A Historical Evaluation of the Prospects and Challenges of Nigeria's Health Sector, 1960–2016

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Over the years, Africa has been designated with unpalatable epithets, such as disease zone and Whiteman graveyard among others because of its salubrious ecology to the survival of pathogens, which had led to pathological disequilibrium in many African states. This study examined Nigeria's health Sector and evaluated its prospects and challenges, since independence. Healthcare delivery predates Nigeria's independence. It is a Man's reaction towards his variegated health challenges, which is considered as old as man's existence. The study uses historical tools of analysis to investigate the prospects and challenges in its response to combating diverse diseases and epidemics. The aim of the study is to evaluate why in spite of the efforts of diverse actors it health sector, Nigerian healthcare delivery still remains weak and unable to meet the challenges of diseases and epidemics.

[Nigeria; Healthcare; Prospects; Challenges; Medicine]

Introduction

Africa Continent is for long laden with diverse pathological problems. In this research, attention is focused on Nigeria. The independence of Nigeria in 1960 was epochal because it marked the disengagement of foreign domination on the socio-political and economic life of the people. On till then, Nigeria's socio-political, economic, education and health among other sectors were dominated by the Europeans. The configuration of the system was perceived by the nationalists as debacle for speedy progress of Nigeria towards its manifest destiny. This obviously underscored part of the reasons the quest for independence was accorded with optimum commitment. Attainment of independence was thus celebrated with fanfare

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and pageantry. This study historically evaluates the state of Health Sector in Nigeria after over fifty year's independence with the primary aim of ascertaining the prospects and challenges. This study partly incorporates the evaluation of the qualitative and quantitative analyses of health sector. In doing this effectively, the study explores the major economic plans of Nigeria, which particularly exhibits the governmental pronouncements on healthcare policies. These policies and their implementations in relation to availability and accessibility to Nigerians were critically evaluated. It utilizes fundamental health indicators such as mortality, morbidity, life expectancy and health security as health measurements in this analysis. The prospects and challenges of Health sector were also considered within the period of study.

Nigerian Healthcare Sector in Retrospect

Nigerian health sector predated Nigerian independence. Health sector as used in this sense encompasses all efforts geared towards healthcare delivery through orthodox and unorthodox mechanisms.[1] Healthcare services are as old as man's existence. One of the challenges men has faced in his chequered history is disease and outbreak of epidemics. Man, in context had mustered available mechanisms to overcome his variegated healthcare challenges. Until the eras of missionary enterprises and colonialism, the primary agents of healthcare services in Nigeria were individuals, families, communities, and Islamic religion. This period is what some health scholars referred to as *"era of self-help and communalism"*.[2] Everybody was responsible to himself. Each family oversaw the members of the family ditto for the communities. Traditional healthcare was predominantly the leading agent of healthcare in Nigeria. However, the spirit of communalism that characterized Africa traditional setting, which also underscores the basis for polygamy and extended family, made related families to oversee the welfare of one another. Minor health cases were handled at the family level. One of the scholars described the situation as follows: *"Medical treatment starts at the household level. Practically everyone can cite recipes for the relief of common symptoms by the use of herbs and materials close to hand. Every household has its own favorite prescription which has been*

1 I. A. PAUL, *A History of Healthcare Services in Okun-Yorubaland, 1900–2000*, an unpublished Ph.D. thesis, Department of History, University of Ilorin, 2015, pp. 189–201.

2 D. S. SHISHIMA, The Holistic Nature of African Traditional Medicine: The TIV Experience, in: G. G. ADERIBIGBE – D. AIYEGBOYIN (eds.), *Religion, Medicine and Healing*, Ikeja 1995, pp. 111–105.

proven over time and many plants growing wild on pitches of waste land between the compounds are recognized for their specific therapeutic properties. Infusions for headache, fever and jaundice, stomachic, purges, inhalation, embrocation and ointments can be recommended by people of all ages."[3]

However, critical illnesses and epidemics were combated concertedly. In this development, the indigenous healthcare practitioners acted as health officers, advisors, and administrators. They specialized in different aspects of healthcare. They had their peculiar methods of diagnosing diseases as well as administering medicines. The knowledge demonstrated by the indigenous health practitioners perhaps made Morley and Roy referred to them as local scientists.[4] This practice was held constant until the coming of Islamic preachers, who were instrumental in the introduction of Islamic medicine in Northern Nigeria around 12th and 13th centuries.[5] Biomedicine or western healthcare system was introduced to Southern Nigeria since 1860s.[6] The Colonial government that took over the administration of Nigeria joined the missionaries to promote western healthcare since 1870s. It must however be emphasized that even though the missionaries and the colonial government involved in western healthcare services since the second half of 19th century, the traditional health care remained the largest and the most populous healthcare services in Nigeria up till 1960s. Reasons are not hard to find. In the first instance, the level of education and awareness of western healthcare services were limited to the urban centres and few villages that had mission stations.[7] Secondly, the attachment of the people to their culture made it difficult to be cut off from patronizing or using indigenous means of taking care of their health challenges.

Ade-Ajayi and Ayandele have argued that in Nigeria, western healthcare was almost the monopoly of missions in the early days of colonialism.[8] Even though the missions ventured into this business, their primary goal initially was to win converts using healthcare as a tool. By 1914, there were up to 18 mission hospitals in south eastern and

3 U. MACLEAN, *Magical Medicine: A Nigerian Case Study*, London 1971, pp. 26–29.
4 P. MORLEY – W. ROY (eds.), *Culture and Curing*, London 1978, pp. 202–209.
5 PAUL, p. 85.
6 R. SCHRAM, *A History of Nigerian Health Care Services*, Ibadan 1971, pp. 37–38.
7 PAUL, pp. 256–258.
8 J. F. ADE-AJAYI, *Christian Mission in Nigeria, the Making of a New Elite, 1841–1891*, Evanston 1965; E. A. AYANDELE, *The Missionary Impact on Modern Nigeria, 1842–1914: A Political Analysis*, New York 1966.

south western Nigeria. The British Colonial Government ventured into western healthcare services as indicated earlier in a manner that would accommodate only the Colonial Officials and the native population that were directly employed in the Colonial Administration. This implies that biomedicine in Nigeria was not initially designed as British responsibility towards the wellbeing of indigenous population. However, the outbreak of World War I, in 1914 endangered the efforts of Colonial Government. Towards the end of 1920s, the British Government took dramatic steps to improve Biomedical healthcare within its territory in West Africa. This development was largely connected to the rumour that filtered across Africa that the Francophone territories of Africa were more developed than the Anglophone territories. In reaction to this development, the British Secretary of State for Colonies appointed Dr Ambrose Thomas Stanton to advise the British Government on all medical and sanitary matters in the British colonies in West Africa.[9] Similarly, it commissioned an Under-Secretary of State for the Colonies, Dr William Ormsby-Gore to tour its West African Territories with the primary aim of surveying the state of socio-economic development including medical and healthcare services.[10] His report at the end of the exercise was unfavourable to the British Government. His observation on medical and healthcare in Nigeria was far behind and could not be compared with other neighbouring West African colonies he had visited. He strongly recommended the need for the government to provide adequate medical services for the entire native population, unlike in the past when it only concerned itself with services to Europeans and native officials. In addition, he recommended the training of indigenous Dispensers, Dressers, Midwives and Welfare workers to undertake medical and healthcare trainings within the various ethnic groups.[11] Barely two years after the above recommendations, Dr Stanton also toured West African Colonies to survey health and medical facilities. His recommendations were like Ormsby-Gore's earlier recommendations. He however suggested the expansion of healthcare services if British colonial administration would compete with its Francophone colonies in West Africa.[12] He added in his recommendation that the Government should establish a Board or Department of Health and Sanitation, which

9 National Archives Ibadan (hereafter NAI), Command Paper (hereafter CMD) Britain 2744: William Ormsby's Report on Public Health in West Africa, 1926.

10 NAI, CMD Britain 3268: Dr Stanton's Reports on Public Health in West Africa, 1928.

11 NAI, Britain 2744: William Ormsby's Report on Public Health in West Africa, 1926.

12 NAI, CMD Britain 3268: Dr Stanton's Reports on Public Health in West Africa, 1928.

would oversee healthcare matters in Nigeria. These two reports were incredibly significant in the western healthcare revolution in Nigeria. In the first instance, it fired the instinct of the government of Ramsay MacDonald that came into power in 1929 to pass the Colonial Development Act, which provided a grant of One Million (1,000,000) pounds to support Nigeria's Annual Budget of 1930.[13] This development also coincided with Governor Graeme Thomson's Traditional Government Reforms in Nigeria, which aimed at the institutionalization of the Native Authorities (NA) in the country to undertake the establishment of social services including healthcare services across the regions.[14] However the outbreak of the World War II in 1939 hampered the colonial health policies in Nigeria. Many of the European health officers left Nigeria back home because their services were highly needed during the war.[15]

It was after the World War II, appreciable developments were reported on bio-medical or western healthcare in Nigeria. In 1945, the Colonial Office requested the local administration to submit a 10 year development plan to act as a guide to the colonial administrative system in Nigeria.[16] This followed the institutionalization of 10 years development and welfare plan for Nigeria in 1946–1956. The plan was supposed to cover the above period.[17] Taiwo has however, gave an insight that the 10 years plan was essentially an ad hoc list of selected projects without a common conceptual framework. The argument was validated when in 1950, it was realized that the project was not feasible. The reason given for the unrealistic of the project hinged on the fact that it was difficult to chart development plan over a period of 10 years in a country that was undergoing rapid structural changes. A decision was then taken to break the interval into two i.e. 5-year periods.[18] A new plan for 1951–1956 was

13 American Registry for Diagnostic Medical Sonography (ARDMS): Annual Reports, Department of Medical and Sanitary Services, 1930.

14 S. PHILLIPSON, *Administrative and Financial Procedure under the New Constitution between Government of Nigeria and the Native Administrations*, Lagos 1947, pp. 54–55.

15 C. L. MOWAT, *Britain between the Wars*, London 1955, p. 353.

16 E. LAMBO, The Role of the Social Scientist in Medical Research, in: C. O. ENWONWU – N. I. ONYEZILI – G. C. EJEZIE (eds.), *Strategy for Medical Research in Nigeria*, Ibadan 1983, p. 59.

17 I. O. TAIWO, A Review of Planning and Budgeting Activities, in: H. O. DANMOLA et al. (eds.), *Contemporary Issues in Nigeria's Affairs*, Ibadan 1995, p. 141.

18 E. O. OJO, Constraints on Budgeting and Development Plan Implementation in Nigeria: An Overview, in: *European Journal of Sustainable Development*, 1, 3, 2012, pp. 445–456.

then formulated. Obviously, the two plans accommodated Healthcare for all Nigerians. The plans were however observed in absolute fiasco due largely to the misplacement of priority by the colonial government.

The next major effort to colonial plan in Nigeria was in 1953 when the World Bank was invited to send an economic mission to Nigeria. The 1955–1960 economic programs followed largely the recommendation of the bank's reports. This plan also failed.[19] Lambo emphasized that the above mentioned plans were actually prepared by colonial government officials and hence, they failed to satisfy the important requirements of a good planning, namely, absence of the people whose welfare the plans was supposed to cater for. Other reasons advanced by scholars why the early national planning were not successful include, attempt at centralizing planning, which gave way to regional uncoordinated planning when the country was balkanized into regional government.[20] Similarly, lack of properly defined objectives relevant to the country's needs and adequate administrative machinery to provide a high level capacity for plan implementation was a clog in the wheel of Nigerian plan. On Health Sector, the plans made unsubstantial provisions that would make the effort workable. However, the major shortcoming that scuttled the plans on healthcare delivery was that western healthcare was made synonymous to building of infrastructures. For instance, the establishment of University College Ibadan in 1948, with a full Faculty of Medicine, was perceived as one of the major successes of the plan. It was assumed that with the establishment of the school, qualitative healthcare delivery would be made available for Nigerians without necessarily considered the distance to the people in the north and in the east, which were not less than one thousand kilometres apart. Secondly, preventive healthcare measures were not given much emphasis. Thirdly, available healthcare centres were located in the urban areas leaving majority of Nigerian population in the rural areas without western healthcare.[21] Fourthly, the Regional Government that came into being in Nigeria in 1946 as mentioned earlier, during John Macpherson administration did not allow cohesive policy on

19 J. A. A. AYOADE, The Administration of Development Plan in Africa: A Comparative Perspective, in: *The Nigerian Journal of Economic and Social Studies*, 25, 1, 1983, p. 91.

20 E. LAMBO, Perspective Planning in Nigeria with Specific Reference to the Social (Health) Sector, in: *The Nigerian Journal of Economic and Social Studies*, 31, 1, 2 & 3, 1989, p. 103.

21 Z. A. ADEMUWAGUN, The Challenge of the Co-Existence of Orthodox and Traditional Medicine in Nigeria, in: *East African Medical Journal*, 53, 1, 1976, p. 78.

health matters across Nigeria. Each region was to design its own as well as to finance it. More importantly, there was serious disparity between the indigenous and western healthcare deliveries in Nigeria. The agents of western health care i.e. the mission and the colonial government did not see anything good from patronizing and using indigenous medicines. For example, in some missions, converts were made to make open declarations of denouncing anything traditional as a symbol of transformation to a new life.

On the part of the colonial government, to operate as a traditional healthcare practitioner, such must register with the colonial government.[22] They made conditions for registration difficult and almost impossible for the prospective traditional healthcare practitioners due to stringent measures they enlisted as pre-requisite for operation. Despite this major challenge, the indigenous healthcare practitioners were resilient. Ade Ajayi and Toyin Falola have however, emphasized the importance of acknowledging the strength and resiliency of various African traditions in the face of European assault.[23] This perspective becomes very important when engaging the agency of Africans in constructing their history, such as with the resiliency of Yoruba healing. However, the success of indigenous health practitioners in India and China, which culminated in the endorsement and approval by the World Health Organization in 1976 as an alternative health therapy to orthodox medicine, strengthened the operation of the indigenous health practitioners in Nigeria as it shall be explored later.

Assessment of Health Sector in Nigeria by 1960

The independence of Nigeria in 1960 was the climax of nationalists' struggles. This achievement left much on the emerging leadership of Nigeria to evolve workable policies that will put the country on proper footing to enhance its speedy development. As Ojo rightly pointed out, the best way to assess the level of development of any nation is by examining the micro-sectors or components of its entire structures.[24] We can argue succinctly that the colonial government transferred an epileptic medical health sector at the independence in 1960. As it has been analysed above, a decade

22 D. D. OYEBOLA, Professional Association, Ethics and Discipline among the Yoruba Traditional Healers of Nigeria, in: *Social Science and Medicine*, 15, 2, 1981, p. 104.

23 J. F. ADE-AJAYI – T. FALOLA, *Tradition and Change in Africa: Essay of J. F Ade Ajayi, Classic Authors and Texts on Africa*, Trenton, NJ 2000, p. 165.

24 OJO, p. 450.

of colonial health plan, 1946–1956 could by no means meet its cardinal objectives. The implication of this was the transfer of weak structures to Nigerian government. It is germane to unearth the general condition of health sector at the time of Nigerian independence. In the first place, the missionaries had the largest hospitals. Schram noted that there were 118 missionary hospitals compared to 101 government owned hospitals.[25] The composition of these figures needs to be analysed. Both the missions and colonial government hospitals were not evenly distributed across Nigeria. For example, the Roman Catholic Mission had 40% of the mission hospital which were largely situated in the southeast and southwest of Nigeria. The Sudan United Mission concentrated on Middle Belt areas, and the Sudan Interior Mission, worked in the Islamic north. Together they operated twenty-five hospitals or other facilities in the northern half of the country, which constituted about 20%. Apart from some designated areas in the north where European activities were predominantly located like Jos, there was no effort made by the government to build hospitals. For instance, until 1912 when colonial government built hospital in Jos there was none in that region. The building of this hospital according to Schram, was to serve the expatriates who were working in the mining sites for the Europeans.[26] However, the Traditional medical practitioners were ubiquitous in the towns and cities in Nigeria. As noted by Owodapo, there was no single town, or armlet that lacked their services with little or no financial constraints.[27] This explains why it was difficult for the missionaries and colonial government to extirpate them despite their pressure against their existence and their services during the colonial period. This perhaps, captures the reason Washington-weik wrote inter-alia among the Yoruba ethnic groups that: *"The diverse range of health assessments* [...] *revealed the high level of their (traditional) acceptability. The efficacy of remedies was some of the reasons for the popularity of and social confidence in Yoruba healing. This was despite the growing number of western medical options available to patients during this period. Mid-century studies reflect that Yoruba people preferred indigenous healing to western medicine for various illnesses."*[28]

25 SCHRAM, p. 108.

26 Ibid, p. 110.

27 T. OWODAPO, Oral Interview, Lagos, 2017.

28 N. WASHINGTON-WEIK, *The Resiliency of Yoruba Traditional Healing*, unpublished Ph.D. thesis, Department of History, University of Texas at Austin, 2009, pp. 122–133. The above argument is not novel on this discussion. Other studies that supported the above include, U. MACLEAN, *Magical Medicine: A Nigerian Case Study*, London 1963;

There are at least 4 notable economic plans after Nigeria's political independence thus: 1962–1968; 1970–1974; 1975–1980; 1981–1985. Each of these plans embodied the goals, strategies, and formulae in form of public investment programs and socio-economic policies that will assist in accelerating the country's development process within a comprehensive framework. Scholar like O' Connel has reasons to believe that none of these plans enumerated above met its goals and objectives.[29] The failure of the plans necessitated other developmental plans like the: 1989–1993; 1996–1999 National Rolling Plan and 1999–2001 National Rolling Plan.

Health Sector, which is the concern of this study could be said to start off with the review of the Colonial health policies, which was far behind expectation. Over 70% of the reported cases of death during the 10 years plan period were due to preventable diseases. Tella puts infant mortality rate during this period at between 400 death per 100,000 population.[30] Due to the above problems, the Federal Government embarked on rigorous measures to improve the healthcare delivery after independence. Tafawa Balewa administration constituted a fact-finding team to investigate the health situation across Nigeria. The outcome of the reports indicated that western healthcare services were only available to few Nigerian populations, especially in the urban areas. It further stated that available ones in the urban centres were inadequately equipped to cope with the demands of the population. As a result, preventive healthcare services for the benefit of all the citizens were recommended. This was reflected in the policy statement of the First National Development Plan of 1962–1968. It read in part: *"Permanent improvement in the nation's health cannot be acquired by clinical medicine alone. There must be a steady advance in all factors which contribute towards healthy life – good water supplies, housing, sanitation and condition of work."*[31]

Z. A. ADEMUWAGUN, The Challenges of Co-Existence of Orthodox and Traditional Medicine in Nigeria, in: *East Africa Medical Journal*, 53, 1, 1976, pp. 21–32; G. E. SIMPSON, *Yoruba Religion and Medicine in Ibadan*, Ibadan 1980; A. S. JEGEDE, The Yoruba Cultural Construction of Health and Illness, in: *Nordic Journal of Africa Studies*, 2002, pp. 103–121; O. A. ERINOSO, Notes and Concept of Diseases and Illness: The Case Study of Yoruba in Nigeria, in: *Journal of Economic and Social Studies*, 18, 3, 1998, pp. 78–93.

29 J. O'CONNEL, Political Constraint on Planning: Nigeria as a Case Study in the Developing World, in: *Nigeria Journal of Economic and Social Science*, 13, 1971, pp. 39–57.

30 A. TELLA, Traditional/Alternative Medicine in Quest of Health for All by the Year 2000 AD, in: *An Inaugural Lecture Series*, No. 51, University of Maiduguri, Nigeria 1992, p. 3.

31 First Nigerian National Development Plan, 1962–1968.

Despite this laudable idea, it is lamentable that the plan was observed in breach due largely to over-concentration on curative medical services in consequence with the pre-independence arrangement. Also, the politicization of Nigerian socio-political system affected the healthcare services. During Nigeria's political quagmire, the military took over the government in January 1966. As part of the effort of the military to bring about change to the nation at large, the country was balkanized into twelve states. However, the unresolved bickering among the army snowballed into Nigerian civil war, 1967–1970. Throughout the war period, there was no appreciable effort by the government to improve healthcare services. Rather, attention of the government was largely focused on the war. The traditional health practitioners were the most highly patronized during the war.[32] This was because of the insecurity that made it almost impossible for free movement of people, goods, and services across the states.

Attention must also be drawn to the roles of the international organization on healthcare delivery in Nigeria. Unfortunately as noted by Okafor, most of the contributions of the international organizations passed through the government (Federal Government), which kept very little records of the impact on the people.[33] The difficulties in keeping the records hinged partly on the pattern of their contributions. Most of the international organizations rendered services in kind and not in cash such as in procurement of equipment and training of personnel, which made their activities impossible to quantify. These organizations include, the World Health Organization (WHO), United States Agency for International Development (USAID), United Nation International Children Emergency Fund (UNICEF) and the British Technical Assistance (BTA).

In a collaborative effort among Nigerian government, USAID and WHO, a very successful program was launched against smallpox and measles in 1967 and 1968 respectively. The USAID financed the cost of technical immunization expenses, while the Nigerian Government and WHO provided medical personnel and local cost. The program was adjured to be successful in Lagos that in 1968 it was 97% estimated efficient while over 90% of the target population was immunized. Several

32 B. E. OWUMI, *Physician Patient Relationships in an Alternative Healthcare Services among the Okpe People of Bendel State*, an Unpublished Ph.D. thesis, Sociology Department, University of Ibadan, 1989, p. 67.

33 E. OKAFOR, Oral Interview, Enugu, 2015.

projects aimed at controlling malaria, which accounted for about 11% of all mortality were launched by WHO and UNICEF in Nigeria in 1960s and 1970s. The expanded program on immunization (EPI), Oral Rehydration Therapy (ORT) and digging of borehole projects for drinking water in the rural areas are some of the areas UNICEF's contributions are immense. Other areas where international organizations have given assistance/aid for treatment or prevention include guinea worm, tuberculosis, Cholera, polio, and Immune Deficiency Syndrome (AIDS) etc.

By 1979, there were estimated of about 562 hospitals, 16 maternity and paediatric hospitals, 11 armed forces hospitals, 6 teaching hospitals and 3 prison hospitals. Altogether, western healthcare accounted for about 44,600 hospital beds. In addition, general health centres were estimated to total slightly less than 600; general clinic 2,740; maternity homes 930 and maternity health centres 1,240. In comparison to the above, although there was no record of the number of the traditional health practitioners, oral history revealed clearly that there was no community in Nigeria, which did not have one type of traditional health practitioner or the other.

In line with the above analysis, Ityavyar noted that there was great disparity between the urban and rural areas in 1980. He found that whereas approximately 80% of the population lived in rural areas, only 42% of the hospitals were located in those areas.[34] The mal-administration of physicians was even more marked because few trained doctors who had no choice wanted to live in rural area. The ratio were estimated at 3,800 people per hospital bed in the north (Borno, Kaduna, Kano, Niger and Sokoto States); 2,200 per bed in the Middle-belt (Bauchi, Benue, Gongola, Kwara and Plateau states); 1,300 per bed in the southeast (Anambra, Cross River, Imo and River states).[35]

Despite the shortfall of western healthcare services in Nigeria, there was sharp disparity between the traditional and western healthcare. Among the educated elite for example, the quest for traditional medicine declined sharply after independence. This was not unconnected to the growing rate of western education at that stage of Nigeria's development. The agents of western education such as the government, missions, and

34 D. A. ITAYVYA, The Colonial Origin of Health Care Services: The Nigeria Example, in: T. FALOLA et al. (eds.), *Political Economy of Health in Africa*, Ohio University Centre for International Studies, 1992, pp. 221–224.

35 *Nigerian Medical Association Bulletin: Survey of State Growth and Development of Western Healthcare in Nigeria*, Lagos 1995, pp. 1–4.

international organizations favoured western healthcare services. This period also saw the emergence of private participation in western healthcare. Private hospitals were built by individuals to facilitate healthcare services to complement the missions and government hospitals. In the school for example, children were taught the importance of hygiene in Social Studies or Civic Education in the elementary and secondary school levels. They were also encouraged to go for medical treatments in the hospitals and shunned traditional healthcare services, concoctions, and any herbal solution, which they regarded as unhygienic for good health. The missionaries forbad their converts from using traditional medicaments. The international organizations also belong to western side. The trilogies favoured the latter, which also aided the popularity and advancement of western medicine over the traditional medicine. The grip and acceptance of traditional medicine began to dwindle in the urban centres especially among the educated elite of the society.[36] However, the traditional healthcare practitioners did not fold their hands. They launched what could be described as campaign for survival and relevance to avoid their profession gliding into absolute extinction. They formed themselves into various associations and began to canvass for government recognition. They employed various strategies such as lobbying and letter writings. Hyma and Ramesh noted, Nigerian government appeared to be in the state of dilemma before 1976 on what should be the position of the government on the clash between traditional and western medicines.[37] However, the success of traditional healthcare practitioners in India, Korea, China, Indonesia and Singapore motivated the traditional healthcare practitioners in most of the developing countries like Nigeria.[38] In the afore-mentioned countries, they did not only win the acceptance of their governments' recognitions but the campaign was wholeheartedly supported, accepted and promoted by the World Health Organization in 1976. The WHO asserted thus: "*Traditional medicine include diversity of health practices, approaches, knowledge, and beliefs incorporating plants, animals, and/or*

36 O. EDWIN, Personal interview, Lagos, 2015.

37 B. HYMA – A. RAMESH, Traditional Medicine: Its Extent and Potentials for Incorporation into Modern National Health System, in: D. R. PHILIP – Y. VERGERSSELT (eds.), *Health and Development*, London 1994, pp. 272–273; O. A. ERINOSHO, *Health Sociology*, Ibadan 1998, p. 38.

38 S. S. KAKAR, *Mystics and Doctors: A Psychological Inquiry into India and Its Healing Traditions*, New York 1982; J. CAIS, Integration of Traditional Chinese Medicine with Western Medicine – Right or Wrong, in: *Journal of Science and medicine*, 27, 1988, pp. 523–525.

mineral-based medicines, spiritual therapies; manual techniques; and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose, or prevent illness. […] *Traditional medical knowledge may be passed on orally from generation to generation, in some cases with families specializing in specific treatments, or it may be taught in officially recognized universities. Sometimes its practice is quite restricted geographically, and it may also be found in diverse region of the world."*[39]

The above implies the official recognition and acceptance of traditional medicine along with the western type. Traditional medical organizations especially in Nigeria began to canvass for legislations in support of the official recognition of traditional healers with the aim of expanding the scope of healthcare services to all persons irrespective of social status. In line with the above, the traditional healthcare association in Nigeria made bold effort to embark on structural re-organization and re-packaging. First, they changed their identity from using the term, "Traditional Medicine" to "Alternative Medicine".[40] It is most probable that the term traditional as they were formerly called was becoming more primitive, hence, the need for the new brand. This strategy became necessary in the face of global age of modernization of culture with the aim of gaining acceptance as well as making it more fascinating and attractive to the people who were gradually losing the confidence reposed in it to embrace the trend of modernism. The Nigerian government was caught in between but had no option than to recognize the decision of the WHO. The Nigerian government while expressing its readiness for integration remarked: *"Judging from close to a hundred year of promoting western medicine in Nigeria, it services are only available to between 25–30 per cent of Nigerian population leaving 70–75 per cent to the care of traditional medicine."*[41]

Thus, the Federal government embarked on path-finding that would facilitate the integration of traditional and western medicine in Nigeria. A delegation of health experts was sent to India and China in 1977 by the Federal Ministry of Health. In summary, the report of the delegation recommended that the integration of western and traditional healthcare services was desirable in Nigeria.[42] Follow-up to this development was the

39 WHO: *African Traditional Medicine*, Afro-Technical Report Series, No. 1, 1976, p. 6.

40 A. TELLA, Traditional/Alternative Medicine; K. A. HARRISON (2009), Transforming Health Systems to Improve Lives of Women and Newborn Babies in Nigeria, Keynote address, Presented to the Nigerian Health Conference, Uyo, Nigeria, 1992.

41 Ibid, p. 23.

42 OWUMI, pp. 41–44.

establishment of National Committee on the re-training of Traditional Birth Attendants (TBAs) by the Federal Ministry of Health. The committee was set up all over the country to upgrade the skills of Traditional Birth Attendants in delivering babies. This committee produced a national syllabus for the training of TBAs. Reinvigorating the Nigeria's attempt to integrate traditional medicine was the declaration of Alma-Ata in 1978. This declaration was especially important in the sense that a redefinition of health was reconsidered to include not only the absence of biological infirmities in man. This suggests that health is holistic and a shift from curative to preventive health approach came into force. Also, the Declaration established Primary Health Care (PHC), which was mandatory on all states.

The component of the PHC includes Community Health that incorporated indigenous health knowledge into the scheme of PHC.[43] Also included in this Declaration was Health For All (HFA) by 2000 AD. It was clearly stated that if states must meet this set target, health care system must not only be affordable, but largely, it must also be accessible. Following the WHO Declaration and recommendation of 1977 delegation to India and China, the Federal Ministry of Health (FMOH) in 1979 organized a National Seminar on Traditional Medicine. This was the first-time practical approach was taken and executed almost immediately. In this seminar, both the western medical practitioners and traditional health practitioners participated as contributors. Recommendations were generally in favour of feasible integration in the country, but the cynics in the Health ministry side-tracked its realization.[44]

Be that as it may, the adoption of National Health Policy based on Primary Health Care in 1987 was a landmark in the history of Nigerian Healthcare. Its goals were comprehensive, restorative, and rehabilitative in nature. The healthcare services based on Primary Healthcare include:

Education concerning the prevailing health problems and the method of preventing and controlling them.

- Promotion of food supply and proper nutrition.
- Maternal and childcare, including family planning.
- Immunization against the major infectious diseases.
- Prevention and control of local endemic and epidemic diseases.
- Provision of essential drugs and supplies.

43 A. O. LUCAS, Oral History, Lagos, 2010.
44 Ibid.

More importantly, the system recognized a 3-tier level healthcare management namely, Primary, Secondary and Tertiary. The motive behind this development was to ensure every Nigerian has access to healthcare delivery. The health needs of the people at the grassroots level are to be addressed at the Primary Healthcare Centres. The provision of healthcare at this level was largely the responsibility of the Local Government. At the Secondary level, specialized services to patients referred from the Primary Healthcare level are to be provided at the District, Division and Zonal levels of the state. The State Government is expected to provide adequate supportive services such as laboratory, diagnostic, blood bank, rehabilitation, and physiotherapy. At the Tertiary level, specialized and specific services such as orthopaedic, eye, psychiatry, maternity and paediatric cases are to be addressed by the Teaching Hospitals.[45]

As part of the government's effort to streamline healthcare delivery between traditional and western, the Lagos State Government went ahead by setting up the State Board of Traditional Medicine in 1980. The Board was saddled with the responsibility of accreditation, attestation, and registration of traditional healers. However, the quacks and charlatans among the traditional healers were to be identified. The Board also established the Code of Conducts, which they all had to adhere to.[46] Despite this laudable development, the Board was faced with two notable challenges. First, the Board was not vested with the power to arrest and to deal with unregistered traditional healers. Thus, many without registration continued to operate without punishment. Second, the Board lacked jurisdiction over those casual traditional healers who would go to Lagos from another State in Nigeria. More importantly, when the military took over the government in 1983, the whole structure went into comatose. However, in 1984, the Federal government set up National Committee on Traditional and Alternative Medicine (NICTAM), which suggested the establishment of Board of Traditional Medicine in all the states of the federation.[47] It has been suggested that the brain behind this development was Professor A. O. Lucas, a renowned expert of Public Health. The body recommended that a study of homeopathy, chiropractic and acupuncture should be carried out and hence, their incorporation into traditional medical system in Nigeria. This was followed in 1988 another

45 PAUL, pp. 256–258.

46 A. O. LUCAS, Oral History, Lagos, 2010.

47 O. ROBERT – K. ANYIAN, *The Government and Traditional Medical Development in Nigeria since 1960*, Lagos 1992, pp. 138–139.

delegation to the United Kingdom, West Germany and India by the Federal Ministry of Health Science and Technology through an established National and Alternative Medicine (NCRDTAM). The recommendations of the delegates were not executed due largely to financial challenges and corruption as it will be discussed later.

Due to the enormous financial problems confronting the healthcare sector in Nigeria, the government embarked on another health policy aimed at resolving the high financial burden on the government through individual involvement. It was due to this reason the Federal Government established the National Insurance Scheme, under ACT 35 of 1999.[48] The idea behind the establishment of the Scheme was to find a lasting solution to the financial problems that had been the major obstacle to healthcare delivery in Nigeria. Indeed, the concept of Social Insurance was first mooted in 1962 by Halevy Committee, which passed the proposal through the Lagos Health Bill. Unfortunately, the idea was truncated midway due to lack of commitment on the part of the government. Forced by the desire to source for more funds for healthcare services in 1984, the National Council on Health under Admiral Patrick Koshoni, the then Minister of Health, inaugurated a Committee, chaired by Prof. Diejomoah. The Committee after thorough consideration advised the government on the desirability of Health Insurance in Nigeria and recommended its adoption again. The Subsequent Ministers appointed for Health such as, Dr Emmanuel Nsan and Professor Olikoye Ransome Kuti also set up different Committees between 1984 and 1989, both Committees as part of their reports remarked in support of the viability of Health Insurance Scheme in Nigeria. Unfortunately, no meaningful action seemed to have followed the recommendations.

However, given the general poor state of the nation's healthcare services and over-dependence on the government to provide healthcare facilities needed by the citizens, the scheme was therefore designed to facilitate fair finance through pooling and judicious utilization of financial risk protection and cost burden sharing for the people. This was done against the high cost of healthcare through institution of prepaid mechanism prior to their falling ill. The Scheme as part of the govern-

[48] I. A. PAUL, Healthcare, Healthcare Policies and Challenges in Nigeria since Independence, in B. L. ADELEKE – T. I. GAFAR (eds), *General Studies in the Social Sciences: Some Fundamental Topics* The General Studies Division, University of Ilorin, 2012, pp. 189–191.

ment's effort to reach every Nigerian operates through these designed programs to cover every segment of the country:

- Former Sector Health Insurance.
- Urban Self-Employed Social Health Insurance Program.
- Rural Community Social Health Insurance Program.
- Children Under-Five Social Health Insurance Program.
- Permanent Disabled Persons Social Health Insurance Program.
- Tertiary Institution and Voluntary Participant Social Health Insurance Program.
- Armed Forces, Police and other Uniformed Services.

Provision was made for Regulatory Oversight on Health Maintenance Organization (HMOs) and other players in the healthcare delivery. The Scheme was officially launched in 2005.

Prospects

There have been enormous improvements in Healthcare Sector in Nigeria since independence. In the first instance, there has been tremendous improvement in the number of available Health Centres in Nigeria. This feat was because of involvement of diverse health agencies in Nigeria. These agents include the mission, government, international organizations, non-governmental organizations, private individuals and faith and traditional health practitioners. The flexibility of the Federal government policies after independence, which tended towards integrating the traditional and western medicines, helped to allay the disparity and pugnacity that had long existed between the two. This development has significantly improved their relationship but has not totally eradicated it. This feat was achieved due to the recognition given to the traditional healthcare by the World Health Organization (WHO) in 1976, which saw traditional medicine as an alternative medicine to the western medicine. As a result of this development, the Federal Government had made several efforts to improve the services of traditional healthcare in Nigeria. This can be seen in the way the traditional medical practitioners dress in white robes, like their western counterparts. Their drug packages have significantly improved and the way they advertise their drugs have incorporated the modern methods. They produced tablets, capsules and in bottles, which made it easy for the users over what had been the practice before.

Today, there are many hospitals across Nigeria owed by the Federal, State, Mission, Corporations, and Private etc. The table below shows an estimate over a period of sixty years.

	Missions	Federal Govt	State Govt	Private	Corporate Organi-zation	Traditional Health Practitioners
1960s	118	112	–	–	–	Everywhere
1970s	124	96	160	15	11	Everywhere
1980s	130	118	234	32	17	Everywhere
1990s	144	156	567	97	21	Everywhere
2000s	155	158	789	159	35	Everywhere
2010s	164	161	794	183	58	Everywhere

Source: Military of Health Bulletin, Vol. 1, Lagos, 2011, p. 13.

The table above gave a rough estimate of the available hospitals in Nigeria over a period of fifty years. It shows a tremendous increase in the numerical numbers. However, Moradeyo has shown that most of what were referred to as hospitals as indicated in the table above were not qualified to be called hospitals.[49] Many of them according to him did not have what it takes to be called a standard hospital, which include trained medical personnel such as doctors and nurses, standard medical equipment among others. Based on this insight, we can reiterate that, quantitatively, Nigeria made appreciable progress but qualitatively, the standard falls below international standard. Some of the hospitals indicated in the table were said to have no qualified personnel.

There is an improvement in the availability of medical personnel such as doctor, nurses, and other para-medical officials in Nigeria. In 1960, there were 5,864 registered medical doctors in Nigeria hospitals to the population of about 46,000,000 people. This was far below the standard set by the World Health Organization. However, the situation improved in 1980. The number of registered medical doctors increased to about 28,000. By 1990, their number had risen to 41,000.[50] The same was also the case for nurses. For instance, there were 7,107 registered nurses (RNs) and 6,917 registered midwives (RMs) in 1962, but by 1972, the figure had increased to 15,529 RNs and 16,034 RMs.[51] The training of all other cadres of healthcare personnel followed the same pattern. It is worthy of mentioning that Nigeria now has more manpower in Health

49 L. MORADEYO, Oral Interview, Lagos, 2015.

50 *Nigerian Medical Association Bulletin*, 1995, p. 4.

51 Nigerian Association of Nurses and Midwifery Survey (1990) Challenges of Nigerian Nurses and Mid-wives.

Sector because of tremendous increase in medical training schools such as Universities, Nursing School etc than what was the situation before independence. As at December 1989, Nigeria had 20 Federal universities and 8 State universities. However, based on the research done by Professor Adesina Olutayo, as at April 2015, Nigeria now has 40 Federal Universities, 39 State Universities and 59 Private Universities (138 in all).[52] Based on the statistical analysis at hand, it shows that majority of these Universities have Faculty of Medicine, Nurse and Mid-wifery. Apart from the above, there are over 48 School of Nurses and Mid-wiveries.

In line with the above, there has been an appreciable advancement on the dissemination of knowledge about healthcare over what is used to be before. According to World Health Organization, only about 22.8% of Nigerians had access to healthcare information in 1960. The situation improved to 59.2% in 2014.[53] The improvement was due to increase in the level of literacy among the Nigerian population and dissemination of information through the mass media, internet, and social media. Similarly, many diseases that were codified as spiritual problem and incurable by the traditional healthcare practitioners before were cured by western medicine because of advancement in medical healthcare research.

Challenges

Most of the Nigeria's development plans that could have propelled Nigeria's development including the Health Sector are faulty. This explains largely why they failed to realize their objectives. Ojo, who did a comparative study on Nigerian plans has argued that if any development plan is to be described as being visionary and comprehensive in all the plans, it was the vision 2010 of General Sani Abacha's administration.[54] The committee that was constituted to work out the plan was inaugurated on 27th November, 1996. The committee composed of 248 members, including 25 foreign stakeholders resident in Nigeria. The rest were government appointed and elected representatives of the people. The committee mandate sets out a 14-item of reference, required it to develop a blue-print that will transform the country. The committee worked for ten months using the following methodologies:

52 O. ADESINA, Nigerian Universities and Shifting Sense of Belonging, in: *The 3rd IFRA Public Lecture*, University of Ibadan 2015, p. 2.
53 WHO: Regional Assessment Reports on Africa, 2014, p. 3.
54 OJO, pp. 448–449.

- Plenary session, held in the form of 12 workshops, spread over the period.
- Sub-committee in particular problem areas.
- 57 external workshops.
- Specifically commissioned studies.
- Consideration of 750 memoranda from the general public.
- Presentation of guest speakers and.
- Intensive brainstorming among committee members.

Arising from the results of this process, the committee concluded that by 2010, Nigeria would have transformed into a country which is a united, industrious, caring and God-fearing democratic society, committed to making the basic needs of life including healthcare affordable for everyone and become the best in Africa. Be that as it may, the vision suffered the same fate of lack of continuity like the preceding plans, mostly because of both political and governmental instability. The vision went into abeyance following the mysterious demise of General Sani Abacha. Ojo, has however pointed out that most of the Nigeria's plan lacked the following essentials:

- Clarity and comprehensibility.
- Measurable and verifiable achievements.
- Reality and consistency.
- Specific period of achievement.
- Intermediate targets or goals that will facilitate the attainment of the major objective.
- Modernity and update.
- Relative importance.
- Legitimacy.
- Spatial fairness in plural society.[55]

Similarly, political instability because of concomitant military interventions in Nigeria's political scene since 1966 have hampered coherent and viable national plan that could have aided development and effective healthcare services in Nigeria. The protracted military rules in Nigeria had thwarted viable policies that could have enhanced better performance including health. Military officers who have spent the greater part of governance are not trained to formulate and implement policies that could enhance development especially on healthcare services. Their coming into politics was misnomer in goal-getting political calculus.

[55] Ibid, p. 450.

More importantly, the unabated corruption in Nigeria system has remained one of the major challenges of health sector. Corruption has affected every gamut of Nigeria's polity. Antonio (2007), the Executive Director of the United Nations on Drugs and Crimes in a speech delivered in Abuja at the 6th National Seminar on Economic Crimes said: *"By some estimates, close to $400 billion was stolen in Nigeria between 1960 and 1999."*[56] He went further to elucidate that, if $400 billion bills are put in a row, one could make a path from here to the Moon and back not once but 75 times. This analysis was to draw home the level of degradation corruption has cost Nigeria. Okon argued, during an interview that money that is meant for procurement of drugs in the public hospitals was often diverted by individual or group of individuals.[57] On the same coin, some importers of drugs into the country collaborated with producers abroad to import fake drugs in order to make more money after they had succeeded in conveying them into the country. Adeyemi said, by estimation, more than 80% of drugs in Nigeria's stores are fake drugs.[58] The damage of this form of corruption is inestimable as the poor in the country bear the heavy burden of the corruption. This problem partly necessitated the establishment of National Agency for Food and Drugs Administration and Control (NAFDAC) in 1993 to checkmate the activities of these nefarious individuals who grow tall in this act of anti-social behaviours. Achebe (2012), having explored the degree of degradation and effects of corruption on Nigeria, gave a prognosis in his parting words that, *"if Nigeria does not kill corruption, corruption will kill Nigeria"*.

Indeed, a lot of programs which attracted massive funds were carried out between 1987 and 2000, all of which were geared towards reducing the morbidity and mortality levels in the country. It is lamentable that the goals of World Health Organization are yet to be met. Healthcare Services in Nigeria is still precarious, poor, and backward. Among the sensitive indices we can use to assess the health standard of any place is the maternal mortality rate of the expectant mothers, infant mortality, under-5 mortality, prematurity, low birth weight, life expectancy, access to safe drinking water and immunization of children and pregnant women. Health statistics of Nigeria measured by the above parameters are still highly and far below the World Health Organization's expectation.

56 C. ANTONIO MARIA, public lecture delivered in Abuja, 17th November 2007, p. 4.
57 C. Z. OKON, Oral Interview, Enugu, 2016.
58 J. ADEYEMI, Oral Interview, Abuja, 2016.

Statistics revealed that out of every One Thousand (1,000) children born alive between 1990s and 2000, One Hundred and Eighty (180) died before they reached the age of five (5) years old.

In addition, routine immunization coverage that stretched above 80% in the early 1990s dropped below 30% in 2000. Frequent outbreak of vaccine preventable diseases such as measles, whooping cough, cerebrospinal meningitis, and polio are still frequent in Nigeria at large. A lot of women still die during childbirth due to complications and preventable diseases. A recent UN report showed that one woman dies every three (3) minutes in Nigeria, due to pregnant related complications. There were high cases of hypertension, stroke, and heart problems among other cardiovascular diseases. The bad situation across the country of similar condition perhaps, had earned Nigeria a World Health Organization's (WHO) ranking of 187 among the 191-member state as at 2015.

The situation above is exacerbated by inequitable distribution of human resources in the Health Sector with most medical personnel working in big urban centres at the detriment of the rural settlements. It is hard to phantom why the State Governments that oversee the hospitals could not recruit enough doctors. Garba believed the high cost of maintaining and servicing doctors could have been responsible.[59] This situation is a general phenomenon all over Nigeria. Also, the perennial industrial crisis of medical experts is an eloquent testimony of the issue under discussion. The usual agitation for better remuneration, consolidated medical salary scale is a strong factor among the causers of re-occurring episode of strikes. Many qualified doctors in Nigeria at large, left the country in search of better pay and better standard of living in other countries in the West and Europe.[60] The haemorrhage of these qualified doctors and nurses is in no doubt left the country in a shortage of qualified medical experts, which in return gave rise to the upsurge of quacks in the profession.[61] Paul has noted that the bastardization of Civil Service by the military had led to the haemorrhage of medical personnel from Nigeria to United Kingdom, United States of America and Saudi Arabia among others. Nigeria cannot

59 K. O. GARBA, Oral Interview, Ibadan, 2016.

60 A. AKANMU, Brain Drain Gain: Leveraging the Nigeria Diaspora for the Revitalization of Nigeria Higher Education, in: *Ibadan Journal of History*, 1, Maiden Edition Commemorating University of Ibadan at 65, 2013, pp. 3–6.

61 I. A. PAUL, Socio-Political and Economic Implications of Brain Drain in Nigeria: A Study of Medical Personnel (1966–1990), in: *Contemporary Humanities, Journal of Babcock University*, 7, 2017, pp. 123–126.

pretend that the exit of these personnel does not have adverse effect on its Health Sector. It is saddening that Nigeria continues to loss huge amount of money to India, China, and Singapore due to high numbers of Nigerian who are travelling there to seek medical attention.

Moreover, health facilities, particularly, at the primary and secondary health care levels have deteriorated considerably. From the above analyses, we can argue conveniently that the failure of the government to its crucial health responsibilities in Nigeria have grossly necessitated the major significant lapses in Health Sector in Nigeria. There is no gainsaying the fact that healthcare services require huge financial burden on the government. Lack of prudent financial management has made healthcare services to suffer great setback since independence. Outbreaks of strange epidemics have also constituted major challenges. Epidemics like cholera, Human Immuno-deficient Viruses (HIV), Ebola, Lassa and Zika fever etc are strange to Nigerians until recently. They have constituted acute challenges to Health Sector especially on methodology of containment, which requires constant training of personnel. Combating these epidemics indeed, require necessary researches and trainings of personnel which require huge financial commitments. Lack of funds to finance these researches made Nigeria to depend on donors and grants from abroad. Grants and donations from abroad are in many instances mismanaged and becoming hard to come-by.

Conclusion

Indeed, healthcare services predated Nigeria's independence. It is noteworthy that healthcare services were predominantly the responsibility of traditional health practitioners before the arrival of the missionaries and colonialists. They administered healthcare and equally served as counsellors and administrators on healthcare matters. However, the arrival of Islam and missionaries ushered in the introduction of Islamic and Western medicines respectively in Nigeria. While Islamic medicine was predominant in Islamic dominated Northern Nigeria, Western healthcare gained currency in the Southern part. The latter introduced it to cater for the health needs of the missionaries in Africa in 1860s. They later extended their hands of fellowships to their converts. In the whole, the idea was to enhance the evangelization of Nigeria. In the same vein, colonial government later ventured into the business of western medicine from 1870s to cater for the health challenges of their colonial agents in Nigeria. It must be noted that there was no central coordination of healthcare

services in Nigeria until 1930s, when the Department of Medical Health and Sanitation was established. However, when regional government was introduced in Nigeria in 1936, the responsibility of administering health was transferred to the Regional Governments across Nigeria. Healthcare services in Nigeria became rather intensified after World War II. This was followed by 10 years colonial plan (1946–1956), which was largely observed in breach. By the time Nigeria attained independence in 1960, healthcare services in Nigeria was still far behind. It was partly for this that the six years post-colonial plan (1962–1968) incorporates healthcare delivery. Other plans, 1970–1974; 1975–1980; 1981–1985, contained laudable programs for health sector. However, the implementation of these plans was not well coordinated, resulting in failure for the realization of the objectives.

In the whole, Health Sector in Nigeria has recorded appreciable improvements, which has aided more effective healthcare delivery for Nigerians since independence. Traditional medicines have improved significantly. In biomedicine, there are more hospitals owned and managed by the missions, government, and private individuals. Not only that, there are more medical personnel such as doctors, nurses and other para-medical officials engaging in the business of healthcare delivery in Nigeria. Serious epidemics and diseases that were foretimes spiritualized and coded as incurable by traditional health practitioners have been cured in the advent of western medicine.

Despite the above major achievements, Healthcare Sector in Nigeria has been faced with diverse challenges. Critical among these include, corruption, fund, brain-drain, political instability, protracted military rule, mal-administration, poor policy implementation and lack of focus.