argentina, which Rostow claims to be at the take-off stage, is structurally as poor if not worse than other Third World countries.

Rostow's neglect of history and the structure of the societies in the Third World makes his theory deficient. The history of Africa is particularly very significant in explaining its development, because Africa as a continent has been greatly influenced by its contact with colonialists. The use of history would explain the structure of Africa and the rest of the Third World. Rostow's model is ineffective policy-wise and theoretically inadequate because inspite of enormous capital and cultural values said to have been transferred from the West to the Third World, no country in the Third World has taken off. If Rostow agrees that Britain helped other countries to develop, why has Britain or other developed countries failed to help any Third World country to take-off? Not even one sector of the Third World is developed. Health care services which form the focus of this research are chronically underdeveloped in all of the Third World inspite of the assistance from the World Bank and other international aid organizations.

The implications of Rostow's theory for an understanding of the development of the health care sector in a Third World country such as Nigeria becomes obvious. Since Nigeria has not been able to reach 10% rate of investment, and since the general attitude of the people is yet to be changed towards fundamental and applied science, the effective development of the health sector will presumably not be attained now.

According to Rostow, a high rate of investment will lead to general improvement in the economy, only then will the health sector, as a substructure of the economy be affected.

If Rostow's argument were to be taken seriously, the next question will be whether the health sector has or has not developed in the Third World in the last five decades. And before Nigeria reaches Rostow's 10% investment pass mark to development, what should be the fate of health care delivery? This present study addresses that problem which Rostow overlooks. Functional theory of development will now be considered, to see to what extent it explains underdevelopment.

C Functionalist theory.

The holistic approach to the study of society could be traced to Montesquieu, Comte; Spencer and Durkheim.[50] An explicit doctrine called functionalism was however the creation of Bronislaw Malinowski and especially A.R. Radcliffe-Brown, who repudiated the term functionalist as applied to himself, yet formulated a set of ideas which encouraged a version of functionalist holism.[51] Recent and methodologically explicit contributions have been made to functionalist theory in America by Talcott Parsons and others such as Robert Merton[52] and Bert Hoselitz.[53] Parsons and Hoselitz for example use the functionalist theory in explaining development and underdevelopment. Both Parsons and Hoselitz have made the ideal-type approach to development clear by the use of pattern variables.

To Parson, pattern variables are crucial in distinguishing the developed from the underdeveloped countries. Pattern variables are

alternative patterns of value orientation in the role expectation of actors in any social system. They are the points of interpenetration of structural characteristics of the social system into the role expectation of individual actors. In this way, pattern variables become the immediate determinants of social behaviour.[54] Here, little more can be done than suggest the significance of these pattern variables and see to what extent they (pattern variables) address adequately the problem of underdevelopment of the health sector in the Third World.

(i) Particularism vs Universalism

According to both Parsons and Hoselitz,[55] role relationships in the developing countries are very particularistic. Role obligations are not couched in terms of universally valid precepts, and as such this inhibits rapid development. This is unlike the developed societies where role obligations are universalistic. Role obligations such as those of economic agents in developed societies derive from

> general moral precepts such that contracts must be honoured, or that one must maximise one's profit, or that first come first served or that putting the right man in the right place is always the best policy.[56]

Because role obligations in the Third World are particularistic, role relationship descriptions are in such terms as "I must try to help him because he is my tribesman", or "I must give him some more credit because he is my cousin or brother-in-law."

The explanation of the underdevelopment of developing countries

is that because they are particularistic, the available avenues of development are not filled by the right people, and the public services e.g. health care services are also not distributed on a universalistic basis.

This point, however, may be criticised on the basis that the reality and the sociological literature on many developed countries reveal substantial particularism, for example, Japan, France and Europe in general.[57] Frank points out that America is equally particularistic.[58]

> much of what flies a universalistic flag in the U.S.A. and other developed countries is little more than the cover for unsavory particularistic private interest

Frank further argues that particularism is dominant in the developed countries and has been exported to the developing countries in the guise of such universalistic slogans as freedom, democracy, justice, the common good, the economic liberalism of free trade, the political liberalism of free election, the social liberalism of social mobility and the cultural liberalism of free flow of ideas.[59] Even casual observation of the economic and political institutions in Europe and America makes it increasingly difficult for many scholars to accept the thesis that developed countries are completely universalistic in their role relationships.

(ii) Ascription vs Achievement

Role relationships in developing countries are predominantly ascriptive. That is to say, the position of a person does not depend on

his abilities, but on where, and to whom he is born. In developed countries the dominant value orientation is that of achievement. Here one's role in society is said to depend primarily on his or her personal achievements. The developing countries are therefore expected to put aside ascriptive role relations and adopt an achievement orientation if they want to develop.

This has also been criticised on the basis that all societies, regardless of their development, manifest some degree of ascribed role performance. In America, rewards within roles are indeed substantially dependent on achievement. However, recruitment into roles, although perhaps to a certain extent a matter of achievement among the middle class, is very much based on ascription in both the higher levels of business and management and among the masses of the poor.[60] Michael Harrington's study Poverty in America has also reported that "recruitment is becoming progressively more ascriptive in America."[61]

The situation in Japan also shows the ascription of roles. Though role recruitment in Japan is based on achievement, the assignment of reward within the role is highly ascriptive, being based on such factors as age, family obligations, etc.[62] Apparently then, both developed and underdeveloped countries manifest both ascriptive and achievement value orientations, and the problem of underdevelopment cannot simply be explained in terms of this pattern variable. In the health care sector for example, Parsons should not expect the son or relative of any physician in the Third World to be employed in the health sector just because his father has been a physician. Such a person must have

medical training of some kind before he would be recruited in the health institutions, just as in the developed countries.

(iii) Functional diffuseness vs Functional specificity

Role relationships in developing countries are said to be diffuse, while those in developed countries are described as functionally specific. Hoogvelt explains that

> -- functional specificity is that between employers and employees in modern type industries, where their role relationships are explicitly clear and each one knows clearly his limitation -- in the case of functional diffuseness, there could be a patron and his apprentice in let's say a carpenter's workshop, where the patron is not just an employer, but also a teacher and guardian to the apprentice, who in turn is not merely an employee but also a pupil, an adopted son to the patron, or his brother in law.[63]

According to Parsons, when roles are functionally diffuse as they are in the Third World, development is inhibited because maximum attention is not given to a particular goal. Parsons therefore looks at underdevelopment as a problem of functional diffuseness of role relationships.

Frank has however argued that, if functional diffuseness of role relationships was the major cause of underdevelopment, then, American society would be equally underdeveloped. He has cited the case of the American Military whose major role is defence, but is also allied with American Corporations for other interests. The recruitment of a very large number of the American retired military men in the giant American corporations is explained by the bulk of military purchases made within

these corporations.[64] C. Wright Mills dismisses the myth that developed countries have functionally specific roles:

> --- the power elite dominates what President Eisenhower dubbed the Military - Industrial Complex, and in which Douglas Dillion of Dillion Reed and Co. comes to sit in the cabinet as Secretary of Treasury; Robert McNamara, President of the General Motors becomes secretary of defence -- and what is good for General Motors is good for America -- and the bulk of military purchases are from a half dozen giant corporations who employ large numbers of retired high level military officers.[65]

The concept of functional specificity in explaining underdevelopment is a myth. The underdeveloped countries are not underdeveloped because their role relationships are diffuse, but because of other reasons which will be considered later in this chapter.

(iv) Affectivity vs affective neutrality

People in underdeveloped countries are presumably affectively oriented while those in developed countries are affectively neutral. The explanation is that people in the Third World have a greater motivation to perform roles that are personal than those that are impersonal. Parsons makes it clear that role relationships which are affectively neutral, and functionally specific, would lead to greater achievement - and development. The developing countries would need to adopt these value patterns if they want to develop.

(v) Self vs collectivity orientation

This pattern variable concerns the question of whether role obligations allow the role incumbent to pursue private interests while carrying out a role or whether the role obligations do not permit any

pursuits other than those in the collective interest. According to Parsons, people in developing countries tend to engage in role relationships which are more self-oriented than collectivity oriented. In developed countries, it is the other way round. For instance, a professor hired by a university primarily to instruct undergraduates, but who devotes more time to research in order to gain promotion would be pursuing self interest at the expense of collective interest. Parsons is of the view that, if the developing countries would give more attention to performing roles of collective interest, as the western countries do, then they (underdeveloped countries) would become developed. Self interest is presumably not favourable for development. For example Parsons contends that the medical practitioner as a professional is characterised by a collectivity or service orientation. The professional is also characterised by affective neutrality.

In the case of health care delivery, Parsons would say that if the planning and distribution of health care services were based on collective interests rather than for self interest; the health sector will be more developed.

The implications of Parsons' pattern variables for the organization and delivery of health care services in developed countries such as Canada and U.S.A. are that, production, supply and distribution of health services are guided by value orientations which are universalistic, functionally specific, affectively neutral and collectively oriented. Recruitment into any roles in the health sector is based on achievement. With these value orientations, their (developed countries) health care services are highly developed. The pattern of the value orientation

further implies that the organization of the health sector in the Third World is based on value orientations which are ascriptive, particularistic, functionally diffuse, affectively and self-oriented. These value orientations have predisposed the Third World countries to underdevelopment. Parsons further makes his explanation clear by outlining the patterned role relationship which exists between doctor and patient. According to him, a physician's role is characterized by universalism, achievement, functional specificity, affective neutrality and collectivity orientation. Physicians in the Third World lack these patterns of relationship, and that contributes to the underdevelopment of health care in the Third World.

The pattern variables seem to suggest that once there is change from the present value orientations of the developing countries to that of the developed World, then the former will be automatically free from underdevelopment. It might be accurate to argue that the question of underdevelopment deserves a better explanation than the one by Parsons in the pattern variables. Parsons has certainly overlooked many important things in his theory. First, it might be necessary to know the origins of the difference in value orientations between the developed and underdeveloped countries. Such knowledge would be useful in showing the Third World how the change from their present value orientations to that of the West could be accomplished. This is crucial because Parsons has not shown in his theory how the change could be organized.

By overemphasizing the functions of value orientations in role re-

lationships, Parsons has failed to take congnisance of the very important influence of economics and politics in the process of development. Parsons is not at all explicit as to whether it is the change in economics and politics that will change value orientations or whether it is the change in value orientations that will influence the economics and politics. For certainly, the economics and politics of a nation play a part in its development. For instance Parsons cannot explain how the change in value orientations will provide money for such very poor countries like Chad and Niger to finance their health care services.

Colonialism and neo-colonialism in Africa, Asia and other developing countries are very important phenomena in explaining development and underdevelopment in these areas but have no place in Parsons' structural functionalism. By avoiding history, Parsons' pattern variables are deficient in adequately determining development or underdevelopment. Frank notes that

> Parsons structuralism and holism is confined to the analysis of a wholly abstract model of any and all real or imaginary societies and not with the study of any existing society. However Marx and Weber may have relied on theoretical models and ideal types, neither ever ventured to depart so far from reality.[66]

Frank's argument is very plausible because no society is yet known which has value orientations which are exclusively good for development or underdevelopment as the pattern variables thesis suggests.

Functionalist theory, like evolutionary theory does not adequately explain why health care institutions are underdeveloped in the Third

World, and how they can be developed.

The ideal-type approach generally attributes blame to the people of the Third World for causing their underdevelopment, and more so the underdevelopment of health care institutions. The evolutionists continue to hope that, through the natural process, entire developing countries will move from the present stage of underdevelopment to development; and only then will their health care institutions become developed. To neo-evolutionists such as Rostow, health care development will be inefficient and inadequate in Third World countries until they are able to have at least 10% investment of the national income. Structural functionalists like Parsons perhaps are more explicit as to who should be blamed for the Third World's underdevelopment. Parsons clearly shows that value orientations and role relationships of people in the Third World are inherently unfavourable for any form of development. The change to Western value orientations according to Parsons is the only path through which the Third World will pass to development; and change in the health care institutions will start from the change in attitudes of the actors within the health sector.

Common to all theories within this approach is the use of two polar ideal types one called developed and the other underdeveloped. Between these two poles several stages presumably exist. But the ideal-type approach has regretably failed to explain adequately for our purpose why health care institutions in the Third World are underdeveloped. If the question of why health services are themselves underdeveloped in the Third World countries is not appropriately answered by this approach,

then it is even more difficult for it to advance solutions. Other theories must, therefore, be considered to see if they can be of help in explaining underdevelopment of health services in the Third World.

II The Diffusionist Approach

The basic assumption of this model is that, the Third World, by the very fact of being underdeveloped, lacks knowledge, skills, organizational values, technology and capital, all of which are necessary prerequisites for development. For these countries to be developed, they would need to acquire the attributes of Western industrial, advanced countries. This view is clearly expressed by Nash[67] and Rostow.[68]

They argue that this diffusion will spread from the metropolis of advanced capitalist countries out to the national capitals of underdeveloped ones, and from there, out to their provincial capitals and finally to the peripheral hinterland.[69] The more any country in the Third World is able to assimilate the diffused entrepreneural values from the west, the more such a country is able to overcome the indigenous cultural traits that obstruct or resist development. This approach presumably offers no practical suggestions to the people of the Third World in regard to removing the causes of underdevelopment, instead suggesting they (Third World People) wait patiently and welcome the diffusion of development aid from the outside. This aid comes mainly in three forms namely capital, technology and skills, and institutions.

On the aspect of capital, diffusionists propose that, being poor, the Third World lacks investment capital and therefore finds it diffi-

cult or impossible to develop. The rich countries of the West therefore should and do diffuse capital to the Third World.[70]

To Baran,[71] Frank[72] and Navarro,[73] this aspect of capital diffusion and in fact the whole theory of diffusion lacks empirical validity. They deny that the rich countries diffuse capital to the poor ones to develop the latter, aruging rather that the wealth of the Third World is diffused to the developed countries. Gunder Frank found out specifically that, the capital sent from the developed countries to the developing countries is not half as much as that taken from the developing countries to the developed world. He quotes Harry Magdoff who found out that "Between 1950-1965, the total flow of capital on investment account from the U.S.A. to the rest of the World was $24.9 billion, while the corresponding capital inflow from profit was $37 billion. Between the U.S.A. and developing countries, the profit was even higher for the U.S.A. They (U.S.A.) invested $9 billion in the Third World but during the same period, there was a net inflow from the Third World countries into U.S.A. of $16.6 billion.[74] Capital is diffused from the developing countries to the developed countries rather than the other way round.

A.E. Safarian[75] in his book Foreign Ownerhsip of Canadian Industry reveals that, even Canada as a developed country is out competed industrially by the U.S.A. He indicated that the U.S.A. brings a little capital and makes more capital out of it in Canada. In the period 1957-64, American capital contribution to the total capital used by American firms in Canada was only 15%. The remainder of the foreign

investment was raised in Canada. America generally depends on foreign capital to finance American foreign investment as shown in the case of the Third World and that of Canada. If Canada as a developed country with a stronger economy than any Third World nation can be out competed by the U.S.A., then, it would be reasonable to accept Frank's thesis that "America and other developed countries rely on developing countries which are chronically weak and more defenceless than Canada economically."[76]

The developed countries also benefit tremendously in the form of brain drain or outflow of human resources that is financed by the underdeveloped countries for the subsequent benefit of the rich nations of the West. For example, Mejia[77] has found out that one of every five physicians in Canada and the U.S.A. is from the developing countries. These are the physicians from the Third World looking for higher wages which are not generally affordable in the Third World.

It is also known that, the so called foreign aid to the Third World has unfavourable effects on the balance of payments, economic integration and capital formation in the Third World. This means that foreign aid tends to determine the character and direction of foreign trade in the Third World countries. Aid to the Third World also stimulates monopolistic competition which usually absorbs and subordinates local firms. For example, in Nigeria, as in other developing countries, local products are not a priority, since the higher quality foreign products dominate the domestic markets.

Regarding technology, the diffusionists also insist that developing countries must obtain the technology of the advanced countries.

Therefore Western technology has consistently been diffused to the developing countries since the emergence of imperialism. As in the case of capital, critics such as Frank are of the view that the diffusion of technology is mainly for the benefit and profit of the producers of the technology and is not meant to be a developmental tool for the underdeveloped countries. The diffusion of technology and capital (foreign investments) is only a basis of promoting the capitalist metropolis' monopolistic control over its underdeveloped economic colonies. Technological diffusion should not therefore, be expressed in the simplistic manner attempted by diffusionists.

The diffusionists also postulate that, beside capital and technology, the underdeveloped countries need the institutions and values of developed countries. In other words they (diffusionists) want the Third World to import Western Liberalism. Patricia Marchak refers to it as liberal ideology. According to her, liberalism is a social reality which does not appear to us directly

> It is revealed to our understanding through a screen of assumptions, beliefs, explanations, values and unexplained knowledge.[78]

Values of Western liberalism emphasize freedom. Freedom of trade, fair election (democracy) and individual freedom of ownership. i.e. liberal capitalist system. In fact "we can distinguish an economic, political and social liberalism"[79]

Economic liberalism has already been discussed. However, it should be added that, the exportation of economic liberalism to the Third World is not only an expression of particular interests of the metropolis, but

its importation by the Third World also meets the interests of a few priviliged individuals within the Third World. Through the value (freedom) of economic liberalism, the developed countries have a monopoly over finance, commerce, industries and even land in the Third World. Indigenous and privileged elite like Awolowo and Jakande used the doctrine of Western economic liberalism in Nigeria to acquire a tenth of the land in Lagos State while the two million inhabitants of Lagos share the remaining portion.[80] The diffusion of economic liberalism from the developed World to the Third World is a response to private interests and produces consequences that can be summed up in a single word - monopoly.

Political liberalism is closely related to economic liberalism, and its diffusion benefits the same group who are the beneficiaries of economic liberalism. For example America particularly tries to watch if liberal democracy as a Western value is correctly practised in Third World countries in which it has economic interests. If America sees that democracy is not practiced correctly, CIA may be sent to topple such undemocratic regimes. Right or wrong, democracy to America is assessed in terms of whether or not such democracy safeguards American interests. An example of diffusion of liberal political values is seen in the activities of CIA's destabilization of Allende's Chile. Both Henry Kissinger and President Ford took refuge in a diffusionist based argument, namely that the U.S.A. government had the task not only to defend American interests abroad but also to safeguard the freedom of opposition parties in democracies abroad in the very interests of these countries.[81]

Lastly, we can consider the diffusion of social and cultural liberalism. The international effects of economic and political liberalism diffused to the Third World results in the problem of social mobility. Since the diffusion of any form of liberalism is ultimately in the interests of the West, they (western countries) try to direct their diffusion where their interest will be most realized. In trying to do this, they favour a privileged section of the Third World with the liberty and freedom to move up the social ladder. But a majority of the people in the Third World do not have opportunities for upward social mobility. The opportunity which some people have in the Third World to move within the existing social structure is on an individual basis.

Cultural liberalism permits the West to diffuse its cultural values to the Third World. To Frank, cultural liberalism is a "liberal production, diffusion and consumption in the name of liberalism of any item that can by the most liberal interpretation be called culture or truth - such as American Press and the U.S.A. Information Service news releases."[82] Frank also indicates that this diffusion occurs in the name of cultural as well as economic and political liberalism.

The implications of the diffusionist theory for health care delivery in the Third World are explicit i.e. the importation of modern medical technology - drugs and laboratory equipment, and medical skills from the Western World. According to this theory, a developing country that is able to internalize more Western medical values would have better health care services. This is contrary to reality. In fact, it could be argued that the problems facing the health care system in the Third

World countries are not because Western medical values have not been diffused, but rather because they have been diffused. In other words diffusion may be the cause and not the solution of the underdevelopment of the health care sector in the Third World.

For instance, the diffusion of medical technology - drugs and equipment from the Western World is never intended to be a tool of health development nearly as much as it is an avenue of commerce. Doctoring as a Western value puts emphasis on forms of health care e.g. curative, that are economically more rewarding. The capitalist spirit that is diffused along with the medical technology creates problems in the Third World such as doctors refusing to stay in the rural areas. In the West, the Medical profession has its professional culture - its values, norms and symbols. Values embrace those functional beliefs of the profession upon which its continued existence is claimed. Bernard Blishen refers to these beliefs as "medical doctrines."[83] This doctrine controls the production, supply and distribution of medical services. The diffusion of these values to the Third World has resulted in a dearth of health personnel (controlling production) and physicians are located only in urban areas (controlling supply and distribution). The liberal capitalist system allows physicians the freedom to seek their economic ends. The more these values are diffused to the Third World, the more the health care sector in the Third World, will be underdeveloped.

III Radical or Conflict Approach

The radical or conflict theories of development have emerged over the years as a challenge to the modernizing theorists. The radical theorists are of the view that modernizing theorists are abstract, formal and ahistorical. To the conflict theorists, the developed countries are themselves ridden with tensions, conflicts and are historically experiencing mighty contradictions and strife which may lead them to various problems.[84] They also assert that, the developed countries are in sharp economic and political conflict with the underdeveloped societies, and that the recognition of the conflicts present in developed and underdeveloped societies should be a necessary premise for elaborating a realistic theory of development. This approach is exemplified by C. Wright Mills in his book The Sociological Imagination.

Conflict theorists draw a lot from history in studying both development and underdevelopment. They highlight the creative role of conflict in shaping the progress of society, and argue that change rather than order is the most essential means of development. They view change as an intrinsic process in society

> --- not merely the outcome of some improperly functioning or imbalanced part of the social system. Structural differentiation is felt to be the source of conflict and social change.[85]

Conflict theory has evolved from the writings of Karl Marx, Lewis Coser and Ralf Dahrendorf. Marx many years ago wrote that "without conflict, no progress, this is the law which civilization has followed to the present day."[86] Marx contended that every society, whatever its stage of

historical development rests on the economic foundation - the mode of production of commodities

> -- the mode of production in material life determines the general character of the social, political and spiritual process of life. It is not the consciousness of men that determines their existence, but on the contrary their social existence that determines their consciousness.[87]

According to Marx, each stage in life is influenced by the mode of production. Conflicts result between two or more opposing economic groups with opposing economic interests

> The history of all hitherto existing society is the history of class struggle. Freeman and slave, patrician and plebian, lord and serf, guild-master and journeyman. In a word, oppressor and oppressed stood in constant opposition to one another, carried on an uninterrupted, now hidden, now open fight, a fight that each time ended either in a revolutionary reconstitution of society at large or in the common ruin of the contending classes.[88]

To Marx, 'conflict' constitutes a normal condition of social life and conflict and change to him cannot be separated. Economic production is the sub-structure upon which the (super-structure) society is built. Social institutions, the government, family, education, health care and religion are all dependent upon the mode of production. Variations and changes in economic production give rise to variation or change in other social instutions with associated values, attitudes and norms. In capitalism, Marx contended, there is opposition between the bourgeoisie and the proletariate. When antoganism between these two groups becomes sufficiently intense, it will result in a revolution which "no man or

groups of men can stop the revolution from occuring."

According to Marxists conflict theory, the problem of underdevelopment rests with the conflicts in relation to production. If there is change in the pattern of economic production in the Third World, then that change will affect all other institutions. Without the change in the mode of production, the efforts to improve health care services will not be successful. He identifies capitalism as the problem of underdevelopment.

Marx employs dialectics in explaining and analysing underdevelopment. Marxists generally believe that the present underdevelopment of the Third World is rooted in the fact that the developed countries underdeveloped them in order to become themselves developed i.e. the west developed precisely because it was underdeveloping the Third World, while the Third World became underdeveloped in aiding the development of the West.[89] To Marxists, a proper understanding of the cause of development and the problems arising out of it can be arrived at only if it is fully understood in the context of the growth of a world wide capitalist system from its mercantalist to its latest imperialist phase of development where a few countries around the Atlantic developed as exploiting centres and the rest of the colonial and semi-colonial countries as the underdeveloped periphery.[90] Marxists deny that the developed countries are helping the Third World to take off economically as Rostow and other Western liberal theorists suggest. Rather they (West) are "using more subtle forms of 'pillage' and exploitation of the Third World under the guise of aid.[91] They are also transforming

the underdeveloped countries into their neo-colonial dependencies. The idea of aid or assistance in the form of diffusion of capital, technology, skills and modernized institutions and values is false and deceptive.

Marxists also label as a myth the popular conception that the developed countries have been using their wealth for the benefit of the Third World. They believe that change in the Third World will not occur through the wealthy, but by the working class. Thus the capitalist class structure and colonial exploitation have been identified by Marxists as the historical source and the contemporary cause of underdevelopment. Capitalism vs Socialism is the central issue confronted by under-developed societies to overcome their backwardness.

Lewis Coser has also made a contribution to the understanding of the conflict approach. He sees conflict as part of the socialization process and argues that no social group can be completely harmonious. In other words, conflict in society is inevitable, since people are predisposed to love and hate. Conflict may be destructive or constructive. It is constructive in the sense that, when disagreement is resolved, this leads to unity and promotes social change. Conflict is analogous to thesis, anti-thesis and synthesis. According to Coser, if people are satisfied with their society they remain stagnant and will not hope for change. However, conflict can lead to change in a a number of ways including the establishment of new group boundaries, drawing off hostility and tension, the development of more complex group

structure to deal with conflict; and the creation of alliances with other parties.

Each of these groups can result in a new distribution of social values with the concomitant formation of a new social order: Therefore conflict should be seen as a creative force that stimulates change in society.[92]

Another well known conflict theorist is Ralf Dahrendorf. He rejects the Marxian version of the production of conflict in society. Rather than determining social classes from the means of production, he focuses on the unequal distribution of authority. He divides all groups in society into those who have authority and those who do not. To him social conflict has a structural origin and is to be "understood as a conflict about the legitimacy of relations of authority."[93] In any group, those who hold the authority and power are interested in preserving the status quo and the subordinated group are interested in change. These two groups are potential antagonists, in that their members share common experiences, roles and interests whether or not they are aware of it.

The more organized the interest groups and the more regulated their conflict, the less violent is the conflict. Conflict by this processleads to planned structural change. The great creative force that leads to change in society is therefore social conflict.

Although Dahrendorf draws his theoretical style from Marx, he differs from Marx in some ways. For example, while Marx emphasized the economy as the sub-structure determining the superstructure, Dahrendorf

emphasizes the political sub-structure as determining the rest of society. While Marx contended that conflicts would always be resolved by a revolution, Dahrendorf contends that many conflicts are not capable of resolution, they can only be controlled and compromised.

The implications of the conflict theory for health care services in the Third World is that of conflict among different interest groups. In the capitalist class structure in Third World countries such as Nigeria, the planners of health care who are the privileged class, have not given sufficient attention to socialized medicine. Health care services are therefore more available to the privileged class that has both wealth and authority.

Even within the health sector, there are conflicts such as who should control the hospital, and the health of the citizens. Both the conflicts between the bourgeoisie and the peasants and that within the health sector will presumably continue, until the peasants who need good health care but are unable to obtain it will stage a double revolution to destroy the capitalist leadership and establish socialized medicine for collective interest.

The review of these broad theoretical approaches points out that there are a number of different ways of explaining change and development of underdevelopment. The first two (ideal-type and diffusionist approach), in other words modernizing theories blame the Third World countries for causing their own underdevelopment, in delaying the adoption of Western culture. The last approach (conflict) generally called dependency perspective blames both the Western entrepreneurs and the

indigenous elite of the Third World for combining to perpetuate underdevelopment in the Third World.

Having reviewed these theories it is now appropriate to turn to the specific problem to be investigated in this research.

(d) Conceptualizing the Research Problem: The Propositions to be Investigated.

The competing theoretical perspectives on the issue of change and development in the Third World leave important questions unanswered. This research will focus on three basic questions; Which will guide the rest of the discussion.

1. Why are the Third World societies not as developed as the Western societies?
2. What are the major obstacles to development facing Third World Societies?
3. How can these societies overcome the problems associated with underdevelopment?

In the review of the major theoretical approaches to development, no common agreement was reached on these crucial questions. There is even no agreement on what constitutes underdevelopment or development. To the modernization perspective, underdevelopment is "an original state or condition characteristic of traditional societies which countries leave behind as they take on more of the attributes, values and characteristics of modern societies."[94] In this regard, the Third World countries are underdeveloped because they are still predominately

traditional in outlook and their traditional value system impedes development. This explanation is clearly expressed by B. Higgins[95] in the thesis of dual economy; a viewpoint which identifies in Third World societies two autonomous sectors, the urban based progressive modern sector which is the centre of development initiative and the rural based and backward traditional sector. Thus, the less traditional the Third World, the more the development.

To the dependency perspective, underdevelopment is not an inherent condition but an ongoing process. Frank puts in clearly

> Underdevelopment is not due to the survival of archaic institutions and the existence of capital shortage in regions that have remained isolated from the stream of world history. On the contrary, underdevelopment was, and still is generated by the very same historical process which also generated economic development: capitalism.[96]

The dependency perspective also insists that, the Third World countries had a fairly good industrial, technological, economic, political and social potential for (indigenous capitalist) development, but that the potential was suddenly arrested by contact with the West usually through colonial conquest which subsequently set in motion the process of underdevelopment.

How, then, are the underdeveloped countries to become developed? According to modernization theorists:

1. The culture and value system of the Third World societies should be changed to approximate that of the West.
2. Links with the West should be intensified so that, the diffusion

of culture, capital, technology and skills will be effective.

3. Entrepreneurial values should be transmitted so that the residents of Third World countries will acquire high achievement, be willing to take calculable risks and invest in productive enterprises.

Manning Nash in his editorial in the Journal of Economic Development and Cultural Change clearly delivered the message of the modernization theorists to the Third World that:

> the development of the West has created an environment in which local progress will inevitably consist in large part of selective imitation and adaptation from this environment. The problem of economics in presently underdeveloped areas therefore can be viewed as one involving the transmittal of culture, rather than one of local innovation.[97]

Turning to the dependency theorists, they believe that underdeveloped countries will remain underdeveloped unless they (Third World) stage a double revolution involving the overthrow of the bourgeoisie of the underdeveloped countries by the working class, and by the severance of dependent links with the Western countries. Frank states this case in respect to Latin America.

> the development of underdevelopment will continue in Latin America until its people free themselves from this structure (capitalist world system) the only way possible, the violent revolutionary victory over their own bourgeoisie and over imperialism.[98]

The conflict here is that the very group of people (entrepreneurial class) regarded in the modernization perspective as crucial for deve-

lopment is seen by the dependency perspective as responsible for underdevelopment and thus deserve to be overthrown. In fact, all known dependency theorists insist on the break with the West as the first step towards development.[99]

What are the obstacles to development of the Third World? According to the Modernization theorists, the lack of capital, foreign exchange, skills and technology constitute major obstacles to development. They also feel that the rural nature of the Third World, over population and lack of infrastructural facilities such as roads makes development extremely difficult. The non-economic obstacles are seen mainly in terms of a traditional value system. They, together, constitute a constellation of hurdles between the present state and development. To the dependency perspective, the dependent links with the West and the class interests of the local or indigenous bourgeoisie are the main obstacles to development. Each of these theories (modernization and dependency) holds that the only way of overcoming underdevelopment is by removing the obstacles which each has identified.

The problems of underdevelopment are many and cannot be adequately handled within the limits of the present study. This research will therefore focus specifically on the problems of underdevelopment in the health sector of Third World countries such as Nigeria. Third World health care problems can be understood in the context of general underdevelopment. Waitzkin and Waterman[100] are of the opinion that the sick do not suffer in isolation from the broad socio-political structure of the society in which they live. In the same vein, the factors which

cause the underdevelopment of health care cannot be separated from the factors which cause the general underdevelopment of the Third World. The problem of health care is but one of a chain of problems resulting from a wider theoretical perspective.

> The rudimentary state of social theory in the health field had led to negative consequence on two levels. First, it has cast a pall on academic medical sociology, which has been viewed as an unexciting area by sociologists interested in broad theoretical issues. Secondly medical sociology has proven largely irrelevant for most health workers - in search of a coherent theory which would aid them in their struggle towards a humane health system.[101]

Connecting sociology of health care with a broad theoretical perspective had earlier also been advocated by Erinosho and Navarro

> -- a penetrating understanding of the health sector in any given society can only be undertaken within the theoretical framework that takes cognisance of the social structure of the society.[102]

Knowing that, the same problems that cause general underdevelopment in the Third World also cause the underdevelopment of health care services, it becomes germane to ask the same questions earlier asked in formulating the problem of general underdevelopment of the Third World. But now the question will be specifically addressed to the problems of health care:

1. Why are health services underdeveloped in the Third World? Why are the available health facilities concentrated in the urban areas? Why are these services unequally distributed among the inhabitants of Third World countries?

2. What are the obstacles facing the development of the health sector in the Third World?

3. How can health care services be developed in the Third World so that, they will be within reach of all the people of the Third World? To give direction to the research, Nigeria will be used as a case study in examining the underdevelopment of health care in the Third World.

Propositions to be investigated

Perhaps it might be accurate to call the proposed theory a "reconciliatory approach" to the study of development. This approach draws very largely on the dependency perspective, and also considers essential some aspects of moderninzing theories. Any particular theory can only go so far. Explanatory powers are limited when theories are overstretched. It may be argued that some aspects of the modernization theories (such as cultural factors) will be germane if integrated with the dependency perspective in constructing a theory of development. Such a theory, drawing from modernization theories and taking the dependency perspectives and trimming its extremes is in this study referred to as a "reconcilatory approach."

J. Zasha[103] was about to take a reconcilatory approach when he observed that, though the dependency perspective was developed as a critique of the modernization perspective, it remains mute on certain key issues emphasized by the latter. This is especially so with regard to the role of the indigenous entrepreneur with high achievement motivation.

Although the dependency perspective is theoretically oriented towards a double revolution, involving the overthrow of the local bourgeoisie and severance of dependent relations with the West, there is nowhere in the perspective any serious theoretical analysis of the entrepreneurial group or its equivalent in the post revolutionary situation.

It is dangerous to assume that today's workers and peasants, most of whom have little formal education, will suddenly be capable of running large corporations and managing 'non-dependent' international econimic transactions tomorrow. The dependency perspective pays too much attention to external factors responsible for underdevelopment and little attention to internal factors except in class terms.

On the other hand the modernization perspective pays little attention to the external, historical factors and too much attention to internal factors, albeit in terms of generalized, abstract opposites of concrete historical development in the West. Left with the modernization perspective alone, we would know little or nothing about the impact of colonialism, the slave trade and neo-colonialism on development. So too, left to the dependency perspective, we would know very little or nothing about tradition, culture and individual (and group) achievement motivational capacities on social and economic development and underdevelopment. Modernization can therefore complement dependency in removing these oversights.

A set of related propositions has been formulated to guide this study, in an effort to find empirical answers to the questions raised above: As a way of testing the complementarity of these theories we need

the two: e.g. from the dependency theory it can be hypothesized that:

1. The problem of underdevelopment in the Third World cannot be separated from colonialism and neo-colonialism. The former set it in action and the latter continues to sustain it. Therefore underdevelopment of the health sector in Nigeria and other Third World countries is caused by the same factors that have caused the general underdevelopment of these countries.
2. From the modernization theory one can hypothesize that diffusion of entrepreneurial values and beliefs affects development. However the dependency theory argues that the diffusion of entrepreneurial values and beliefs to developing countries in general and Nigeria in particular has exacerbated the underdevelopment of health services.
3. From the dependency theory it can be hypothesized that conflicting interest groups affect development. For example, the indigenous elite of the Third World who plan the economy and in fact the health care sector are controlled by Western powers. They (indigenous elite) plan to safeguard their own interests and that of the Western imperialists, and therefore perpetuate the underdevelopment of health services.

It is intended that proposition 1 will guide the discussion of why the Third World countries are underdeveloped and why health care services are also underdeveloped. Underdevelopment of health manifests itself in problems of unequal distribution of health care services,

and access constraints such as roads.

Proposition 2 will guide discussion of the impact of entrepreneural values on the health care services. For example, the competition between Western Scientific medicine and traditional medicine; and the impact of the competition on health care. The commodification of medicine,(using medical skills as commodities), the emergence of medical dominance and their impact on health care will also be considered.

The last proposition will guide the discussion of class differences and the delivery of health care services. This proposition argues that, the indigenous elite are themselves developed and often don't care about the underdevelopment of the masses. Their position in the society has enabled them to promote underdevelopment rather than development.

(e) Methodology: Measuring the Impact of Development on Nigerian Health Care Services

This is intended to be a library research based on the analysis of data from secondary sources. Perhaps it might be appropriate now to point out the problem of obtaining statistical data (Vital Statistics) especially in countries of the Third World such as Nigeria. Vital statistics are never properly kept, and their (Vital Statistics) absence sometimes poses analytical limitations to some important research concerns.

To investigate the first proposition historical data will be generally employed to analyse or investigate the cause of underdevelopment in the Third World, and especially in Nigeria. That is to say, infor-

mation will be extracted from the works of researchers and authors such as Frank, Rodney and Davidson. These authors have tried to relate the underdevelopment of the Third Wrold countries in South America, Asia and Africa to slave trade, colonialism and neo-colonialism. Researchers such as Peter Lloyd have related particularly the impact of neo-colonialism on the Nigerian socio-political economy. These sources will be used to guide the discussion of why the Third World countries like Nigeria are underdeveloped.

A measure of the general consequences of underdevelopment of Third World will be done by comparing them (Third World) with developed countries using variables such as GNP per capita in dollars, percentage of population with access to safe water, sewage system, daily per capita calorie supply as percentage of requirement, adult literacy rates and annual natural increase in population. These variables will clearly portray the consequences of underdevelopment in the Third World.

The underdevelopment of health in the Third World will be measured by using epidemiological data - morbidity rates, death rates, infant mortality rates and the general pattern of diseases. Attempts will be made to compare developed countries such as Canada and the U.S.A. with the developing countries such as Nigeria and Tanzania using variables such as population-physician ratios, available health care units, bed-population ratios, admissions per thousand and life expectancy at birth. The effective comparison of health personnel and hospitals in developed countries e.g., Canada and developing countries e.g., Nigeria will explain adequately the problem and nature of the underdevelopment of health care services in the Third World.

To investigate proposition 2, an attempt will be made to show the relative impact of entrepreneural values on the Nigerian society. For example, it might be accurate to investigate the current position of traditional healers now that modern medicine dominates in Nigeria. The number of doctors, nurses and health facilities will explain to what extent entrepreneural values have been diffused. Efforts will be made to look at the commodification of health by physicians and the medicalization of the Nigerian Society. Data concerning these issues will be obtained from personal correspondence with the WHO and other agencies such as Ministry of Health, Lagos, Nigeria. Some information will be adapted from Journals - such as Social Science and Medicine and from other publications such as World Bank Policy Papers on Health.

To investigate proposition 3 (role of indigenous elite) similar sources will be consulted. Attention will be paid to the distribution of health and other social services such as physicians, water supply, housing, schools, electricity, markets etc. to see if they reflect any class differences.

In each of the 3 propositions, epidemiological data, health utilization patterns etc. will be used to show underdevelopment of health services.

NOTES

1. M. Hoogvelt, Sociology of developing societies, London, McMilliam 1978, p. 145-165. He has reported that between 1960-1970, there were 11 coups d'etat in Africa which were in some cases followed by counter coups. From 1960-1975, Nigeria alone had 5 coups d'etat.

2. For a comprehensive look at the Characteristics of underdevelopment see Gunnar Myrdal: Asian Drama, Penguin books 1968 and A.R. Desai. Essays on The Modernization of Underdeveloped Societies. Bombay, Thacker and Co. Ltd. 1971, Introduction (p. vi-viii).

3. The work of Parsons, Suchman and MauriceKing represents such approaches eg. see Maurice King (ed.) Health Care in Developing Countries: A Symposium from Makare, Nairobi Oxford Press 1966.

4. Vicente Navarro. Medicine Under Capitalism, (New York, Neale Watson 1976), p. vii.

5. H. Waitzkin and B. Waterman. The exploitation of Illness in Capitalist Society (Bobbs-Meril Company Inc.) Indianapolis 1974, p. 8.

6. A.R. Desai (ed.) op.cit. has categorised theories of change and development in five groups. In my grouping, Psychological Theories are ommited because, they are not relevant for my goal. Marxists and other critical theorists are grouped under conflict approach.

7. A. Radcliff Brown, Structure and function in primitive societies. Glencoe Ill. The Free Press, 1952, B. Malinowski, Dynamics of Culture Change, New Haven, Yale University Press, 1945.

8. T. Parsons, The Social System, Glencoe Ill. The Free Press, 1957.

9. B. Hoselitz, Social Stratification and Economic Development: "International Social Science Journal," Vol. 16, No. 2, 1964.

10. J. Steward, A neo-evolutionarist Approach: Social Change: Sources, Patterns and Consequences by Etzioni, New York, Basic Books, 1964, p. 133.

11. S. Vago, Social Change, New York, Holt, Rinehart and Winston, 1980, p. 24.

12. A. Comte, "The progress of civilization through three stages." In Etzioni (ed.) op. cit. p. 15-16.

13. Ibid, p. 19.

14. Ibid, p. 20.

15. H. Spencer, "The Evolution of Societies," In Etzioni (ed.) op. cit. p. 14.

16. S. Vago, op. cit., p. 36.

17. Ibid, p. 37.

18. Etzioni, op. cit., p. 15.

19. R. Redfield. "The folk Society" American Journal of Sociology, 52, 1946, p. 294.

20. A. Redfield, The folk culture of Yacaton, Chicago, Univ. of Chicago Press, 1941, p. 369.

21. Among major critics are: A. Etzioni (ed.) op. cit. p. 80. Eisenstadt in Etzioni (ed.) Ibid, p. 375; Bock in Etzioni (ed.) Ibid, p. 231-232, Quotation is on p. 80.

22. Ibid, p. 231.

23. W. Rostow, Stages of Economic Growth. A non-Communist Manifesto.

24. Ibid, p. 4.

25. Ibid, p. 4.

26. Ibid, p. 5.

27. Ibid, p. 6. If the characteristics of Rostow's Traditional society are seen in some Third World countries as he (Rostow) argues, then it means such societies have never changed in history, which is not true of any society.

28. Ibid, p. 6.

29. Ibid, p. 6.

30. Ibid, p. 71.

31. Ibid, p. 8.

32. Rostow considers such countries as Argentina and Venezuela to be at the take-off stage. But he is not certain if these are really at take-off.

33. Ibid, p. 10.

34. Ibid, p. 11.

35. Ibid, p. 20.

36. Ibid, p. 20.

37. Gunder Frank, The development of underdevelopment, New York, Monthly Review Press, 1969, p. 40-47.

38. Ibid, p. 40-47.

39. Ibid, p. 40.

40. Jawaharlal Nehru- The discovery of India, New York, 1946, p. 306. Quoted from Paul Baran, The political Economy of growth, New York, Monthly Review Press, 1957, p. 149-50.

41. There are several studies which show clearly that Europe and in fact the developed countries developed because of cheap raw materials and wealth from the Third World Countries. See footnotes, 31-35.

42. Basil Davidson, The African Slave Trade. Old Africa Rediscovered. London, Gallanex, 1959.

43. Walter Rodney, How Europe Underdeveloped Africa, Washington, Howard Univ. Press, 1972.

44. Frank, op.cit.

45. Vicente Navarro, op. cit., He draws more from the work of Andre Frank op. cit.

46. Thomas Mun, Englands Treasure by Foreign Trade, Oxford, Basil Blackward 1959. Quoted from Gunder Frank, op. cit. p. 46.

47. Karl Marx, Capital Vol. III. Moscow Foreign Language Pub. House (n.d.).

48. Earl Hamilton, "American Treasure and the rise of Capitalism:" In Economics London 27, 1979. American Treasure and the Price Revolution in Spain. 1501-1650, Cambridge, Howard Univ. Press, 1934.

49. Frank, op. cit., p. 46.

50. Percy Cohen, Modern Social Theory, London, Heneimann, Pub. Co. 1968, p. 34-35.

51. Ibid, p. 37.

52. Ibid, p. 45.

53. Bert Hozelitz, op. cit.

54. T. Parson, The Social System, op. cit.

55. In his use of the pattern variables, Hoselitz eliminates two of the five contrasting pairs of value orientation earlier suggested and used by Parsons. Hoselitz does not include in his analysis affectivity vs affective neutrality and self orientation vs collectivity orientation which Parsons uses.

56. M. Hoggvelt, op. cit., p. 55.

57. Frank, op. cit., p. 20. For Japan see James Abegglen, The Japanese Factory, Glencoe Ill, The Free Press, 1958.

58. Frank, op. cit., p. 26.

59. Ibid, p. 26.

60. David Franick, The Red Executive, Garden City, Doubleday, 1960. He compares American and Soviet management and maintains that in America the roles of the poor and the bourgeoisie are ascriptive.

61. M. Harrington, The Other America, Poverty in the USA. New York, McMillian 1963. See Gabriel Kolko, Wealth and Power in America: An Analysis of Social Class and Income Distribution, New York, Praeger, 1962.

62. This is a result of studies conducted by James Abegglen in Japanese factory. It is quoted in Gunder Frank, op. cit.

63. M. Hoogvelt, op. cit., p. 56.

64. Frank, op. cit., p. 27.

65. C. Wright Mills, The Power Elite, New York, Oxford Univ. Press, 1956. The portion is quoted from G. Frank, op. cit. p. 27.

66. Frank, op. cit., p. 36.

67. Manning Nash, "Editorial." Economic Development and Cultural Change 1, 1 1952, p. 4. This viewpoint is also stated by Hoselitz in the same volume, in his article "Non economic barriers to economic development," p. 10.

68. Rostow, op. cit.

69. Frank, op. cit., p. 48.

70. Rostow, op. cit., p. 6-8.

71. Paul Baran - Political Economy of Growth. See Chapters 5-7, p. 134-148.

72. Frank, op. cit.

73. V. Navarro, op. cit., Chapter 1-2.

74. Harry Magdoff, The Age of Imperialism, New York, Monthly Review Press, 1969, p. 150. Quoted in Frank. op. cit. p. 49.

75. A.E. Safarian. Foreign Ownership of Canadian Industry. Toronto McGraw Hill, 1966, p. 235-241.

76. This is a summary of Frank's criticism of the capital diffusion thesis. Emphasis added. See Frank op. cit., p. 49-51.

77. Mejia et al. Physician and Nurse Migration Analysis and Policy Implication, Geneva, WHO Pub. 1979.

78. Patricia Marchak, Ideological Perspective on Canada, McGraw Hill, Toronto, 1981, p. 1.

79. Gunder Frank, On Capitalist Underdevelopment. Bombay, Oxford Univ. Press, 1975, p. 29.

80. The Nigerian Concord, 1981, See front page "Land Scandal."

81. M. Hoggvelt, op. cit., p. 109.

82. Frank - On Capitalist Underdevelopment, p. 34.

83. Benard Blishen, Doctors and Doctrines: The Ideology of Medical Care in Canada, Toronto, Univ. of Toronto, 1969.

84. A.R. Desai, op. cit., p. xv.

85. S. Vago, op. cit., p. 40.

86. Karl Marx - quoted in Dahrendorf- Preface to Democratic Theory, Chicago, Univ. of Chicago Press, 1956, p. 27.

87. Karl Marx, The German Ideology, Part 1, in Marx-Engels Reader 2 ed. by Robert Tucker, (ed.) New York, Norton & Company, 1978, p. 154-155.

88. Karl Marx and F. Engels, Manifesto to the Communist Party. In Marx-Engels Reader. Ibid, p. 473-474.

89. A.R. Desai, op. cit., Introduction p. xiv.

90. A.R. Desai, Ibid, p. svi. Introduction. This view is best represented by Marx - Capital and On colonialism (ed.) by Moxcow, Foreign Lang Press, 1960, V. Lenin, Imperialism the highest Stage of Capitalism. London, Lawrence and Wishard, 1919. Modern authors who subscribe to this view include Paul Baran. The political Economy of growth, op. cit., A.G. Frank, op. cit., M. Hoogvelt, op. cit.

91. A.R. Desai, op. cit., p. xvi, Introduction.

92. Lewis Coser, The Functions of Social Conflict, London, Routledge, 1956.

93. Ralf Dahrendorf, A preface to democratic Theory, Chicago, Univ. of Chicago Press, 1956, p. 176.

94. Bert Hoselitz, The progress of underdeveloped Areas. Chicago, Univ. of Chicago Press, 1952, p. vi.

95. B. Higgins, "The dualist theory of Underdevelopment". Economic Development and Cultural Change 4, 2 1956.

96. Gunder Frank, op. cit., p. 9.

97. Manning Nash, op. cit., p. 10.

98. Gunder Frank, op. cit., Preface PX.

99. K. Malina, "Overcoming Underdevelopment." World Marxist Review. May 1978, p. 51. Paul Baran, A.R. Desai and Vincente Navarro and Frank all subscribe to this view.

100. H. Waitzkin and B. Waterman, op. cit., p. 8.

101. Ibid, p. 16.

102. Vicente Navarro, op. cit., Introduction p. vii. The same view is expressed by O. Erinosho - "Health Planning in Nigeria." Paper presented at Nigerian Anthropological and Sociological Association, March 29-April 1, 1981, p. 4.

103. Zasha James. Term Paper in Sociology of Development. McMaster University, Hamilton, 1981, p. 10.

CHAPTER TWO

THE NATURE OF HEALTH SERVICES IN THE THIRD WORLD

In the preceding Chapter, alternative theoretical approaches to an understanding of the causes and consequences of underdevelopment were reviewed. This chapter will now discuss some of the practical problems which face the health care sector in certain underdeveloped countries today. Health care in Nigeria will then be analysed in the context of general underdevelopment and health cares services in the Third World.

Just as there are economic, social and political differences between the countries of the Third World, there are also substantital differences between their health care systems. According to the World Health Organization, Latin American countries such as Argentina and Venezuela have better health care services than Asian countries such as India (which in turn are better than African countries like Nigeria). The World Health Organization further shows that countries in Africa (Mali, Niger, Uganda) are below the World's minimum health level.[1] In total, health care services in the Third World (Latin America, Asia and Africa) are generally inferior to that in the affluent countries such as Canada.[2] The extent of this inferiority can be demonstrated by epidemiological data - morbidity rates, death rates, doctor-population ratios, access to health services, number of beds for a given population, etc.

Although some privileged individuals in the Third World have satisfactory health care services for themselves, the general condition of the health care system is deficient with insufficient physicians, beds, and other facilities resulting in high infant and adult mortality rates, and high morbidity rates.

(a) Measurement of Health Status in The Third World[3]

The following table shows a measure of health status in various regions of the World. Developed countries such as Canada have a population per physician ratio of 630 people; 130 people for each nurse; and 65 general hospital beds per 10,000 population. In the Third World, these rates are higher, eg. Mali in West Africa has one doctor for 33, 330 population, one nurse to serve 2,170 persons; and 1.4 beds for 10, 000 population. With this low level of health status, Mali is still better than some African countries such as Upper Volta (see Table 1) which has a doctor-population ratio of 1.75,200 and 3,890 people for each nurse. In Niger, each doctor attends to 43,430 people and each nurse 4,650 patients. Countries such as Burundi, Ethiopia, Malawi, Rwanda and Chad have a physician-population ratio which ranges from a doctor for 43-86,000 population.

Other measures of health status are shown in Table 2. Developing countries have high birth rates while developed countries have low birth rates e.g. in 1977 Canada had 16 births/1,000 women while developing countries such as Nigeria had 49 births/1,000 women. In the same year, Canada had an infant mortality rate of 15 infants/1,000; while Nigeria

TABLE 1

HEALTH RESOURCES IN SOME REGIONS OF THE WORLD

	Pop./Phys.	Pop./Nurse	Gen. Hosp. Beds/10,000
North America			
Canada	630	130	65.7
U.S.A.	600	100	48.1
North Africa			
Libya	1,260	410	11.7
Morocco	13,830	-	25.0
West Africa			
Ghana	12,390	780	3.7
Upper Volta	75,200	3,890	2.3
East Africa			
Kenya	5,800	900	-
Malawi	85,830	5,210	4.1
Middle Africa			
Gabon	5,210	540	11.4
Chad	63,180	8,300	4.1
South Africa			
Swaziland	8,040	540	11.4
Lesotho	24,610	3,210	3.4
Latin America			
Panama	1,420	1,440	21.3
Guatemala	4,430	6,000	17.5
Caribbean			
Cuba	1,150	670	19.9
Haiti	12,310	8,950	4.0
Tropical South America			
Guyana	3,950	1,030	25.6
Venezuela	950	420	15.3
Temperate South America			
Argentina	480	1,640	38.3
Chile	2,230	3,290	20.0
Southwest Asia			
Israel	360	240	34.5
Yeman (Peoples Republic)	32,380	1,940	3.6
Middle South Asia			
Iran	3,040	1,760	5.8
Nepal	49,770	35,600	
Southeast Asia			
Singapore	1,410	330	20.2
Portuguese Timor	25,580	4,040	13.6
East Asia			
Mongolia	520	200	38.0
Taiwan	3,170	4,260	1.5
North Europe			
Denmark	620	120	60.5
Ireland	850	160	39.4
West Europe			
Austria	520	320	-
Luxembourg	930	350	58.0
East Europe			
Hungary	480	230	43.0
Romania	830	460	49.1

Source: Adapted from Timothy Baker Assessment of Health Status and Needs: New York, Spyinger Publishing Company, 1977, p. 49-55.

Notes: Nurses include Midwives. In each region, two countries were selected. One with the lowest and the other with the highest rates on these indicators of health status.

had a rate of 163/1,000. In 1977, the World average rate of infant mortality was 103/1,000 and birth rate was 30/1,000.

Death rates in the Third World countries are also higher. For example, the average death rate in North America is 9 persons per 1,000 population, while in Africa the average rate is 20,/1,000. (In Asia the average death rate is 14, in Europe the death rate is estimated at 10/1,000).

Life expectancy at birth in the Third World is generally low. In North America, e.g. U.S.A., the life expectancy at birth is 72 years, while in Africa, e.g. Mali, it is as low as 38 years. It is slightly higher in Asia, e.g. India has 50 years and other Asian countries such as Kuwait, Lebanon and Sri Lanka have up to 64 years life expectancy. In South America, average life expectancy at birth is estimated at 68 years in Argentina and Uruguay. It is slightly lower in some other South American countries like Peru and Bolivia.

The amount of money voted for health care services in the Third World is also lower than that in the developed World eg. U.S.A. This is because the developing countries generally have low per capita income, e.g. Canada had a per capita income of U$1,460 in 1976, while African countries such as Central African Republic, Niger, Rwanda and Mali had a per capita income of $30 or less in the same year. In other parts of the developing world like Bangladesh and Cambodia, the per capita in 1977 was less than US $100. The developing countries spend only a very small percentage of their GNP on health care, e.g. Morocco voted 3.3% of its national expenditures for health; Sudan spent about 1.6%; Pakistan spent 1.8%. In the developed countries, e.g. Germany (the Republic of) 19.6% of GNP was devoted for health expenditure in 1976. In the U.S.A. 9.7% was voted for health in 1976. This reflects a Socialist-Capitalist difference as well as developed vs underdeveloped.

The implication of the small percentage of GNP voted for health expenditure in the Third World is poor health status. For example, lack of money allows only a few persons in the developing countries to have

TABLE 2

MEASURES OF HEALTH STATUS IN REGIONS OF THE WORLD 1977

Region	Birth Rates/1000	Natural Increase (% Annually)	Death Rates/1000	Infant Mortality Rates/1000	Pop. under 15 yrs.	Life Expectancy at Birth	Per Capita GNP US
World Average	30	1.8	12	103	36	59	1530
N. Africa	42	2.8	14	130	44	53	570
W. Africa	49	2.6	23	175	45	42	300
E. Africa	46	2.7	19	151	44	45	220
Mid. Africa	44	2.3	22	165	43	42	270
S. Africa	46	2.5	16	119	41	51	1220
S. Asia	42	2.8	14	114	44	55	1370
Mid. S. Asia	37	2.3	14	125	41	49	200
S.E. Asia	38	2.4	14	116	43	52	260
E. Asia	26	1.6	9	16	26	72	820
N. America	15	0.6	9	16	26	72	7020
Mid. America	42	3.4	8	70	46	62	1062
Caribbean	30	2.1	9	75	41	64	970
Tr. S. America	37	2.8	9	84	43	61	960
Tp. S. America	23	1.3	9	63	31	67	1340
Oceania	22	0.3	9	55	32	67	4490
N. Europe	15	0.4	10	22	24	71	4090
W. Europe	12	0.1	11	15	23	70	6150
E. Europe	18	0.7	11	26	23	70	2800
S. Europe	17	0.8	9	26	26	71	2470

SOURCE: Adapted from Timothy Baker, Ibid, p. 49-55.

NOTE: The lower the population of those under 15 years of age, the better the health care services. See Europe and N. America.

decent water or access to health care services. Public health and health education are also not funded adequately.

The differences in life expectancy at birth, crude death rates, infant mortality, population per physician and nurse ratios between the developed and the developing countries clearly indicate that the Third World countries have a lower standard of living and a disadvantaged health status.

(b) Pattern of Diseases

The World Health Organization (WHO) is not impressed with the nature of health care in the Third World. The 6th Report on world health stated that:

> "As regards the many diseases that plague the less developed countries, there appears to have been little or no progress in recent years in reducing either their incidence or their prevalence. The threat posed by such diseases like Malaria, Schistosomiasis, filariasis, trypanosomiasis, leishmaniesis, cholera and leprosy has either not lessened in recent years or has actually increased. The incidence of foodborne diseases, sexually transmitted diseases ... seems to be increasing.[4]

The report also indicated the debilitating and often fatal consequences of widespread nutritional deficiencies. The malnutrition and infections, parasitic, and respiratory diseases that have been largely eliminated in the more developed countries are still the principal source of suffering, disability and death in the less developed regions of the world.[5] The World Bank policy paper on health has shown a similar pattern of diseases in the Third World.

The World Bank points out that the most widespread diseases in developing countries are those transmitted by human feces -- the intes-

TABLE 3

PERCENTAGE DISTRIBUTION OF DEATH BY CAUSE IN TWO MODELS

	Model Developing Country	Model Developed Country
Infectious, Parasitic and Respiratory Disease	47.3	10.8
Cancer	3.7	15.2
Diseases of the Circulatory System	14.8	32.2
Traumatic Injury	3.5	6.8
Other Causes	34.3	35.0
All Causes	100.0	100.0

SOURCE: Adapted from World Bank Health Policy Paper 1980, p. 13.

NOTE: The main cause of death in developing countries is infectious diseases and the main cause of death in developed countries is Diseases of Affluence.

tinal parasitic and infectious diarrheal diseases. Poliomyelitis, typhoid and cholera are also common.[6] Dysentery and amoebiasis, enteritis and other diarrheal diseases were the leading identified causes of death in Paraguay in 1971, Guatemala in 1970 and El Salvador in 1971. From 1969-74, dysentery was the most common disease in Pakistan.[7] A case study in Punjab, India found a death rate of 3466/100,000 infants

from acute diarrheal diseases.[8] In Egypt, Iran and Venezuela, the monthly incidence of diarrhea among children of pre-school age has been estimated to be between 40-50%.[9] Basta and Churchill found 85% of the construction workers in Java, and Indonesia to be infected with hookworms.[10] Van Zijl's studies in Sri Lanka, Bangladesh and Venezuela showed 70% of the pre-school children infected by round worms and whipworm and at the age of 6, the infection rates for helminths were 95% in Sri Lanka, 97% in Bangladesh and 93% in Venezuela.[11]

The second major group of diseases in the Third World reported by the World Bank includes tuberculosis, pneumonia, diptheria, bronchitis, whooping cough, meningitis, influenza, measles, small pox and chicken pox. These diseases accounted for 29% of deaths in Guatemala in 1975, and 16% in Chile. In the Caribbean, 70% of the deaths were caused by fecally-related diseases, airborne diseases and malnutrition.[12]

Some of the diseases are restricted to certain geographical areas. For example, vector borne diseases like malaria are more prevalent in the tropics. Onchocerciasis is the most common in West Africa. Schistosomiasis is more common in East Asia and in irrigated areas of Africa and South America, than in West Africa. Robert Stock in his book Cholera in Africa shows the high incidence and prevalence of cholera in West Africa.[13] In Nigeria, the city of Lagos alone reported 922 cases of cholera in 16 weeks in 1971. The Malaria infection rate is also quite high in Africa. In 1972 Willer reported 15,247 cases of malaria per 100,000 in Central African Republic and 11,433/100,000 in Senegal.

A similarly high rate is found in Upper Volta of 10,439/100,000. In Uganda, there were 1.6 million cases of malaria in a population of 10 million.[14]

Malnutrition is a serious health problem in the Third World, responsible for many diseases and the death of children under five years of age in Africa, Asia and Latin America. The impact of malnutrition on health care will be considered later in this chapter.

Generally, it is not easy to compare either the incidence or prevalence of diseases within the countries of the Third World; because of the absence of vital statistics. The pattern of diseases in the Third World suggests that diseases are influenced by many factors including the climate, cultural practices, and socio-economic characteristics of the population.[15] It must, however, be noted that the most common diseases in the Third World are those that can be eliminated. These are called "known available mortality."[16] Given more attention to health care, more education, more food and improved living conditions, these diseases can be eliminated. Perhaps Maurice King is accurate in his assertion that the main determinant of the pattern of medical care (and diseases) in developing countries is poverty, rather than a warm climate.[17]

The living environment of an average person in the Third World plays a major role in disease causation. Contamination of food, water and soil with human waste is cited by Nyako,[18] The World Bank[19] and the World Health Organization.[20-21] Nyako[22] points out that such foods like fried fish, beans, cake etc. are "prepared and or sold in open places, usually dusty or muddy, filthy, stinking surroundings." He was commenting

on the interactions of environment and human beings as the causal factors of ill-health in his plateau village in Nigeria. He also mentioned the problem of drinking water, and water for other domestic use. Pipe-borne water is not sufficiently available to people of the Third World; and it is completely absent in the rural areas. The rural inhabitants obtain water from streams, ponds and rivers which are never chemically treated and purified or boiled. Nyako gives a vivid description of his village:

> "Uncovered wells are observable -- latrine pits are still largely unknown and little employed, instead human excreta is freely discharged in the bush by adults and the backyard by children. When the rains come, the earth's surface is cleaned of all this accumulated waste which almost inevitably flows into the nearby rivers, streams, ponds and wells ... water from these sources unless chemically treated, or at least boiled is unfit for human consumption. Drinking water is thus a potential health hazard."[23]

This type of situation is known to be responsible for the cause of typhoid, dysentery, cholera and diarrhea. Lack of water in the cities causes even more harm. Partly due to a lack of water and poverty, most town dwellers resort to using buckets and pit privies and septic tanks which are not connected to a public sewer system. Even among the rich countries of the Third Worlk like Libya, Kuwait, Quater, Iraq, Brazil,

and Venezuela, facilities connected with city sewer systems are not widespread. Most of the modern facilities like pipe-borne water, sewage systems and good housing are limited to only a few persons in privileged positions. Pipe-borne water and sewer systems are also used in public schools and colleges, government and company offices. A conservative estimate by the World Bank shows that 66% of people in the Third World depend on polluted river water and wells and 33% have access to some public stand posts and only the middle and high income groups use more sophisticated facilities. Table 4 shows the percentage of population with access to community water supply and excreta disposal in selected countries of the Third World. In Indonesia only 11% on the population has access to water supply. In Ethopia only 8% of the population has access to water supply.

Surveys of water supply, environment and health have been conducted by both the World Health Organization and the World Bank.[25-26] The published results of both show a relation between Socio-economic level of a country and inhabitants' access to water supply and sewage. In the Philippines, there was 70% cut in the incidence of Cholera when water and toilet facilities were improved.[27] Van Zijl in his study of seven countries agreed that developing countries reduce the incidence of diarrheal diseases by better water supply and sanitational facilities.[28]

Access to safe water supply and excreta disposal services affects health even among people in developed countries. For example, Schliessman's studies of Kentucky and California in the U.S.A. indicate that the incidence of dysentery in children varies dramatically depending

TABLE 4

ACCESS TO COMMUNITY WATER SUPPLY AND EXCRETA DISPOSAL SERVICES FOR SELECTED DEVELOPING COUNTRIES

(% OF POPULATION SERVED)

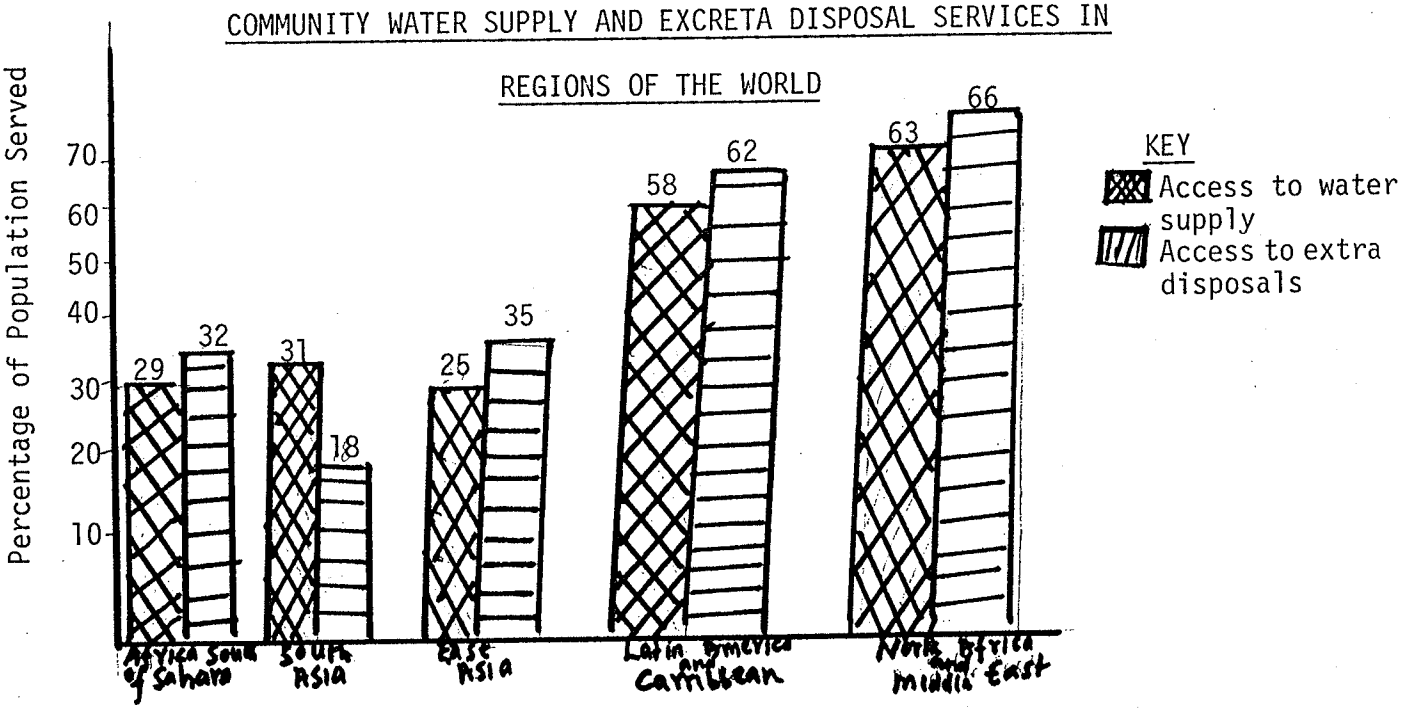
Selected Countries	Water Supply			Excreta Disposal		
	Urban	Rural	Total	Urban	Rural	Total
India	80	18	31	87	2	20
Ethiopia	58	1	8	56	8	14
Zaire	38	12	19	65	6	22
Pakistan	75	5	25	21	N/A	6
Tanzania	59	36	38	100	4	10
Indonesia	41	4	11	60	5	15
El Salvador	89	28	53	71	17	39
Philippines	82	31	50	70	44	56
Ghana	86	14	35	95	40	56
Chile	78	28	70	36	11	32
Turkey	74	64	68	13	5	8
Uruguay	100	87	98	97	17	83
Iraz	100	11	66	75	1	47
Costa Rica	100	50	72	94	93	93

SOURCE: Report by Director General WHO 1976: From World Bank Sector Paper 1980 p. 24. Total refers to Total Population Served.

NOTE: The total percentage of people with access to water and excreta disposal in these countries is generally lower than developed countries. The percentage of the rural population in developed countries is even lower than developing countries.

on the water and sewage standards of dwellings. The incidence among children living in dwellings with inside water supply, but outside privies was twice as great as for children in dwellings with inside flush toilets.[29] The situation in developing countries is even worse than that in California and Kentucky shown by Schliessman. This explains why the main cause of death in developing countries is from "the intestinal parasitic and infectious diarrheal diseases".[30] Figure I shows a percentage of people with access to water supply and access to excreta disposal in the Third World. Latin America, Asia and Middle East have more water and excreta disposal facilities than Africa and their health is consequently better than Africa.

Figure I



SOURCE: World Bank, Sector Policy Paper on Health 1980, p. 25.

Housing is another problem that affects the health of people in the Third World. The houses are not only located in an unsanitary enviornment but are also insufficiently ventilated. The World Bank notes that:

> ... in addition to poor sanitation and water supplies, very sizable proportions of the total population of cities in developing countries live in sub-standard dwellings lacking space, ventilation and sunlight ... which increase the incidence of air-born diseases.[31]

This short discussion has so far shown that the pattern of disease in the Third World is associated with underdevelopment.

Both Table 4 and Figure 1 have shown how underdevelopment affects the health care sector in the Third World. For example, only 31% of the population in India has water supply and only 20% has excreta disposal services and Chile supplies 70% of its population with water and 32% with excreta disposal services. India's health status is at a greater disadvantage than Chile which has more of these facilities. Similarly, India's health status is better than Indonesia where only 11% of the population has water supply and 15% has excreta disposal services. Table 4 also shows the rural-urban difference. For example, out of the 31% population in India served with water supply, 80% are in urban areas and out of the 20% population with extra disposal services, only 2% are served in the rural areas. In this case too, the

health status of Indians who live in urban areas is better than those in the rural areas. This clearly shows that, underdevelopment affects the health sector in the Third World; and consequently contributes to poor health status of people in Third World countries.

(c) Organization and Delivery of Health Services

The present structure of health care in the Third World is a colonial invention. The colonial governments established health care services in their colonies before they granted independence to them. The Third World eg. Nigeria has maintained the structure left behind by the European imperialists. Changes in health care in these nations have occurred, but the structure remains essentially the same.

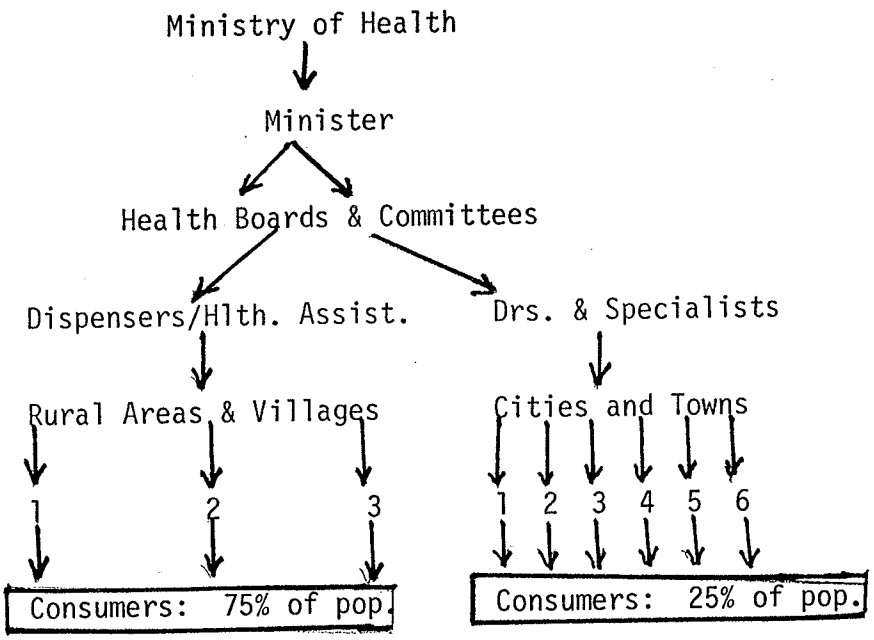
In the colonial structure, hospitals were built in the urban centres and dispensaries in the rural areas. In the urban areas, there were specialist hospitals for the use of colonial administrators and general hospitals for the general public. The picture is the same today except that more hospitals have been added in the cities and more dispensaries in the rural areas. Recently,[32] The World Health Organization (WHO) introduced primary health centres for the rural areas, but these are conceptually similar to the dispensaries, and are manned by the same category of staff. Some dispensaries have only been renamed, with no change in the physical structure, staffing and sphere of duties. Since there are no hospitals in the rural areas, there are no doctors either.

There are ministries of health and health commissioners or ministers.

All responsibilities and co-ordination of health care services are within the purview of the Ministry of Health. There may be more committees and Commissions within the ministry of health, or affiliated with it, but the basic structure remains the same. For example, Nigeria has a Committee for the Implementation of Basic Health Services and the National Health Council, all being structures within the Ministry of Health.

Figure II

STRUCTURE AND ORGANIZATION OF HEALTH CARE IN NIGERIA



NOTES

1. Dispensaries
2. Basic Health Clinics

1. General Hospitals
2. Teaching Hospitals

continued ... 77

3. Rural Health Centres	3. Specialist Hospitals
	4. Missionary & Company Hospitals
	5. Private Hospitals
	6. Mental, Orthopedic, Maternity Pediatric, Eye, Dental, etc. Hospitals.

In Figure II the dual structure shows physicians and hospitals in cities and health assistants and dispensaries in rural areas.

The structure allows unequal distribution of available health care services among members of the population. Because of inadequate money and facilities, the developing countries like Nigeria and Kenya do not have the same health standards as developed countries such as Canada. Maurice King has reported that "a developing country is fortunate if it has as few as 15,000 patients for each of its doctors or can spend more than one dollar a year on the medical care of each of its people."[33] Though the situation now is better than it was when Maurice King reported 15 years ago, lack of basic facilities continues to be a problem in the Third World. Many countries in the Third World have a pouplation per physician ratio of more than 1:20,000, such as Niger, Mali and Chad. In West Africa the ratios are large, ranging from Liberia and Guinea Bissau with a ratio of 1:10,000 to Upper Volta where one doctor serves 75,000 patients. Apart from South African Republic, no African country has less than 4,000 patients per doctor and not less than 1,000 patients per nurse except for Libya and Egypt. South Africa has 400 patients per

nurse. In South America, all countries have less than 5,000 patients per doctor. Countries such as Argentina, Venezuela and Puerto Rico have less than 1,000 patients per doctor and less than 500 patients per nurse. Israel has one doctor to 360 patients and 240 patients for each nurse.[34]

Nepal, Yeman Arab Republic, Yemen People's Republic, Indonesia and Portuguese Timor have the highest ratios in the Asian continent, each with one physician per 23,000 patients. East Asian countries like Hong Kong, Japan, Korea and Mongolia have very low ratios which compare favorably with Western countries of Europe and North America all of which have less than 1,000 patients per physician.[35]

While many countries of the Third World eg. Nigeria have impressive figures of hopsitals and other health facilities, only very few persons in these countries have access to them. (see Table 9-11). This situation exists because the urban areas have most or all of the facilities, and if ratios were calculated on the basis of real users of the facilities, they would be lower. In Ghana, 62% of the country's physicians were in the urban areas in 1969, but only 15% of the population was living in the urban areas at that time. The Greater Accra Metropolitan area in the same period had 23% of the nation's hospital beds but its population was only 9% of the total population.[36] Hospitals are generally insufficient in numbers and some of those that exist lack even the basic amentities. Hospitals lack basic facilities like ambulances and some have not even have needles.

A dearth of drugs, beds, electricity, water and personnel makes

the problem complicated and in some cases hopeless. Margaret Murphy[37] and (also Maurice King) indicated that donkeys and bicycles are used to convey patients from their homes to the nearest hospital in a radius of 50 miles or even 100 miles in Northern Nigeria. A young doctor in East Africa has written about his experience which is germane to this topic. He noted about his hospital:

> "The hospital had a hundred beds and there was one other doctor though he mostly looked after the district and the administration (like European colonial doctors who were usually Assistant District Officers besides Medical Officers). ... My problems were overwork, lack of equipment, lack of staff, shortage of beds and lack of diagnostic facilities. I had to look after the medical, surgical, maternity and children's wards ... I had one major operating day each week. I had to collect blood for transfusions, do many police post mortems ... I was needed in several places at the same time. ... Very few trained nurses and medical assistants were employed at the hospital. Only one medical assistant or a certified nurse was on duty each night for the whole hospital ... We did not have any Balkan beams, but I asked a carpenter to make one ... We did not have any pulleys ... I could not obtain any scalp

> vein needles, nor enough of the big ones for taking blood ... There were a pressure lamp in the theatre which attracted flying arthopods, these frequently hit the lamp and fell into the operation wound. There was one laboratory assistant, but he could not do a blood urea, a blood sugar, test for urolilinogen in the urine or count reticulocytes. He was also busy and could not cope with all the stools I wanted him to look at ... We were very short of beds, there were lots of floor cases and often two children in the same cot ... The premature babies had to be nursed at the general ward. There was no physiotherapist or social worker. It was difficult to look after paraplegics and impossible to discharge the homeless. There was no fence around the hospital and visitors came in at any time."[38]

This account represents an accurate picture of a typical hospital in the Third World, especially the category called "General Hospitals." General hospitals are seen as hospitals for the poor, and only a token fee is paid for service. In some countries like Nigeria, no money is paid to receive service at a general hospital. In the rural areas, some dispensaries virtually have no means of preserving available medicines. The distribution of drugs, pesticides and other health equipment is often another difficulty due to lack of motorable roads.

> "Mobile clinics frequently do not reach remote posts because vehicles break down or fuel is not available. In the absence of reliable services, the patients become frustrated and cease to rely upon the services of government facilities."[39]

The frustration of patients over the years has affected their attitudes toward the rural dispensaries. For example, a health facilities survey conducted in Northern Nigeria in 1980 found out that even the facilities that were available in the rural areas were not used effectively. There was a daily attendance of less than 100 persons for each dispensary serving 50,000 people. Many patients who visited the dispensaries were given only 6 tablets of aspirin, regardless of their complaints. Patients interviewed in the wake of their frustration revealed that they would visit a traditional healer next time.[40]

The services are often of doubtful value, provided by undertrained staff with inadequate equipment, a lack of supervision, low staff morale and casual distribution of available drugs and materials by community health workers are frequent problems. Many developing countries eg. Nigeria have free medical services, in principle, for all their population, but the actual number of people that benefit from them are critically small.

Emphasis is on curative medicine. Since physicians are at the helm of affairs in planning health care for these countries, they tend to emphasize building of hospitals, dispensaries and rural clinics as the main way of expanding health care to all. This may be due to their

professional training. Most physicians are to be found in teaching hospitals or specialist hospitals, while some general hospitals have one or none.

The drugs and other equipment imported by the Third World from the Western World are usually likely to be of inferior types, and drugs are often likely to be expired.[41] David Piachand has shown that each Third World country in 1975 spent an average of 1% GNP on medicines. Drugs comprised of 2.5% of total imports in Africa and South America and 1% in Asia. He reported an increase of 4.4% every year in expenditure on imported medicines.[42] In 1976 the developed countries exported $1915 million worth of medicines to the Third World. The present situation in the Third World becomes a source of income for the Western Countries, eg. USA who are sure of selling their drugs once they are produced.

An average physician in the Third World is trained according to Western standards. Until of late, most or all of Nigerian Physicians were actually trained in Europe and North America. The professional socialization these physicians undergo changes their view of the world. Shared understandings between physicians and their patients become quite difficult. The doctor is trained in a modern environment and becomes accustomed to electricity, pipe-borne water and other healthy equipment. He uses a clock or a watch to plan his time, the villager uses the position of the sun or other means to plan his time.

This situation invites conflict. For example, uneducated patients in the village find it difficult to adhere to medication periods of 9

a.m., and 12 and 6 p.m. And when they are given several types of drugs, with different doses, they face the dilemma of knowing which of the drugs should be taken twice a day and which requires two tables at a time. The pills may all appear similar to the patient whose inability to read constitutes a serious handicap. Drugs and prescriptions are usually stopped once symptoms disappear. The social distance between the doctor and his patient often constitutes another problem since the doctor tends to interpret certain cultural traits of the patients as symptomatic. For example, Hausa women, and especially those from rural areas appear extremely shy when they meet strangers such as 'the physician'. Although they (Hausa women) are culturally expected to be shy, physicians unaware of this expectation may misunderstand the shyness to be symptomatic. Shared understandings between physicians and their patients are necesary if problems of this kind are to be avoided.

The doctor in the Third World adopts the behaviour and style of doctoring in the Western world. They (doctors) do not only examine and diagnose, but also administer and control their hospitals. Unlike in Western countries where the administration of hospitals is directed by hospital administrators, physicians control both the administrative and medical life of hospitals in Third World countries. For example, the organizational structure of many Nigerian hospitals has no room for hospital administrators. In Teaching Hospitals the only hospitals where hospital adminis-

trators exit, there are usually power struggles between the Medical director and the hospital administrator. For instance, a medical director and hospital administrator may be involved in a feud over who should sign contracts for hospital buildings and supplies. Maurice King found out that physicians in the Third World prefer administrative work to medical tasks. He noted

> the supverision of child welfare clinics, the consultant role in an outpatient department major surgery in a district hospital, director of several hospitals is both a logical and more satisfying role for a doctor in the Third World than the routine task in any of these.[43]

The desire by physicians in Third World countries to combine administrative and medical tasks may have been copied from the colonial physicians who often had to be physicians as well as administrators. Implicitly, the behaviour and style of life of physicians in Third World countries is a colonial invention, i.e. the pattern of behaviour that was diffused to the Third World along with the medical skills. (entrepreneural values).

The Third World is also seriously affected by the rate of physician and nurse migration to the Developed World. The pull factor has been higher wages and better conditions of living which are not attainable in the Third World. Physicians and nurses therefore migrate to richer countries. Table 5 shows average number of physicians entering the USA

every year from the Third World. Most of the physicians (86%) that migrate from the Third World go to five main Western countries - USA, Canada, UK, Germany and Australia.[44] Every 5th physician and every 3rd hospital based practitioner in the USA is a foreign medical graduate.[45]

If the world's physicians were evenly distributed, there would be one doctor to 1,219 population, but today three quarters of the world doctors are in the developed world which constitutes one third of the world's population. The developed world also gains about 90% of migrant doctors. The main donors in the Third World are poor countries of Asia. India alone has 75,000 physicians abroad including 13,000 in U.S.A. and UK.[46] Philippines, Pakistan, Korea, Egypt and Bangladesh also have high physician migration rates to richer countries of the West.[47]

This pattern of migration of doctors reflects important differences between countries in terms of level and pattern of social and economic development. While many countries of the Third World eg. India produce enough manpower for their health services, they are unable to retain them. A.Mejia notes the role of development in this issue.

> beyond and above any individual push or pull force influencing migration or combination of such forces is the overall international problem of unequal development which manifests itself in structural maladjustment and inner disequilibrium in both the country of emigration and the country of immigration.[48]

TABLE 5

PHYSICIAN MIGRATION: AVERAGE NUMBER ENTERING THE U.S.A. EVERY YEAR FROM THE THIRD WORLD

Origin	Year 1965-69	Year 1970-73	Change
Asia	3336	3766	+13%
South America	572	776	+36%
Africa	233	353	+52%
Totals	4141	4895	

SOURCE: Adapted from A. Mejia et. al., Physician and Nurse Migration op. cit. p. 27. The migration rate of the developed countries are excluded from the table.

Ironically, the countries that lose the highest number of doctors to the Western World eg. India and Pakistan are those with very low GNP per capita, low life expectancy at birth and poor physician coverage per 10,000 population. For donor countries, the loss of physicians represents a lot of investment which could have gone into the training of simpler and cheaper forms of health manpower such as Medical Assistants who would have been employable as well as less inclined to emigrate.[49]

Traditional Versus Modern Scientific Medicine

Today 80-90% of the population of many developing countries receive their health care from the traditional healers. Doctors refuse to practice in the rural areas where the majority of the population resides, so these people continue to rely on traditional medicine. In fact, Oyebola has indicated that, even in places where modern hospitals and doctors are in good supply, traditional medicine is still patronized.[51] In Sri Lanka 10,000 traditional healers were registered in 1976 and 6000 were counted. In Sudan and Egypt traditional medicine is used on a large scale. India has 500,000 practitioners of traditional medicine.[52]

The biggest problem that confronts traditional medicine is the open confrontation and opposition by modern medical practitioners. Modern practitioners are skeptical of the efficacy of traditional medicine. Asuni feels that people who advocate integration of traditional and modern medicine are foreigners to the situation. He recommends more efforts at providing modern facilities and suggests traditional medicine be avoided because it presents a dilemma to the healer himself, the consumers and the modern practitioner.[53]

Another problem associated with traditional medicine is the lip-service paid to it by policy makers and politicians. To date official recognition of traditional medicine is still debated in some legislative houses in the Third World eg. Nigeria. Due to the absence of sufficient numbers of modern practitioners and the need for health care among the fast growing population of the nations of the Third World, traditional

medicine continues to be practiced. This topic warrants further attention and will be discussed in more detail in a subsequent chapter.

The focus of the next 3 chapters will be health care in Nigeria - a case study to explore in more detail the causes and consequences of underdevelopment. This task demands a closer look at one developing nation (Nigeria) and one sector of Society (health care). As indicated in Chapter 1, an attempt will be made in Chapter 3 "Health care in Nigeria: An Historical Review" to address the question - Why are health services underdeveloped in the Third World? The influence of historical factors (colonialism) upon the production and distribution of health goods and services among the people of Nigeria will be examined.

Chapter 4 "Health Care in Nigeria Today" will address the question What are the obstacles facing the development of the health sector in the Third World? This will examine the distribution of disease, organization and delivery of health services in Nigeria.

Chapter 5 "Unresolved Health Care Issues: Some Policy Recommendations will address the question - How can health services be developed in the Third World? A critical examination of issues such as commodification of health, class factors, rural-urban discrepancies will be attempted. Further attempt will then be made to recommend some policy changes in the Nigerian health care system.

NOTES

1. This can be seen in the available resources. Most countries of Latin America have a doctor population ratio of 1 doctor to 2000 patients. In Asia the average is 1 doctor to 10,000. For Africa, the average is 25,000 patients per doctor. See World Health Statistics Annual 1972, published in 1976, Vol. III, Health Personnel and Hospital Establishments. Further evidence of Africa's poor health status can be found in World Population Data Sheet- Population Reference Bureau Inc., 1337 Connecticut, N.W. Washington, D.C. And Timothy Baker, Assessment of Health Status and Needs. Springer Pub. Co., New York, 1977, p. 41-55.

2. Health Sector Policy Paper. World Bank, 1980, p. 5.

3. Data on this section are taken from World Bank, ibid, p. 67-85.

4. World Health Forum 22, 1981, p. 271.

5. Ibid, p. 271.

6. World Bank, op. cit., p. 13.

7. Ibid, p. 13.

8. Scrimshaw, N.S., Taylor, E.E. Interactions of Nutrition and Infection. World Health Monograph Series No. 57, Geneva, WHO, 1968, p. 240. From Ibid., p. 13.

9. Van Zijl, Studies of Diarrheal Diseases in Seven Countries. Bulletin of the World Health Org. 35, Geneva, WHO, 1966, p. 249-261.

10. Basta, S.S. and Churchill, A. Iron Deficiency America and the Productivity of Adult Males in Indonesia. World Bank Staff Working Paper No. 175, Washington 1974.

11. Van Zijl, op. cit., p. 249-261. Quoted from World Bank Health Policy Paper 1980, p. 14.

12. World Bank, op. cit., p. 14 Ibid., p. 14.

13. Robert Stock, Cholera in Africa, African Environment Special Report. International African Institute Publ. Clark Doble and Brendon St. London 1976, p. 68. See also appendix p. 97-ff.

14. World Bank, op. cit., p. 11-12.

15. For culture and disease see A. Segall, "Socio-cultural Variation in Sick Role Behavioural Expectations." Social Science and Medicine, Vol. 10, 1976, p. 47-51. For socio-cultural and Socio Economic Status, See World Health Forum, Vol. 2, 1981, p. 271-273. See also World Health Policy Paper, 1975, p. 15-18.

16. World Bank, op. cit., p. 11-12.

17. Maurice King, Medical Care in Developing Countries. Lusaka and Oxford University Press, p. 14.

18. J.A. Nyako, Malaria and Diarrhea: Case Study of Plateau State in Health Problems in Rural Africa, ed. Okello Oculi, ABU, 1981, p. 28-32, p. 34-35.

19. World Bank, op. cit., p. 13.

20-21. World Health Forum, op. cit., p. 265-271. This is inferred from those pages and not exactly stated.

22. Nyako op. cit., p. 30.

23. Ibid, p. 28-29.

24. World Bank, op. cit., p. 19.

25. Ibid., p. 19-20.

26. Ibid., p. 26.

27. Philippines Cholera Committee: Field Evaluation of Environmental Sanitation Measures Against Cholera, WHO Strategy of Cholera Control Table 5. Geneva WHO 1971, Ibid, p. 26.

28. Van Zijl, op. cit., p. 249-261.

29. D.J. Schliessman, Diarrheal Diseases and Environment. Quoted from World Bank, op. cit., p. 20.

30. World Bank, Ibid, p. 13.

31. World Bank Health Policy Paper, op. cit., p. 22.

32. 'Primary Health Care.' A joint report by the Director-General of WHO and the Executive-Director of UNICEF Geneva 1978. See also Wolfgang Birchman "Primary Health Care and Traditional Medicine" Social Science and Medicine, 13, 1979, p. 175.

33. Maurice King, op. cit., p. 11.

34. Timothy Baker, op. cit., p. 23-55, Adapted from different tables in his book.

35. Ibid., p. 23-55.

36. World Bank Policy Paper on Health, op. cit., p. 34.

37. M. Murphy and Tukur Baba. "Rural dwellers and Health Care in Northern Nigeria." Social Science and Medicine 15, 1981, p. 261-270.

38. Maurice King, op. cit., p. 13-14.

39. World Bank Health, op. cit., p. 239.

40. Ityavyar, D.A., Planning Health care in Nigeria: Studies in Medical Sociology, Jos, unpublished 1981.

41. World Bank, op. cit., p. 42.

42. David Piachaud, "Medicines and The Third World" Social Science and Medicine 14, 1980, p. 184-185.

43. Maurice King, op. cit., p. 15.

44. A. Mejia et. al. Physician and Nurse Migration: Analysis and Policy Implication WHO Geneva 1979, p. 25.

45. Ibid., p. 25.

46. Ibid., p. 26.

47. Ibid., p. 30.

48. Ibid., p. 104.

49. Ibid., p. 105-149.

50. D.D. Oyebola, Professional Associations, Ethics and Discipline Among Yonuba Traditional Healers of Nigeria. Social Science and Medicine 15, 1981, p. 87.

51. D.D. Oyeloba, op. cit. (1980), p. 31.

52. World Health Org. Promotion of Traditional Medicine WHO Technical Report Series 622, 1978, p. 10, 12-13.

53. Tonali Asuni, "The Dilemma of Traditional Healing with Special Reference to Nigeria," Social Science and Medicine, 13, 1979, p. 33-38.

CHAPTER THREE

HEALTH CARE IN NIGERIA: AN HISTORICAL REVIEW

The history of modern health care services in Nigeria allows a division into three distinctive periods - the pre-colonial, the colonial and the post-colonial or independence eras. The political and economic experiences in each of these three periods influenced the structural organization of public services. An attempt to understand the nature of health care services in Nigeria today must include an effort to delve into not only its historical development, but also the nature of the economy and politics that prevailed at those periods. This is necessary because the present structure and organization of health care in Nigeria is based on the foundation earlier established by European imperialists. In this thesis, the term 'imperialists' is generally used to refer to European colonial administrators, traders and missionaries who colonized Nigeria and the other Third World countries. The relationship between history, economy and politics, and health care development in Nigeria will become apparent in the discussion that follows.

(a) The Pre-Colonial Period

The period before 1861 was the pre-colonial era in Nigeria, i.e., Nigeria was not yet colonized or controlled by European imperialists. At this time Nigeria had many political units called Kingdoms. Each Kingdom had a powerful and effective traditional form of government which was based on democracy. The rulers were called Kings or Chiefs. Such

popular Kingdoms as Oyo, Yoruba, Hausa, Fulani, Benin, Dahomey and Nupe lasted until the late 19th century. These Kingdoms were politically stable and economically adequate. Their economic system was based on agriculture and there was enough food to feed all, and reserve for periods of bad weather. Food was not imported. Pearce bears witness to this fact[1]

> --- the economic system that flourished in the pre-colonial era was based on subsistence agriculture. The family was the basic economic unit and individuals had rights to land as lineage members in the community. This stable agricultural system provided enough food surplus to support the emergence of specialist groups like wood carvers, smiths-potters and leather workers. They also had enough for the inter-regional traders.

Medical institutions were also developed, and health care services were adequate and sufficient for all the members. Some of the healers were full time specialists, while others were only part-time healers. The traditional doctors could not necessarily engage in agriculture because the economic surplus circulating through the community 'exchange system' allowed several members of the community the time and energy to pursue some specialized areas of knowledge. Those concerned with medical care could concentrate on the development of an intergrated body of knowledge for a more efficient explanation and treatment of illness.[2]

People specialized in different branches of medicine - the social and the pathological. There were healers specialized in making charms and amulets to ward off evil spirits. The traditional medical practitioners had an effective referral system. In every family, there was at least one individual with a fair knowledge of medicine. If his attempt to

cure illness in the home failed, a more specialized herbalist or traditional doctor would be consulted. Fadipo in his book Studies of the Yoruba of Nigeria commented that medical services in the pre-colonial era were decentralized. Medical care was easily available even to slaves."[3] Patients consulted practitioners in their (practitioner's) own homes, shrines and other designated locations, e.g. rivers, forests, and hills. Some chronically ill individuals like lepers, ulcer victims and mental patients were often accommodated in some special rooms in the practitioner's home. Some of these patients were attended in their own homes. The traditional doctors were often needed to visit such homes.[4] Common cases that required patients to be attended in their own homes included childbirth and other incapaciting diseases.

The traditional doctors performed more than mere herbal medicine. The fame of a traditional doctor in the Nigerian pre-colonial society depended on his ability to provide complete therapy i.e. his thorough knowledge of the cultural, social and physical environment, since diagnosis involved social analysis and therapy was often an avenue of cementing fragmented relationships. By reducing interpersonal friction and stress, the balance was probably tipped in favour of the patients' recovery and opposing parties were once again at peace.[5] The situation was the same in pre-colonial Ghana.[6]

Famous traditional doctors had a lot of respect in the society. This was because of the people's belief that traditional doctors had medicines that could inflict misfortune even on a King or Chief. Such misfortune would lead to overthrow or dethronement of such Kings. Tra-

ditional doctors had medicine for fortune and good luck. Services for fortune, good luck and inflicting of misfortune on an individual were fairly expensive and often could cost the client a goat, chicken or money. In pre-colonial Nigeria, such services were available only to very wealthy persons.[7] Pearce found out that the traditional doctors were political figures too.[8]

> --- traditional doctors themselves were sometimes part of the shift in power relations between community groups. Their special relationship with the super-natural put them in a strategic position to intimidate even political officials.

Talbot indicates that, even a powerful King like the Chief of Bonny confessed his reluctance to bring traditional doctors to justice in the 1840s. The traditional doctor was held sacred and his office allowed him to commit with impunity any crime; even murder.[9] Not all traditional doctors were however accorded this respect. In all, there was a steady supply of all forms of healers, because the tradition had effective ways of training and initiating people in the act of doctoring. The cultural norms were such that there were no shortage of doctors.

Doctors from Europe first came to Nigeria in between 1789-1807. This was during the slave trade period, and European slave traders often brought western doctors who were to examine slaves before they were shipped to Europe. The doctors were also of service to the slave traders. This justifies the name "ship-doctors" which Schram gave to these early doctors, because most of their services were provided in the ship.[10]

> They (ship-doctors) were first introduced from poor motives, to care for traders who did not deserve attention, and to select slaves to ensure no loss of profit.

None of these doctors stayed in Nigeria and so had no effects on the health of the people until 1807 when slave trading was outlawed in Britain. Slave trade then gave way to legitimate trade. During 1834-1854 doctors from the west continued to pass through the ports and harbours of Nigeria, but there was no organized medical care even for the European traders. The doctors and surgeons that were hired by these early traders were not skillful in Tropical diseases. This can be established from the very high mortality rate of explorers and traders. In 1847 it was 54.4/1,000. In fact the doctors themselves often died shortly after their arrival at the Coast of Nigeria.[11] Between 1789 and 1807, 634 doctors were known to be hired by explorers and traders in Europe for voyages to Africa. Most died on the way and for those that reached Africa, "there is nothing to indicate that these doctors and surgeons even landed or stayed any length of time."[12] The Catholic Christian Missionaries who first came to Nigeria opened a hospital in 1504 in St. Thomes Island off the Nigerian territory. But this little hospital was similar to African traditional medicine because it had no drugs. Patients were expected to recover after the Pastor prayed for them. It was basically prayers along with counselling services. The builders of the hospital were not medically qualified, and possibly were uninformed of modern medicine because modern medicine as we understand it did not exist until the 19th century.

The first doctors who really stayed in Nigeria, were those sent by the missionary society of England. The first 9 doctors arrived in 1850 and most died a few months after that. Another set came in 1851 and many of them died after two years. The last of the 9 doctors was Walter Miller who stayed for more than two decades in Nigeria.[14] These doctors were in the service of the missionaries and were not to attend to Nigerian patients.

It was not until 1859 that Nigerians, Dr. Africanus Beale Horton and William Broughton Davis qualified as medical doctors and came back to Africa. Horton worked mostly in Ghana, but was instrumental in the growth of health care services in Nigeria. He joined the British Royal Army and suggested that the war office should open a small training school as a preliminary to the medical school training in Europe for African students.

Horton was famous not only because he was the first Nigerian modern doctor but also because of his profound interest in politics. He also wrote several books. Most of his influence was effective during the colonial era and will be considered later in the discussion. These two Nigerian doctors were indispensable in establishing medicine and mission work in Nigeria. They lived longer than European doctors in Nigeria because of their ability to resist malaria. Schram notes that

> There is no doubt that missionaries and medical work too would have been held up half a century or longer if the mission had not had men and women of African descent -- Nigeria may be thankful that these men appeared i.e. the early Nigerian doctors.[15]

Up to this time, only Southern Nigeria had contact with western people and missionaries. The North was still in its pre-colonial setting. The Baptist Mission tried in 1850 to take Christianity to the North but were turned back at Ilorin. The Baptist Mission therefore settled at Ogbomosho where they later built their first hospital. Missionaries and explorers were now in Nigeria, but Nigeria was still governed by the Chiefs and Kings (Natives). Nigeria was yet to be colonized by Britain.

Although the British government was interested in colonizing Nigeria, it did not do so until 1861. At this time there was a feud between Kosoko and Akitoye over the leadership of Lagos.[16] The feud disturbed the order and peace of the Nigerian coast, and since 1861 was a year when European powers were "Scrambling for Africa", the situation easily facilitated the take over of Nigeria. Southern Nigeria was colonized first, but it took 40 more years for the British government to take over Northern Nigeria. At the end of the pre-colonial era, there was no organized health care system for Nigeria. The presence of European physicians in the Nigerian society was not noticed by the natives. There were no hopsitals and dispensaries. Traditional healers were still in control of the medical system and even helped in treating the European who fell sick. For example, the Tiv people of Nigeria are said to have healed one European anthropologist with their "igbe medicine" in about 1911. "Igbe medicine" is for the cure of malaria, dysentery and diarrhea.[17]

(b) The Colonial Era

Before 1861, West Africa was seen as one Unit eg. there was a West African Army Corps, Medical corps, etc. In 1861, the British government took over a large part of West Africa which was later to be called Nigeria. The West African medical corps; part of the West African Army Corps which was stationed in Ghana, was now to be decentralized. From this military origin, health care in Nigeria took a colonial structure. Health stations were managed by the army medical departments which had to post people in various European settlements in West Africa e.g. Accra, Lagos and Sierra Leone.

In 1864, there were 35 western doctors in the West African Army. Every doctor including the three African Western trained doctors were in the army. Even at this time, the presence of these doctors never helped in lowering the mortality rate among the Europeans in West Africa. For instance out of the 1,658 sent out to West Africa between 1822-1830, 1,298 died within 6 months or one year, and 360 became invalids, and 123 died on the voyage home.[18] Only 57 were ever discharged in the U.K. By 1870, almost all had died, leaving only seven doctors in West Africa.

As a result of the increasing contact between Europeans and Lagos, (the capital of the newly acquired British Colony) there was a need for a hospital in Lagos for the Europeans. The first hospital was built in 1871. It started as a centre for sick seamen of the Royal Navy. By 1873 the hospital had 43 beds divided between ranks - 3 beds for the captain's ward, 4 beds each for the mates' ward and sailors' ward. On

the ground floor was a 4 bed soldier's ward, 18 beds were in the natives' ward (12 for female patients). The natives were West African Service men and their families.[19]

In 1873, the British government opened another hospital for infectious diseases in Lagos. In the same year, a section of the prison built for native debtors was turned into a mental health clinic for natives members of the British Royal Army. All these health facilities were in Lagos; and there is no indication that the facilities were meant for the entire native population. In any case, the natives were very proud of their medicines and were generally skeptical of the white man's healing ability.[20] This was particularly so, because a white man's death was announced in Lagos every-day, and natives wondered why the white man's medicine could not heal.

Northern Nigeria was still at a pre-colonial stage. It was difficult for the British government to conquer the North until Lord Lugard succeeded in influencing the indigenous Northern rulers with an indirect system of rule.[21] An Army medical sub-station was therefore established at Lokoja and managed by Lugard and Captain Goldie. Other European traders and especially those of the Royal Niger Company with their headquarters at Lokoja enormously benefitted from the Lokoja Army health post. The capital of the North was later moved to Kaduna because the Lokoja environment was unhealthy and unattractive. In the first decade of the 20th century, other small military hospitals were located in several parts of the North e.g. Zaria, Zungeru, Jebba. These were however in all respects inferior to those in Southern Nigeria which were

larger and better equipped.[22]

It was during the colonial era that imperialists and missionaries were most concerned with their health and the health of the Natives. Missionaries and imperialists had a mutual agreement to help in improving each others' health. The concern for disease prompted the British government to establish a sanitary department in Lagos in 1897. It was hoped that, if the environment was kept clean, disease would be reduced. The sanitary department staffed with 9 Europeans and 3 Nigerians helped in drawing up city ordinances for meat markets, slaughter houses and the general environment. There were rules for sewage and waste disposal.

At this point in time, health facilities established were strictly for the Europeans and some well placed African staff in their employment. It was not until the arrival of Governor MacGregor, a renown physician, that an attempt was made to provide modern health services for the natives. He ordered quinine be distributed to Lagos mothers and children to control malaria. He was concerned with public health. More health facilities were established including a dispensary at Ibadan. Inspite of his efforts, Schram maintains that

> --- the main concern of the medical officers was to remain for sometime the care of the employees on the new railway, the mission school children and those fortunate to obtain employment with firms.[23]

Health facilities continued to expand and were invariably located where there were European traders, miners, missions and British government men. For example, in 1912 a hospital was established in Port-Harcourt

because a mineral oil deposit was discovered there, and Europeans were there in numbers to extract it. Kano was the greatest trading centre in the interior of Nigeria. The Kano market attracted all forms of trade with Europeans and North Africans. Because of this a hospital was established there for the use of the European traders. In 1902, the small town of Jos had a hospital because tin was discovered in Jos and Europeans were there in numbers for mining. The colonial government did not only locate hospitals at these strategic economic centres, but also wisely built railways from Kano and from Jos down to Port-Harcourt and Lagos. Lagos and Port-Harcourt were harbours from which these raw materials were shipped to Europe.

Another interesting paradox was that, Africans were heavily taxed so that money could be realized to build hospitals and dispensaries for the use of Europeans. Health facilities which in turn kept the Europeans healthy and able to arrange for the exploitation of the natives. In 1904, every native who owned a hut had to pay a certain amount of money as tax. It started with 3 pence and increased to 9 pence per month.[24]

In 1909, health services were generally available to many natives working in mines, railways and other government establishments. The next problem now was how to get enough physicians from Europe. Although, there were natives qualified as western physicians, they were not allowed to practice. They faced discrimination even when they were employed in the government hospitals. A doctor of Indian and African descent was on a lower salary scale even if he was senior to a European doctor.

For example, Dr. W. Renner of Sierra Leone was 11 years senior to Dr. W.T. Prout, but because Dr. W. Renner was of African descent, he was paid £300, while Dr. Prout was paid £1000 annually.[25]

A report of a panel of inquiry into the West African Medical staff in 1909 considered such treatment appropriate for African doctors. The committee noted that, African doctors, though also trained in the United Kingdom were not to be treated on equal terms with European doctors. Denton reported this:

> They do not believe that in professional capabilities, West African native doctors are on par, except in very rare instances with European doctors or that they possess the confidence of European patients on the coast. Social conditions, particularly in Southern Nigeria, where European officers live together and have their meals in common under the mess system, and in Northern Nigeria where a larger population of the European staff consists of officers of the Regular Army makes it extremely undesirable to introduce native medical officers protectorates. ----- in hospitals where patients are practically always natives, it may be desirable to employ a native doctor, but such cases may be regarded as exceptional, and may be left to the discretion of the local governments -- if they are employed, they should be put in a separate roster and European officers should in no circumstances be placed under their orders.[26]

This obviously discouraged the Nigerian doctors and inhibited the zeal for Africans to study western medicine. A radical African physician Dr. Edward Boyle reacted sharply against the above report when it was published: -

> The Europeans frequently scheduled to serve the British government have almost invariably been that cheap trashy hide of human extraction which being incapable of more than the meanest possible livelihood in their own country have now and again been

inflicted on West Africa.

> Godless whitemen, some of them the verist heathen, who go to our country to teach vice, inebriety and all the follies of their vaunted western civilization. We regret the recommendation did not exclude English doctors from attending West Africans. This would, of course, simply give official confirmation to the accepted rule of English physicians refusing to attend the natives (except at hospitals), prevent their get rich-quick fee, and save some of my people from some of those frightful alcohol sodden spectres which sometimes terrorise their bedside.[27]

The few Nigerian doctors that existed at this time also staged a demonstration against the committee's report. They also quoted the enormous contribution of the first Nigerian doctors like Horton and Davis in saving the life of the Europeans on the West African Army Corps. They argued that:[28]

> to allow them to run hospitals with African or natives patients, if they were not considered competent to treat Europeans would be only to expose the African population to their incompetency if such was the case.

It was indeed difficult to believe the report that projected the professional inferiority of the native doctors because, their individual records in training and after graduation were consistently of international recotnition. For example, Dr. Beale Horton was famous and his contribution to the health of the Europeans in Nigeria was praised. By 1868 he had published A Treatise Of The Guinea Worm. He adviced against slum conditions and poor hygiene in the cities. Beale Horton also published Physical, And Medical Climate And Meterology Of The West Coast

Of Africa in 1807. This book was a good source material for social and preventive medicine. He urged the creation of public health inspectors. Schram considers Beale-Horton one of the best doctors who ever lived. Beside Beale-Horton and Davis, other African doctors like Dr. F. Easmon won the Liston Clinical medal for surgery and five other prizes for excellent performance in medicine. Clyde mentions the outstanding performance of some East African doctors like Adrien Atiman who was honoured by the British and Belgian government for excellent performance and contribution to medicine and health care.[29] Dr. Adrien Atiman was also decorated by France in 1912, and by the Pope in 1955. All these achievements by the African doctors bear witness to the fact that the committee based its decision on racial grounds rather than professional competency.

Meanwhile, the work of the European colonial doctors was to provide health care for the government officials, police, soldiers, prisoners and labourers. Criminals in prison were the first people outside those in government employment to have access to modern health care. The colonial government provided health services to them so that, they would not die in prison.

Each year however the number of health facilities was increased. Southern Nigeria with longer contact with the West, and with more European missionaries had 3 times more facilities than the North, the hostile moslem part of Nigeria. Hospitals in the South were now located at Abakiliki, Afikpo, Okwoga, Ogoja, Okigwi, Oweri, Ikom and Ikot Ekpere.

The main problem that caused delay in the development of health

services for the Northern part of Nigeria was the misunderstanding and conflicts between the Northern missionaries and the colonial government. The introduction of Christianity to the North, which already had Moslem religion caused trouble which the colonial government could not contain. For this reason the British colonial administration in Northern Nigeria was most unwilling to allow missionary work as in the South. After insisting the missionaries were later allowed to concentrate on educational and health care work. The Sudan Interior Mission (SIM) then started work in the North, building dispensaries and clinics. By 1914 they had stations in Kano, Jos, Rano, Zaria Bida, Wukari, Donga, Biron Lantang and Bukuru. Their first hospital was built in Vom in Plateau State in 1922 and another at Maiduguri in 1938, Nguru in 1949. They also trained Africans as health workers including the first 2 Northern doctors Barau Dikko and Musa who were trained in Britain at the suggestion of Walter Miller.[30]

After World War I the health care situation deterioriated. The hospitals opened earlier had no staff and many were closed, never to be opened again. By 1919-21 both Northern and Southern Nigeria with a population of about 15 million had only 133 doctors. Of these, 96 were officers of the West African Medical Service, 11 were senior sanitary officers, 4 were specialists in various fields of medicine, and the rest were Indian or African doctors.[31] Disease also increased after the first World War with the importation from Eruope of such diseases as gonorrhoea and syphilis. Soldiers found to have these veneral diseases were paid only half of their monthly salaries. This

practice led to further spreading of the disease because soldiers who had gonorrhoea did not report inorder to avoid the loss of half of their salary. The mortality rate at this time rose from 261 to 275.4 /1000.

The only significant improvement after World War I was the construction of roads, which in many respects helped the growth of health care in remote towns. Nationalism also started after the war. Herbert Macaulay, a civil engineer organized a political party; the leading members of which were medical doctors. The treasurer Dr. A.B. Oluron Nimbe was also a physician. The aim of this nationalist party was to agitate not only for self rule but for rights and amenities for Nigerians.

For instance, most African countries at this time had medical schools except Nigeria. It was in 1920-24 that a dispensary attendant training school was opened in Calabar. In 1930 Yaba Medical School was opened to train medical assistants. Most of the early students of the Yaba College of Medicine were qualified as doctors in Britain. Nine of the 35 of them became full time politicians after graduation and only 9 worked with the government hospitals. Thirteen were administrators with the colonial government and the rest set up private clinics. The opening of the Yaba College of Medicine and other institutions for the training of para-medical staff increased health manpower in Nigeria. In 1937, Nigeria had 220 doctors out of which 116 were Europeans, 53 missionaries and 19 were Africans who had official appointment with the government. There were clinics in some of the mines and industries;

with five industrial physicians. At this time 4 Europeans and 23 Africans were in private practice. There were more Africans in private practice because they were never comfortable in the government hospitals where discrimination against them was legitimatized. As there were more natives in the employment of the British government, there were also more Africans now who were qualified to have access to the modern health care services. Health services were available now to almost all government service men even of African descent.

(c) Towards Independence

The side-effects of the Second World War brought more changes to the medical health scene in Nigeria than the First World War. At this time, the general economy of the nation improved. The ports were reorganized and were now managed by the Nigerian Ports Authority. Plus the rate of exporting to Europe increased. Roads were improved and many more were built to connect towns and villages. Nigeria was less involved in the second World War than in the first World War. There were fewer wounded soldiers to occupy the hospitals and many of the army nurses and doctors were now able to provide services for the public. Army hospitals were erected specifically at Kaduna, Aboekuta, Enugu, Ibadan, Lagos and Zaria. For the first time, health services were not only for the government officials, but also members of the public, especially those who were near the government stations and hospitals.

The development of modern health care at this stage was not a pleasant happening for the traditional practitioners. They felt that the

spread of modern medicine was a calculated effort by the colonial government to put them out of the healing business which they had monopolized. The general Nigerian population also intensified its skepticism toward modern medicine and therefore continued to patronise their traditional healers. The few natives who went to these hospitals were the curious ones who merely wanted to try the new healers (western doctors) and see if they were also great healers.

The traditional doctors' fame was not shaken for a long time and the hospitals continued to be empty. The colonial government had to initiate an aggressive policy against all traditional healers. This made many of the traditional healers flee to the rural areas in order to avoid the wrath of the colonial government.[32] In the Northern part of Nigeria where indirect rule flourished, traditional medicine was not outlawed until it became a threat to the growth of western medicine. Traditional medicine therefore became unpopular in the cities and people found dealing in traditional medical practices, such as the Sopona cult in Yorubaland were prosecuted.

Even after fleeing to the villages, the traditional medicine men were still confronted by the Christian missionaries. The missionaries did not understand the culture of the people, and had even more difficulty in understanding the nature of traditional medicine. Again the missionaries had problems of language and a corresponding difficulty in preaching to the local people. In the wake of these difficulties, it was easier for missionaries to tell the rural people that traditional doctors were servants of the devil and consumers of traditional medicine

were also servants of satan. They equated traditional medicine with witchcraft and idolatory. Those who were converted by the missionaries therefore were expected to visit the mission dispensary when taken ill. To this date, the use of traditional medicine in Nigeria is an indication that one is not a Christian. A decent Christian is one who does not take or use traditional medicine.[33]

With traditional medicine dying out in the towns and villages, and because of the enormous growth of health personnel, it became necessary to plan health care services for Nigeria. The first attempt at this was in 1946 when the Director of colonial health services for Nigeria, Dr. J. Harkness and his deputy Dr. G.B. Walker prepared a document. The planning in the document was nothing more than location of hospitals and dispensaries and arrangements to post health personnel to such places. Dr. Walter Miller considers this the first failure of the colonial government. In his book Have We Failed in Nigeria? Miller felt that, it was better to look for the causes rather than cure of the diseases

> In the forefront of everything must come mass investigation and treatment of causes of diseases.[34]

The need for research on the causes of diseases which Miller had envisaged in the early 20th century is yet to be taken seriously. After 40 years in Nigeria, Miller also identified what was to become the cancerworm of the Nigerian health care.[35]

> --- the prevalent dishonesty, injustice, corruption, callousness, quarrelling, tribal factions, and the

> seeming total lack of anyone who cared for the blind, the deaf, dumb and lame.

He made a cursory remark about the emerging Nigerian nurses who "could be so kind to the European patient and so cruel to the Africans"[36] Today nurses are kind to the wealthy patients and cruel to the poor ones. Miller was an exceptional European who fearlessly outlined the unfairness of the British colonial government in Nigeria. He saw an immediate need for a university and school of medicine in Nigeria, so as to spare the time, cost and distance of training Nigerians in Great Britain. A year after Miller's request, a university and a medical school were established in Ibadan in 1948. It was affiliated with the University of London.

Fortunately for Nigeria, an economic boom occured at this time, enabling the financing of the university college and the teaching hospital when the British government could not finance them. Britain however contributed 5000 for the university[37] out of the 4.5 million used in the project.

Christian missionaries continued to spread their gospel along with schools, dispensaries and hospitals all over Nigeria. In 1947, there were 160 mission physicians in 92 hospitals, maternity homes and dispensaries with 2,200 beds. The health facilities of the missionaries were compared favourably with those of the government with 73 facilities and 5,650 beds.[38]

The position of Nigerian general practitioners (natives) was yet to be improved from the earlier discrimination. They were given very

low wages so that, many of them preferred private practice to government employment. This was a good alternative for southern native physicians in Lagos, Ibadan, Enugu and other southern cities where people did not only know more of modern medicine but also desired to make use of it. They were also wealthy enough to buy these services from the private physicians. Private practice became a lucrative business with a lot of clients. Some government employed physicians also had clinics in which they provided services to people on a part time basis after government closing hours. Schram notes this[39]

> --- to gain additional income, the practitioners often obtained a part-time appointment with a commercial firm -- or on some occasion they would establish surgeries or clinics in a whole area and tour these -- some doctors made a succession of tours giving injections virtually on demand, with minimal clinical examination or none at all, and charged high fees which were forthcoming because of the unusual faith people placed in the needle.

Phillipson has also written about this practice which was generally frowned on, but which existed. He noted a case where 35 individuals, mostlychildren, died after such injection tours. Nurses, midwives and any person who had had the privilege of working in the hospital did the same illicit injections for money.[40]

The Nigerian general practitioners who were in private practice also faced a ferocious competition from the traditional healers who were now regaining their former position. Traditional healers were popular because the average Nigerian patient was poor and could not afford the grandiose fees charged by the private western trained doctors.

Furthermore, the native population still did not understand modern medicine. Those that understood preferred to consult quacks who would give them injections with no clinical examination. The natives had higher regard for injection rather than drugs. A recent study at Mkar near Gboko showed that, Nigerians still prefer treatments that would include injection and capsules.[41] Traditional doctors are becoming more prominent and constitute "a threat to the very existence of the qualified medical doctor."[42]

Authors such as Schram indicate that rural health in Nigeria was a bigger failure than health care in cities.[43] Hospitals were in cities and dispensaries were conventionally built in the rural areas. Dispensaries were

> --- displayed often in poorly built, ill-lit and dirty premises, with a handful of mixtures outdated by several decades and usually kept in unlabelled, disused beer bottles.[44]

The dispenser in charge of a dispensary was entirely another issue. He often had the benefit of only very poor training, amounting to watching and assisting the dispenser at a government city hospital for a year or two. On some occasions, these rural dispensers themselves had to consult traditional healers because they (dispensers) never trusted the efficacy of Western medicine. This is even true of some dispensers at Sokoto who in a study in 1980, were found to have left their dispensaries to consult 'Mallams' for their ailments.[45]

In Northern Nigeria, some dispensaries were opened only for political reasons and were closed after the minister or councillor had done

the official opening. Both urban and rural health care were not given the required attention.[46] By 1958, there were still no mental hospitals, psychiatrists, or trained psychiatrist nurses, in the whole of Northern Nigeria with a population of 35 million.[47]

Modern planning was also difficult because the British government had never emphasized the keeping of vital statistics. As Sklar noted,[48] the collection of medical statistics was complicated by political undercurrents. The people feared tax pressure, and any move to obtaining information was met with resistance. Even today, an average Nigerian resists questions that demand vital information, with the fear that this could be a way of seeking information to increase taxes. Zasha met the same problem in his 1977 study of the Gboko Rice Mills.[49] The 1932 census was also inaccurate because of such resistance. Ekundare found out that people were not educated to appreciate the importance of accurate vital statistics. Besides, the culture of some Nigerian ethnic groups does not permit counting of their children or talking of such things as abortion, barreness etc.[50]

The problem was even clearer in Western Nigeria in 1955 when a survey was conducted in order to implement universal primary education. Parents reported having fewer of children than they really had because they thought they would be taxed on each child. In one village, every mother that answered the questionnaire of the 1932 census had two children, and all had one dead and one alive; and in another all mothers denied having ever been pregnant. The colonial government shared the blame for this because campaigns were never done to give enough publi-

city to the populace concerning intended projects. The absence of accurate vital statistics still affects planning in Nigeria today.

Long term planning, in any form, only started in 1946. There was no Health Ministry until 1953 when a new Nigerian constitution divided the country into 3 administrative regions. A Federal Ministry of Health was to arrange and supervise medical and health services in Lagos Territory and also to co-ordinate health services in the whole federation. Without a health ministry prior to 1953, it was fairly difficult to provide health services adequately and effectively to the public. Water supplies and sewage were particularly messy. In 1955, Lagos had a daily average of 23 gallons of water per person, 300 stand pipes, and 1,400 wells. Ibadan had 4 gallons of water per person in a day. The situation was not conducive for the water system toilets which the city ordinances required. The non-existence of the Ministry of Health meant that the responsibilities were shared between Health and Works departments which often argued amongst themselves about what the other's role should be.

Sanitation was a problem because the government never seemed to play its parts in the environmental sanitation. For instance there were only 11 public dust-bins in the whole of Ibadan in 1949. Ibadan then had a population of 400,000.[51] Norman William[52] has pointed out that primary schools and even colleges were not provided with toilets and had no dust-bins. Factories employing over 10,000 people had no toilet facilities. The absence of toilets led to indiscriminate disposal of human feces and rubbish. This situation is very much the same

today in Nigeria.

Nutrition was another problem. Protein was still insufficient, because meat was about the only source. The milk, pasturised at Vom was critically insufficient. Bello Tamawa in his recent study of the problems of nutrition in Kano state paints a picture of malnutrition, blacker than that in the colonial era.[53]

Health education also lagged behind. There was no health education programe either for children or adults. Drivers with impaired health caused a lot of motor accidents. In 1959 Nigeria had 85,303 motor vehicles and had 10,541 road accidents half of which were not reported. About 1134 people died in these accidents. The government ordinances, codes and rules for health were not particularly useful. For instance, one was to avoid noise making - drumming in the marekt, singing or playing gramaphone records was considered hazardous to health. There were also rules concerning buildings and allocation of stalls by the health inspectors.

As Nigeria came closer to independence, there were improvements in all sectors of the economy. Roads, railways, hospitals and schools became more available. Health care was better than 10 years earlier. The infant mortality rate dropped from 324 per1000 in the pre-colonial era to 62.9 per 1,000 in 1959. This rate was however higher in the rural areas which ranged between 150 - 200 per 1,000. Child mortality was still as high as 450 - 500/1000.[54] It was in this state of affairs that the British government handed over power to an indigenous elected government on 1st October 1960.

(d) The Independence Era

Nigeria gained her independence from the British colonial government in 1960, and in 1963 the country became a Federal Republic. At the time of independence, there were three provinces in Nigeria - the Northern, Eastern and Western Regions. Two years after independence, the mid-western region was also created, making four administrative regions each with a governor, and of course each had a Ministry of Health. There was also a Federal Ministry of Health. At this time Lagos had 23 general hospitals and nursing homes. There were 24 maternity centres. The Eastern Region had 58 hospitals, and dispensaries together with 373 maternity centres. The Western Region had 54 hospitals and dispensaries, 387 maternity centres and the Northern Region 74 hospitals and only 55 maternity centres. There were a total of 1,655 dispensaries in Nigeria located in urban and rural areas in 1960. There were 1,079 registered physicians and surgeons. Nigeria now had a physician population ratio of 1 doctor to 82,569 patients.[55]

Most of the physicians were employed either by the Federal or Regional governments. The Federal government employed 258, closely followed by the Northern Region. (N=208). There were 160 missionary physicians distributed all over the country. The Northern Region however had the lion's share of the missionary doctors. At the time of independence, only 84 doctors were in private practice. The Armed Forces had only 19 doctors. All these physicians were in the urban centres.[56] There were about 49 dental surgeons, 542 pharmacists, 60007 nurses, 5,558 midwives and about 4,783 nurses and midwives in training in Ni-

TABLE 6

DISTRIBUTION OF NIGERIAN DOCTORS ACCORDING TO REGIONS IN 1960

Employer	**Unspecified	Western	Eastern	Northern	Totals
Government	87	121	80	123	411
Local Authority	2	-	-	-	2
Universities	110	1	-	-	111
Missionary	2	37	56	65	160
Industrial	9	5	12	2	28
Army	8	2	1	8	19
Private Practice	40	18	16	10	84
Others*	-	-	-	-	264
Totals	258	184	165	208	1,079

SOURCE: Ralph Schram. A history of the Nigerian health services, Ibadan 1971. Appendix 8, p. 433.

* 264 doctors were unaccounted for.

** Doctors listed under 'unspecified' were generally servicing any of the 3 regions.

geria as a whole. The nature of the post-independence hospitals, and the quality and quantity of health care services will be considered in the next chapter. The implications of an historical review of health care development in Nigeria is now apparent. Colonialism and neo-colonialism have contributed to the general underdevelopment of Nigerian

Society including the health care sector. The question Why health care services are underdeveloped in Nigeria may not be answered. Historical evidence clearly indicates that colonialism contributed substantially to the impoverishment of the Nigerian Socio-political economy, and especially the health sector. It might now be appropriate to move on to health care in Nigeria today, where the effects of colonialism on the health sector are even more apparent.

FOOTNOTES

1. Tola Pearce - Political and Economic Changes in Nigeria. Social Science and Medicine, Vol 14 B 1980. p. 91. Emphasis added.

2. Ibid, p. 92.

3. N.A. Fadipe. Sociology of the Yoruba. Ibadan, Ibadan University Press, 1970, p. 180-187.

4. Pearce, op. cit., p. 92.

5. R. Horton, Traditional Background in Medical Practice in Nigeria Ibadan, University Press, 1971, p. 38-45.

6. Patrick Twumasi, Medical Systems in Ghana, Ghana Pub. House Accra, 1975, p. 37-41.

7. N.A. Fadipo, op. cit., p. 92.

8. Tola Pearce, op. cit., p. 92.

9. P.A. Talbot - The peoples of Southern Nigeria, Vol, II, Cass, London, 1969, p. 155.

10. Ralph Schram - A history of the Nigerian Health Services Ibadan Univ. Press, 1971, p. 10.

11. Ibid, p. 53.

12. J.M. Leggate, Progression Liverpool - Biochemistry Pioneer Medical News Jan 24, 1964, Quoted from R. Schram, p. 35.

13. Ralph Schram, op. cit., p. 60.

14. Ibid, p. 73.

15. Ibid, p. 73.

16. Kosoko was King of Lagos, but a feud with Eletu led to his rejection by the people. Kosoko fled to Dahomey and his uncle Akitoye ruled in his stead. After four years Kosoko returned from Dahomey and conquered the city of Lagos after 21 days of heavy fighting. Akitoye also fled to mobilize support and return to fight. It was at this time that Britain took over Lagos in 1861. See also Schram op. cit., p. 79.

17. Ityavyar, Dennis - A Sociological Study in a Hospital - Case Study of Mkar Christian Hospital - Gboko Zaria, June 1979 B.Sc. Thesis, Ahmadu Bello University, p. 42, unpublished.

18. Ralph Schram, op. cit., p. 102.

19. Ibid, p. 103-4.

20. Ibid, p. 104.

21. Indirect rule refers to a system where the British government ruled Northern Nigeria through the indigenous rulers. Unlike in Lagos where Kosoko and AKitoye were robbed of leadership power, the Northern emirs still were powerful and were the leaders of the natives. They were only influenced by the British government in their everyday leadership roles.

22. Ralph Schram, op. cit., p. 109.

23. Ibid, p. 125.

24. Ibid, p. 126.

25. Ibid, p. 130.

26. G.C. Denton, Observations on the West African Medical Staff Committee's Report to the Secretary of State dated July 26, 1909. No. 27556 Colonial Office 1901 and NO. 158 Gambia. Quoted from Schram, Ibid, p. 131.

27. Edward Mayfield Boyle wrote these words from Washington, and the words are quoted from Schram, op. cit., p. 132.

28. Ralph Schram, op. cit., p. 133.

29. F.C. Clyde. History of the Medical Services in Tanganyika Govt. Printer Dar es Salaam 1962.

30. Schram, op. cit., p. 155.

31. Ibid, p. 191.

32. Tola Pearce, op. cit., p. 95.

33. This idea is more true of the TIV people, but it is even true of the whole of Nigeria. The evidence in this paragraph is based on my personal observations of Christianity and their practices. My Christian neighbours who took traditional medicine did so secretly so that the pastor or elders would not know. This is more true of the traditional conservative churches like SUM, SIM and

Anglican churches. The picture is different for young Chrstians who are more radical.

34. Walter Miller. "Have we failed in Nigeria." United Society for Christian literature, London. Quoted from Schram, op. cit., p. 263.

35. Ibid, p. 263.

36. Ibid, p. 263.

37. Ibid, p. 272.

38. Ibid, p. 289.

39. Ibid, p. 341.

40. Sydney Phillipson. Report of a Commission on the private practice of medicine and surgery by officers of the department of medical services, Nigeria. Govt Printer, Lagos 1949a. Quoted from Schram Ibid, p. 341 and 345.

41. D.A. Ityavyar, op. cit., p. 52-54. The study found out that 52% preferred injection to any other form of modern medicine and 4% actually demanded injections in the hospital. To them capsules, tablets could be taken for any kind of disease. Patients who get capsules in the hospital are satisfied even if they are given just a few of them.

42. Ralph Schram, p. 347.

43. Ibid, p. 349.

44. Ibid, p. 347.

45. The study was conducted by the author in 1980. It is unpublished research which surveyed the health care facilities in Sokoto State of Nigeria. Mallams are religious (Moslem) healers.

46. Tola Pearce, op. cit., p. 94.

47. Schram, op. cit., p. 387.

48. Richard Sklar, Nigerian political parties: Power in an emergent African Nation, OUP Princeton, Oxford 1963.

49. James Zasha, Migration into Gboko rice-mills, A Socio-economic perspective. Zaria, 1977 B.Sc. Thesis. Ahmadu Bello University Sociology.

50. Olufumi Ekundare. Economic History of Nigeria, p. 351. See also Afolabi Ojo. Culture and modernization in Nigeria. Univ. of Ife Press, 1974, p. 8-9.

51. Ralph Schram, op. cit., p. 397.

52. Norman, William - Health.

53. Bello Tamawa: Nutrition and Health in Kano State: In Health problems in rural and urban Africa. Pol. Sci. Dept., Zaria 1981, p. 38-57. In 1954, there were 8.8 million cattle, 6 million goats, 3 million sheep and 200,000 pigs in Nigeria.

54. Ralph Schram, op. cit., p. 393.

55. Ekundare, op. cit., p. 352, 354-356.

56. There were no hospitals in the rural areas at this time and therefore, there was no need for doctors to be in the rural areas. Even today, there are no doctors in the rural areas. In fact by 1960, local govt. had only 2 doctors. Local govt's were in charge of health services in rural areas.

CHAPTER FOUR

HEALTH CARE IN NIGERIA TODAY

(a) Measurement of Health Status in Nigeria:[1]

In 1977, 45% of the 80 million Nigerians were under 15 years of age. The infant mortality rate was 180/1000 population and the crude death rate was 23/1000. Birth rate was estimated at 49/1000 with an annual natural increase of 2.7. Life expectancy at birth in Nigeria was 41 years. Population per physician ratio was 1 physician to 25, 550 people and seven nurses for each physician, or 1 nurse for 3460 people. There were 5.3 general hospital beds for 10,000 population. All these are below the world's minimum health level.[2] The low level of health care gives rise to high morbidity rates (incidence and prevalence of diseases). In the same year Nigeria budgeted U$118.5 million for health services and in 1978 it was increased to U$ 420 million.

Compared with an advanced industrial country e.g. Canada, the poor health status of Nigeria becomes even more obvious. For instance, in 1976, Canada had a birth rate of 16/1000 and a death rate of 7/1000; better than the world's average of 9/1000. Canada had a natural increase in its population of 0.8 annually. Infant mortality in Canada was 15/1000 and life expectancy at birth in Canada was 73 with a per capita income of $6,650.

TABLE 7

HEALTH STATUS: A COMPARISON OF NIGERIA AND CANADA

	NIGERIA	CANADA
Population	80 million	24 million
Birth Rate	49	16
Death rate	23	7
Natural increase	2.7	0.8
Infant Mortality rate	180	15
Life expectancy	41	73
Population/Physican	25,550	630
Population/Nurse	3,460	130
Gen. Hosp. Beds/Population	5.3	65.7
GNP per capita income	U$310	U$6,650

SOURCE: 1977 World Population data sheet (Health Index). Adapted from Timothy Baker op. cit., p. 41-48

Other factors that influence health status include access to safe water, education, nutrition and environment. These too are critically under-developed in Nigeria. Only about 26% of Nigerians have access to safe water and a lower rate in regard to sewage or flush toilets.

In 1975 only 25% of Nigerian adults were literate. Eighty-eight percent of the daily per capita calorie supply, as a percentage of requirement, was realized. However, in real terms urban dwellers have higher percentages than rural dwellers. Again if these rates are compared with Canada, the difference is great. For example, in the same year (1975) Canada had an adult literary rate of 98%, and a daily per capita calorie supply of 230, (highest in the world). Only 1.6% of the Canadian population had no access to flush toilets. Nigeria voted only U$0.7 per capita income for public health, while Canada voted U$5.5. Nigeria voted U$3 per capita income for general health expenditures in 1976 while Canada in the same year voted U$457.

The problem of underdevelopment of health care in Nigeria is not therefore a myth, but a serious problem that requires close attention if it is to be resolved.

(b) Pattern of Diseases

The common cause of death in Nigeria is communicable diseases such as dysentery, pneumonia, tuberculosis, cholera, typhoid. This fact was revealed by the Chief Medical Advisor to the federal government in a paper presented in a National Conference on Health.

> --- most of the morbidity and mortality in our community are due to communicable diseases, most of which can either be prevented or readily treated -- such as malaria -- with effective organization of communicable disease programmes, mortality from these diseases can be drastically reduced.[3]

Awolowo has in another instance shown that three quarters of the ailments which afflict Nigerians are water borne,[4] and that the provision of clean water will save people of Nigeria from these ailments. In 1966, 43% of all deaths in Lagos (capital city of Nigeria) were due to a number of preventable causes like pneumonia, malaria dysentery, diarrhoea, malnutriton, tuberculosis and measles. A year later, the percentage of all deaths resulting from these same causes had risen slightly, from 43% to 44.6%. In absolute figures, 2,407 people in Lagos lost their lives in 1966 as a result of diseases that could have been prevented, while 2,692 suffered the same fate in 1967. In other words about 5000 people in Lagos died within two years from diseases which are easily preventable through immunization.[5]

Although the statistics on causes of death in the rural areas are not available, it is reasonable to expect that the situation in the rural area is even worse. Particularly if Lagos which enjoys perhaps the highest standard of medical care in the country has such high morbidity rates.

Ademola has also indicated that 79,000 cases of dysentery were reported in 1964 and 10,000 cases of tuberculosis were diagnosised annually and that these conditions were in the main due to poor housing and enviornment.[6]

Dr. Ransome Kuti has published the morbidity and mortality rates for children in Lagos. In these, he has noted that the most common cause of death is communicable diseases (See Table 8). He noted

> -- the fact that all except sickle cell anemia are caused or provoked by infection clearly indicates that there are gross deficiencies in the health standard of the environment in which these children live ... From our study of one disease in particular Kwashiorkor, it is clear that poor social and economic conditions play a vital role in causing this disease.[7]

The pattern of diseases in Nigeria has not changed over the years. The most common cause of death in Nigeria continues to be communicable diseases.

This is shown by the recent study by Igun.[8] His study"Child-Feeding Habits in a Situation of Social Change: The Case of Maiduguri, Nigeria"shows the same pattern of diseases (See Table 9).

In the developed countries e.g. Canada, the pattern of disease and the major causes of death are different from those in Nigeria. In Canada, only 0.7% of thepopulation in 1973 died from infectious and parasitic diseases. In Nigeria in the same year 43% of the people died from these same diseases.[9] In Canada 49% of the population died from diseases of affluence such as diseases of the circulatory system,heart diseases, cerebrovascular disease. In all, diseases of over eating and accidents constituted about 80% of all deaths in Canada in 1973 (See Table 3).

The main differences between the causes of mortality in Canada and Nigeria are clear. The causes of death in Nigeria are mainly from communicable diseases due to poverty and unclean environment. In Canada death is caused by diseases of affluence, overeating, accidents and old age.[10]

TABLE 8

MOST COMMON CONDITIONS TREATED

IN NIGERIAN HOSPITAL EMERGENCY ROOMS

	No. Examined	Percentage Examined	No. Dead	Percentage Dead
Gastroenteritis	1652	16	41	9
Bronchopneumonia	1237	12	23	5
Febrile Convulsion	572	6	52	11
Malaria	434	4	-	-
Burns	387	4	-	-
Neo-natal Jaundice	329	3	18	4
Measles	280	3	2	0.5
Anemia	260	3	10	3.5
Respiratory Tract Infection	222	2	-	-
Abscess	209	2	9	2
Kwashiokor	197	2	8	2
Bronchiolitis	189	2	8	2
Meningitis	141	1.5	12	3
Sicle Cell Anemia	138	1.5	2	0.5
Brochial Asthma	135	1	-	-
Totals	6,382	63%	178	39.5

SOURCE: "The Morbidity and Mortality rates for Children in Lagos" In "Priorities in National Health Planning (ed.) O. Akinkugbe op. cit., p. 58-59.

TABLE 9

ILLNESS EPISODES AND CAUSES OF WEIGHT LOSS
FOR BABIES IN MAIDUGURI, NIGERIA IN 1979

Illness episode	Distribution	% of Total
Diarrhoea	108	16
Vomiting	35	5
Catarrh	124	18.4
Abdominal pains	18	2.7
Fever	112	16.6
Constipation	13	1.93
Cough (various)	145	21.5
Eye infection	38	5.6
Skin rashes	31	4.6
Pneumonia	1	0.15
Malaria	5	0.74
Boils	16	2.4
Dysentery	4	0.6
Fungi infection	1	0.15
Ear ache	9	1.34
Loss of appetite	5	0.74
Skin infection	2	0.3
Measles	3	0.445
Chest pain	2	0.3
Septic wound	1	0.15
Sore tongue	1	0.15
Total	674	100

SOURCE: U.A. Igun "Child-Feeding Habits in a Situation of Social Change" Social Science and Medicine 16, 1982, p. 775.

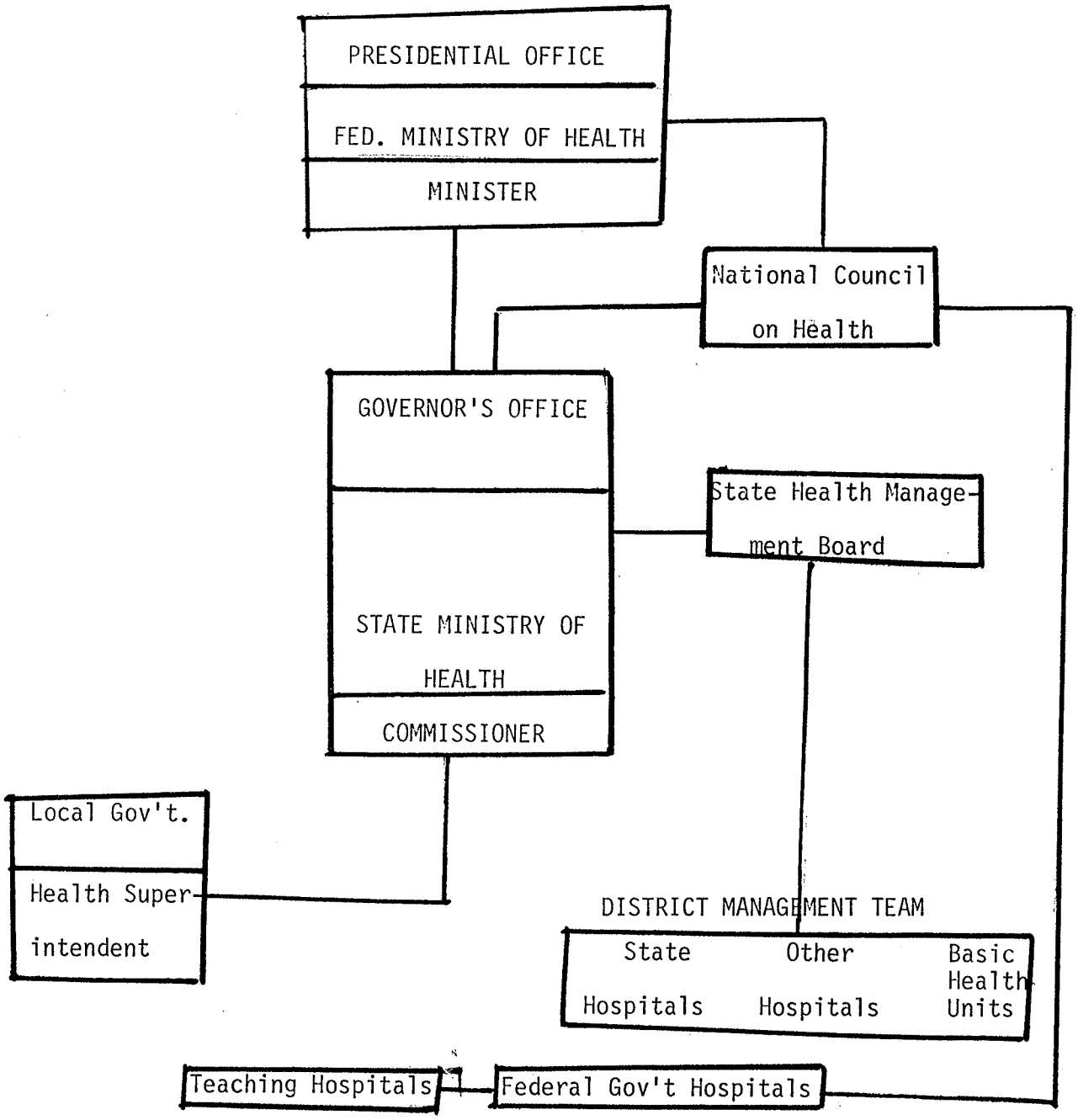
(c) Organization and delivery of health services in Nigeria

The structure of health care services in Nigeria has not changed since independence. Each of the 19 states has a ministry of health. The Federal Ministry of Health co-ordinates national health programmes and works hand in hand with the state health ministries. There is a National Council of Health that advises the Federal government in formulating national health policies.

The state health ministries execute the national health policies and also make health policies to meet the local requirement of each state. The state ministries of health supervise all hospitals except those designated teaching, neuropsychiatric and orthopedic hospitals.

Figure 3

HEALTH ORGNIZATIONAL FRAMEWORK IN NIGERIA



SOURCE: Measurement of Coverage and Effectiveness of Health Care in Nigeria, 1979. Unpublished memo. Ministry of Health, Lagos Diagram I, p. 15.

These are supervised directly by the Federal Ministry of Health. Recently,[11] the State Health Management Boards have been created to take over the management of the technical and curative aspects of health while the State Ministries of Health plan, finance and promote health care.

There have been significant changes in all aspects of health care in the last 22 years since Nigeria gained independence in 1960. In 1960, Nigeria had a population of 55 million with 197 hospitals and 1655 dispensaries.[12] Today, there are over 7,000 health care units in Nigeria owned by the Federal, state and local governments. Some are still owned by private individuals, corporations and missionaries. In 1977 there were 495 general hospitals, most of which were in the Southern part of Nigeria. Imo State had 62 with 3,838 beds, Anambra and Lagos both had 54 general hospitals with 3203 and 1192 beds respectively. Niger state with a population of 1.2 million had only six general hospitals with 1,212 beds. Benue, Bauchi, Borno and Gongola states had less than 20 hospitals with less than 1000 beds.[13]

All the general hospitals are located in cities. Each of the 303 local government headquarters of Nigeria had a general hospital.

There are several other health establishments run by the various communities, missions, industries and local governments, In 1977, there were 7,163 health establishments in Nigeria with 57,944 beds. The population of Nigeria at this time was estimated at 80 million, giving a population-bed ratio of about one bed to 1170 people; and a health establishment in every 127 square KM of Nigeria. In 1977 there were 771

TABLE 10

DISTRIBUTION OF HEALTH FACILITIES ACCORDING TO STATES AND POPULATION IN NIGERIA 1977

States	Pop/Million	No. of Gen. Hosp.	No. of beds
Anambra	3.1	54	3203
Bauchi	2.4	9	1018
Bendel	2.6	52	2744
Benue	2.4	13	1109
Borno	3.	11	1330
Cross River	3.6	24	3348
Gongola	2.7	10	1316
Imo	4.1	62	3838
Kaduna	4.1	18	1662
Kano	5.8	22	1813
Kwara	1.7	22	1578
Lagos	1.4	43	1192
Niger	1.2	6	1212
Ogun	1.6	15	1404
Ondo	2.7	30	1467
Oyo	5.2	35	1802
Plateau	2.0	13	1472
Rivers	1.5	35	1345
Sokoto	45	5	760
Total	56	495	34,586

SOURCE: Special report by the Ministry of Health for World Health Organization 1979. The population here is low because it is based on the 1963 census. The population in 1977 was estimated at 80 million.

mission health care units with 9001 beds, and one mission hospital to every 1, 184 square KMs. The 3,172 local government health establishments are mostly dispensaries, maternity centres and clinics. These together have 3,977 beds. In a survey of health care facilities in Sokoto State in 1980, it was found that, some of these local government health facilities are seasonal.[14] Sometimes the local government runs out of drugs or health personnel to run the units. Pearce found the same trend in Nigeria and reported that

> political pressures gave rise to the construction of hospitals, maternity centres and dispensaries throughout the nation: Many have to remain closed or poorly maintained for years due to lack of staff or supplies.[15]

Apart from a few mission and community hospitals in rural Nigerian locations, the rest of them are in the urban centres. Industries and corporations are all in the cities and so are their health facilities.

TABLE 11

OWNERSHIP AND MANAGEMENT OF HEALTH ESTABLISHMENTS IN NIGERIA

Ownership Management	No. of Hosp.	No. of Beds	Consumers of Services	Type of Service
Federal government	63	8,688	Urban/Town Dwellers	All types
State government	2,382	27,691	Urban	All types
Local government	3,172	13,977	Rural/ Urban	Mostly out-patient
Mission hospitals	771	9,001	Rural/ Urban	All types
Private hospitals	675	5,013	Urban	All types
Corporations	32	202	Urban	All types
Community hospitals	39	741	Rural/ Urban	Mostly out-patient
Industrial	17	133	Urban	All types
Joint (Govt. & Missions)	12	1,513	Rural/ Urban	All types
Totals	7,163	57,944		

SOURCE: Ibid, p. 7. All types refers to hospitals with in and out patient services.

Private individuals also locate their hospitals where they will get the best profits. In general, there are more hospitals in the Southern and richer part of Nigeria. Richer states (they have industries and large

corporations) such as Lagos, Kano, Anambra, Bendel, Oyo and Rivers have several private hospitals while such poor states as Benue, Niger, Gongola and Sokoto do not have private hospitals. The wealth of a state determines the number of health facilities that it can have. The consumers of these services are mostly urban dwellers, where these services are located.

There are different kinds of hospitals beside the general ones. For example, there is one paediatric hospital situated in Lagos, 7 maternity hospitals and 627 maternity homes with 1,309 beds all located in Lagos. There are four specialist hospitals for tuberculosis, 42 infectious diseases hospitals and 10 psychiatric hospitals located in different parts of Nigeria.

In 1977, there were only 6 teaching hospitals and five medical schools in Ibadan, Lagos, Ife Nsukka and Ahmadu Bello University with a teaching hospital at Kaduna, Malumfashi and Zaria. In 1979 more medical schools were started in Benin, Ilorin, Port-Harcourt, Jos Maduguri and Sokoto. Each of these has one teaching hospital. Each of the old and new medical schools have a School of Nursing attached to it and more health manpower is expected by 1985 when all medical schools are expected to have started turning out graduates.

The difference in health manpower between 1960 and today is enormous. For example in 1960 Nigeria had only 306 hospitals with 20,000 beds, but in 1977 there were 7,163 hospitals, a difference of 6,859 in 17 years. In 1960 there were 722 doctors on register, but in 1979 there were 6,584 doctors, a difference of 5862 in 19 years. There was also

TABLE 12

TYPES OF HEALTH FACILITIES IN THE FEDERAL REPUBLIC OF NIGERIA IN 1979

Name of facility	No. of Hospitals	No. of Beds	No. of States Having
1. General Hospitals	495	34586	19
2. Paediatric hosp	1	92	1
3. Maternity hosp	14	1309	7
4. Maternity homes	627	3601	11
5. Maternal health centre	856	4664	19
6. Infectious Diseases	42	534	11
7. Psychiatric	10	1737	9
8. Orthopaedic	3	710	3
9. Tuberculosis	4	247	4
10. Ophthalmic	3	277	3
11. Health Centres	389	2294	19
12. Leprosaria	27	1270	15
13. Leprosy Clinics	2530	-	19
14. Dental Clinics	22	-	9
15. Others	2109	138	19
16. Prison hospitals	3	68	3
17. Teaching hosp.	6	3724	5
18. Armed forces Hosp	10	2033	8
19. Medical Recreation	4	660	4
Totals	7,163	57,944	19

SOURCE: Adapted from Federal Ministry of Health Lagos, Special Report submitted to World Health Organization, 1979, op. cit., Some states in Nigeria did not turn returns.

a dramatic increase in para-medical personnel such as nurses, midwives and pharmacists as well as the emergence of new health specialists such as dental, and medical laboratory technicians (see Table 13).

TABLE 13

NIGERIAN HEALTH PERSONNEL IN 1960-1979

Personnel	Total No. 1960	Total No. 1979	Total Difference
Physicians	722	6584	5862
Dentist and Dental Therapists	49	499	392
Dental Technicians	-	138	138
Pharmacists	542	2780	2238
Veterinary Surgeons	53	740	687
Midwives	7023	25730*	18707
All Nurses	9325	29515*	20190
Medical Lab Technicians	-	1082	-
Medical Lab Assistants	-	3320	-
Radiographers	-	300	300
Totals	17,714	71,693	53,989

SOURCES: 1960 figures adapted from Schram, R. History of Nigerian Health Services, Appendix p. 433. 1979 figures from WHO statistics yet to be published. *Figure excludes student midwives and student nurses.

- Figures not available.

There has been a corresponding increase in budgetary allocation for health care in Nigeria since 1960. Table 14 shows the difference in budgetary allocations for health care between colonial years (1939-48) and post colonial years (1971-80). In the 1977/78 Fiscal year, the health ministry allocated N109.5 million. This alone was 20 times larger than the amount allocated for 10 years (1939-1948) in the colonial days. Although the population of Nigeria was only about 55 million in the colonial days and the natural increase was only 2.1, the amount allocated for the 10 years was critically inadequate for any meaningful health care development. The 1977-80 allocations are equally low, but show significance increase over the past years. The figures are low relative to the population of Nigeria which was 80 million in 1977 with annual natural increase of 2.7.

TABLE 14

FEDERAL GOVERNMENT OF NIGERIA: EXPENDITURE

ON MEDICAL SERVICES FROM 1939-1980

Colonial Years	Amount in N	Estimated pop. (in millions)	Post-Colonial Years	Amount in N	Estimated Pop. (in millions)
1939-40	0.9 million	49	1977/78	109.5 million	80
1944-5	1.3 million	52	1978/79	81.1 million	82
1947-8	2.3 million	55	1979/80	97.2 million	84

SOURCE: Colonial figures adapted from R.O. Ekundare op. cit., p. 353. Post Colonial figures from Europa Yearbook: A world survey 1981, Vol. II, p. 1105.

Though there have been significant increases in all aspects of health care in Nigeria since independence, the health of an average Nigerian still leaves much to be desired. This may be as a result of the fast increasing population, with annual natural increase of 2.7 . Beside the issue of population growth, there is the role of health care planners. Their major emphasis is on hospital based care which is expensive and which can reach only a small population living in cities. Health facilities are also unevenly distributed within the country. For example, the city of Lagos alone has 7 out of the 14 maternity hospitals in Nigeria and 54 out of 495 government hospitals in Nigeria. The only peadiatric hospital in Nigeria is also located in Lagos. The rural areas lack these facilities, although they need them as much as people living in urban areas. Beyond and above the problem of facilities, is the colonial culture which Nigeria has adopted. The colonial government in the pre-1960 era never established hospitals or other health facilities in rural areas. Their facilities were all in the cities. Health planning in the colonial era was not effective. Colonial doctors were performing two roles at a time - both as physicians and administrators. Colonial government officials had better housing, health services and other social services than the natives. They (colonial government officials) also disregarded traditional medicine.

Nigeria is no longer a colonial state, but the colonial culture still dominates the thinking of those in control of the State apparatus; and health practitioners, many of whom were actually trained by the colonial masters. The method of administration is still the same. Colo-

nial culture had complicated the problems of the independent Nigeria leading to general underdevelopment and the underdevelopment of the health sector. The health sector has problems which are the result of class factors within the country, and the professional interests (commodification of health and medicalization of the society) which the state managers and health practitioners have adopted. This will be discussed in the following chapter.

(d) Traditional versus modern medicine in Nigeria

Although the number of traditional healers in Nigeria is not actually known, several people such as Una Maclean,[16] D. Oyebola[17] and Zacchaeus Ademuwagun[18] have shown that Nigeria has a lot of traditional healers. In fact they have shown that almost every home, in some parts of Nigeria has a traditional healer. Una Maclean has spoken of 1000 healers in Ibadan city alone. Ademuwagun, has indicated that

> --- there are many medicine men in every locality; in rural areas they form 10 percent of the adult population and in urban areas about 4 percent.[20]

Both the Nigerian government and international agencies e.g. WHO and World Bank have belatedly realized the potential contribution of traditional healers in national health care.

In 1978, the WHO officially adopted a health policy which incorporated traditional medicine. In order to achieve the target of "health for all by the year 2000," the WHO adviced its 151 member countries in-

cluding Nigeria to make use of traditional healers. The document stated:

> --- they (traditional healers) are often part of the local community, culture and tradition and continue to exert considerable influence on local health practices. With the support of the local health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community.[21]

The WHO's plea regarding traditional medicine has not been taken far in some member countries such as Nigeria. In Nigeria, the Nigerian Medical Association seems to be a stumbling block to traditional medicine. For example, it was soon after the WHO policy on traidtional medicine was declared that a renowed Nigerian physician (Dr. O. Ofodile) published a thesis to warn that any politician or medical personnel who recommends traditional medicine as part of the official health policy of Nigeria will "ultimately bear responsibility for any deaths and injuries that will result from it."[22] Recently, one of the founding fathers of the Nigerian Medical Association (Tola Asuni) took the campaign against traditional medicine further into the Journal of Social Science and Medicine.[23] To him (Tola Asuni), the official recognition of traditional medicine in Nigeria will lead to the extermination of large sections of the population by epidemics such as cholera and small-pox since the whole concept of infection and contagion does not enter into the consideration of traditional healers.[24] Asuni's argument is very much like a Nigerian physician who is trained to perceive health and disease in terms of cure and never in terms of prevention. Asuni has failed to think of the potential contribution of traditional healers

in preventing social and psychological ills through traditional psychotherapy. Again, his failure to cure cholera or small pox does not exhaust the contribution of a traditional healer in health care.

In the same thesis, Asuni made a caricature of traditional medicine and healers, mentioning their illiteracy and inability to issue a 'certificate of sick leave' and ignorance of antibiotics and medical records.

Asuni also commented on the healers' wickedness to psychotic patients:

> --- the status of the traditional healer as a powerful man has diminished. His method of flogging, beating, purging and chaining of patients is being rejected --- I know a few who ran away from the traditional healer to come to the psychiatric hospital -- sometimes with the traditional healer on their heels.[25]

Asuni's thesis reflects his value judgements. He mentioned the negative cases of smallpox, cholera and other infectious diseases which traditional healers are deficient in treating, but he never mentioned bone-setting, deliveries, diarrheoa and dysentery with which traditional healers show excellence. Asuni presented the dilemma of the traditional healer to sign "certificates of sick leave" but he never mentioned the non-recognition by the government agencies and complete refusal of sick permits signed by literate members of traditional healers.

Oyebola is equally critical of traditional medicine. He reported that:

> The healer who claims to treat hypertension and cardiovascular diseases does not know how to measure blood pressure. He claims to treat hypertension with herbal concoctions whose components were not disclosed -- and this casts serious doubts on his claim. His practice may be mere deceit of a gullible clientelle. It is important to protect the public from this type of practitioner.[26]

Oyebola also condemned the healer who specializes in gonorrhoea treatment. He expreses it with scientific flavor "the much advertised gonorrhoea medicine had no effects on plates of Neisseria gonorrhoea cultured in virto. Although in vitro tests were not done, the effects of antibiotics can usually be demonstrated in vitro. The absence of activity in vitro puts the efficacy of this medicine in doubt."[27] Oyebola needs to repeat his experiments before he can disregard traditional gonorrhoea treatment. Besides, research has shown that in some cases, no scientific relation can be established between the medicine and disease that traditional healers cure.[28] He has also limited his investigations to two negative cases. It is not because a healer does not use apparatus to measure hypertension that he is unable to cure.

This brief sample of attitudes of the Nigerian physicians can be explained in terms of the socialization they acquired in medical schools in Europea and in Nigeria. A study in the University of Jos, Nigeria has shown that medical students tend to deny the efficacy of traditional healing more than their counterparts in other faculties. A respondent in a study sample had a friend whose broken leg was set by a traditional bone-setter. The victim consequently resumed his soccer playing. When

the respondent (a 4th year medical student) was asked to appraise the work of the bone-setter in this particular case, he (respondent) expressed the hope that, the set leg of his friend would later develop complications because the bone setter never had X-rays to examine the joining bones.[29] Medical schools socialize their students to be critical of traditional medicine. This attitude has untold effects on the delviery of health care services, because traditional healers are not allowed officially to contribute to the health care needs of Nigerians.

In this regard, Zacchaeus Ademuwagun might have been accurate in his findings that:

> the clash of interest between the orthodox and traditional health personnel is due more to professional, cultural pride and defence than to professional philosophy.[30]

Aside from this fact, there is no reason why the Nigerian physicians are unwilling to recognize the abilities of the traditional healers even when they deserve it.

According to the Nigerian Medical Association, traditional medicine should be avoided because

1. The healers are too often associated with divinity, black magic or witch craft. This seaparates traditional medicine from the scientific foundation of modern medical practice.
2. Traditional medicine is not codified, indexed or quantified and so its effects cannot be scientifically assessed.

3. Traditional healers know little or nothing about bacteria and infectious agents.
4. Traditional healers are not trained in the structure and anatomy of the body or on the pathology of diseases.

Although the Nigerian Medical Associaton has made its position on traditional medicine clear, the Federal government still entrusts it (medical profession) with the responsibility to study and advice the government on the potential use of traditional medicine. Ueagwu blames the Nigerian government for not taking note of the bias of the Nigerian Medical Association. He noted that

> --- No government concerened with the good health of its citizens can afford to ignore the differences of opinion which results in humiliation and intimidation, in trying to deny one his or her rights in fear of interferring with the autonomy of a professional body.[31]

Western medicine and its therapeutic glory and triumphs are well known in Nigeria, but not all the people of Nigeria have access to it, and according to Ademawagun "the consumer consciously and rationally decides which particular health service to consult for a particular ailment even at the cost of having to do a lot of shopping around."[32] It is for this reason that our health care system remains incomplete until traditional medicine is officially recognized and legitimatized.

The main problem facing traditional healers in Nigeria today is one of obtaining government recognition. The Traditional Medical Association (TMA) has made several representations to successive governors and

health ministers on the matter. Oyebola noted that "they (traditional healers) have seized every available opportunity to convince western trained doctors and relevant government functionaries of the need to accord them official recognition.[33]

A Nigerian Scientist Dr. Teller blames the Nigerian Medical Associaton for hindering progress in traditional healing:

> the insincerity and cynicism of our medical researchers are creating a stumbling block to the development of traditional medicine in this country.[34]

Social scientists such as Ademuwagun, based on his research on traditional medicine have suggested the possibility of intergrating traditional and modern medicine into one medical system. This recommendation has been rejected or not considered seriously by the government. Instead, the Nigerian Medical Association seems to join the famous surgeon who wanted to know the part of the human anatomy that specialists in social medicine treat. Traditional medicine may have faults, but modern medicine too has faults. To Ivan Illich, the scientific medical system is an epidemic causing pain, dysfunction, disability and anguish, (ie, it has become a major threat to people's health).[35]

(e) The emergence of Medical dominance

Medical dominance as a sociological concept is stressed in the work of Eliot Freidson who also attempts to differentiate professional autonomy from professional dominance.[36] According to Freidson,

> While the members of all professions may be committed to their work, may be dedicated to service, and may be specially educated, the dominant profession stands in an entirely different structural relationship to the division of labour than does the subordinate profession.... the difference reflects the existence of a hierarcy of institutionalized expertise.[37]

Freidson therefore attributes the dominance of the medical profession to its expertise. The medical profession also controls its work, education and evaluates its members. Medicine influences health policies and decisions and has the monopoly of determining who is sick and who is healthy.

Recently, medicine has included many more things (i.e., specific behaviors and actions) under the concept of disease, extending its domain of dominance and thus medicalizing society. Freidson refers to disease as ideology, while Blishen comments on doctor's doctrines in his discussion of the ideology of medical care.

Before 1960, medicine in Nigeria was not yet at a take-off stage and so had nothing to dominate. But today, the medical profession in Nigeria is as dominant as that in the western countries e.g. U.S.A. described by Freidson.

The medical profession in Nigeria informally and formally controls many decisions and policies that affect the health sector. The chief Medical Advisor to the Federal government is a physician. Physicians form the majority in the Nigerian health council. In 1975, when the Basic Health Care services were launched, for the rural areas, physicians rather than medical sociologists or social scientists

were the directors as well as administrators of the programme. The medical Association has contacts with medical schools and indirectly controls the production, and supply of physicians. The medical profession assigns roles and defines the limits of the medical practice of all para-medicals.

The traditional healers in Nigeria too have been medicalized by the Nigerian Medical Association. This is why hundreds of the Nigerian traditional healers can't practice officially. The medical profession has a monopoly to determine who should practice medicine and more than that who is healthy and who is not.

The Medical Association dominates all other occupations in the health sector such as nurses, pharmacists, midwives and laboratory technologists. Nigerian physicians serve as principals and directors of Schools of Nursing, hygiene and laboratory technology. Physicians are virtually at the head of whatever is implicitly or directly related to health such as public health and sanitation officers. Several other behaviours like crime are now been included in the purview of medicine. Potential couples are expected to be examined by a certified physician before a sound and healthy marriage can be assured. Although the Nigerian society is not as medicalized as the western world portrayed by Freidson and Navarro, there is certainly a wave of medicalization which is still expanding. Traditional medicine has fallen a victim to this medicalization.

The discussion of health care in Nigeria today has clearly shown the effects of the diffusion of entrepreneurial values (scientific me-

dicine, professional dominance etc) and the underdevelopment of health services in Nigeria. The diffusion has led to a set of complicated problems. For example, medical dominance which is diffused along with scientific medicine is a stumbling block to the development of health care. Traditional healers are dominated and are unable to contribute their quarter to national health care. Health is now perceived as a commodity by physicians and as such they (physicians) try to locate their skills in places that they will have profits (urban areas). In the same vein; liberal democracy is diffused to Nigeria together with class interests, making health services more available to privileged members of the society.

Explicitly stated, health services were underdeveloped in the pre-independent era because the colonial government provided health services only to its staff and disregarded the natives. Health services were later extended to natives who were in the employment of the colonial government and who worked to support the exploitation of the natives. Today, wealthy people in Nigeria are in the position that colonial administrators were in the pre-independence era. The method and style of administration is the same. The distribution of health care services takes the same shape and form. It might be appropriate to reiterate the fact that underdevelopment in Nigeria was caused by colonialism and is sustained today by neo-colonialism. This takes many forms such as diffussion of entrepreneurial values (scientific medicine, commodification of health, liberal democracy, technology, etc.).

NOTES

1. Unless other wise stated, all the statistical data presented in this discussion of the measurement of health status are taken from World Population Data Sheet (Appendix A in Timothy Baker: Assessment of Health Status and Needs, New York: Springer Pub. Co. 1977, p. 41-55. World Bank Health Sector Policy Paper, p. 67-85.

2. The world's minimum rates are: birth rate 30; death rate 12; natural annual increase 1.8; infant mortality 103; life expectancy 59. Ibid, p. 41.

3. S.L. Adesuyi, "Priorities in Health Care" In Priorities in National health planning, eg. by Akinkugbe et al, 1973, p. 14.

4. Obafemi Awolowo, The Strategy and Tactics of the People's Republic of Nigeria, London, Macmillan and Co. (1970), p. 59.

5. Ibid, p. 61.

6. G.A. Ademola, Environmental Sanitation. Quoted from Awolowo, Ibid, p. 61.

7. Ransome Kuti, Priorities in Health Care, op. cit., p. 58-59.

8. U.A. Igun,"Child- Feeding Habits in a Situation of Social Change" Social Science and Medicine 16, 1982, p. 769-781.

9. For Canadian Statistics, Canada Vital Statistics, 1973, Vol. III, Cat. No. 84 - 206 Ottawa. Feb. 1975, Table 20. For Nigeria see footnote 8.

10. Statistical data for this is taken from footnotes 9 above. For Nigeria see Measurement of Coverage and Effectiveness of Health Care in Nigeria, Unpublished memo, Ministry of Health, Lagos, 1977, p. 1-14 and Tables 1-3.

11. The Federal government asked the States to create State Health Management boards in 1976.

12. Ekundare Olufemi, op. cit., p. 352.

13. Federal government of Nigeria - Measurement of coverage and effectiveness of health care in Nigeria, Tables 1-3.

14. D.A. Ityavyar. Planning health care in Nigeria. Unpublished report op cit., 1981.

15. Tola Pearce, op. cit., p. 94.

16. Una Maclean - Magical Medicine, A Nigerian Case Study, Penguin books, 1971.

17. D. Oyebola. "Professional Association, Ethic, op. cit.

18. Zaccheaus Ademuwagun - "The relevance of Yoruba medicine men in public health practice in Nigeria" In Z. Ademuwagun (ed) Therapeutic Systems in Africa. New York, 1975.

19. Ibid, p. 153.

20. Primary Health Care - joint report op. cit., p. 33.

21. F.O. Ofodile, "On Traditional Medicine." West Africa 3301, Nov. 3, 1980.

22. Tola, Asuni, "The dilemma of Traditional Healing in Nigeria" Social Science and Medicine 13 (1979).

23. Ibid, p. 33.

24. Ibid, p. 38.

25. D. Oyebola, op. cit., p. 92.

26. Ibid, p. 92.

27. Ibid, p. 95.

28. Several cures administered by traditional healers are not scientifically proven. Research is still in progress in many areas in Africa e.g. Ghana to show relations between Traditional medicine and the diseases they cure.

29. S.K. Bonsi, Attitudes of Medical Students towards Traditional Medicine, Jos, unpublished, 1982.

30. Z. Ademuwagun, op.cit., p. 165.

31. G.C. Ueaguri, "On traditonal versus Modern Medicine", Daily Times, January, 1980.

32. Daily Times, Jan. 14, 1980.

33. Oyebola, op. cit., p. 91.

34. Daily Times, Daily Newspaper, Jan. 14, 1980.

35. Ivan Illich, Medical Nemisis, op. cit., p. 17.

36. Eliot Freidson, The Profession of Medicine, Chicago, Aldine Publishing Co, 1970, p. 137.

CHAPTER FIVE

UNRESOLVED HEALTH CARE ISSUES: SOME POLICY RECOMMENDATIONS

The historical antecedents (eg. colonialism) which contributed to the underdevelopment of Nigerian Society (including the health care sector) have been reviewed (Chapter 3). Some of the consequences of this underdevelopment for health care in Nigeria have been considered (Chapter 4). For example the health status of the people and the organizational structure of the health care delivery system today. However, patterns of disease among the people and the distribution of health care personnel alone cannot provide an adequate understanding of the impact of underdevelopment on health care in Nigeria and the unresolved problems facing the health care system. The political economy of Nigerian society as a whole must also be considered i.e. the ways in which the inequitable distribution of power, authority and wealth affects the organization and delivery of health care services.

This chapter will therefore explore some unresolved health care issues in Nigeria. Some policy recommendations will also be suggested as a means of resolving the problems of the health care sector in Nigeria.

The economy of Nigeria is based on the capitalist system established by the British colonial government in the early 20th century. Today, the Nigerian economy is sustained by the neo-colonial forces of Europe and America through International agencies and Multi-national companies such as Lever Brothers, Coca-cola, and Baclays Bank International. In the colonial capitalist system (also known as a mixed economy), the domestic capitalist relations of production derive their operative force and support from the international capitalist system of Europe and America. The colonial capitalist system has polarised the Nigerian society into two major social classes. One of these classes is comprised of big landowners, traders, industrialists, top military and civilian officers, as well as professionals such as bankers, physicians and university professors. This social class is comparatively smaller in number than the other major class which consists of peasants, factory workers and petty traders.

The former, (the bourgeois class) is politically and economically more powerful than the latter (working or peasant class), because members of the bourgeois class exploit members of the peasant class. The peasants are exploited economically, politically and socially. Economically the exploitation of the peasants can be explained in two ways. First the farm products of the peasants such as cocoa, rubber, groundnuts, and palm kernel are bought from at very low prices and are

in turn exported at greater profit by the indigenous exporters (middle-men). The international traders from Europe and America who buy these raw materials from the Nigerian bourgeois traders further export the same materials to Nigeria in the form of finished products. For example, cocoa which Nigeria exports to Europe is subsequently imported by Nigera in the form of cookies, beverages and biscuits. In the end, the middle-men profit more from the farm products of the peasants than the peasants themselves and the multinational companies profit the most of all. Secondly, the labour of the working class is exploited by the industrialists. For example many factory workers in Nigeria barely survive on the wages paid them in return for their labour. The labour of the workers contributes to the production of goods and services which enrich the industrialists. The low wages paid to the workers means that the owners of the industries grow richer while the workers grow poorer.

Politically, the peasant class is exploited of its electoral franchise. Through political intimidation the peasants, who constitute the majority of Nigerian Society; are compelled to vote into power the bourgeois politicians who often fail to appreciate the social and economic problems of the poor. Social exploitation takes the form of social injustice and selfishness on the part of the managers of state affairs. For example, social services such as schools, transportation, telephone, water, and electricity are available only to the bourgeois class and not to all Nigerians.

Health care services similarly are not available to the peasants

in general, and especially those that live in the rural areas. Even in the cities, social facilities for the poor are deficient in quality. For example Peter Lloyd[1] has shown that Nigeria has better schools for the children of the rich than for the children of the poor. The social class to which a Nigerian belongs determines the type and quality of both the education which his children receive, and the health care services available to him and his family.

(a) Class factors and the distribution of health care services

The health status of Nigerians in the bourgeois class is on the average better than that of the working class. One doctor serves about 400 patients of the bourgeois class while one doctor serves 25,000 peasants. Life expectancy at birth in Nigeria is 41 years for the poor but as high as 62 years for the more privileged class because they have better healthcare services as well as good housing and food which the poor people do not have.[2]

The structure of the Nigerian health care delivery system provides more and better health care facilities in the cities where the more privileged social class live, than in the rural areas which are predominantly inhabited by the peasants. Even within the cities, there are hospitals and clinics which are built and reserved for the bourgeoise class. For example, the Plateau Hospital in Jos is reserved specifically for senior government bureaucrats, businessmen and professionals such as professors and bankers who are wealthy enough to afford the cost of services offered. The general hospitals which are built by the government to serve all people in Nigerian society are not as well equipped

as the ones reserved for the wealthy. In Nigeria, government general hospitals primarily serve the poor population who can not afford anything better. The general hospitals have fewer physicians and lack essential hospital facilities including even very simple equipment such as drugs, syringes, needles, coolers and beds. O. Okedeji has reported that, even in these general hospitals 'families with elitist connections are served better.'[3]

The health situation in the rural areas where the Nigerian peasants live is even worse than the urban slums. Rural dwellers who constitute 75% of the Nigerian population are served by dispensaries and rural clinics, some of which operate only seasonally, due to a lack of drugs or personnel or both. In some states in Nigeria e.g. Sokoto state, clinics are located in villages such as Dancadi and Dingyadi which have no acess roads connecting them with the cities. The absence of roads makes it more difficult to get health care equipment to such inaccessable areas. The Nigerian health care policy is influenced greatly by the bourgeois class. The influence has in effect caused the rural-urban inbalance in health care development and in health services distribution. If the rural areas were inhabited by the bourgeois class, health care services would presumably be equally available to these areas.

To the Nigerian government, a dearth of capital rather than class factors is the main problem confronting health care in Nigeria. The Nigerian government's argument is however contrary to fact and the reality of the Nigeria health situation. For example, while some rural

areas have only a clinic for every 200 square kms, new government health budgets may provide for specialist hospitals or sophisticated cancer treatment laboratories; even though the main cause of death in Nigeria is from infectious and preventable diseases, and not cancer or other diseases of affluence. (see Table 3) The establishment of hospitals for the treatment of diseases such as cancer, that are not even common in Nigeria is interpreted by the government as a sign of medical and health care development in Nigeria. Maurice King has noted this problem:

> --- latest operating theatres are built to replace still servicable ones, while most children are still unvaccinated against measles or where rural clinics are still short of syringes -- a thoracic surgeon or a cancer specialist is recruited before an expert on health education. They make lavish provision for the few rather than for the many.[4]

The production of manpower in Nigeria also reflects the class structure. The British colonial government introduced medicine in Nigeria as a prestigious bourgeois occupation. The early Nigerian physicians trained by the British government were not arbitrarily chosen but were carefully selected from the families of Kings, Chiefs, and Emirs.[5] The colonial government used the strategy of training sons of native Chiefs and Kings in order to lobby these native leaders, and have easy penetration and exploitation of the Nigerian colony. The Nigerian physicians who were trained by Christian missionaries, e.g. Dr. Barau Dikko, were also selected from influential families. The Christian missionaries used this strategy to win favours and permission

to preach the gospel, especially in Northern Nigeria which already had Islamic religion. Since the early Nigerian physicians all had some sanguine relations with the political leaders (native Chiefs and Kings), the medical profession emerged more as a powerful political group than a medical group.

For example, Schram[6] has shown that nine out of 35 Nigerian physicians in the 1950s were full time politicians and 3 consequently became regional governors of Nigeria between 1955-1957. In Nigeria today, the opportunities for medical training are largely available to sons and daughters of influential, wealthy and privileged families, usually residing in cities. The production of medical manpower in Nigeria therefore has class implications. This may also explain why Nigerian physicians refuse to practice in the rural areas. They (the physicians) are partly justified because they were born and raised in urban areas, and would not survive life in the rural areas with no pipe-born water, electricity, markets and schools for their children. The situation may have been different if opportunities for medical training were available to all including children of the peasants, who would perhaps agree to serve in the rural areas after they graduate. In countries such as Canada where opportunities for medical training are availabe to all including children of farmers, physicians still refuse to practice in the rural areas because the ideology of Capitalism and professionalism are well developed and they mitigate against this outcome.

Related to the problem of limited opportunities for the peasants

to gain a medical education is the absence of primary and secondary schools in the rural areas. The few schools that are in the rural areas are ill-equipped and have no scholarship for children who would want to study medicine. Educated people including school teachers, prefer to stay in the cities, and so the rural inhabitants lack schools, teachers and instructors. The many years required in training a physician also contributes to scare away even the few fortunate children that would have access to medical training. Children of poor parental background lack a sound financial support that would enable them to spend 6 or 7 years beyond high school in the medical training. The most successful and fortunate children in the rural areas in Nigeria are those that have opportunities to obtain a bachelor's degree in the Arts or in the Humanities. Some go on to become midwives and nurses, and are employed by the urban hospitals after graduation. If hospitals were in the rural areas; nurses and midwives, most of whom are originally from the rural areas may want to practice in the rural hospitals. Schools for nurses and midwives are all in cities.

The inequality in the distribution of health care facilities in Nigeria is therefore a social structural problem. For example, it is the socio-economic structure of Nigeria that determines the production, supply and distribution of health care services. The underdevelopment of the health sector in Nigeria is not merely a factor of poverty as the government suggests, but more of a social-structural problem which is embedded in Western Liberalism which has been imported into Nigeria. The Western liberal values embodied in the profession of medicine do

not favour the introduction of socialized medicine, which may contribute to solving the problem of health care in Nigeria.

Perhaps, the introduction of a carefully planned, classless form of health insurance would be useful in making health care services more available to the Nigerian population. With government subsidized health insurance, all patients will have access to any hospital of their choice. In the present situation, only general hospitals are available to the poor masses. Health insurance will however not solve the problem of rural-urban imbalance, and that is why the solution to the Nigerian health care problem transcends the health care sector. The problem of social inequality in the provision of schools, water, electricity, roads and markets must be dealt with first, before health care issues will be resolved. Good health means more than the availability of hospitals and dispensaries, it means the total social, psychological and physical well being of individuals.

After independence, the effects of colonialism are still felt in Third World countries which had been European colonies. One of the main effects of colonialism in the Third World today is the existence of a group called the 'indigenous bourgeoisie.' The indigenous bourgeoisie consists of a small, powerful and wealthy group of natives who had been favoured and trained by the European imperialists. After independence, the scepter of authority was handed over to this powerful native group, which still maintains good economic and political relations

with its former colonial masters. These new leaders of the Third World are allied with the metropolitan bourgeoisie in promoting the exploitation of Third World countries through neo-colonial economic links.

The indigenous bourgeoisie are the managers of the state affairs in their various countries within the Third World. They formulate national economic and political policies that benefit the developed countries and their multi-national companies and which also satisfy the economic and social interests of these indigenous bourgeoisie.

The interactional effects of the neo-colonial forces and the interests of the indigenous bourgoisie are therefore the main obstacles to the development of the Third World, and particularly the development of the health care sector. These interactional effects include the diffusion of entrepreneural values into the Third World countries. For example, the diffusion of professional, scientific medicine to the Third World came along with Western capitalist values. In Western countries such as the USA, doctoring is a form of business enterprise and medical skill a 'commodity' to be sold. In a bid to keep the business of doctoring profitable, physicians employ marketing mechanisms for controlling the production and supply of physicians. By so doing, physicians protect their economic and professional interests at the expense of national health care.

This supports proposition three which states that the indigenous elite of the Third World who plan the economy and in fact the health care sector are controlled by Western powers. They (indigenous elite) plan to safeguard their own interests and that of the Western imperial-

ists and therefore perpetuate the underdevelopment of health services in Nigeria.

(b) 'Health for the people versus health by the people'

In 1975 the 29th World Health Assembly officially accepted the concept of primary health care as a World Health policy. According to the WHO, primary health care is a

> practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. It has social and developmental dimensions and if properly applied, will influence the way in which the rest of the health system functions.[7]

In 1978, the various member governments of the International Conference on Primary Health Care (including Nigeria) identified the following characteristics of primary health care:

(i) A health system that would be patterned after the life-style of the local people to be served.

(ii) Villagers as Primary Health Care Workers, families from the local area and who are also acceptable to the local community.

(iii) Health care offered shall place maximum reliance on available community resources e.g. community members.

(iv) Primary health workers be trained for a few weeks only in basic hygiene.

(v) Primary health workers be non-salaried workers. The primary

health worker should only enjoy dignity and pride presumably associated with serving the community.[8]

Primary health care is therefore health by the people and not health for the people. The central idea of primary health care reflects the understanding that there is not enough money in the countries of the Third World such as Nigeria to consider any other solutions for health care needs, and that community health priorities are more likely to be met if the people themselves both raise and spend the resources required.[9]

The Nigerian government has accepted the idea of primary health care and the Health Ministry has a programme for influencing local communities to provide their own health care i.e. the Basic Health Implementation Agency with headquarters in Lagos. This agency will certainly contribute to improving the health of the local or rural communities, if these communities have the resources to provide health care by themselves. But underlying the idea of health by the people are two key issues that must not be overlooked, particularly in the Nigerian situation. These crucial matters are:

1. The issue of social justice.
2. The issue of quality and quantity of rural resources.

It is nothing less than social injustice on the part of the Nigerian leadership if the richer and more privileged bourgeois class living in cities has adequate health care services while the poor masses in the

rural areas are asked to provide health care services by themselves. If any social class was to provide health services for itself in Nigeria, the bourgeois class should be the one, and yet, many wealthy senior government bureaucrats and their families have free medical services.

It would be good if the rural people could provide their own health care, but they do not have the necessary resources. The so called primary health worker can treat wounds with iodine and dispense aspirins. He can also organize traditional birth attendants and most importantly he or she can contribute by organizing the community to construct an access road. What else can those health workers do? Preventive health services which should be the main concern at this stage of development will have no place in primary health care if the villageers are to provide their own health services. For instance, the primary health worker himself is uneducated and does not know enough about hygiene and the agents of infection. In this regard, an assistant health officer should be trained. His training should be less (in duration and quality) than that of a general practitioner. If such persons are produced, and the rural areas are improved, health personnel may become sufficient to meet the needs of Nigeria. Mejia has found out that it is cheaper to train low cadre health personnel than training full fledged doctors. In Thailand, 19 auxiliary health workers are produced at the cost of educating one physician. In East Africa, 20 medical assistants are produced at the cost of educating one physician. In Pakistan, 24 medical assistants, 60 midwives, 60 sanitary inspectors are produced at

the cost of educating one physician.[10]

In Nigeria, the Nigerian Medical Association is not in favour of the training of any medical assistants. The president of the Nigerian Medical association and the Chief Medical advisor to the Nigerian Federal Government are both opposed to the idea of producing medical assistants. The chief Medical advisor clearly stated his opposition: -

> ... the money required to established training facilities for such lower grade personnel might as well be used to expand medical schools.[11]

The president of the Nigerian Medical Association is perhaps more concerned with the potential social status of such medical assistans in the heirerchy of health occupations. He is worried that such medical assistants, if produced, may be as powerful as physicians in the health sector:

> ... very soon such mini-doctors will upgrade themselves and become full fledged doctors or masquerade as such and it would then be too late to ...[12]

The Nigerian Medical Association supports the training of village level primary health workers but opposes the training of medical assistants probably because the social distance between the physicians and the village health workers is typically great and does not threaten the medical monopoly of physicians in the business of doctoring. Local health workers and medical assistants might play complimentary roles and together improve the health of rural Nigerians. Both are necessary to improve the health care system. Village level health workers might

in fact play a more important role if medical assistants are also trained. The so called village workers will have difficulty in dealing with the complexity and red-tape of the Nigerian bureaucracy. The medical assistants will be better educated and qualified than village level health workers to face adequately the cumbersome task of transacting official health business with various government agencies.

The rural community can contribute to changing the health care system, but this contribution will not be in the form envisaged by the government's primary health care scheme. The rural inhabitants are too poor to provide health care services by themselves. However, Nigeria does in fact possess the resources necessary to provide all the people with health care services. For example Nigeria is two times richer than Tanzania and yet Tanzania's health services are available to a larger percentage of the population than Nigeria's health services.[13] In 1977 the GNP per capita of Nigeria was U$420 and that of Tanzania was U$190. Tanzania emphasises preventive health care services and its health care development plans are intrisically related to the general development of the Tanzanian economy. Health care facilities are provided along with schools, roads, water, food and etc. For example, the present adult literacy rate in Tanzania is 66% and that of Nigeria is about 30 percent.

About 40% of Tanzanians have access to safe water and only 26% of Nigerians have access to safe water. THe comparison between Tanzania and Nigeria shows that Nigeria is richer than Tanzania, and has a better physician-population ratio than Tanzania but the health status

TABLE 15

A COMPARISON OF HEALTH STATUS MEASURES IN TANZANIA AND NIGERIA

	Tanzania	Nigeria
GNP per capita in U$	190	420
Crude birth rate/1000	48	50
Crude death rate/1000	16	18
Infant mortality rate/1000	-	163
Life expectancy at birth	51	48
**Adult literacy	66	30
*Population-per physician	18490	14810
Daily calorie supply as % of requirements	86	88
% of expenditure on health	07	-
Preventive health as % of total health budget	1.9	0.7

NOTES: Data not available

** Refers to 1974 Statistics

* Refers to 1976 Statistics

All others 1977 estimates.

SOURCE: Health Sector Policy Paper op. cit., p. 71-72.

of an average person in Tanzania is higher than that in Nigeria (see Table 15) This situation may be due to the differences in the health care policies between these two countries. Tanzania tries not only to provide its population with health care facilities, but also other social amenities such as water, and agricultural incentives (this leads to higher food production and consequently sufficient calorie supply). Although Nigeria has comparatively more calorie supply to its people than Tanzania, the agricultural land of Tanzania is less fertile, and it is rocky and dry. It takes more efforts in Tanzania to get food crops, than in Nigeria. Nigeria on the other hand, takes a different approach, providing sufficient health services only to a small sector of the population residing in cities, while primarily emphasising curative services. For instance, Tanzania voted 1.9% of its health budget on preventive services in 1977 and Nigeria voted only 0.7% for preventive services and 99.3% for curative services. Since Nigeria is richer than Tanzania and has more medical facilities (see Table 15 Population per physician ratio) policies influencing the management of the health care system must be responsible for Nigeria's lower health status.[14]

Tanzania uses village level health workers, but in between the village health workers and the physicians are medical assistants. The medical assistants receive a shorter period of training than full fledged physicians, but are capable of adequately providing rural health care services which physicians have neglected. The Nigerian government should maximise its efforts to provide health for the people because health by the people is not a realistic approach to solving the problem of health

care especially in Nigeria where the rural inhabitants are critically impoverished. In Tanzania the major effort to solve health care problems started with a change in political philosophy and political goals. Perhaps Nigeria may reconsider its political ideology as a realistic starting point for a substantial change in the health care system. A change in the health care system may be far fetched unless the political leaders of Nigeria begin to perceive health care as a basic necessity rather than a mere commodity to be sold for economic gain.

(c) The commodification of health

To Freidson, the foundation on which the analysis of a profession must be based is its relation to the ultimate power and authority in the modern society (the state). It is from the state that the medical profession obtains its power and legally supported monopoly over health practice.

> this monopoly operates through a system of licencing ... it is the state that grants this monopoly the exact form of which varies widely throughout the world.[15]

In Nigeria, as in other countries such as Canada and USA, the medical association has a monopoly over the practice of medicine. This monopoly is granted and protected by the state. The relationship between the state and the medical profession in Nigeria as in other countries is cordial and complimentary. Freidson and Krause[16] have indicated that there is a cordial relationship between the medical profession and the state in the USA. Navarro[17] notes the same kind of rela-

tionship in the USA and in Latin American countries such as Chile and Argentina. Twumasi has shown the same pattern of state-medical professional relations in Ghana[18] and Medvevdev and Medvevdev[19] show that the state and the medical profession enjoy a good relation in the Soviet Union. The good relations between the state and the medical profession in many countries of the world show the political character of the medical profession. Freidson has also noted this

> the foundation of medicine's control over its work is clearly political (and economic) in character involving the aid of the state in establishing and maintaining the professional pre-eminence ... the occupation itself has formal representatives, organizational or individual attempt to direct the efforts of the state towards policies desired by the occupational group.[20]

The relationship between the state the the medical profession in Nigeria can be identified both formally and informally. Formally, the Nigerian Medical Association has representatives on the National Health Council (the highest health policy making body in Nigeria) and the Federal government calls on the Nigerian Medical Association from time to time for expert advice on health care matters e.g. in determing the potential use of traditional medicine and healers in the health care system. Informally, the medical association influences health policies through its members in the Senate, State Assembly and those physicians in other positions of power such as governors and ministers.

The relationship between the state and the medical profession is cordial and complimentary because each side obtains some benefits from the relationship. For example, health care policies in Nigeria are de-

signed to favour the more privileged social class in which members of the state belong (how this is done is discussed more in the next chapter). The medical profession, on the other hand, exploits the good relations with the state to protect its economic and political interests e.g. determination of working condition of physicians in the public sector and protection of the association's monopoly and other interests which together make the medical profession a very powerful occupation in and outside the health sector. Implicitly, the health needs of the general population are considered only after the various private interests of the state and the medical association have been satisfied.

The fundamental ideology of the modern medical profession in Nigeria is implicitly opposed to the rapid development of health care services for all the population. The beliefs, values, norms and symbols of the medical profession correspond to the very basic tenants of capitalism. For example, capitalism allows minimum government intervention in business, and maximization of profits is the main value and belief of capitalism. Capitalism also values monopolistic competition. In Nigeria doctoring has very clearly emerged as a form of business enterprise acquiring all the characteristics of capitalism. For example, doctoring does not want any government intervention in its business and that is why the good relations between the state and the medical profession are essential in protecting the latter's economic interests. The medical profession also wants an unshakable monopoly in the practice of medicine and that explains why traditional medicine is not officially recognised and healers are not licenced to practice in spite of the mount-

ing pressure put on the government by both the traditional healers and their clients. The Nigerian physician sees his medical skills as a valuable commodity and seeks to place his skills where there are good markets. The peasants in the rural areas lack the wealth required to buy expensive commodities such as the doctor's medical skills and the doctor on the other hand does not want to practice in the rural areas where the market for his skills is presumably unprofitable.

Like capitalism, the medical profession requires freedom to control its work and to determine how economic political and legal power affects medical practice. The medical profession is very influential in directing Nigerian health care policy towards curative services rather than preventive care. Preventive medicine is not economically rewarding to physicians because the elimination of disease would critically reduce the high demand for physicians. The ultimate desire of the physician appear to be making as much profit as possible from his medical skills. The growing desire of physicians in Nigeria to set up their private clinics and hospitals also stems from the same fact that the Nigerian society has a constant supply of sick persons. The agents of the diseases are never destroyed and so in spite of the many private clinics and hospitals in the cities, physicians still have an overwhelming number of customers. The great desire for profit pushed almost all physicians in Nigeria before 1975 to set up their private hospitals and clinics. The government hospitals at this time ran out of physicians because the government salary was not as handsome as the income accruing from private practice. It was at this time that the

traditional good relations between the state and the medical profession was strained. The government, in order to retain physicians in the general hospitals, enacted a decree which requires five years of compulsory medical practice in a government hospital clinic or in a mission hospital by graduating physicians before they (physicians) may be free to set up their own private hospitals and clinics. In a recent study, Pearce noted that 'the Nigerian Medical Association is still fighting to have the decree repealed.'[21]

The enactment of a decree to regulate medical practice in Nigeria in 1975 in effect shows that the Nigerian government can control the medical profession and in fact can have the medical profession dance to the government's music if it wants to do so. For instance, the problem of a shortage of doctors in the Nigerian health care system seems to be a carefully worked out strategy by the medical association, which is supported by the state bureaucracy in order to control the production and supply of physicians. This argument is plausible because both the Nigerian Medical Association and the Federal Government are aware of the shortage of health personnel (especially doctors) and yet the Nigerian medical schools are not expanded to meet this need. In the 1967/70 school session, 1357 qualified candidates applied for admission to the University of Ibadan Medical school and only 108 of the 1,357 were admitted. In the 1971/72 session, 1,200 candidates applied, and only 150 were admitted.[22]

The excuse given for not expanding the medical schools is always a lack of capital. However, if Nigeria has a problem; it is the pro-

blem of misuse rather than a lack of capital. The Nigerian government has other priorities. For instance, between October 1979 and July 1982, the Federal and the state governments sponsored overseas tours for over 500 legislators, ministers and senators. In 1979 almost all members of the Nigerian senate were sponsored on a tour of the American continent under the veil of studying the machinery of democracy. A conservative estimate places the amount wasted in this manner at U$ 3.5 billion. This amount alone is large enough to build a medical school. Corruption has also affected national health care development. For example U$4.2 billion of the government money was recently stolen by a Nigerian official from the government account. Half of the national budget in some departments such as the health department is misappropriated.[23] The proposition that the indigenous bourgeoisie in the Third World and especially in Nigeria are obstacles to the development of health care services in the Third World in general and Nigeria in particular is very plausible. The medical profession in countries of the Third World may also be blamed for turning health care into a money making venture as has been shown in this thesis. Although the profession of medicine parades itself as a humanitarian occupation, evidence does not support such an assertion. As long as medical skill remains a commodity to be sold for money, the medical profession will never be a truly humanitarian occupation. As long as the working class lacks the wealth to buy the doctors' services, adequate health care services will continue to be unavailable. The contribution of the science of medicine to the well being of modern society is unimaginable and very

precious, however, the commodification of health and the current wave of medicalization of society by the medical profession are likely to cast a pall on all that medicine has to offer to the modern world.

(d) Health and Culture: In defence of traditional medicine

Culture refers to the tradition of a people - a set of everyday behaviour or way of life of a people who have settled in one place for a long time and who share common beliefs, customs, and traditions. Several studies such as those of Suchman[24] Mechanic[25] Zola[26] and Segall[27] have shown a relationship between culture and health behaviour, reactions to pain, perceptions of causal factors and ideas about prevention and cure. Culture influences the medical system one uses for a given illness. For example, culture influences a Nigerian patient to see a traditional healer for illnesses such as jaundice and ailments caused by bewitchment, and to see a modern doctor when taken ill by diseases such as gonorrhea.

Every medical system has its own pattern of consumption. The pattern of consumption is often based on the cultural understanding of disease and its causation. For example, a traditional healer treats headaches by either touching the victim's head or applying medicine on the victim's head. A Western trained physician understands the cause of headaches to be not necessarily located around the head and so a doctor gives drugs to a headache victim. The healing practice is therefore based on the understanding of the cause. Though the modern doctor's drugs go into the stomach, the aim is to heal the headache. The traditional healer applies his medicine directly to the affected part of the

body. In both cases the patient recovers.

According to Suchman, the understanding of a people's culture is necessary before any health care policy formulations for such a people can be successful. He noted that:

> many health care programmes have failed because they did not recognise and accept the cultural definition of psychosocial environment in which they had to work.[28]

Suchman's argument becomes even more plausible in a situation where a highly scientific and bureaucratic system of medical care is forced upon urban and rural slums where customs are not congruent with what is offered. For example, health planning in Nigeria does not take cognisance of the cultural factors. The health planners also make the mistake of thinking that the people need only modern health care facilities, and not Traditional medical care. The failure of the Nigerian health system is partly due to the blatant neglect of cultural factors involved in the delivery of health care. There are cases in the Northern states of Nigeria e.g. Sokoto and Niger where sophisticated health care has been planned for people who continue to have a great attachment to traditional medicine. That is the reason why health education, modern medicine, and traditional medicine all must come together in order to build a healthy Nigerian society.

Margaret Mead[29] in her book Culture and Health has noted that, traditional medicine is acceptable particularly in the treatment of native diseases. Natives of India and Africa identify three groups of diseases. The first group comprises everyday diseases. According to

them (natives) every day diseases are caused by over eating, eating bad food, and over working. These are usually not serious, and according to them such ailments can be treated by drinking warm water or having a hot bath and adequate rest. The second group comprises native diseases which are presumably caused by the native devils, witches and other supernatural forces. Diseases in this group are not usually taken to the hospital. According to the natives, only traditional healers deal adequately with such diseases. In most cases diseases in this group are long term, incapacitating types such as mental illness. The third cateogry of diseases identified by the Indians and Africans in Mead's study were 'foreign diseases.' According to them foreign diseases are those imported from the Western World e.g. gonorrhea and syphilis. The natives claim that traditional medicine heals foreign diseases too, but western medicine treats them better and faster than traditional healers.

This typology of diseases was also found in Nigeria in a study in Mkar Benue state.[30] The natives are not foolish. They know what to do in every illness situation. They know the diseases to take to the modern doctor and the ones to take to the traditional healer. They selectively use the type of care that their culture permits and that which gives them social and psychological satisfaction. The Nigerian people, including those in the rural areas, like and use Western medicine but do not want to throw away traditional medicine for modern medicine. To them, that would be throwing away the baby with the bathwater. They need traditional as well as modern medicine, and they

should not be blamed for this because traditional medicine and the culture of the native people can not be seperated.

Birchman has warned that physicians should not focus on objectively measurable parameters in evaluating traditional medicine because traditional healers do not primarily treat disease but sick people. There is usually a connection between health and harmony in the traditional medical system which is understood in cultural terms and social relationships. For example, Lambo relates the story of an African bureaucrat who fell sick a week after he was promoted to a higher rank by the government. The timing of his sickness and his promotion left the victim no further doubts that he was bewitched by his enemies who were jealous of his promotion. As an educated person living in the city this bureaucrat considered it more fashionable to visit a hospital though in the back of his mind he knew that bewitchment was best cured by a traditional healer. Several visits to specialists in Western medicine did not help his situation. It was not until he visited a traditional healer that he was cured. The traditional healer made sacrifices and destroyed the power of bewitchment that was haunting him. The story helps to relate explicitly, the use of traditional healers in the Nigerian society.

If Nigeria produced one physician for every household; the Nigerian people would still need the services of traditional healers. Traditional medicine is intricately related to the people's culture, and this indicates the necessity for the Nigerian government to defend and promote the use of traditional medicine in Nigerian society. Giving

official recognition to traditional medical institutions through legislation may be a desirable starting point towards their official recognition. Traditional healers should be licenced to practice in public. Nigerian scholars and those especially in the disciplines of anthropology and sociology should be eager and willing to conduct research that will enlighten health planners on the dynamics of culture and its impact on illness behaviour. Physicians should also be given more education in this aspect of social science. This may instill in them (physicians) respect for traditional medicine which is regretably lacking in their present training. Physicians should be able to learn and appreciate the fact that traditional medicine provides curative and preventive services. Preventive services for ailments such as psychiatric traumas are provided by traditional healers in forms of medicines for love, marriage, riches, good farms, and medicines to find jobs. These may be scientifically unproven, but the traditional healing ideology services a purpose and brings satisfaction to those that use traditional medicine. This is because the traditional medical ideology brings the totality of the patient's social and cultural environment into the context of therapy.

The provision of modern health care services to the Nigerian people together with traditional medicine is most desirable because it will enable even the poor masses of Nigeria to choose from the available health services, and one (s) that would be most relevant for a given sickness. The culture of the Nigerian people allows a division of diseases into "native" and "foreign" diseases and so they need two medical

systems with modern medicine concentrating on 'foreign diseases' and traditional medicine concentrating on 'native diseases.' The issues discussed in this chapter must be resolved before health care services in Nigeria will be developed.

NOTES

1. Peter Lloyd (ed.), The New Elite of Tropical Africa: London, Oxford University Press, 1966, p. 23.

2. The statistics in this section are based on estimates calculated using WHO data. It is not possible to obtain vital statistics for such class analysis in Nigeria. For example, if a city (Lagos) with a population of 1 million has 1500 physicians and the rest of the country has 4,500, then, the physician-population ratio in Lagos will be considerably better than in the ratio for the whole of Nigeria. The ratio for Nigeria is 14,810 patients per physician. But, over half of the 80 million Nigerians in rural areas have no accesss to physicians.

3. Olu Okedeji, 'Priorities in national health planning,' op. cit., p. 115.

4. Maurice King: 'Medical Care in Developing Countries' op. cit., p. 1-11.

5. Emirs are Moslen leaders. Emirs are powerful in Northern Nigeria even to date.

6. Ralph Schram: History of Nigerian Health Services, op. cit., p. 205.

7. Primary Health Care - "Joint Report", op. cit., p. 8.

8. See Birchman, op. cit., p. 175 for a comprehensive list of the characteristics of primary health care.

9. K. Newell: "Health by the People", op. cit., p. 195.

10. A. Mejia, et. al., op. cit., p. 149.

11. S.L. Adesuyi, "Priorities in National Health Planning", op. cit., p. 12.

12. A. Jose Williams: "Presidential address at the conference on national health planning" in Akinkuge (ed.) op. cit., p. 271.

13. All the statistical data used in the comparism between Nigeria and Tanzania are taken from: Health Sector Policy Paper. World Bank 1980, p. 67-85.

14. Some scholars may argue that ethnic differences and nepotism contribute to health care underdevelopment in Nigeria. But the effects of ethnic favouritism alone would not have created a major difference in the distribution of health care facilities. For example, even within the states that comprise one ethnic group such as Hausa, Yorubas and Ibos, health services are underdeveloped. In these states, ethnic factors are not responsible for the allocation and distribution of health facilities since all the inhabitants are of the same ethnic group. It should also be noted that Tanzania as well as Nigeria had many ethnic groups, and so both of them are exposed to the evils of tribalism.

15. E. Freidson, Professional dominance, op. cit., p. 83.

16. Eliot Krause, Power and Illness. The political sociology of health and medical care. New York, Elsevier Pub. (1977), p. 11-15.

17. V. Navarro, Medicine under capitalism, op. cit.

18. Patrick Twumasi, "Colonialism and international study in Ghana." Social Science and Medicine 15, 1981, p. 50.

19. Medvevdev, M. and Medvevdev: A question of madness. Repression by Psychiatry in the Soviet Union, London Nortem & Coy, 1981, p. 38-87.

20. E. Freidson: The profession of medicine: A case study of the sociology of applied knowledge, New York, Dodd Mead & Co, 1975, p. 5.

21. Tola Pearce, "Political and Economic Changes in Nigeria and the organization of Medical Care", op. cit., p. 95.

22. See "Presidential address of the president of the Nigerian Medical Association", Priorities For National Health Planning, op. cit., Footnote 13.

23. The data here are based on a very careful estimation. Every month Nigeria sends 5-10 senators and legislators to Europe and America to observe the working of democracy. This is obviously wasteful. Corruption and embezzlement of government funds are profitable business to bureaucrats in Nigeria because civil servants who embezzle government money do not replay it even when they are convicted. They are only dismissed from the service without the usual retirement benefits. Corruption is difficult to document but its presence in the Nigerian bureaucracy is obvious.

24. Edward Suchman, "Sociomedical variations among ethnic groups" American Journal of Sociology, 70, 1964, p. 3119-3331.

25. David Mechanic, "Illness and social disability" Pacific Sociological Review, 2, 1959, p. 37-41.

26. Irving Zola, "Culture and systems: An analysis of patients presenting complaints." American Sociological Review, 31, 1966, p. 615.

27. Alexander Segall, "Socio-cultural Variations in Sick Role Behaviours. Social Science and Medicine 10, 1976.

28. Edward Suchman, Health Attitudes and Behaviour. Archives of environmental health. 20, 1970, p. 108.

29. Margaret Mead, "Health and Culture, Tavistock Publication, London (1966).

30. D.A. Ityavyar, A sociological study in a hospital - A case study of Mkar Hospital. Unpublished Thesis, A.B.U. Zaria, 1979.

CHAPTER SIX

SUMMARY AND CONCLUSION

The task of this research was to investigate the underdevelopment of health care services in the Third World. An attempt has been made to show that the underdevelopment of health care in countries of the Third World such as Nigeria is inextricably related to general underdevelopment. The contact between the Western countries of Europe and Third World countries such as Nigeria in the early 19th century set the stage for the underdevelopment of Third World countries. Their economic, political and social institutions were destroyed, and in some cases replaced with Western liberalism e.g. the Nigerian traditional form of government was replaced by Western democracy. Colonialsim and neo-colonialism are therefore the real cause of underdevelopment of Third World countries. Leaders in the Third World have now adopted the culture of colonial administrators which has further increased the problem of underdevelopment. For instance, the colonial administrators supported and pursued private and class interests in their colonies. Health and other essential services such as water and electricity were only for colonial administrators. Members of the state bureaucracy in the Third World countries are similarly pursuing private and class interests at the expense of common good. This affects general development and the development of health care in the Third World.

The state, the medical profession and the multi-national companies

each has an interest to protect in the course of health policy formulation. All their interests are antithetical to health care development. To members of the state bureaucracy in countries of the Third World, a successful health care policy is one that would earn them (state bureaucrats) big kick-backs from the multi-national firms which are often awarded contracts for the construction or provision of various health facilities. Members of the state bureaucracy also formulate health policies that are of more benefit to themselves and their families than the poorer population comprising the peasant class. The co-operation of physicians is needed to enable health planners to attain their interests. The multi-national drug companies also have their share of interests and benefits in the Third world countries. The prevalence and incidence of epidemics in the Third World usually means higher profits from the sale of drugs. If through foreign aid, the health status of people in the Third World improves to equal that of Western countries, epidemics and infectious diseases may be eliminated. The multi-national drug companies would then have considerably fewer consumers or buyers because drugs such as 'anti-malaria' are produced to be sold in the mosquito infested areas of the Third World such as Nigeria. Physicians also benefit from the high rate of morbidity in the Third World, and if a strong health policy is designed to eliminate the infectious diseases (the main source of death in the Third World) the demand for physicians will fall, and the doctoring business will become less profitable. Invariably, economic interest are the main factors that influence health care policies in the Third World. The medi-

cal profession particularly uses both informal and formal channels in influencing the state to protect its monopoly and control over its work. While colonialism set the stage for the underdevelopment of health in the Third World, neo-colonialism in combination with professional and class interests within countries of the Third World work to sustain this underdevelopment.

(a) 'Implications of the Study for Health Care Planning in the Third World.'

The Third World countries have a common problem i.e. underdevelopment, caused by a common source (colonialism) and sustained by neo-colonialism. The first step towards the development of the Third World cuntries requires their political and economic unity. It is through unity that Third World countries will develop conscious and determined efforts to weaken the strings of neo-colonialism. Disunity among the countries of the Third World is manifested in wars between one developing country and another (e.g. Iran and Iraq in the Middle East). The frequent wars and conflicts within the Third World do not favour the development of these nations economically and politically. The developed countries such as the USA and Russia ususally derive benefits from instability in the Third World, and particularly conflicts requiring arms. For example, the USA and Russia make a fortune by selling ammunition to Iran, Iraq, PLO, and other Third World countries involved in armed conflicts e.g. Morroco, Kampuchia, El Salvador, Chad. Civil wars are also rampant in the Third World e.g. in Chad, Morroco and El Salvador. Sometimes these conflicts are deliberately incited by the developed

countries to derive economic and political benefits e.g. France in Chad, US in Vietnam. The amount of foreign exchange wasted by the developing countries on arms could be used to develop health care and other sectors of the political economy such as the agricultural sector.

Beside and above the need for unity and peace in the Third World is the necessity to develop and be self-sufficient. J.S. Horn[1] has rightly observed that a country no matter whether it is big or small, rich or poor must rely chiefly on its efforts in order to advance. If it places its destiny, its future in the hands of some other country, then trouble looms ahead. The neo-colonial economy with which Third World countries such as Nigeria operate clearly places the destiny of these countries economically and politically in the hands of the developed countries. The international agencies such as the World Health Organization, the World Bank and the United Nations all design or sponsor policies and programmes that help promote and strengthen the Third World's dependency on the developing countries. For example, the idea of foreign aid and transfer of technology to the Third World, makes the Third World countries such as Nigeria rely wholly on Europe and America for many things ranging from food (Nigeria imports rice from US, milk and dairy products from Canada) and clothing, to mosquito nets and war jets.

The suggestion is not that the countries of the Third World completely sever their economic relations with the West, as dependency theorists such as Gunder Frank[2] suggest, but to readjust their degree

of dependence on the West. For example, Nigeria may ask Bell Canada or British Petroleum for technological assistance, but Nigeria should not allow these companies to establish branches and operate in Nigeria under the veil of technological assistance. The Third World in general should think of importing technology but not to allow the parent companies to establish their branches in the Third World. As much as it is practically possible, Third World countries should invest money in training their young persons to acquire the skills necessary for maintaining and managing the imported technology. Experience in Nigeria, Iran, Lybia and Ghana has shown that when technology is transferred to the Third World together with the branches of the parent companies in the form of foreign aid, they directly compete with the local companies in the Third Wrold and by so doing, block all the possible avenues of indigenous development. In other words, capital generated by multi-national companies in foreign countries is usually shipped to the country of the parent companies. For example, the Standard Bank and Baclays Bank of Britain which were established in Nigeria to develop the banking industry are today out competing the local and indigenous banks such as the African Continental Bank which they were presumably supposed to assist.

The strategy of unity among the Third World and careful disengagement of relations with the West must be followed by a determination to develop a comprehensive health care policy. Such a policy would include an emphasis on agriculture in order to avert food importation and fight malnutrition in the society. Education must also be another tar-

get to be pursued: the training of engineers should be encouraged to produce personnel with skills necessary for the technological development of essential services such as water, and electricity. This is because improved standard of living consequently leads to improved health status.

Finally, all Third World countries that utilize the so called mixed-economy must realise that every economic goal or enterprise is usually based on the philosophy, (whether it is explicitly stated or implied) that competitive capitalism is desirable. However; competitive capitalism has proven to be irrelevant for Third World countries in pursuit of development. The political actors in the developing countries should therefore consider a more progressive philosophy which among other things must emphasize the independence of the Third World. Perhaps African democracy may be a reasonable political philosophy to be tried in Third World countries. African democracy emphasizes the need for African countries to be independent politically and economically from Europe and America. Political and economic independence by African countries will ultimately affect the health sector since the health sector is just a part of the socio-political economy. If the political and economic sectors become developed, the health sector must also become developed.

(b) Implications of the Study for Health Care Planning in Nigeria

This study has shown that the Nigerian health care system is critically underdeveloped. This is reflected in the organization and delivery of health care services and in the health status of Nigerians.

The slave trade in the early 19th century and the colonization of Nigeria by the Imperialist European powers in the late 19th century contributed enormously to Nigeria's underdevelopment. The political and economic institutions of Nigeria were suddenly destroyed and were replaced by Western Liberalism e.g. the production of food crops was replaced by cash crops which were consequently shipped to Europe as raw materials. The traditional segmentary government was replaced by Western democracy and the Native leaders were replaced by colonial administrators. The administration of social justice in Nigerian society which was hitherto the role of arbitration courts controlled by native elders was now shifted to the colonial magistrate courts which were presided over by the European magistrates. This pattern of colonization set the stage for the underdevelopment of Nigeria.

The traditional medical system was destroyed and replaced by Western scientific medicine. Traditional healers were persecuted for spreading illiteracy and were therefore replaced by Western trained physicians. The British government then established a health care system in Nigeria which was aimed particularly at serving the colonial administrators. In the 1950s these health care services were extended to the native population. Under the colonial health care structure, health care facilities were established only in the cities because both the colonial administrators and the native population who were to benefit from these health facilities were all in the urban areas. Toward the time of Nigeria's independence (as discussed in Chapter Two) the British government established a few dispensaries and clinics in the

villages and more hospitals in the cities. From the time of independence to the present, the location of dispensaries in the rural areas and hospitals in the cities is the only known health policy in Nigeria. Each government in Nigeria merely extends the structure earlier founded by the British government by budgeting for more hospitals in the cities and dispensaries in the rural areas. Explicitly stated therefore, Nigeria has no comprehensive health care policy designed to serve its population. Both the 2nd and 3rd national development plan programmes in Nigeria never initiated structural changes in the health policy for the country. For example the 3rd National plan merely budgeted for more doctors, nurses and other health personnel.[3]

> ---critical shortages exist in the essential categories of health manpower, shortage of doctors continues to be a major problem---to achieve the WHO target, we need more than double the present number of doctors by 1980.

The third National Development plan programme equally emphasized the need for the production of more doctors in Nigeria:

> -- in recognition of the highly strategic roles of doctors in the health care system and current critical shortages of these personnel in most parts of the country, steps will be taken to undertake in the plan period, accelerated expansion of medical colleges and associated facilities for clinical training.[4]

Health care policy in Nigeria always centres on the concern for the production of more health personnel and the building of more hospitals. However, as shown in Chapters Four and Five, the health status

of an average Nigerian is still rather poor. A comprehensive health care policy for Nigeria will require more than the mere training of additional professional health personnel. It will include clear goals and objectives for combating disease with a solid preventive programme. Such a comprehensive health programme in Nigeria may centre on the following issues:

1. Research and evaluation of health care delivery.
2. Structural reorganization of the health sector.
3. Redefinition of the roles and limitations of the various occupations within the health sector.
4. Employment of strategies and tactics for health care development.

These changes are urgently needed in the Nigerian health policy in order to overcome the obstacles to the development of health care. In conclusion then, each of these four factors shaping health care policy in Nigeria will be discussed.

(1) Research and Evaluation.

In modern societies, the role of research in policy formulation cannot be overemphasized. Research does more than identifying problems, it also suggests solutions to problems. In the advanced industrial countries of the West such as Britain, Canada, and USA, research in the area of health care delivery is encouraged particularly by the government e.g. the Canadian government encourages research in health care by providing funds such as the Canadian National Health Scholar Grants to researchers interested in health studies. Other government sponsored

research institutes like the Canadian Heart Foundation are also useful in encouraging the pursuit of knowledge in the area of medicine. Health care research is therefore necessary in the formulation of national health policies e.g. on health care utilization, location and relocation of general and mental health care institutions.

The Nigerian government has neglected the role of research in nation building. Health care research is particularly unknown in Nigeria. This leads to ill-formulated health programmes which lack precision, focus, and objectivity. The encouragement of health care research should be given priority in the health care policy of Nigeria. It is through health research that a meaningful reorganization of the health care delivery system can be attained. Furthermore, research would be helpful in determining the type of health personnel needed in different geographical areas and the type and number of health facilities that can be utlized without a waste of resources. Research is also needed to provide a basis for promoting the integration of traditional and scientific medicine into one medical system and for constructing an effective preventive health programme. For example, the following hypotheses could be scientifically tested as an effort toward improving health care services:

1. Health Care Utilization Patterns
   (a) Preventive health services tend to lower the rate of morbidity more than curative services (i.e. hospital based).
   (b) Rate of utilization rather than access to health care services is responsible for high mortality among poor urban and rural Nigerians.

(c) The decision to use a particular health facility is influenced by socio-economic factors (income, transport etc.) and not proximity to a health facility.

(d) Bureaucratic inconsistencies between new health programs (e.g. training paramedical workers, procurement, distribution and control of drugs and pesticides) and existing laws and regulations are obstacles to the development of health services in Nigeria today.

2. Rural-Urban discrepancies

(a) There tends to be no difference in the incidence and prevalence of diseases between rural areas with health clinics and areas without clinics.

(b) Environmental factors (such as water, energy, sewage system) rather than the absence of health facilities give rise to high morbidity rates in urban and rural areas of Nigeria.

(c) The diseases of poverty (diarrhea and infectious) are main cause of morbidity and mortality in Nigeria.

3. Health and Culture

Cultural factors (eg. hygenic and dietary practices) and not the absence of health facilities determines the disease pattern of a people.

Finally, evaluation research is required to measure the success or failure of past policies and programmes and their consequent modernization. This may further require emphasis or even incentives for the

keeping of vital statistics e.g. registration of births, deaths, hospital attendance, and morbidity rates. Vital statistics can be used by researchers and planners to predict future health care needs of the population.

I suggest for Nigeria the establishment of a Health Research Institute which would promote inter-disciplinary research in health care delivery. Professional researchers in sociology, anthropology, economics, psychology, demography and medicine would constitute the staff of such a research institute. The Nigerian government can also encourage health research by providing research funds to University faculties. The determination by the Nigerian government to implement policies suggested by researchers will also be necessary because research will be wasted effort if its findings are merely relegated to some dark corner in a file cabinet to gather dust.

(2) Structural Reorganization of the Health Sector.

The basic structure of the health care system in Nigeria involves locating hospitals in the cities and dispensaries in the villages, both of which emphasize curative services at the expense of preventive services. In the present structure of the health care sector, adequate attention is not given to the health needs of the rural and urban slums of Nigeria. The preventive aspects of health care are neglected by the Nigerian government. For example, the government in 1976 voted only 0.9% of the health expenditure budget to preventive health care services. Both the medical schools and the Ministry of Health have not given the required attention to preventive health care services. The curriculum

of the Nigerian Medical Schools does not include preventive health care and in a similar vein, the Ministry of Health votes only a very small portion of the health expenditure budget for preventive services. Any health care structure that provides only curative services is deficient because the sources of the diseases themselves will not be destroyed or attacked. For example, patients may receive treatment for malaria fever in the hospital or dispensary after which they go back to their homes to be bitten by the same mosquitoes and again be infected. In this way the disease cycle continues. Nigeria should therefore develop a health care system that will not only treat malaria fever but will also prevent or seek to destroy the agents of the infection. Such a policy would promote a solid preventive health care programme. The basic and most essential components of preventive medical care are immunization and health education.

Health education needs to be emphasized and included in the curriculum of schools, at the unviersity level, as well as the secondary and even primary school levels. This arrangement would affect the preventive health behaviour of the students' families, as the students shared their health knowledge with other members of their families.

The mass media - TV and radio stations and newspapers can all be used to promote health education in Nigerian society. Television may help in educating the common man on ways to improve his environment and his health. For example, TV and radio stations may have regular lessons on how to keep bugs away from mats, bamboo beds and the hygienic ways that would prevent epidemics of cholera, measles and neo-natal te-

tanus. Although only a few people in Nigeria are able to own TVs and radios, the government can introduce public radio and TV listening and viewing stations in every village and urban slum. Even the richest government cannot afford radios or TV sets for all its citizens, but even a very poor country e.g. Malawi can afford a few radios and TVs for public use especially for the underprivileged members of the society. If the emphasis presently placed on curative health care is shifted to preventive medical care, a significant and positive change in the health status of Nigerians may be observed within a few years. It must be reiterated that this strategy for change is only relevant when it occurs together with other changes (education, structural and organizational changes in society).

(3) Redefinition of the Roles and Limitations of Health Occupations

This study has established that physicians dominate the health sector both in Nigeria and other Third World countries. In the developed countries such as Canada and the USA, physicians also dominate and control all other occupations within the health sector. In Nigeria, whatever is good for the physicians is presumably good for the health sector and is also assumed to be good for the health care system. Physicians direct and define the role limitations of all other occupations within the health sector such as nurses, pharmacists and laboratory technologists. It has been pointed out earlier that Nigerian physicians cross their role boundaries to serve as directors and principals of Schools of Nursing and Laboratory technology.

In government hospitals, Medical Officers rather than Hospital administrators are in charge of the day to day administration of the hospitals e.g. signing payment vouchers and contracts. The increasing me-

dicalization of life has also affected the position of traditional medicine in Nigerian society (as discussed in Chapter Five). The overriding dominance of the medical profession within the health sector has in effect created a great deal of tension within the health sector. For example, there are conflicts between the physicians and the hospitals administrators over who should be the director of the hospital. There is also mounting tension between pharmacists and physicians over the prescription of drugs, while the nurses and laboratory technologists wage war to liberate themselves from the dominance of the physicians. Nurses feel particularly out of place when their professional roles are limited to only dressing of wounds and feeding of patients. The Nigerian government should intervene in the war between professions within the health sector. Unless these issues are resolved, the occupations within the health sector may all continue to survive but the health care system will collapse and the common man who should benefit from the system will suffer even more. The powers of the medical profession in the health sector should be limited specifically by legislation. This will enable other occupations in the health sector such as hospital administrators, psychologists, nurses and social workers to contribute their skills to building a comprehensive health care system in Nigeria.

Areas such as family planning, sanitation, health education and counselling services can be administered adequately by other health personnel without the intervention of physicians. For example, midwives and public health nurses can provide efficient family planning

services. Social workers can provide counselling services as well as health education.

The introduction of health sanitation officers will also help the preventive health care programme. Health sanitation officers will range from the village to national level. This category of health workers would be concerned primarily with a clean and healthy environment for the whole country. Training programmes for these health workers could be introduced in polytechnics, schools of technology and in medical schools. The Ministry of Health should also create a sanitation division for the management of the environment e.g. placing dust bins, garbage boxes and trash containers in strategic and convenient locations in order to keep the environment clean. Sanitation vehicles could also be used appropriately in the disposal of garbage. Keeping the environment clean would be an important strategy for destroying the agents of infection in Nigerian society. Legislation to limit the medicalization of other occupations in the health sector by physicians may not be initiated readily by the state because of the traditional cordial relation between the state and the medical profession. However, such a bold step is needed to develop the health care system.

To be fair to all members of the health sector, and in order to have desirable health care services for all the population, the Nigerian government will have to improve the conditions of service for the young physicians that serve in government hospitals. The younger physicians in Nigeria are made scapegoats by their senior counterparts who are in favourable positions to influence health policies. The younger physi-

cians are those who have been in the medical practice for less than five years. Under the Nigerian Statutory laws, Nigerian medical graduates must work in a government health establishment for fives years before they may be free to work with a private hospital, clinic or establish their own private practice. After the five years of imperative service, Nigerian physicians become seniors in the hierarchy of the Nigerian Medical Association. During their five years of imperative service, these younger doctors receive poor salaries and work under difficult conditions. The younger doctors have complained repeatedly to the government but there has been no change in both their salaries and terms of service. It is not by maltreating the younger physicians that the Nigerian medical profession and the state bureaucracy can provide adequate health services to Nigerians. It is unfair to give the senior physicians all the freedom and privileges to practice in comfort. Medicine in a noble science whose miraculous role in saving human lives in the modern society must be appreciated. The Nigerian government therefore should change its policies regarding the condition of service of the younger physicians. Similarly, legitimating a role for traditional healers is necessary in the Nigerian health care system.

(4) Strategies and Tactics for Health Care Development in Nigeria.

A number of factors influence the health of a people. These factors include fresh water, good food, housing and a clean environment. The health status of a people depends to a great extent on the quantity

and quality of these amenities. For example, pit toilets may help reduce the incidence of epidemics such as cholera which are caused by indiscriminate disposal of waste and excreta. Flush toilets may even be better than pit toilets in serving the same purpose. People who use flush toilets may be less likely to have fecally-related diseases than those that use pit latrines. Countries such as Nigeria which have less than 25% of the population using flush toilets may have more problems with epidemics than other countries in the Third World such as Argentina. Argentina has over 50% of its population using decent waste disposal mechanisms eg. flush toilets.

Good housing also contributes to good health. Nigerians and especially those that live in the slums lack decent housing. The large size of families creates an additional problem of insufficent space. In 1979, the Nigerian government started a housing program to assist the poor urban dwellers who could not afford the money to own a decent home. That is obviously a laudable project which should also be extended to the rural areas so that the villagers too will enjoy decent housing. Housing projects in the rural areas can employ community efforts. The rural dwellers lack money to pay to the government, but they (the community) can definitely agree to contribute their labour for such a scheme. The houses that will be built in the villages may not be of the same standard as those in the cities but will be much better than the village huts. To instill a sense of pride in them, the government might arrange for quarterly rental payments. Most villagers are subsistence farmers and sell their surplus only seasonally

and so the conventional monthly payment of housing rent may be inappropriate in the case of the villagers.

The community may be encouraged to use its labour to construct access roads from one village to another. These access roads may not be as good as city streets but will be at least motorable and will also ease the problems facing rural health workers. If the rural communities have roads, the government can also provide public transport services which will replace the inefficient current transport system in the rural areas which depends on camels, donkeys, bicycles and in rare cases motor-cycles. The Nigerian government can influence the introduction of consumer co-operative shops in the rural areas for the use of the villagers so that they will no longer need to visit the cities to buy even the basic necessities such as salt, soap and kerosine.

With roads, consumer shops, water and good housing in the villages, industrialists would be attracted to the rural areas for cheap labour. Labour intensive industries such as mining will be particularly good in the rural areas. With the establishment of industries in the rural areas, there will also be a need for machine energy such as electricity which will serve both the industries and the villagers. The rural socio-political economy will be transformed into a modern one. The health care of the people will improve as the general standard of living rises in the villages. There will also be more health facilities along with a strong preventive programme. As the health of the people is improved, the hours which were formerly wasted in pain, agony and disability will now be invested in industrial production. These strategies will there-

fore not lead only to the development of the health care sector but also to the general development of the Nigerian economy.

NOTES

1. J.S. Horn, "Priorities in National Health" in Akinkugbe, O, (ed.) op. cit., p. 20.
2. Gunder Frank. On Capitalist Underdevelopment, op. cit.
3. Third National Development Plan, 1975-1980, Vol. 1.
4. Ibid, Vol. 1.

APPENDIX

BIBLIOGRAPHY

Abegglen, James, The Japanese Factory. Glencoe, Illinois Free Press (1958).

Ajose, O.A. "Ways and means of carrying out environmental sanitation programs" Report on African Seminar on Sanitation. Ibadan, WHO Pub. (1957).

Akenzua, I.G. et a., "Maternal and Child Care in Rural Areas: The role of the TBA in Bendel State of Nigeria" Journal of Tropical Pediatrics 27, 4 (1981). p. 210-213.

Akinkugbe, O.O. et al (ed.), Priorities in National Health Planning. Ibadan, Caxton Press Ltd. (1973).

American Hospital Association, Delivery of Health Care in Rural America, Wuakigaz, Illinois (1977).

Amin, Samir. Neo-colonialism in West Africa, Middlesex, Penguin Books Ltd. (1973).

Anderson, C., The Political Economy of Social Classes, New Jersey, Prentice Hall (1974).

Appelbaum, R., Theories of Social Change, Chicago, Markham Pub. Coy (1970).

Asuni, Tola, "The dilemma of Traditional healing with special reference to Nigeria" Social Science and Medicine 13 (1979). p. 91-97.

Awolowo, Oba, The Strategy and Tactics of the Peoples Republic of Nigeria. London, MacMilliam Co. (1970).

Ayasi, Eric, An Introduction to the Study of African Culture, Accra, Ghana Pub. Co. (1975).

Baker, Timothy, Assessment of Health Status and Needs. International Health Perspectives: New York. Springer Pub. Co. (1977).

Baran, Paul, The Political Economy of Growth. New York, Monthly Review Press (1956).

Bannerman, R.H. et al, "Discussion of D. Oyebolas' Paper on Traditional Medicine" Social Science and Medicine 15, 2 (1981).

Basta, S.S. and Churchill, A Iron Deficiency: Anemia and productivity of Adult Males in Indonesia. World Bank Staff Working Paper 175, Washington, 1974.

Berwick, D.M., "Politics of Medicine" Book Review. Social Science and Medicine 9 (1975).

Bhatia, J.C. et al., "Traditional Healers and Modern Medicine" Social Science and Med (1975).

Bichmann, Wolfgang, "Primary Health care and Traditional Medicine" Social Science and Medicine 13 (1979), p. 175-181.

Blishen, Benard, Doctors and Doctrines: The Ideology of Medical Care in Canada. Toronto, Univ. of Toronto Press (1969).

Blomquist, Ake, The Health Care Business - International Evidence on Private versus Public Health Care System. Vancouver, Fraser Inst. Pub. (1979).

Bryant, John, "WHO's programme of health for all by the year 2000. A macro-system for health Policy Making - Challenge to Social Science Research" Social Science and Medicine. 14, 5 (1980), p. 381-386.

Bull, Graham, "Impressions of a Medical Tour of Eastern and Western Regions of Nigeria" West African Medical Journal 9, 139 (1960).

Burns, Alan, History of Nigeria. London, George Allen and Unwin Ltd. (1929).

Chen, Paul, "Traditional and Modern Medicine in Malaysia. Social Science and Medicine 15 (1981).

Clarke, Peter, Short history of Public Health in Nigeria. Unpublished Ibadan, (1958).

Clyde, F.C., History of Medical Services in (sic) Tanganyka. Dares Sallam, Gov't Printer (1962).

Comte, August, "The progress of civilization through three stages." In Etzioni (ed.) Social Change Sources Patterns and Consequences. New York, Basic Books (1964).

Cohen, Percy. Modern Social Theory: Studies in Sociology. London, Heinemann Ed. Books (1968).

Colfax, D.J. et al. (ed.), Radical Sociology. New York, Basic Books, (1971).

Coser, Lewis. The Functions of Social Conflict. London, Routledge (1956).

Crichton, Anne, "Equality: A Concept in Canadian Health Care. From intention to reality" Social Science and Medicine 14, 4 (1980).

Dahrendorf, R.A., Preface to Democratic Theory. Chicago, Univ. of Chicago Press (1956).

Davidson, Basil, The African Slave Trade. Old Africa Rediscovered. London, Gallanex (1959).

Denton, D.G., Observation on the West African Medical Staff Committee's Report to the Sec. of State. July 26, 1909. Relating to Medical and Sanitary Matters in Tropical Africa. London, Colonial Office. (1911).

Desai, A.R., Essays on Modernization of Underdevelopment. Bombay, Thacker and Co. Ltd. (1971).

Dodu, S.R.A., Meeting Health Needs of our Developing Countries. Occasional Papers. London, Commonwealth Conditon Pub. (1974).

Dayol, Lesley, The Political economy of Health. London, Phito Press (1979).

Durojaiye, I.A., Study of Indigenous Non-enclatory System of Phychotric disorder among Nsukka Igbo in Eastern Nigeria. Unpublished (1979).

Dunlop, David, "Anternatives to Modern Health delivery Systems in Africa: Public Policy issues of Traditional Health System: Social Science and Medicine 9, 12 (1975).

Ekundare, Olu, An Economic history of Nigeria 1860-1760. New York, African Pub. Co. (1973).

Elling, Ray, "Introduction: Relation between traditional and modern medical systems; Social Science and Medicine 15, 2 (1981).

Elling, Ray, "Political economy, cultural hegemony and mixes of traditional and modern medicine" Social Science and Medicine 15, 2 (1981).

Erinosho, O., "Health Planning in Nigeria." Paper presented at Nigerian Anthropological and Sociological Association. Seminar. ABU Zaria (1981).

Etten, G.M. et al., "Training for Rural Health in Tanzania" Social Science and Medicine 19 (1975), p. 89-92.

Etzioni, A., Social Change, Sources, Patterns and Consequences. New York, Basic Books (1964).

Fadipe, N.A., Sociology of Yoruba, Ibadan, Ibadan University Press, (1970).

Field, M.G., "The Soviet Health Service: A Historical and Comparative Study. A review article. Social Science and Medicine 9, (1975). p. 271-274.

Folta, J.R. et. al., A Sociological framework for patients. Washington, Wiley Pub. (1979).

Frank, A.G., Latin America: Underdevelopment or Revolution. New York, Monthly Review Press (1969).

Frank, A.G., On Capitalist Underdevelopment. Bombay, Oxford Univ. Press, (1975).

Frank, A.G., Crisis in the Third World. New York, Holmes and Meier Pub., (1981).

Frankenberg, R., "Allopathic Medicine, Profession and Capitalist Ideology in India" Social Science and Medicine, 15 (1981).

Freidson, Eliot, Professional dominance: The Social Structure of Medical Care. New York Atherton Press (1970).

Freidson, Eliot, Profession of Medicine: A Case Study of the Sociology of Applied Knowledge. New York, Dodd, Mead and Co. (1975).

Freeman, H.E. et. al., Handbook of Medical Sociology, New Jersey. Prentice Hall Inc. (1972).

Fromm, Erich. Marxist Concept of Man. New York. Unger Pub. Co. (1961).

Gilles, H.M., Akufo: An environmental Study of a Nigerian Village Community. Ibadan. Univ. of Iba Press (1964).

Gish, Oscar, "The political economy of primaery care and Helath by the people - An Historical explanation," 21st Annual Meeting of the African Studies Ass. Baltimore (1978).

Good, Charles et. al., "The intefere of dual systems of health care in developing world: Towards Health Policy initiative in Africa." Social Science and Medicine 12, 1979, p, 141-154.

Goldsmith, C., "The disease of exploitation" African Currents, 21, 22 (1980).

Granic, David, The Red Executive, Garden City, Doubleday (1960).

Haffenden, J.R., The Red Men of Nigeria. London, Frank Class and Co. Ltd., (1967).

Hamilton, Earl, "American Treasure and the Rise of Capitalism" Economics, London 27, (1979).

Hamilton, Ear, "American Treasures and the Price Revolution in Spain, 1501-1650. Cambridge, Howard Univ. Press (1934).

Harrington, M., The Other Amrica: Poverty in the USA, New York, McMilliam (1963).

Haunt, Alan (ed.). Class and Class Structure. London, Lawrence and Wishart, (1977).

_____ Health: Sector Policy Paper. World Bank. (1975).

_____ Health: Sector Policy Paper. World Bank. Feb. (1980).

Higgins, B., "The dualist theory of underdevelopment: Economic Development and Cultural Change 4, 2 (1956). p. 99-115.

Hoogvelt, M.M., The Sociology of developing societies. London, McMilliam (1978).

Horton, R., Traditional Background in Medical Practice in Nigeria, Ibadan, Ibadan Univ. Press (1970).

Hoselitz, Bert., The Sociological Aspects of Economic Development. Chicago, Free Press. (1965).

Hoselitz, Bert., "Non-economic Barriers to Economic Development" Economic Development and Cultural Change 1, 1 (1952).

Hoselitz, Bert., The Progress of underdeveloped Areas. Chicago Univ. of Chicago Press (1952).

Hoselitz, Bert, "Patterns of Economic Growth" Canadian Journal of Economics and Political Science (1955).

Hyman, H., "Reflection on the relation between Theory and Research" Centennial Review 7, (1963), p. 443-453.

Illich, Ivan, Medical Nemesis. The expropriation of Health. New York, Bantam Books (1975).

Illich, Ivan et. al., Disabling Profession: Ideas in Progress. London, Burns and MacEachern Ltd., (1977).

Igun, U.A., "Child Feeding Habits in a Situation of Social Change" Social Science and Medicine, 16, 1982, p. 775.

Johnson, M.L., "Medical Sociology and Sociological Theory: Social Science and Medicine 4, 9, (1975) p. 227-232.

Johnson, O., The History of the Yoruba. West Port, Negro Univ. Press (1921).

King, Maurice (ed.), Medical Care in Developing Countries A Symposium from Makerere. Nairobi, Oxford, Univ. Press, (1966).

Kleiman, A., "Serve the people: Observation on Medicine in the Peoples Republic of China by Victor Sidel and Ruth Sidel" Social Science and Medicine, 9, (1975), p. 339.

Kleiman, A., "Why do indigenous practitioners successfully heal," Social Science and Medicine 13, (1979), p. 7-26.

Kolko, Gabriel, Wealth and Power in America: An analysis of Social Class and Income Distribution, New York, Praeger (1962).

Krause, Elliot, Power and Illness: The Political Sociology of Health and Medical Care, New York, Elsevier (1977).

Lambo, T.A., "Mental health of man in Africa." Journal of the Royal African Society 70, (1981), p. 319.

Lambo, T.A., Role of cultural factors in Paranoid Psychoses in Yoraba Tribe" Journal of Mental Science 101 (1955).

Lambo, T.A., "Evaluation of the Scope of Traditional Medicine" Paper presented in seminar on Traditional Medicine, Lagos, Ministry of Health (1979).

Lasker, Judith,"Choosing among the Therapists: Illness behavior in Ivory Coast," Social Science and Medicine 15 (1981).

Leggate, J.M., "Progressive Liverpool Biochemistry Pioneer." Medical News, Jan. 24, (1976).

Lehmman, N., Development Theories: Four critical Studies, London, Frank Class and Co. (1979).

Lenin, V., Imperialism, the Highest Stage of Capitalism. London, Lawrence and Wishard (1919).

Lipset, S.M., Revolution and Counterrevolution. New York, Basic Books (1968).

Lloyd, Peter, The New elite of Tropical Africa, London Oxford Univ. Press, (1966).

Lloyd, Peter, Slums of hope? Shanty town of the Third World. Middlesex Pelican Books, (1974).

Maclean, Una, Magical Medicine - A Nigerian Case Study. London, Allen Lane Penguin Press, (1971).

Magdoff, Harry, The Age of Imperialism, New York, Monthly Review Press (1970).

Malina, K., "Overcoming Underdevelopment" World Marxist Review, May (1978), p. 51-ff.

Mandel, E., Marxist, Economic Theory, New York, Monthly Review Press (1970).

Marchak, Patricia. Ideological Perspectives on Canada, Toronto, McGraw Hill Pyerson Ltd., (1981).

Marx, Karl, Capital - A Critique of political economy. London, Charles Ker & Co. (1906).

Marx, Karl, The German ideology, Part I. In Marx-Engels Reader, by Robert Tucker (ed.) New York, Norton & Co. (1978).

Marx, K. and Engels, F., Manifesto to the Communist Party. In Marx-Engels Reader, Ibid, (1978).

Mathewson, Eli, An enterprise so perilious. London, East Africa, Literature Bureau, Nairobi. (1960).

Mburu, F.M., "Critique of Bryants Paper on Health for All in the Year 2000", Social Science and Medicine 14, (1980), p. 387-389.

McDonald, Cathy, Political-economic Structures. Approaches to traditional and Modern Medical Systems" Social Science and Medicine 15 (1981).

_____ Measurement of Coverage, Efficiency and Effectiveness of Health Care in Nigeria. Geneva, WHO, Unpublished Memographs (1980).

Mechanic, David, "The Concept of Illness Behaviour". Journal of Chronic Diseases 15, p. 189-194 (1962).

Medvedev, Z.A. and Medvedev, A., A Question of Madness Repression by Psychiatry in the Soviet Union, London, Norton and Company (1971).

Mejia, A. et. al., Physicians and Nurse Migration. Analysis and Policy Implication. Geneva WHO (1979).

Miller, Walter, Have we failed in Nigeria. London, United Society for Christian Literature (1947).

Mills, C. Wright, The Marxists, New York, Dell Pub. Co. (1963).

Mills, C. Wright, The Power Elite. New York, Oxford Univ. Press (1956).

Mitchison, Lois. Nigeria: Newest Nation. London Pall Mall Press (1960).

Morrow, William, Public Administration Policy and the Political System. New York Randon House (1980).

Mun, Thomas, England's Treasure by Foreign Trade, Oxford, Basil Blackward (1959).

Murphy, M. and Baba, T., "Rural dwellers and Health Care in Northern Nigeria" Social Science and Medicine, 15, (1981), p. 263-271.

Nadim, Nawal, Rural Health Care in Egypt. Ottawa, Int. . Dev. Res. Centre (1980).

Nash, Manning, "Editorial" Economic Development and Cultural Change 1, (1954), p. 4.

Navarro, Vicente, Medicine Under Capitalism. New York, Neale Watson

Navarro, Vicente, "The Political Economy of Medical Care" International Journal of Health Services 5 (1975).

Navarro, Vicente, "The Society - its influence on Health Care." In Corey, L. et. al., Medicine in a Changing Society. Saint Louis, Mosby Co. (1977).

Nathanson, C.A. "Illness and the Feminine Role A theoretical Review" Social Science and Medicine 19, (1975), p. 57-62.

Newell, Kenneth (ed.) Health by the People. Geneva WHO (1975).

Nkrumah, Kwame, Neo-colonialism - the Last Stage of Imperialism. London, Heinman Ed. Books (1965).

Norman, J.C., "Medicine in the Ghetto." Journal of Medicine 281, (1969). p. 1271-ff.

Northcott, H., "Convergence or Divergence: The Rural-Urban distribution of Physicians and Dentists in Census divisions and incorporated cities, Towns and Villages in Alberta, Canada" Social Science and Medicine 14, (1981), p. 17-22.

Nwokolo, Uche, "The Practice of Medicine by Laymen in Nigeria" Dokita 1 (1960).

Nyako, J.A., "Malaria and Diarrhea: Case Study of Plateau State" In Okello Oculi (ed.) Health Problems in Rural Africa, Zaria, Political Science Dept. (1981).

Oculi, Okello, Health Problems in Rural and Urban Africa. Zavia, Pol. Science Dept. ABU (1981).

Ofodile, F.O., "On Traditional Vs Western Medicine" West Africa 3301, (1950).

Ojo, Afolabi, Culture and Modernization in Nigeria. Ife, Univ. of the Press (1974).

Olatunbosun, D., Nigeria's Neglected Rural Majority. Ibadan, Oxford Univ. Press (1975).

Oyebola, D.D., "Professional Association, Ethics and Discipline among Traditional Healers of Nigeria" Social Science and Medicine 15, (1981).

Oyebola, D.D., "Reply to Banner man et al" Social Science and Medicine 15 (1981).

Oyebola, D.D., "Traditional Medicine and its practitioners among the Yoruba of Nigeria: A Classification" Social Science and Medicine 14 (1980), p. 23-29.

Oyebola, D.D., "The Methods of Training Traditional Healers and Midwives Among the Yoruba of Nigeria" Social Science and Medicine 14 1980 p, 31-36.

Parsons, T., The Social Systems, London, Routledge and Kegan Paul Ltd. (1951).

Parsons, T., Structure and Process in Modern Societies, New York (1960).

Pearce, Tola, "Political and Economic Changes in Nigeria and Organization of Medical Care" Social Science and Medicine 14, (1980), p. 91-98.

Pflang, Mantred, "Relations between Social Scientist, Physician and Medical Organization in Health Research" Social Science and Medicine 9, (1975).

Phillipson, Sydney, Report of a Commission on the private practice of Medicine and Surgery by Officers of the Dept. of Medical Services in Nigeria. Lagos, Government Printer (1949).

_____ Primary Health Care: A Joint Report by the Director-General of the World Health Organization and the Director General of the United Nations Children's Fund, Geneva WHO (1978).

Quah, Stella, "Health Policy and Traditional Medicine in Singapore" Social Science and Medicine 15 (1981).

Redfield, R., "The Folk Society" American Journal of Sociology 52 (1940), p. 294.

Redfield, R., The Folk Culture of Yocaton Chicago, Univ. of Chicago Press (1961).

Rodney, Walter, How Europe Underdeveloped Africa. Washington, Howard Univ. Press (1972).

Roemer, Milton, "Organizational issues relating to Medical Priorities in Latin America" Social Science and Medicine 9, (1975), p. 93-96.

Roemer, Milton, Systems of Health. International Health Perspective. New York, Springer Pub. Co. (1977).

Roemer, Milton, Comparative National Policies on Health Care New York, Dekker Inc. (1977).

Rosenthal, G., "Does Good Health Services Research produce good health policies?" Health Policy Quarterly Evaluation and Utilization 1, 1, (1981).

Rostow, W.W., The States of Economic Growth: A non-Communist Manifesto, London, Cambridge Univ. Press (1960).

Safarian, A.E., Foreign Ownership of Canadian Industry, Toronto, McCraw Hill (1966).

Scrimshaw, N.S., et. al., "Interactions of Nutrition and Infection." World Health Monograph Series 57, Geneva, WHO (1968), p. 240.

Segall, Alex, "Socio-Cultural Variations in Sick-role Behavioural expectations" Social Science and Medicine 10, (1976), p. 47-51.

Sklar, Richard, Nigerian Political Parties. Princeton, Oxford Univ. Press (1963).

Sigerist, Henry, Socialized Medicine in the Soviet Union. London Camelot Press (1937).

Smith, K.A., "Health Priorities in the Poorer Countries" Social Science and Medicine 9 (1975).

Smith, H.W., Strategies of Social Research. New Jersey Prentice-Hall Inc. (1980).

Spencer, Herbert, "The evolution of Societies" In Etzioni (ed.) Social Change: Sources, Patterns and Consequences" New York, Basic Books (1964).

Stephen, Joseph, Worldwide Overview of Health and Disease. International Health Perspectives New York, Springer Pub. Co. (1977).

Stock, Robert, Cholela in Africa. Diffusion of the Disease 1970-1975 with particular emphasis on West Africa. London Inter. Af. Inst. Pub. (1976).

Suchman, E.A., "Health attitudes and Behaviour" Archives of Environmental Health, 20 (1970), p. 105.

Suchman, E.A., "Sociomedical variations among Ethic Groups" American Journal of Sociology 70 (1964), p. 319-ff.

Suman, H.N., Industrial Economics for Underdeveloped Countries. New Delhi, Jund. Pub. (1971).

Sweezy, P.M., The Theory of Capitalist Development. New York, Monthly Review Press (1968).

Toffler, Alvin, Future Shock, New York, Randon House (1970).

Talbot, P.A., The people of Southern Nigeria Vol. II. London, Cass. Pub. (1969).

Taylor, Carol, "Implication for the delivery of Health Care" Social Science and Medicine 13, (1979), pp. 77-84.

_____ "The World's Main Health Problems, WHO 6th Report on the World Health Situation." World Health Forum, 2, (1981).

Twumasi, P., Medical Systems in Ghana: A Study in Medical Sociology. Ghana, Ghana Pub. Co. (1975).

Twumasi, P., "Colonialism and International Health Study in Social Change in Ghana." Social Science and Medicine 15 (1981), p. 147-152.

Twumasi, P., "Community Involvement in Solving Local Health Problems" Social Science and Medicine 15 (1981), p. 169-174.

Ueagwu, J., "On Traditional VS Modern Medicine" Daily Times, January 1982.

Van-Etten, G.M., Rural Health Development in Tanzania. Netherlands Van Forum Co. (1976).

Vago, Steve, Social Change, New York, Holt, Rinehart and Winston (1980).

Waitzkin, H., and Waterman, B., The exploitation of Illness in Capitalist Society. Indianapolis. Boobs-Merril Co. Inc. (1974).

Wallestein, Immanuel, Social Change: The colonial Situation. New York, John Wiley and Sons (1966).

Wayas, Joseph, Nigeria's leadership role in Africa. London, MacMillan Co. (1979).

Wells, Alan (ed.), Contemporary Sociological Theories, California, Goodyear Pub. (1978).

_____, World Health Statistical Annual, Geneva (1972).

_____, World Bank Atlas, (1978).

_____, World Development Report (1978).

Yaaya, Mario, Primary Health Care Delivery Services. A comparative Approach. Bsc. Thesis ABU Zaria, Sociology Department (1979).

Zasha, James, Migration to Gboko Rice-Mills. B.Sc. Thesis, ABU, Zaria, Sociology Dept. (1977).

Zijl, Van, "Studies of Diarrheal Diseases in Seven Countries." Bulletin of WHO 25, Geneva WHO (1966).

Zola, Kenneth, "Healthism and Disabling Medicalization". In Disabling Professions (ed.) Ivan Illich et. al. Don Mills, Burns & Mae Eachen (1977).

Zola, Kenneth, "Culture and Symptoms - An Analysis of Patients presenting Complaints" American Sociological Review 3, 1 p. 615 (1966).