

**WESTERN HEALTH CARE SYSTEM
IN NORTHERN NIGERIA:
AN OUTLINE OF ITS FOUNDATION AND DEVELOPMENT**

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LECTURE**

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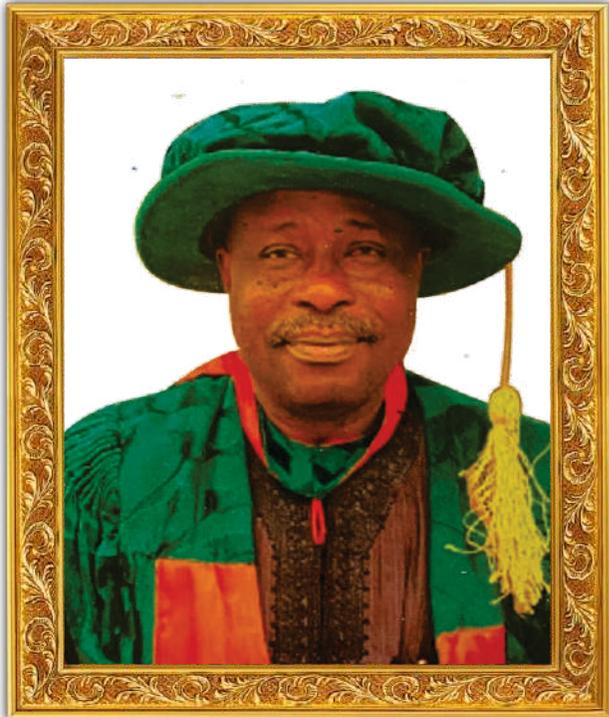
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FIRST INAUGURAL LECTURE OF GOMBE STATE UNIVERSITY

BY

**PROFESSOR IBRAHIM WAZIRI ABUBAKAR
DEPARTMENT OF HISTORY
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PREFACE

I have been into the study of health care provision since 1986. That was the year when the groundwork preparation for a new health care policy and system was introduced in Nigeria. The then Minister of Health, late Professor Olukoye Ransome-Kuti led the drive for the reform of the Nigerian health care system based on the World Health Organization's (WHO) recommended approach to addressing health care issues in the world, especially in developing countries. The Primary Health Care (PHC) system was launched in Nigeria in 1988 which led to vigorous/flurry of activities in the implementation of components of the system such as emphasis on preventive medicine and strategies, provision of accessible health care system at the grass-roots, promotion of exclusive breast-feeding, free immunization to children and use of oral rehydration therapy (ORT), birth control and a host of other related issues. The media, both print and electronic were daily awash with news, news analysis and opinions on the subject matter.

I was attracted by the attention Government, the international community and the Nigerian public gave to the activities and inspired by my historical consciousness and its principle of investigating and interrogating the origins, causes, forces and factors that influence or even determine human activities over time, on events and issues that dominate public space as did the health care issue in the late 1980s. I came to notice that most of the history taught and written was political history, pre-colonial and colonial history, not much was done on health care especially on the Northern Region, and this gave me the impetus to delve into the issue.

My over 30 years of research on health care provision began with the study of impact of colonialism on health in Bauchi Province, later I researched on the state of health care in Gombe State from 1960 to 2000 in my Masters and PhD respectively. My other researches covered the whole of Nigeria and to a little

extent Africa, but I chose to focus my Inaugural lecture on Northern Nigeria believing that little attention has been given to the subject matter on the region. I hope to also attract the attention of young scholars to the field of not only health care research, but also social history in general. I have been encouraging historical research outside the traditional domain to areas ranging from environmental history, energy and transport infrastructure, water resources, agriculture and industry to mobile phones, tricycle transport system and similar social issues because history is about understanding all actions and activities in the entire superstructure of human society.

History is a discipline that deals with the study of what goes on in the universe and among the human race in its totality as well as the documentation, exposition and analysis of events and developments within a given society over time, it also involves all human actions and activities; any event or happening anywhere from this moment backwards is history, it is an objective reality¹. Whether one is conscious of it or not history is being made every minute, every hour, every week, month and year. History is part and parcel of human existence as water is to the body. It is about how human society has come to be what it is today². History is about the study of change and motion in human society as society is never static. As Alagoa asserted, history enables us to acquire knowledge of the nature and capabilities of man and to understand the origins and nature of issues and problems confronting human society, by this history provides a guide to the present and future generations in shaping their destinies as a people. History is

¹ Sa'ad, A. "History as a Tool for Nation Building," Lecture delivered at the Annual Congress of the Students Historical Society of Nigeria (SHSN), University of Abuja Chapter, 25th July, 2005, p. 1. See also Mahadi, A. "Who is Afraid of History?" in *Gombe Studies: Journal of Gombe State University*, Vol. 1, No. 1, December, 2008, pp. 1-27

² Usman, Y.B.; "History, Tradition and Reaction: The Perception of Nigeria History in the 19th and 20th Centuries" in Kwanashie, G. A., Abba, A., Adamu S. H., Muhammed, B. (eds); *Beyond Fairy Tales: Selected Historical Writings of Dr. Yusuf Bala Usman*, Abdullahi Smith Centre for Historical Research, Zaria, 2006, p. 39

ever present in all aspects of human activities, as it is the sum total of human thought, words and deeds which have left surviving evidence that can be studied.³

Mr. Chairman, human development is about learning from previous experiences and examples to improve the present, and prepare and plan for the future. History is a process of permanent review of human activities by which individuals, groups and nations learn from the positive and negative out-come of human actions or inactions and our activities in general to improve the future and avoid the mistakes and pitfalls of the past. There is a general saying that people should strive to make tomorrow better than today and yesterday, but how can people achieve this without knowing and understanding of yesterday? History makes us acquainted with the conditions of the past and help us explain the causes and origins of events;⁴ these and the pervasive presence of history provided me the tool, platform and opportunity to study the subject matter of health care provision in Nigeria.

In the broad field of History, I chose to focus my research on health care delivery system, dealing mainly with the ideas and factors that inform the formulation of policies, establishment of health care infrastructure and facilities, health care budget provision, training and deployment of manpower and the impact of these on the health and well-being of people and society in general; because of its importance to the existence and survival of society, and because of its role in living productive and meaningful life. Let me at this juncture state clearly that my work is not on medical history which has to do with the science of medicine and medical practices.

CONCEPTUAL CLARIFICATION

³ Afigbo, A. E.; "African Historical Consciousness and Development" in Alagoa, E. J. (ed) *Dike Remembered: African Reflections on History, Dike Memorial Lectures 1985-1995*, Historical Society of Nigeria, 1998, p. 111

⁴ Ibn. Khaldun; *The Muqaddima: An Introduction to History*, translated by Franz Rosenthal and edited by Dawud, N. J. London: Routledge and Kegan Paul, 1978, p. 11

From time immemorial the protection and promotion of good health, prevention illnesses and provision of health services has been one of the pre-occupations of man, because various diseases, epidemics, pests, hunger, malnutrition, famines, physical and psychological disorders have been pestering human society which had been directly or indirectly affecting the health and well-being of the people. In modern times other health issues such as high blood pressure, diabetics, cancers, industrial and transport sector accidents, pollution and environmental issues have been discovered and added to the list of human health problems. Governments all over the world have been striving to improve the health and well-being of the teeming population by trying to provide good, accessible and sustainable health care services to its citizens.

The importance of health to humanity has been expressed in various sayings. The English adage “health is wealth” and the Hausa variant “lafiya uwar jiki” underscore the value and worth of health to human society. A 16th Century French Essayist emphasized the critical role of health to human society when he stated:

Health is a precious thing..., the only thing that deserves to be pursued at the expense of not only time, sweat, labour worldly goods, but life itself. Since without health, life becomes a burden and an affliction.⁵

The question of health has engaged the attention of man throughout history and today it is used as one of the indices in measuring the level of development of countries/society. My study of health care services provision has been in the context of the World Health Organization’s definition at the Alma-Ata Conference in 1978 at which health was defined as: “a state of complete, physical, mental and social well-being and not merely the absence of disease and infirmity.”⁶

⁵ Schultz, M. G. “The Forgotten Problems of Forgotten People” in *Health Policies in Developing Countries*, published by the *Royal Society of Medicine*, 1980, p. 57

⁶ World Health Organization (WHO) *World Health Forum: An International Journal of Health*; Geneva, Vol.2No.1, 1981, p.21

Since the emergence of the WHO definition health care provision and concerns went beyond treatment in hospitals and clinics with drugs and surgery to include good balanced diet that is food nutrition, good housing conditions, education, work, living conditions etc. Positive health can be assured only when there are adequate good housing and treated water supply, sufficient quantity and quality of food and good nutrition, Sanitation and clean environment, efficient waste and refuse disposal system.

By declaring that health “is a fundamental right...The inequalities are politically, socially and economically unacceptable”⁷ at the 1978 Alma-Ata meeting the WHO added political weight and dimension to the issue of health care provision. It also gave room for the mobilization of international support and assistance to developing countries in the provision of health care.

Overall health is more than just biological balance of the body due to, freedom from pains, discomfort, stress and boredom. It entails social adaptation to the environment and community which could lead to adequate functioning in physical, social and mental sense of the people in society and giving meaning and purpose to life. Health is the sum-total of material, physiological and psychological well-being and security of the people at any given time. A balanced health care provision must pay attention at all times to five areas, namely; promotive, protective, preventive, restorative and rehabilitative components.

INTRODUCTION

One of the lasting legacies of British rule in Nigeria is the modern health care system that was introduced, developed and handed over to the government at independence in 1960. This Inaugural lecture is an attempt to trace the history of the evolution and development of the health care system in the Northern Region of

⁷ WHO: *World Health Forum*, p. 21

Nigeria. This involves a discussion on the motives for the introduction of the system, its nature, pattern and characteristics. The role of the colonial state, bilateral international bodies and voluntary organizations in the establishment of the health care system shall also be highlighted. Developments in the sector, achievements that have been made, problems affecting the performance of the system and the extent of the improvement of the health and well-being of the people since independence shall be discussed.

It is important to note that, at the time the British introduced modern health care in the colonies, including Nigeria the perception of health was not as defined by the WHO in 1978. Before this definition came up, health care provision was more of the cure of diseases, little or inadequate attention was given to other relevant or associated issues that affect human health. This was due the low-level of advancement in medical and health sciences. With the gradual development of the sciences in general, especially medical sciences and increasing entrenchment of the colonial system, realities in the colonies necessitated the need to extend health care beyond the cure of diseases, in other words, health care was expanded beyond the confines of medicine, to include other factors such as good food and nutrition, maternity services, sanitation and water supply, housing and the control and even possible eradication of disease vectors like mosquitoes, guinea worm, tsetse fly etc. This change in perception was manifested in the changing pattern of health policies and strategies during the colonial period as the system was being developed.

Rudimentary western medical work in Nigeria began in the coastal areas in the 1830s by European expeditioners and explorers such as John and MacGregor Laird, Mr. R. A. F. Oldfield, Richard Lander, Sir Thomas F. Buxton, William Wilberforce, Mungo Park to mention but a few. Dr. W. B, Baike introduced the use

of quinine in the Niger Delta region in 1854.⁸ The first health care facility in Nigeria was a dispensary opened in Obosi in 1880 by the Church Missionary Society (CMS) followed by others in Onitsha and Ibadan in 1886. The first hospital in Southern Nigeria was built and opened in 1885 by the Roman Catholic Mission in Abeokuta named the Sacred Heart Hospital.⁹ The first health care facility in Northern Nigeria was built in 1901 at Jebba and later moved to Lokoja in the same year. Sir Samuel Manuwa ascribed the late arrival of western health care to the Northern Region to the history of the country's geographical exploration by Europeans, pacification, conquest and colonization by the British.¹⁰ All started from the coastal areas in the 1880s and subsequently advanced to the interior in the early 20th Century. The Northern Region being the last area to come under British control partially explains the delay but there was also the problem of deep suspicion of the British by the local rulers and their subjects' reluctance to accept and allow the introduction of anything British including the health care system. Nevertheless, by the end of the colonial period the Region had an established modern health care system which the Regional Government inherited at independence and continued to build on.

COLONIAL MOTIVES AND THE EVOLUTION OF THE WESTERN HEALTH CARE SYSTEM

It is pertinent to begin this section by noting that long before the introduction of modern health care by the British into northern Nigeria, the peoples and communities of the area had well developed medical and health care systems that were to a large extent indigenous to the region. It is the system commonly called

⁸ For detailed discussion of early attempts by Europeans to introduce Western medical system in Nigeria see Schram, R.; *A History of the Nigerian Health Care Services*, University of Ibadan Press, Ibadan, 1971, pp. 35-55

⁹ Scott-Emuakpor, A.; "The Evolution of Health Care Systems in Nigeria: Which Way Forward in the 21st Century: in *Niger Medical Journal Vol. 51*

¹⁰ Schram, R., *A History of the Nigerian Health Services*, Ibadan: University of Ibadan Press, 1971, p. xiii.

traditional medicine. In the north, irrespective of differing cultural, environmental and religious backgrounds and practices, generally the perception of what constitutes good health involved the sum total of the physical, mental, social, moral and spiritual welfare and fitness of the individual in particular and the community in general. This perception is rooted in the magico-traditional, religious and spiritual cosmology or world-outlook of the local people and communities and based on these numerous medicines based largely on herbs, tree barks and leaves, animals and birds' parts as well as medical practices such as incantations, prayers and sacrifices for the healing, cure and prevention of diseases and methods and ways of keeping and maintaining health were developed and practiced.¹¹ The Sokoto Caliphate leaders namely; Sheikh Usman Dan Fodio, his brother Sheikh Abdullahi and his son Sheikh Muhammad Bello wrote a lot among which was on health care and medicine. Muhammad Bello wrote the largest number of works on various aspects of health and medicine. Aliyu Dansidi the Amir of Zazzau also contributed a lot on the matter¹². Both writers gave the Islamic perspective of health and medicine.

From the period of early contact with Africa, Europeans have been challenged by various tropical diseases, most especially malaria, yellow fever and black water fever that were claiming their lives in large numbers. On reaching the Northern Region in the 20th Century, these diseases posed a serious challenge to their imperial ambitions as they caused numerous deaths and indigence amongst them. This did not diminish in any way their determination to conquer and colonize the area primarily for economic reasons and therefore resolved to control the devastations caused on them by tropical diseases in the region to realize their goal. The British came into Northern Nigeria with the experience and knowledge

¹¹ Abubakar, I.W. "Health Under Colonialism: A Study of the Impact of British Colonialism and its Health Policies in Bauchi Province 1900-1960," M.A. Thesis, Department of History, ABU, Zaria, 1994 pp. 121-22 (unpublished).

¹² Bugaje, U.; "Contributions of Sokoto Caliphate Scholars to Medicine" ; New Nigeria Newspaper, Thursday 15th, Friday 16th and Monday 19th, June, 1995

they gathered in the coastal areas which they used in maintaining their health. This led to the introduction and gradual development of a new health care and medical system in the region. The introduction of the system was initially aimed at catering exclusively for the health care needs of expatriates who were considered patriots by the British Royals and business men as Mary Kinsley stated “for a man who has got the grit in him to go and fight in West Africa for those things worth fighting for – duty, honour and gold is a man whose death is a dead loss to his country.”¹³ She did not mince words as to the importance, necessity and purpose of protecting the health of the British when she posited that:

Yet grievous as is the price England pays for her West African possession, to us who know the men who risk their lives and die, for them England gets a good equivalent value for it, for she is the greatest manufacturing country in the world and as such requires markets.... West Africa remains for hundreds of years a region that will supply the manufacturer, with his raw materials and take in exchange for it his manufactured articles giving him a good margin of profit.¹⁴

Kinsley’s statements succinctly underscored the philosophy that informed and guided British colonial health policies. It is clear that the essence of the early ideas and subsequent measures of the colonial health and medical care system were aimed mainly at protecting and preserving the health of Europeans in order to enable them conquer and colonize for the primary purpose of the development of trade and commerce for British industry and capitalism.

The pattern of growth of the modern health care services system in the region could be divided into three distinct stages, namely, conquest and early colonial period 1900 – 1920; the period of consolidation 1920 – 1945 and the last

¹³ Kinsley, M. *Travels in West Africa*, London: Fran Cass, 1965, p. 691

¹⁴ Kinsley, *Travels in West Africa*, p. 691

phase of colonial rule 1945 – 1960. The first stage coincided with the conquest and establishment of colonial rule. Thus, the first modern medical and health care introduced was to cater for a hand full of British administrators and military personnel in hospitals established for that purpose and were very few. When the First World War broke out in 1914, the need for more health establishments arose for the purpose of screening Africans that were conscripted into the British Army to fight in the war. Many makeshift screening centres were hurriedly set up. The second stage coincided with the period of increasing British exploitation of the region for the reconstruction of damages in Britain caused by the war. This led to the influx of expatriates who came in as civil servants or colonial administrators and technicians in the railways, roads and ports construction and management, mining sectors, teachers, merchants, health workers, police and army etc. who together manned the entire colonial machinery. Christian Missionaries also followed closely. The third stage began with the outbreak of the Second World War when men and materials were needed for the execution of the war. After the war, nationalist agitation for independence heightened and the gradual preparation for granting of political independence began. The British were also in desperate need of resources for the reconstruction of damages caused by the war and economic recovery. During this stage colonial capitalism had already been extended deeply into the rural areas and exploitation of labour and resources was intensified. As the agitations for independence intensified especially from the 1950s, the British were convinced of the ultimate death of colonial rule, hence they embarked on the establishment of more health facilities and extended them to the rural areas, partly to save their face against accusation of deliberate negligence and marginalization of the colonial populace and partly to further entrench their interests.

The increasing penetration of colonial capitalism driven by the need for raw materials and the need for labour to produce the raw materials and to serve in the army, the question of a healthy labour force become imperative to the British. This was succinctly posited by a French writer in 1923 when he wrote;” Medical aid...is our duty. But it is also matter of fact interest. For the work of colonialism, all the need to create wealth is dominated in the colonies by the question of labour.”¹⁵

The extension of the colonial machinery into all nooks and corners of the region brought out in bold relief to the British who were desperately in need of labour and products of African peasants and labour force for other purposes, the problems of an ill housed, badly fed, disease infected and illiterate population who’s economy needed to be modernized and incorporated into the international capitalist system may retard this objective. Thus, the colonial administrators realized that “there was crying need for medical work in the native population, not only for government stations and officials”¹⁶ as has been the practice. Apart from providing health care to have a healthy population for more effective and efficient exploitation, its provision was also seen as the demonstration of “superiority,” of Western civilization. In respect of the latter point, Tiyambe Zeleza noted that “disease become part of the wider condemnation of African backwardness”, just as medicine became a hallmark of the racial pride and technological assurance that underpinned the “new imperialism” of the late nineteenth century. Indeed, imperialist intervention was increasingly justified in the name of spreading the benefits of western medicine.¹⁷

It was therefore not coincidental that the priority in the Ten-Year Plan of Development and Welfare for Nigeria 1946-1955 was the “welfare” of the people.

¹⁵ Saurrant, A. “La Mise envaleur de Colonies” in Suret-Canale; *French Colonialism in Tropical Africa 1900-45*, London, 1971, p.47

¹⁶ Bauprof 734, 1927-51, NAK.

¹⁷ Zeleza, T., *A Modern Economic History of Africa: The Nineteenth Century Vol.1*, CODESRIA, Dakar, 1993, p. 41.

One of the major objectives of the Plan was to improve the general health and mental conditions of the colonial subjects as it was stated in the Plan that “a healthy body, reasonably nourished, is essential before further production effort can be expected.” Justifying the thinking, the Plan argued that “it would have been useless to consider any policy of wide economic development until plans had first been made to ensure that people were at least simultaneously put in a position where they could participate and take full advantage of such activities.”¹⁸ This was the ideological foundation on which the western healthcare was introduced and developed by the British not only in Northern Nigeria but in the country as a whole and in all its colonies the world over.

PATTERN OF ESTABLISHMENT AND GROWTH OF THE HEALTH CARE DELIVERY SYSTEM

The Northern Region, by its geographical location, the attitude and behavior of the people to hygiene and lack of precise scientific knowledge of the causes of some diseases and disorders was largely responsible for the debilitating effects of many diseases and ailments on the population, despite the availability of the traditional health care system. The region was home to diseases that can be categorized into three groups, namely, diseases that are common to mankind in any climate and any level of development, like measles, chicken pox, tuberculosis, mumps, venereal diseases, asthma, pneumonia, bronchitis and various types of ulcers.¹⁹ The second being diseases common in areas with low living standards and poor hygiene such as typhus fevers, relapsing fever, small pox, leprosy, intestinal worms and nutritional deficiencies and thirdly, those common to tropical climates like malaria, yaws, sleeping sickness, bilharzias, guinea worm, yellow fever.²⁰

¹⁸ Okigbo, P. N. C.; *National Development Planning in Nigeria 1900-1992*, Heinemann, London, 1989, pp.20-22.

¹⁹ Buchanan, K. M. and Pugh, J. C. ; *Land and People of Nigeria*, University Press, London, 1969, p.41.

²⁰ Buchanan and Pugh, *Land and People*, p.42

In establishing the health care system, the British were confronted with a number of problems such as the vastness and lack of sufficient knowledge of the region, lack of manpower, remoteness of many areas of the region, lack of efficient transport and communications systems and also the cautious or even outright rejection by the local people of the new system being introduced as well as constraints of very inadequate funding. But the most immediate concern was the problem of the effect of diseases, especially malaria on expatriate Europeans because many were dying and many others were invalidated by some of the diseases. There was also the problem of the effect of the diseases on the health of the colonial subjects whose labour was needed for the exploitation of resources and construction of the superstructure of the colonial machinery in the region. The British understood that the challenges have to be surmounted if they are to realize their objective of colonization in the first place.

Thus, from the early stages of conquest and pacification of the region, the Europeans began to carefully investigate and study the nature, causes, effects, pattern and spread of the diseases by medical teams under the supervision of the medical services unit. In the process large numbers of cases of the diseases and deaths from them were recorded.²¹ Based on the information gathered and new discoveries made, a number of strategies and methods for dealing with the situation, specially the curing of the diseases were worked out and applied. Preventive measures were also pursued but on a much lower scale than curative care.

Like in some parts of the country, the first health care system introduced into the Northern Region was the hospital system, which was later followed by the

²¹ Cerebro-spinal Meningitis was first recorded in Nigeria in 1885, in the Northern Provinces cases exceeding 10,000 were recorded in 1944 and 1945. Relapsing Fever epidemic, thought to have spread to Nigeria from North Africa broke out in 1947 when 832 cases were recorded and in 1948 in Bauchi, Borno, Kano, Katsina, Sokoto and Zaria when 4,000 were recorded. In 1910 about 9,366 cases of leprosy were recorded in Kano alone. Other diseases include yaws 14,397, syphilis 11,080 etc in 1935 alone. See *AR1/66, Report on Medical and Health Department for the years 1931- 1940*, NAK. Kaduna.

establishment of dispensaries, largely in the rural areas and solely the responsibility of the Native Authorities. The first hospital to be built in the Region was at Jebba which was later moved to Lokoja along the Niger River in 1901 to cater for the West African Frontier Forces. In the same year a temporary hospital was opened at Baro, but it was closed down a few years later.²² No hospitals were established again until between 1914 and 1915 when new ones were opened in Kaduna, Zungeru, Ilorin, Ibi and Offa and a Nursing Home in Kano.

One of the major characteristics of these early hospitals was that they were small and often temporary. According to Schram, “these were hardly hospitals by the standards,” as they were, “merely shelters, constructed of grass, thatch and mud”. Also, for many years these so-called hospital facilities had no doctors or any qualified para-medical practitioners, thus throughout the first decade of the twentieth century political/administrative officers sometimes acted as medical officers and physicians.²³

However, when the First World War broke out in 1914, hospital construction was expanded because of the need to screen Africans for conscription into the British army for the war. Thus between 1914 and 1917 some of the early hospitals were expanded and new ones were constructed. For instance, the Kaduna hospital was provided with four beds, that of Lokoja with (52), Kano (36) and Zungeru (40). The new ones constructed were those at Zaria 16 beds, Maiduguri (10), and Bauchi (10).²⁴

The period between the First and Second World wars was another phase of rapid expansion of hospital construction in the region. This, as noted earlier coincided with the period of the intensification of the exploitation of resources

²² Schram, *A History*, p.136. See also *Colonial Annual Reports, Northern Nigeria 1900-1914*.

²³ Schram, *A History*, pp.136-139. This was a situation peculiar to the North because of chronic lack of medical personnel of any kind nearby. Infact from 1900-1910 administrative officers posted to the Region were given courses on simple treatments and sanitation.

²⁴ Schram, *A History*, p.186 and *Colonial Report-Annual, Northern Nigeria, 1917*.

from the region for post-war reconstruction in Europe in general and Britain in particular. It also extended to the period when the Second World War was eminently impending hence the need for preparations for the war. During this phase, in addition to expanding hospital services, attempts were made to identify and classify the major diseases that cause morbidity and mortality amongst the people of the region.

Thus, new government hospitals were added to the existing ones by the colonial state. These included the Jos, Minna and Mubi hospitals, Nursing Homes, exclusively for expatriates in Jos and Kaduna all of which were opened between 1925 and 1930. Between 1930 and 1934, government hospitals were opened in Pankshin (1930), Azare, Wukari, Bida, Gusau, Ibi, Ilorin, Katsina, Lafia, Makurdi, Yola and Zuru, all in 1931. While those of Sokoto and Hadejia were opened in 1933 and 1934 respectively.²⁵

The establishment of hospital services was not the only aspect of health care the British provided. They also initiated and undertook actions to control and eradicate endemic and epidemic diseases to complement services provided in the relatively few hospitals in the region. As the British discovered that endemic diseases like sleeping sickness, malaria, yaws, leprosy, guinea worm infection, tuberculosis, etc and epidemic disease such as cerebro-spinal meningitis, small pox, chicken pox and cholera were devastating the populations, they made attempts to bring these under control, by establishing of medical service centres and Mobile Medical Field Units (MFU).²⁶ In respect to the former, centres for the control of sleeping sickness, leprosy and guinea worm were opened in some parts of the region. The earliest of such centres were the leprosy services and control centres opened in Garkida in 1929, and those of Zaria, Numan, Mkar, Mangu and Katsina

²⁵ Schram, *A History*, pp.426-428. See also AR1/27 and 166; *Reports on the Medical and Health Department of Nigeria, 1931-1940*, NAK. Kaduna.

²⁶ Schram, *A History*, pp.157-63 and pp.325-37; Buchanan and Pugh, *op. cit.* pp. 41-55

which were all opened in 1936. In 1937 another centre was opened in Kano, while that of Maiduguri was opened in 1938. In 1940 a new centre was established in Sokoto and in 1952 those of Bauchi and Takum were opened.²⁷

The Medical Field Units were established for the purpose of moving all over the region to conduct surveys and undertake control and eradication measures by spraying chemicals in the infected areas, especially in respect of malaria and sleeping sickness. For sleeping sickness, bushes that were found to harbour the tsetse fly were cleared in addition to the spraying. The units also administered mass vaccinations against epidemic diseases like yaws, small pox, measles, cholera and distributed drugs and treated patients that were already infected. The earliest of such was the sleeping sickness unit, first opened in Sherifari in Katagum emirate of Bauchi Province in 1927; this was later moved to Gadau, a village 10 kilometers from Azare, in 1929. The unit was finally closed in 1937 when a Regional headquarters of the unit was established in Kaduna.²⁸ Onchocerciasis (river blindness) also had a field unit that took care of the disease in the region. This type of extensive work or activities involved the deployment of a lot of men and materials like drugs, insecticides, and means of transportation such as land rovers, horses, donkeys, camels, bicycles and the use of headportage. In terms of men, a typical team consists of doctors, chemists, entomologists, rural health supervisors, control officers, clerks, spraying men, mechanics, carpenters, MUF Assistants, scouts, drivers, porters, guards etc.²⁹ The works of the medical teams brought out the links between migrations and the spread of diseases in the north in to bold relief as already shown by the works of Prothero.³⁰ This discovery led to the

²⁷ Schram, *A History*, pp. 426-428; *Colonial Annual Reports 1901-1914 and Medical and Health Department Reports, 1931- 1940*.

²⁸ Schram, *A History*, pp.238-241

²⁹ Schram, *A History*, p.321

³⁰ Prothero, R.M.; "Population Movements and Problems of Malaria Eradication in Africa" in *Bulletin of the World Health Organization*, 24, 1961, pp.405-425

introduction of policies like quarantine,³¹ migration control and monitoring of migrant groups.³²

For the control of malaria, two public health measures were used. One was the spraying of DDT on the streets and in houses in the towns. The other is the use of sanitary inspectors called “*duba gari*” in Hausa, who were recruited and trained and deployed to cities and towns to enforce sanitary measures. They inspect streets, houses, markets and abattoirs where animals were slaughtered for human consumption to ensure cleanliness; refuse dumps are far away from human settlements. People were not allowed to leave open containers outside or using them on top of walls around houses.

Dispensaries and maternity centres were among the main arms of the colonial health care system, the others being hospitals and medical field units. Dispensaries were the main source of health care service provision in the rural areas. In the first two decades of the 20th Century, medical field units were the main outreach to rural areas. Dispensaries were an off-shoot of the field units. They were first built to provide shelter for villagers who report to the units for medical examination. These shelters were later developed to serve as outpatient clinics that were run by low level health workers who were trained to recognize and treat some few common diseases. These later became the basic infrastructure of curative services in the villages and small settlements in Nigeria in general. The policy of establishing proper dispensaries was muted in 1924 but did not become a full-pledge policy until 1927 and did not fully take-off formally until the 1930s.

Later on, maternity centres were built in the same villages as the dispensaries run by Grades II and I Midwives. There were also village health

³¹ The term quarantine has been derived from the Italian language for “forty”, being the number of days people identified with communicable diseases at sea ports were isolated and treated. Although the practice was formalized in 1397, it has ancient origins and is referred in the Qur’an and the Bible, especially in respect to leprosy. See WHO; *World Health Report, 2007*, p.2

³² Schram, *A History*, p. 322 and Prothero, R. M. “*Population Movement and Migrants and Malaria*”, London: Longmans, 1965

overseers that had their offices in the dispensaries and maternity centres. In 1948 the dispensaries and maternity workers, and the health overseers were brought under the same roof into what was named Health Centres. These were built, run and maintained by the Native Authorities who receive some grant from the central government as assistance.³³

In the 1920s and 1930s, provision of maternity services, water supply by sinking and construction of boreholes, draining of swamps, provision of public latrines and night soil disposal, sanitation measures and training were considered important public health measures that need to be introduced, but were not given serious attention until from about 1950 when they were vigorously implemented. Other new ones like public health education through mobile cinemas and popular radio programmes and schools' medical services were introduced.

FUNDING OF THE HEALTH CARE SYSTEM

Funding has been one of the weakest links in the establishment of the health care system. The success of the programme to a large extent rests or depends on the availability of funds. Funds were required for the construction of health infrastructure like the building of hospitals, dispensaries and storage facilities, equipping the buildings, supplies of drugs, medicines and equipments. Equally important the provision of transportation for effective mobility, water supply, electricity and feeding of patient. The establishment of institutions for the training of staff and equipping and staffing them, as well as the salaries and emoluments of all categories of the manpower in the health sector were also required. These no doubt required huge amounts of money which was not forthcoming because the

³³ CUR/2473; Nigeria: Health Manpower Study: Report on the Dispensary and Maternity Centres, 1967, NAK. To improve PHC governance, a similar policy- Bringing PHC under One Roof (PHCUOR) was adapted by the Federal Ministry of Health in 2014.

British have been deliberately careful in allocating funds for the development of their colonies as a policy. While arguing that the colonies should be financially self-supporting, yet the colonial State was not willing to use such locally generated revenues for that purpose. A substantial part of these revenues was repatriated to the home country officially and the profits generated from the share of the colony were kept as savings on behalf of the Region in British banks in the name of “reserves”. Even with the introduction of the Colonial Development and Welfare Act of 1945, this policy did not change.

For the funding of the health care system generally, the British used part of the proceeds from the revenue generated largely through taxation, levies and fines, licensing fees etc. from which substantial amounts were realized. For example, locally generated revenue in the Northern Provinces rose from £50,315 in the 1902-1903 financial year to £326,500 in 1914, the year the Region was merged with the Southern Protectorate to form what is today Nigeria. At the end of that year, the Native Authorities of the Region had surplus funds amounting to £72,224 out of which £54,650 was invested in England.³⁴

Below is a table showing the revenue generated internally for some few years and expenditure on health care for the years 1907-1914. These are sampled just to illustrate the finances and expenditure pattern on the health care system by the colonial government in the region.

Table showing revenue generated internally 1902 – 1914 and expenditure on health care 1907 – 1911

YEAR	REVENUE*	EXPENDITURE ON HEALTH
1907 – 08	£215,005	£29,178.8.6
1908 – 09	£248,444	£30,090.6.119
1909 – 10	£283,450	£30,942.14.119
1910 – 11	£344,589	£32,556

³⁴ *Colonial Reports-Annual*, No.785, Northern Nigeria for 1912, p. 5 and No.878, for 1914, p.4.

1913	£325,006	£114,050
1914	£326,500	£123,305

Source: Compiled from Colonial Annual Reports, Northern Nigeria 1907 – 1914. *These were revenues generated internally. They do not include contributions from Southern Nigeria and Grants -in-Aid from the Colonial Office in London*

As the years went by expenditure on health care increased gradually that by 1968/69 financial year the six states in the Region had a total recurrent expenditure of £3, 495, 000, in the 1969/70 year £4, 301, 000 in the 1970/71 year £3, 012, 465 and in the 1971/72 year £1, 914, 786. The table below gives a breakdown of the allocation of recurrent expenditure of each of the six states. These totals do not include capital allocations.

Table: Recurrent expenditure for health and welfare for the six northern states 1968/69 to 1971/72 fiscal years £, 000

Fiscal years	1968/69	1969/70	1970/71	1971/72
Benue Plateau	670	780	700	996
Kano	497	948	2. 209	1. 492
Kwara	566	590	754	-
North Central	480	485	680	914
North Eastern	606	642	875	1.267
North Western	676	856	1.256	2. 027

Source: Akinkugbe, O. O, Olatunbosun, D and Folayan Esan, G. J (eds.) *Priorities in National Health Planning: Proceedings of an International Symposium*, Ibadan, Spectrum Books: 1973, p. 119.

HEALTH AND MEDICAL SERVICES PROVIDERS

The main providers of Western health care in the Northern Region during the colonial period were the Regional Government, Native Authorities, and Christian Missions. The Nigerian Railway Corporation had also contributed in health care

provision but to a lesser extent.³⁵ The mining companies too extended the services to other people apart from their staff.³⁶ Later, multilateral international organizations, especially the U.N. and its agencies, particularly the W.H.O. and U.N.I.C.E.F. which were created in 1948, became major participants in virtually all health matters in the region. There were also assistance and aid from bilateral sources from countries like Britain, America, Canada, Australia, etc. Foreign assistance was secured by the Federal Government of Nigeria as part of its foreign relations activities and this form of sources continued to become increasingly important long after independence in to the present.

It is pertinent at this juncture to note that most of the facilities and services especially hospitals, water supply and curative measures provided by the colonial state were concentrated in the urban areas and large towns of economic and administrative importance to the colonial system. The rural areas were largely neglected except for the activities of the medical field units that tour the region from time to time. In respect of curative services however, dispensaries were established in almost all the district headquarters in the region as a whole. But dispensary services were solely provided by the Native Authorities which were financially and politically weak in the colonial dispensation; nevertheless, they were able to do their best.

THE CHRISTIAN MISSIONS MEDICAL AND HEALTH SERVICES

No discussion on the history of the development of modern health care in the Northern Region will be complete without mentioning the role of Christian Missionaries, who had contributed immensely in this regard. They established hospitals, dispensaries, maternity centres and leprosy treatment centres. Infact, in the Central Nigerian area which was predominantly non-Muslim, the Christian

³⁵ Jackel, F.; *The History of the Nigerian Railway, Vol.3: Organization, Structure and Related Matters*, Spectrum, Ibadan, 1997, pp.375-386.

³⁶ KADMOH/20/S1/vol.1; *Annual Medical and Health Reports, 1946 and 1950*, NAK

Missionaries were the pioneers and for a long time remained the major providers. The prominent missions that operated in the Region were the Roman Catholic Mission (RCM); the Sudan United Mission (SUM); the Sudan Interior Mission (SIM); the Church Missionary Society (CMS); the Church of Brethren Mission (CBM) and the Seventy Day Adventist Mission (SDAM),³⁷ these along with other smaller missions provided valuable services. The Christian Missions' efforts to establish health services began with their early evangelization activities which led them to make concerted efforts to penetrate into the region since the 1890s. The pioneer missionaries that began and spread western health care in the North included people such as Graham Wilmot Brook, Reverend John Alfred Robinson, Eric Lewis and Miss Lewis, Charles Harford-Battersby and many others, but the most famous of them was Dr. Walter Miller. The contributions of Christian Missionaries were acknowledged by the Prime Minister of Nigeria Sir Abubakar Tafawa Balewa in his speech on the motion for Independence in January 1960 when he said:

We are grateful to the missionaries who have done so much to assist in the development of Nigeria, especially in the field of education and by the provision of medical facilities for so many of our people.³⁸

The first mission hospital in the region was opened in Numan in 1914, followed by the one at Vom in 1922, all by the SUM. In 1929, two hospitals, one in Kafanchan and another at Zaria were opened by the CMS. Then in 1938 the Church of Brethren Mission opened a hospital in Lassa, and in the same year the SIM opened one at Mkar. In 1942 the SIM opened an eye hospital in Kano and the SDAM opened a general hospital in 1942 at Jengre.³⁹

³⁷ For detailed discussion on Missions medical works see Schram; *A History*, pp143-156 and list of Missions that built General Hospitals in the North see Schram, p431, and *Medical and Health Department Reports, 1931-1934*, NAK.

³⁸ Schram, *A History*, p. 59

³⁹ *Medical and Health Reports 1931-34*

In the period between 1950 and 1964, the Missions opened many more hospitals. In 1950 the United Missionary Society (UMS) opened one at Tungan Magajiya in Niger Province. The SUM opened more hospitals in this period at Bambur 1951, Gwoza 1956 and Takum 1958. The RCM opened one in Kaduna and another in Zonkwa in 1952, Yelwa in 1959 and Akwanga in 1964. The SIM began providing medical services in 1902 in Pategi and continued to expand that in all their missions across the north up to 1959.⁴⁰ It opened the Kaltungo and Jos hospitals in 1955 and 1959 respectively, and the Baptist Mission opened one in Kontagora.⁴¹ The Missions also opened leprosy treatment centres in places such as Kano, Katsina, Sokoto, Garkida, Bayara, Ilorin, Kabba.

The missions were also involved in the provision of maternity and dispensary services. Between 1958 and 1961 four maternity hospitals were established by various missions. These were the Ochadamu Maternity opened in 1959 by the Qua Ibo Mission and in Jos and Kakuri in 1958 and 1961 respectively by the CBM (Stewards Company).⁴² The missions were also involved in the training of para-medical personnel especially nurses and midwives to man the various health institutions under their control. To finance their health services the missions depended largely on charities from their home countries in Europe, America and Canada and small grants from the government.

MANPOWER AND TRAINING

With a vast geographical area to cover, a large number of people to cater for and numerous health problems to attend to and to have requisite and adequate health personnel or manpower was a critical matter. More so the system is new and introduced in to an area where it is alien. At the initial stages the Europeans had to do with the very few medical personnel available, but as they expanded their

⁴⁰ Turaki, Y. ; *An Introduction to the History of SIM/ECWA in Nigeria 1893-1993*, Jos, Challenge Press, 1993, pp. 172-173

⁴¹ Schram, *A History*, p.349 and Bauprof. *Medical and Health Reports 1936-1951*, NAK

⁴² Schram, *A History*, p.431

control the pressure increased and even desperate measures had to be resorted to. In the first decade of 1900-1910, colonial Administrative Officers acted as medical officers that is why all such category of officers to be posted the Northern Region were given courses on simple treatments, first aid and sanitation before assuming duty.⁴³

The administrator who at the same time acted as a physician had to train local people on rudimentary treatments and vaccination by merely watching and giving small assistance to a dispenser at a government hospital or a Native Authority dispensary for a year or two in the city. That was how the first batch of dispensary attendants was trained and sent to dispensaries in the rural areas. Many of such dispensers were recruited from the local police force called *dogarai*.⁴⁴

Government policy of establishing training institutions in Nigeria in general began to be taken seriously from around 1925 after the Conference of Senior Medical Officers of West Africa which recommended for a training of medical assistants scheme to be started.⁴⁵ By 1950 there were some training programmes in schools and in some recognized hospitals in the North which were Nurses' Preliminary Training School in Kaduna, Nurses' Training Schools at Government General Hospitals in Kaduna, Zaria and Jos, at Native Administration Hospitals of Kano and Sokoto and at the Mission Hospitals at Vom near Jos and Wusasa at Zaria.⁴⁶ There was a Grade II Midwives Training Centre for Native Administrations in Ilorin and a Grade III school was opened after the completion of the Maternity Ward at Kano City Hospital.

The School of Hygiene Kano was the only Sanitary Inspectors training institution in the North. There was also the Kano Medical School opened in 1954

⁴³ Sshram, A History, pg. 139; *KADMOH/20/SI/Vol.1; Annual Medical and Health Reports, Northern Provinces, 1950*, p.20

⁴⁴ *KADMOH/20/Vol.3; Annual Report: Medical and Health Services 1945-1956, NAK*

⁴⁵ Schram, A History, p. 203

⁴⁶ *KADMO/20/SI/Vol. 1; Annual Medical and Health Reports, Northern Provinces, 1950*, p. 20

and the School of Health Technology located in the General Hospital Kano⁴⁷. There were also two training schools for Native Administration Dispensary Attendants at Kano and Zaria, opened in 1949, as well as the School of Pharmacy Zaria for the training of Pharmacists Grade IV. Also, by 1950 there was a proposal to open a Medical Assistants' Training School at Kano. Meanwhile, training of Medical Field Units and Sleeping Sickness personnel was done in Kaduna and Laboratory Assistants were trained at Kano and Kaduna. Dental Technical Assistants, X-Ray Technicians and Assistant Physiotherapists were sent to Lagos for their training.⁴⁸

In respect to the training of Doctors and high-level Pharmacists, there were no higher institutions like Universities in the country for the training of such high caliber manpower, so all the pioneers in these fields were trained overseas, mainly in England. The University College Ibadan Medical School opened in 1948, began training doctors in the country. Then in 1962 Ahmadu Bello University was established with its Medical School that was formally opened in 1967 and the Department of Pharmaceutical Sciences opened in 1970 which became a Faculty in 1977 that catered for the training of a wide range of health personnel from not only the North but from all over Nigeria and beyond.⁴⁹

By at independence in 1960, the Region was able to build up its manpower base; albeit slowly and in small numbers.⁵⁰ For instance, according to the 1963 Annual Abstract of Statistics, by the end of 1958 there were a total of 200 medical practitioners, comprising of 110 in Government health establishments and 90 in

⁴⁷ KADMOH/20/Vol.3; *Annual Report: Medical and Health Services 1945-1956*, NAK

⁴⁸ KADMOH/20/SI/Vol. 1; PP. 21-22; Schram; *A History*, p. 280

⁴⁹ Manzo, S.K., Gaji, A and Muhammed, I.; "Academic Development of Institute of Agricultural Research and the Faculties of Agriculture, Veterinary Medicine, Human Medicine and Pharmaceutical Sciences" in Mahadi, A. (ed.); *A History of Ahmadu Bello University 1962-1987*, A. B. U. Press, pp. 186 and 192

⁵⁰ The small numbers of workers and very slow development of the manpower base in the region had to do with the problem of having Northerners with the requisite qualifications to be admitted in the training centres and schools due to the limited number of primary and secondary schools, very poor attendances in the few existing ones, as a result of general apathy to western education especially in the Muslim areas. For more on this see KADMOH/20/SI/Vol. 1, 1950 and MH/5070/S.2, Vol. 1, *Kano Medical School Policy, 1950*, NAK

Mission facilities and private practitioners out of the total of 868 in the whole of Nigeria.⁵¹ But according to Schram, there was a total of 208 Doctors in the Region by 1960, comprising of 123 in Government establishments, 65 in Mission, 2 in Industrial, 8 in the Army establishments and 10 in Private practice.⁵² Another source put the total number of in the Region by 1960 at 121, comprising of 113 expatriates and gave the numbers of other categories of health workers as follows: 411 qualified registered Nurses, 70 Nursing Sisters/Superintendents, 19 Midwives, 20 Health Sisters, 175 Sanitary Inspectors, 32 Laboratory Assistants, 82 Pharmacists, 33 Medical Field Units Superintendants and Tsetse Control Officers, and 291 Nurses in Training⁵³. However, the number of Doctors and some other categories of health workers reduced as the country were approaching independence in 1960. The exodus of British Medical officers and other health personnel began in 1959, thus by end of the year there were only 124 Doctors remaining.⁵⁴

As colonial rule gradually penetrated into areas hitherto not reached and became more entrenched the British came into contact with more and more people, they realized that there were increasing number of people to cater for who were in dire need of medical attention and the need to establish public health and preventive measures. The gradual improvement of medical services and the impact of public health measures in bringing under control of diseases like smallpox, sleeping sickness, cerebro-spinal meningitis and the increasing use of antibiotics and other medicines for the treatment of diseases like gonorrhoea and syphilis which increased fertility and the reduction of deaths from malaria and other diseases led to slight increase in population. According to colonial census, in 1948/9 the

⁵¹ Federal Office of Statistics; *Annual Abstract of Statistics*, 1963, Lagos, p.128

⁵² Schram,; *A History*, p. 433

⁵³ Federal Office of Statistics: *Annual Abstract of Statistics*, Republic of Nigeria, 1963, p. 128

⁵⁴ Ministry of Health, Northern Nigeria: *Annual Report*, 1960, p. 1. To make up for loss due to the exodus of expatriate staff, the Regional Government embarked on the recruitment of doctors from Great Britain, Pakistan, India and Western Europe.

population of the Region was put at 13,500,000 and in the 1952/3 census⁵⁵, it was put at 16,835,000 and in 1959 the population was estimated at 18.4 million. In 1952 the Region had a total of 2,859 hospital beds comprising of 2,403 in Government establishments and 456 in Mission facilities and non in the private sector⁵⁶.

RESPONSE AND REACTION OF THE PEOPLE TO THE NEW SYSTEM

History has shown that generally human society does not accept change easily or quickly, rather people usually react to new developments with caution and in some cases outright rejection. The introduction of modern health and medical care in Northern Nigeria was received with caution and in some areas, outright rejection. This was evident from the remarks of some colonial administrators and some of the policies adapted to force compliance on the people like the introduction of compulsory vaccination and directing Emirs and Chiefs to use their authority on the people to be inoculated, vaccinated and for sanitary measures.⁵⁷

While the British colonialists blamed the situation on the ignorance, illiteracy, backward and uncivilized nature of the people, but the perception of the people that the new system being introduced is alien and by “strangers” who used force and violence to impose themselves in the first place, hence the deep suspicion was also an important factor. In addition, the people had already had their system of health care and medicine that have been used over the centuries; it is certainly difficult to expect them to easily accept a new system from culturally and racially different people from distant lands. There were also entrenched or

⁵⁵ Buchanan and Pugh; *Land and People*, p. 58. According to Buchanan and Pugh as of 1952 the ratio of hospital beds to population was 1: 6,000

⁵⁶ Mahadi, A., *Demography and Standard of Living in Colonial Nigeria* (undated manuscript) p. 16

⁵⁷ For a detailed discussion on the role of Emirs in the development and spread of Western health care in the Northern Region see Shobana Shankar; “Medical Missionaries and Modernizing Emirs in Colonial Hausaland: Leprosy Control and Native Authority in the 1930s” in *Journal of African History*, 48, 2007, pp. 45-68. It was also reported that in 1902 the Lamido of Adamawa gave a mud house to the first medical doctor in Yola for use as a hospital until 1934 when a 28 bed hospital was opened. See Jackel, *A History of the Railway*, p. 360

established interests in the indigenous system like the traditional healers who had enormous respect among the people and would not certainly allow their powers to be eroded by the new system.

It is however important to note that the degree of the rejection was not uniform. Some classes like the rulers and those working closely with the Europeans accepted the new system relatively quicker than the rest of the populace and indeed helped the British in developing the system. Also where Christian Missionaries activities were predominant the acceptance was faster, perhaps because of methods of proselytization and persuasion they used. The Government on the other hand used propaganda and enlightenment mixed with mild force, a strategy that was effective only after a long time.

With persistent campaigns and enlightenments, increasing spread of hospitals and dispensaries whose staff toured the rural and remote areas, the activities of Mobile Medical Field Units and the use of threats, resistance to the system was gradually weakened as more and more people began to accept it. This change of attitude can be discerned from the increasing number of people visiting or attending health facilities and receiving vaccinations as hospital records over the years show. Hospital attendance increased from 146,183 in 1934 to about 1,334,249 in 1960⁵⁸.

THE HEALTH CARE DELIVERY SYSTEM AT INDEPENDENCE

At independence in 1960, the Northern Region was bequeathed a health care delivery system that was patterned along that of Britain. By 1959 an administrative structure was established, with the Regional Ministry of Health located in Kaduna as the Regional headquarters. It comprised of five sections called divisions, namely, curative service, endemic diseases, and urban health, dentistry and chemistry divisions. The whole region was divided into units called Medical Areas,

⁵⁸ Ministry of Health; Reports on Medical and Health Services 1934 and 1960

each comprising of a number of provinces; these in turn were divided into Medical Division in each province. The Regional Government took care of the health facilities and services of provinces and divisions, while the Native Authorities were left mainly with the provision of dispensaries at the District level.

The Ministry of Health was divided into two broad arms; the curative/ Medical and preventive/ Health arms. The curative services arm was responsible of the management of government hospitals, some few dispensaries in some urban areas mainly Kano and Kaduna and nursing homes which were exclusively for expatriates, senior government officials, high level traditional rulers and some wealthy people.

The preventive services division was in turn divided into two, namely Rural Health and Urban Health units. The Urban Health Unit consisted of public health, malaria control, nutrition and health education, school of hygiene and community nurses training school. While the Rural Health Section comprised of six units, viz medical field units, medical auxiliaries training unit, leprosy, onchocerciasis (river blindness) rural health centres and sleeping sickness unit.⁵⁹

Prevention services were mainly provided in the rural areas by the Regional Government. These were in the form of surveys for the identification, treatment and control of certain diseases, but most especially leprosy, malaria, sleeping sickness, yaws, guinea worm, onchocerciasis, and epidemic disease like cerebro-spinal meningitis, chicken and small pox and cholera. It was the medical field units that undertook these activities with the support of the provincial, divisional and native authorities' health facilities and personnel. These activities consisted of vaccination campaigns and mass vector control through spraying and clearing of infected areas and bushes. They were also involved in Health education. The mobile field units operated film shows and organized drama for the rural

⁵⁹ Ministry of Health, Northern Nigeria; *Annual Report 1960*.

communities regarding basic principles of hygiene and sanitation, but these were also taught to pupils in all primary schools in addition to the provision of school health services. By 1960 there were six specialized medical field units catering for various endemic diseases. The yaws unit was located in Benue Province while at Argungu in Sokoto Province, were located the tuberculoses and onchocerciasis (river blindness) units, and those for sleeping sickness, leprosy and onchocerciasis were all located at Kankiya in Katsina Province.⁶⁰

In 1960, the Regional Government inherited twenty-seven General Hospitals located at Azare, Bama, Barikin Ladi, Bauchi, Bida, Birnin Kebbi, Ganye, Gombe, Gusau, Hadejia, Ilorin, Idah, Jos, Kaduna, Kafanchan, Katsina, Lokoja, Makurdi, Maiduguri, Minna, Mubi, Offa, Pankshin, Wukari, Yola and Zaria⁶¹. Three Government Nursing Homes located at Jos, Kaduna and Kano, one Orthopedic Hospital at Kano, one Maternity hospital at Ilorin, three combined hospitals at Shendam, Oturkpo and Nguru and two hospitals established by the Native Authorities in Kano and Sokoto.⁶² In respect of dispensaries which were the sole responsibility of the Native Authorities there were about six hundred (600) scattered all over the region.⁶³ The Christian Missions who were also active in health care provision had a total of twenty (20) hospitals located at Bambur, Garkida, Lassa, Numan, Kaltungo, Mkar, Takum, Egbe, Kontagora, Tungun Magajiya, Jengre, Jos, Vom, Gwoza, Yelwa, Kaduna South, Wusasa, Zonkwa and Kano.⁶⁴

In terms of manpower, the region in 1960 had one hundred and twenty-three (123) doctors, all working in government hospitals, sixty-five (65) doctors in Missions health facilities, two (2) in industrial establishments, eight (8) army and

⁶⁰ Ministry of Health, Northern Nigeria; *Annual Report* 1960, p.7

⁶¹ Ministry of Health, Northern Nigeria; *Annual Report*, 1960, p. 7

⁶² Ministry of Health Northern Nigeria; *Annual Report* 1960, p.8

⁶³ Ministry of Health, Northern Nigeria; *Annual Report for the Year 1961*, Government Printer, Kaduna, p.5

⁶⁴ Ministry of Health, Northern Nigeria; *Annual Report*, 1961

ten (10) in private practices.⁶⁵ None of the dispensaries had a doctor, it was the government and missions doctors that supervised and assisted the dispensaries whenever the need arises. In respect of the paramedical cadres, there were a total of 61 Nurses with 31 in Government Hospitals and 30 in Mission Hospitals and a total of 32 Grade I and II Midwives with 30 in Government Hospitals and 12 in Mission facilities.⁶⁶ There were also a number of nurses, midwives, dispensers and health and sanitary inspectors who were working in the Native Authority controlled dispensaries and the government hospitals.

As regards training, in addition to sending people for training to the United Kingdom by the Regional Government, there were few institutions in the region that trained various categories of health personnel. These included the Kano Medical School opened in 1954 which trained Assistant Medical Officers. Before 1960 the products of this school were allowed to practice only in the Northern Region, while their counterparts from a similar school, the Lagos Medical School could practice anywhere in the country, this had to do with differences in qualification requirements; the requirements for that of Lagos was higher reflecting the educational gap between the South and the North. There was also the School of Hygiene in Kano which trained Health Inspectors for both the Regional Government and native authorities. Two Nurses Preliminary Training schools located in Kano and Kaduna and five general hospitals of Katsina, Zaria, Kaduna, Jos and Makurdi trained nurses. The Kaduna General Hospital trained Midwives Grade I while Grade II Midwives were trained at Zaria, Jos, Maiduguri, Yola, Makurdi, Lokoja, Gusau and Idah General Hospitals. The missions trained their personnel locally at Mkar, Vom and Wusasa. Medical Auxiliaries were trained at the Kaduna Medical Auxiliaries Training School, where Leprosy Inspectors and

⁶⁵ Schram, *A History*, p.433

⁶⁶ Ministry of Health Northern Nigeria, *Annual Report 1963-1964*, Government Printer, Kaduna, p. 20

Attendants were trained. There was also the Community Nurses Training Centre at Kaduna.⁶⁷

After independence the Northern Regional Government continued to grapple with among other problems improving manpower and staffing shortages by stepping-up training of various cadres. Medical Officers were trained in Kano Medical School, Chemist and Druggist Diploma in Pharmacy School Zaria, Nurses were trained in Nurses Preliminary Training Schools in Kano and Kaduna, Midwives were trained in Government training schools attached to General Hospital Kaduna for Grade I Midwives and at General Hospitals in Zaria, Jos, Maiduguri, Yola, Makurdi, Lokoja, Idah and Ilorin for Grade II Midwives. Other cadres were trained included Government Health Inspectors comprising of Government Health Assistants and Native Authority Sanitary Inspectors. The training of Medical Auxiliaries for Government Rural Health, Sleeping Sickness Service and Dispensary Attendants for Native Authorities and Leprosy Service that include Leprosy Attendants and Assistant Leprosy Inspectors.

Other cadres trained include Community Nurses Training in Kaduna for Native Authority Midwives; Tsetse Control Assistants in Katagum to serve the Sleeping Sickness Service. Health Superintendents who offer health education to mothers at Maternity and Child Welfare Clinics were trained at the School of Administration, Zaria. Also trained were staffs for Infant Welfare Services, Rural Health Services, Dental and Mental Health.

There were serious concerns on epidemic and endemic diseases such as small pox, chicken pox, cerebro-spinal meningitis, malaria, leprosy, yaws, sleeping sickness, guinea worm infection, onchocerciasis and many other health challenges in the region. The expansion, maintenance of hospitals, dispensaries and clinics

⁶⁷ *Annual Report, 1960, pp.1-3*

were also engaging for all tiers of government and posing the challenge of adequacy of manpower.

The history of Western health care in the North like in all other parts of Nigeria cannot be complete without acknowledging the contributions made by international bilateral and multilateral organizations. The outstanding bodies or organizations were the World Health Organization (WHO), a United Nations Agency, and its agencies such as the United Nations Children's Emergency Fund (UNICEF). Non-governmental organizations such as the United States Agency for International Development (USAID), the International Red Cross, The Catholic Relief (CARE), the Ford, Rockefeller and McAuthor Foundations, etc. also contributed in various aspects of the health care system. Another major source of assistance to Nigeria was from the Commonwealth countries especially from Britain, Canada, and Australia. Generally, the assistance came in the form of cash grants, provision of equipments, transportation vehicles, chemicals and drugs. Indeed, these agencies and organizations helped a lot in enhancing the activities of the medical field units in the control and eradication efforts of both endemic and epidemic disease. Other forms of assistance included the granting of fellowship for the training of health personnel like doctors, pharmacists, nurses, and midwives. In addition, various types of experts were brought to the Region to assist in running the health facilities and coordinating other health activities.⁶⁸

POST-INDEPENDENCE POLICY SHIFT IN HEALTH CARE PROVISION

Nigeria launched its First Development Plan 1962-1968 as an independent nation. The main thrust of health policy objectives in the Plan were to address shortage of medical man power, putting more emphasis on preventive services, improvement of hospital management and environmental sanitation, as well as shortages of finance and materials. While the Regions were semi-autonomous, they

⁶⁸ For details of assistance and contributions from the International community see Schram, *A History*, Pp.312-40

were guided by the central government in most of their policies; hence each Region developed its own Plan based on the tenets of the Federal Plan. Northern Regional Government drew its own the health sector plan that had three objectives:

1. Establishment of one hospital of 60-100 beds in each of the 177 Parliamentary Constituencies in the region.
2. Establishment of a Local Council Dispensary per 10,000 persons
3. Expansion of training programmes for various cadres of health staff.⁶⁹

In 1962 the Regional Government planned to provide a country-type hospital for every 100,000, a Combined Centre for treatment and base for social medicine at a walking distance in 200 square miles radius which required establishing 200 hospitals and 1,900 rural health centres.⁷⁰

Before the end of the 1962-68 First Plan the 1966 coup took place and the civil war broke out in 1967. This led to the division of Nigeria into twelve states six of which were in the North; they were North Western, North Central, West-Central, Kano, North Eastern and Benue-Plateau. Despite this political development government activities continued as usual to a large extent and a decision was taken to ensure smooth transition and handing over government affairs to the newly created states, for that an agency named the Interim Common Services Agency (ICSA) was created. At the Northern States Medical Advisory Board Meeting on 31st January, 1968 at Kaduna, it was resolved that some health services need to be run by the Agency, the services included small pox and measles eradication, leprosy school Wusasa, sleeping sickness units, Medical Auxiliaries School in Kaduna, Schools of Hygiene and Nursing Kano.⁷¹

⁶⁹ Madubuike, I, Health Care Delivery Services in Nigeria: Recent Reforms in the Health Sector, Lecture delivered on 29th April, at NIPSS, Kuru, Jos, 1997

⁷⁰ Bases for Assessing the Quantitative and Qualitative Needs for Various Types of Health Staff; *Report Written by the Permanent Secretary Ministry of Health Northern Region*, Dr. R. A. B. Dikko to the Federal Ministry of Economic Development, Lagos, 1962

⁷¹ Minutes of Meeting of Northern States Medical Advisory Board, 31st January, 1968, Kaduna, pp. 2-3

Meanwhile a 20-year health sector Plan to be phased in segments of five years each was drawn with the assistance of UNICEF. A report prepared as the basis of the Plan decried the inadequacy of health services coverage when it observed that there was only one dispensary for 50,000, covering an area of 400 square miles, with average service radius of 12 square miles. In India the coverage area was 2.5 miles yet considered inadequate by the country. Similarly, the shortage of doctors in rural areas was also cause for concern with the ration of 1 doctor per 250,000 and critical shortages of Nursing Sisters, Midwives, Dispensary Assistants, Sanitary and Community Nurses. In the face of these problems the 1968 health Plan listed the following objectives:

1. To improve facilities available for mainly preventive and to a less extent curative medicine in the rural areas.
2. To provide health infrastructure
3. To establish a pilot area on the North Central State which will consist of well-organized system of referral hospitals, rural health centres and sub-centres supervised through co-ordination between the Ministry of Health, Native Authorities and Ahmadu Bello University,
4. The pilot scheme shall serve as in-service training and demonstration area for all the six Northern States.

It was stated in the Plan that the main focus for clinical training will be oriented to the need of both rural and urban poor populations. Therefore, emphasis was laid on teaching community medicine for the first year. This was aimed at inculcating in medical students, sympathy to the needs of rural and urban poor⁷².

Mr. Chairman, at this juncture it is pertinent to acknowledge the efforts and contributions of people that were superintending the early post-colonial health care system, but before that, it is necessary to have an idea of the organizational

⁷² Minutes of Meeting between UNICEF Representatives and the Northern Ministry of Health at Hamdala Hotel, Kaduna, December, 5th, 1967, pp. 8-11

structure of the health sector. From the 1940s up to the end of colonial rule the administrative structure had the National Council on Health stationed in Lagos as the overall supervisory body in the country. The Regions had what was called Regional Medical Advisory Boards. Up to the mid-1950s the Northern Medical Advisory Board was dominated by the British comprising of government, Christian Missions representatives and members from the Native Authorities. From 1954 administration of the health sector began to be handed over to the Regions. In 1955 the Board's membership was revised and included the Director of Medical Services Northern Region, Deputy Director of Medical Services, Permanent Secretary Ministry of Health, Regional Matron, 4 Mission Representatives who were all Europeans and 4 Native Authority Representatives, up to 1964. This was when the leadership responsibility began to be handed over to the Regional Governments in the country. In 1965 Northerners took over leadership and worked with some British Medical Officers who chose to remain in the region after independence, as well as Medical Officers of Christian Mission hospitals mainly the Church Missionary Society (C. M. S) Sudan United Mission (S. U. M,) Sudan Interior Mission (S. I. M) and the Roman Catholic Mission (R. C. M.). Among the major drivers of the sector by the late 1960s were medical Doctors like Dr. J. D. Soley, Dr. A. I. Attah, Dr. Umaru Shehu, and Dr. R. F. Addy. Dr. L. N. Dutt, Dr. S. Hussain, Dr. A. Imam. By 1966 the Northern Region Medical Advisory Board membership was made up of Dr. Rowland A. B. Dikko, Permanent Secretary, Northern Region Ministry of Health, based in Kaduna was Chairman, Dr. J. D. Soley C. M. O/P. S. D; Dr. Umaru Shehu P. M. O/Hospitals; Mr. M. O. Kwanashie Ag. C. N. O (1966) and was the Principal Nursing Officer (P. N. O) by 1967. From the Native Authorities were people like Alh. Muhammadu Kobo the Emir of Lapai, Mal. Muhammadu Gwadabawa from Sokoto, Alh. Rabi'u from Kano, Alh. Ahmadu Kankia from Katsina and Alh. Z. O. Abbas. Meanwhile, Alh.

Ahman Galadiman Pategi was the Minister, Northern Region Ministry of Health since 1960. As for the Christian Missions there were people like Dr. E. T. Mess of the C. M.S; Dr. S. Thomson of S. U. M.; Dr. R. Troup of the S. U. M. and Dr. F. O’Kiely of the R. C. M as members of the Board in 1955. There were Dr. Hartly of the Vom Christian Hospital; Sister Mary Raphael of R. C, M., Kakuri Kaduna, Dean B. Olewiler of the S. U. M. Bambur/Lau, Rev. R. E. Pfaltzgraff of the Church of the Brethren Garkida, Dr. P. Yates of the U. M. S. Memorial Hospital Tungan Magajiya in present Niger State, G. F. Champion of S. I. M. Hospital in Ilorin were members of the Advisory Board in 1966 and 1967⁷³. Mr. Chairman, these are just a few among those that labored to develop the Northern Regional health care system from the mid-1950s some of them even earlier, up to the early 1970s. These are just members of the Advisory Board, there were hundreds spread all across the region administering to the health needs of the populations in Divisional Headquarters, District Headquarters, small towns and in villages in the rural areas whose efforts contributed in establishing the western health care system in the Region that gradually improved the quality of health of the population.

NEWLY CREATED STATES AND CHANGING HEALTH CAR POLICY

As has been noted earlier in the lecture when states were created in 1967 decision was taken to superintend the health delivery affairs of the newly created states of the North through the Interim Common Service Agency (ICSA). The Regional Medical Advisory Board was renamed States Medical Advisory Board. Meanwhile a gradual shift in policy has begun at the international level.

In the 1970s there was movement to a new approach to health care provision led by the World Health Organization (WHO) when at its General Assembly in 1971 adopted the Basic Health Service Programme (BHSP) and recommended its implementation by developing countries. Nigeria adapted the

⁷³ Minutes of Meeting of Regional Advisory Board, April 1965, 1966, 1967 and January, 1968

policy and in 1974 directed all states of the Federation to start implementing it under the name Basic Health Services Scheme (BHSS). One of the main objectives of the Scheme was to establish a health unit for every 50,000 people.⁷⁴

Provisions were made for the new Scheme in the Second National Development Plan 1970-1974 but did not properly take-off. Meanwhile, the Federal Ministry of Health under Malam Aminu Kano who was the then Federal Commissioner of Health organized a Symposium titled Priorities in National Health Planning in 1973. The symposium analyzed virtually all the problems of the Nigerian health care sector and offered valuable suggestions on addressing them⁷⁵. From 1974 the new states began to lay the foundations for implementing the Basic Health Services Scheme but before they could properly grasp the essentials of the Scheme the World Health Organization again declared a new commitment at Alma Ata in the former Soviet Union called Health for All by the Year 2000 in 1978 and the policy was named Primary Health Care System (PHCS) which was defined as:

Health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to all individuals and families in the community and through their full participation and at a cost that the community and country can afford at every stage of their development in the spirit of self-reliance and self-determination⁷⁶.

LAUNCHING OF THE PRIMARY HEALTH CARE SYSTEM IN NIGERIA

Not much was achieved by the initial efforts to implement the Basic Health Services Scheme the precursor of the Primary Health Care System due to lack of inter-sectoral coordination, inadequate community mobilization and participation,

⁷⁴ Federal Republic of Nigeria; The Fourth National Development Plan 1981-1985

⁷⁵ Akinkugbe, O. O., Olatunbosu, D. and Folayan Esan, G. J. (eds.) *Priorities in National Health Planning*, Ibadan, Spectrum Books, 1981

⁷⁶ Alma Ata "Primary Health Care" *Report of the International Conference on Primary Health Care*, USSR, September, 1978

inappropriate training of manpower etc.⁷⁷ To address these and other relevant issues the Federal Government of Nigeria designed and launched the new National Policy and Strategy to Achieve Health for All Nigerians (NHPS) in 1988. All states of the Federation were directed to key into the new policy with assistance from the Federal Government and foreign donor agencies and other members of the international community.

The main components of the Primary Health Care policy are; health education, promotion of food supply and nutrition, supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against major childhood diseases, prevention and control of local endemic and epidemic diseases, promotion of mental health and supply of essential drugs.

For the implementation of the PHC, Local Government Areas were made to conduct baseline surveys to determine their basic health problems and immediate requirements for the establishment of the system. A take-off grant of N500, 000 was given to each Local Government. Health management committees were set up at villages, districts, local governments, and state, zonal and federal levels. An essential drugs scheme and drug revolving fund system were setup. The Bamako Initiative which was an intervention strategy for encouraging community participation and the use of essential drugs list for supplying health establishments was implemented⁷⁸.

A country Plan for Action for implementing the minimum District Health-for -All Package 1995-2000 was developed consisting of thirteen components such as child survival, safe motherhood, basic immunization coverage, family planning, essential drug coverage, adult health literacy, household food security, water

⁷⁷ Federal Government of Nigeria, *National Health Policy and Strategy for All Nigerians*, Government Printer, Lagos, 1988

⁷⁸ National Health Policy, 1988

supply and sanitation, HIV/AIDS control, emergency preparedness and response, health education and financing.

For an integrated functioning health services referral system, efforts were made to establish referral hospitals in each locality by state governments which would be linked up with tertiary health institutions especially teaching hospitals in each state. Where there were no teaching hospitals, Federal Medical Centres were established. The Federal Government designated four Centres of Excellence namely; Ahmadu Bello University for oncology and radiotherapy, University of Maiduguri for immunology and infectious diseases, University of Ibadan for neurosciences and Enugu for cardio-thoracic disorders⁷⁹.

Private and some aspects of traditional medical practitioners were also keyed into the new system. Relevant laws and institutions were established in an effort to maximize effectiveness. A Decree recognizing and incorporating traditional medicine into the national health care system was enacted and a Traditional Medicine Policy for Nigeria was launched in 2007, the National Foods and Drug Administration Commission (NAFDAC) Decree No. 15 enacted in 1993 and the Commission was officially established on January 1st 1994 to protect Nigerians from fake and adulterated foods, drugs and drinks. The Nigerian Standard Organization was involved in ensuring standards of equipment used in the health sector. Nigeria participated actively in regional and international organizations so as to benefit from what they offer to member countries. The Abacha regime established the Petroleum Trust Fund (PTF) which contributed a lot in providing drugs, equipment and consumables to hospitals all over the country.

HEALTH CARE POLICIES FROM THE FOURTH REPUBLIC 1999

With the assumption of power by the civilian regime in 1999 another round of health sector reform came alive. New policies, plans and programmes to address

⁷⁹ Madubuike, I., *Health Care Delivery in Nigeria*, 1997

the observed problems of the sector were designed. It was a period of reviews of previous policies and plans. The new approach was in the context of the World Bank's Poverty Reduction Strategies policy, based on which Nigeria developed the National Economic Empowerment and Development Strategy (NEEDS) launched in 2004. In the same year the country wrote its version of the Millennium Development Goals developed by the United Nations in 2001. In all these the Federal Ministry of Health wrote the health components that included reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.⁸⁰

Some of the major broad programmes included the reduction by more than half of infant and maternal mortality rates, increase in general life expectancy by provision of high-quality health care services which are accessible and affordable to all. The rehabilitation of facilities in existing hospitals and secondary health care institutions, intensification of primary health care programmes, completion of on-going university teaching hospitals projects, establishment of Federal Medical Centres in newly created states and development of the permanent sites of proposed teaching hospitals and provision of counterpart funding through external loans were the priority areas. Targets to be achieved in the period 1999-2003 were set and they were to increase nutritional level from 2,120 daily calories to 2,500, reduction of child malnutrition from 46% to 20%, infant mortality from 78 per 1,000 live births to 50, maternal mortality from 800 per 100,000 births to 400, access to PHC to increased from 40% to 70%, immunization from 40 to 100% and access to safe potable water from 40% to 60%.⁸¹

After the 2003 election the administration realized that very little was achieved of the 1999-2003 targets and the plans and strategies were reviewed and

⁸⁰ Federal Ministry of Health; *Achieving Health-Related Millennium Development Goals in Nigeria*, Report, August 9th, 2004, p.2

⁸¹ National Planning Commission: *Nigerian Economic Policy 1999-2003*, p. 2

33 strategies were proposed for the health sector and the goal was to improve the health status of Nigerians as a significant co-factor in the country's poverty reduction strategy. The Federal Government listed seven key areas as the main thrust of the new plan:

1. To improve government's performance of its stewardship role of policy formulation, health legislation and regulation, resource mobilization, coordination, monitoring and evaluation.
2. To strengthen the national health system and improve management.
3. To improve availability and management of financial and material health resources
4. To reduce disease burden attributed to diseases like malaria, HIV/AIDS, reproductive health etc.
5. To improve the population's physical and financial access to quality health care.
6. To increase consumers' awareness of their health rights and obligations.
7. To foster effective collaboration and partnership with all health actors.

About fourteen strategies and interventions were proposed to achieve the aims and policy objectives. Amongst them were redefinition of the roles and responsibilities of the Federal Ministry of Health and all other relevant government institutions concerned with health care provision, reviewing of existing health policies and legislations policies and establishment of the National Health Insurance Scheme and its implementation, strengthening Local Governments' capacity in primary health care management, refurbishing of primary health care facilities and making them operational, rehabilitation of the National Drug

Production Laboratory, operationalization of the National Institute for Production of vaccines, establishment of a National Blood Transfusion system etc.⁸²

The problem of adequate funding of the health care system has been an issue throughout the development of the system since the colonial period there thought had been given on how to address the problem. One of the solutions was the health insurance scheme which has been working well in developed countries. Nigeria also wished to follow suit. The idea of a national health insurance scheme for the country began since 1962 by the Federal Government, but did not take-off. The issue was revived in 1988 when the Primary Health Care System was launched then at the 1995 National Health Summit; finally the National Health Insurance Scheme Act 35 was enacted in 1999.⁸³ Mr. Chairman, the mission, aims and objectives, the structure, operations and benefits and problems are not subject of discussion of this lecture, but certainly there are a lot of problems, even though if the problems will be addressed the scheme may be beneficial.

The National Health Policy and Strategy to Achieve Health for All Nigerians launched in 1988 was revised in 2004. The 2004 Policy was again revised in 2016. These reviews were necessitated against the background of emerging new challenges and trends that have direct or indirect effect and relevance on health issues. Such challenges included the unfinished agenda of the Millennium Development Goals (MDGs), the new Sustainable Development Goals (SDGs), the enactment of the National Health Act in 2014, the new PHC governance of bringing PHC Under One Roof (PHCUOR), effects of globalization, climate change, challenges of insurgency and its impact on the country's health care

⁸² National Planning Commission: NIGERIA: *National Economic Empowerment and Development Strategy (NEEDS)*, Abuja, 2004

⁸³ Imoisili, J. E.; *Understanding the National Health Insurance Scheme in Public Hospitals in Nigeria*, Benin City: Mindex Press Ltd, 2009

system and the launching of the National Strategic Health Development Plan 2010-2015.⁸⁴

Currently there is the Second National Strategic Health Plan 2018-2022. The National Health Promotion Policy launched in 2006 has been revised in 2019. The revision of the Health Promotion Policy was against the background of increasing burden of communicable and non-communicable diseases, low level of health literacy, poor sanitation and inadequate attention to key social determinants of health. It was necessitated by the challenges in rising disturbing consumption pattern of alcohol, food and tobacco. Disease patterns are also changing with more people being affected by cancers, diabetics and hypertension. Other threats include increasing mental health conditions, road accidents, both domestic and non-domestic violence, insecurity, floods, and diseases like Lassa fever, Ebola, cholera, Avian Influenza etc.⁸⁵

The availability of health human resource is critical in achieving whatever policy goals and objectives set. Without physicians, general practitioners, surgeons, public health workers, nurses, midwives, pharmacists, Community health workers, etc., health services cannot be delivered to the population effectively and efficiently. Recognizing this the Federal government wrote the National Human Resource For Health Strategic Plan for 2008-2012 to address problems like shortages, skewed rural/urban disparity in distribution of health service providers and utilization of health work force, dysfunctional health management system, high attrition among health professionals all of which lead to limited attainment of all health sector goals.⁸⁶ The Plan noted that there was shortage of professional staff in the North and an oversupply in the South.⁸⁷

⁸⁴ Federal Ministry of Health; The National Health Policy, 2016, p. 18

⁸⁵ Federal Ministry of Health; Health Promotion Policy, 2019, pp. 1-2

⁸⁶ Federal Ministry of Health: Health Promotion, pp. 7-8

⁸⁷ Federal Ministry of Health: Health Promotion, p.23

Mr. Chairman, there are so many policies and strategic plans on virtually every aspect of health care delivery; including those on Reproductive health, Immunization, Malaria, HIV/AIDS, Population, Food and Nutrition, Control of Leprosy, Tuberculosis and Onchocerciasis, Blood Transfusion, Adolescent and Child Health, Drug and Food hygiene and safety; and on manpower and training, funding, health education, infrastructure, facilities and equipment, sanitation, water supply, remunerations and conditions of service, on drugs and medicines, primary, secondary and tertiary health care and various other related matters.

Highlighting the broad outline of health policies at the Federal level only is based on the fact that the Federal Ministry of Health provides the leadership in all the policies, sometimes with inputs from the states. Local Governments make input to the state government which are harmonized and taken as that of the state. Most local governments do not even have the capacity to cope with the intellectual and administrative rigors in producing such plans and strategies. It was clearly stated in the National Strategic Health Development Plan 2018-2022 that the Plan is a framework to provide uniform guidance for states to produce their respective plans and use the framework to develop costed plans by the 36 states and the FCT.⁸⁸ What obtains essentially is states key into the strategies and plans produced by the Federal Ministry of Health. By that they benefit from Federal funding through grants and assistance. The Federal Government also gets enormous grants and assistance from international sources like donors, philanthropists, from Governments of individual countries and the United Nations system which it extends to states. There is no state that develops its own policies independent of the Federal Ministry.

Mr. Chairman, it was clearly stated in section II of the National Health Act of 2014 that states and local governments of the Federation are to key into the

⁸⁸ Federal Ministry of Health: Health Promotion, pp.i-ii

Federal policies. This is because the Federal Government provides support and assistance in implementation of the policies to the states and local governments. For some interventions they are required to pay counter-part funding of about 25% to qualify to get Federal support and assistance. Further more the 2016 health policy states that “states shall mirror the roles and responsibilities of the Federal Ministry of Health at the state level.”⁸⁹

THE STATE OF HEALTH AND THE HEALTH SECTOR IN THE NORTH

Despite the inadequacies and limitations, the health sector in Northern Nigeria had been facing, we have to acknowledge that there has been some progress and improvements in the quality of health among the people compared to what it was when the system was introduced. Diseases such as polio, guinea worm, onchocerciasis (river blindness) and sleeping sickness have been eradicated. Rates of infections and mortality from yaws, cerebro-spinal meningitis, measles, chicken pox, small pox, bilharzia, yellow fever have been considerably reduced. There are fewer cases of typhus fever, mumps, tuberculosis, and similar diseases.

Today there are about 12 Teaching Hospitals and 31 Schools of Nursing in the region with at least one in each state and the FCT, 10 Post Basic Nursing Schools and specialized post basic schools in psychiatry, Orthopedic, pediatrics, ophthalmic, ear, nose and throat and critical care nursing.

Mr. Chairman, in 2019 there was a total of 5, 603 Medical Doctors in the nineteen northern states and 2, 523 in the FCT. Kaduna state has the highest with 711 while Taraba state had the lowest with only 186. The south had a total of 9, 609 with Lagos state alone having 2,561 which is the highest, while Ebonyi state had the lowest with 185. Table below provides number of Doctors per each state in the North.⁹⁰

⁸⁹ Federal Ministry of Health: The National Health Plan, 2016

⁹⁰ National Bureau of Statistics (NBS) 2020 Statistical Report on Women and Men in Nigeria, August, 2021

Table: Distribution of Medical Doctors in the Northern States and the FCT 2019

S/N	State	Number of Doctors
1	Kaduna	711
2	Kano	632
3	Plateau	538
4	Kwara	446
5	Borno	377
6	Benue	332
7	Gombe	286
8	Katsina	266
9	Nasarawa	258
10	Bauchi	243
11	Kogi	218
12	Niger	217
13	Sokoto	201
14	Adamawa	147
15	Kebbi	144
16	Zamfara	137
17	Yobe	133
18	Jigawa	131
19	Taraba	186
Total	For States	5, 603
	FCT	2, 523
Grand	Total	8,126

SOURCE: National Bureau of Statistics (NBS) 2020 *Statistical Report on Women and Men in Nigeria*, August, 2021; Accessed from Legit.ng on 26/10/2021

Funding is a very critical factor in the achievement of any social goal. As the health sector was expanding so the expenditure. Over the years, more health facilities were established, the number of various cadres in the sector has increased, population was also increasing, and these naturally demand more and more financial resources. In 1984 Prof. Nwokolo was so alarmed and literally screaming that between 10% and 20% of funds allocated to health care delivery in Nigeria goes to the purchase of drugs alone, which he estimated to be well over

N150 million every year for the whole country.⁹¹ When one looks at the expenditure in recent years what might have been allocated in 1984 was chicken feed. BudgiT a policy analysis group estimated that the Federal Government alone expended over N52.67 trillion between 1999 and 2016 and in the same period the 36 states and 774 local governments in the country collectively expended N55.36 trillion. Meanwhile out-of-pocket expenses accounted for about 72% of total health spending in 2014, now it is estimated to be about 75%. Thirteen states of the North together allocated a total of N206.39 billion to their health sector in 2018.⁹² Details are shown below.

Table: Budgetary Allocation to Health Sector of thirteen Northern States for 2018

S/no.	State	Allocation in Billions	% of Total Budget
1	Bauchi	25.57	15.23
2	Borno	17.7	9.77
3	Gombe	9.7	8.51
4	Jigawa	6.7	4.83
5	Kaduna	17.58	8.12
6	Kano	32.24	13.07
7	Katsina	23	10.80
8	Kogi	13.31	8.81
9	Kwara	23.92	12.53
10	Plateau	4.35	2.97
11	Sokoto	20.93	9.49
12	Yobe	6.29	6.82
13	Zamfara	5.1	3.83

SOURCE: BudgiT: Nigeria: Health Budget Analysis, Policy Brief, 1st Quarter 2018

It is important to note that the WHO recommends countries to allocate at least 15% of their total budget to the health sector. However, it has been impossible to do this for many developing countries due weak economies and

⁹¹ Nwokolo, C. The Place of Traditional Medicine and other Local Resources in A Modern Health Care Programme in Nigeria, Lecture delivered at the Fourth Convocation Ceremony, University of Maiduguri, Friday, 27th January, 1984, p. 2

⁹² BudgiT: Nigeria: Health Budget Analysis, Policy Brief, 1st Quarter, 2018

many other challenges of development that require similar serious attention as the health sector. Secondly, the trend has most a time been that what was allocated in budgets is not what is actually released. Budget performance always shows that funds allocated were not released in total and expended in reality. Nevertheless, more had been spent on the sector incrementally over the years.

Today the private sector is a major player in the provision of health services in the region. Private individuals, some few foreign interests and religious organizations are operating hospitals and clinics in many parts of the north. There is even what is called Islamic medicine that is attracting attention gradually.

However, as noted in the 2016 Health Policy other new health challenges have emerged. Today non-communicable diseases such diabetics, hypertension and road accidents are causes of high mortality; ulcer has become a common ailment. Nowadays, many cases of typhoid and malaria are being diagnosed among a large number of people. Maternal and child mortalities have reduced in the urban areas but still high in the rural areas. There are threats of SARs, HIV/AIDS and now COVID-19 in the horizon. Diseases related to poverty such as mal-nutrition are still debilitating thousands in the region. Malaria is still a challenge in the Region. In 2007 about 3, 122, 311 cases were reported, 2, 925, 478 cases were reported in 2008, in 2009, there were 3, 416, 886, while 1, 971, 763 cases were recorded and in 2011 there were 3, 838, 510. Total deaths reported for the period 2007-2011 was over 33, 744.⁹³

While the British introduced and spread the modern health care system to serve their interests, it nevertheless proved to be of value to the people of the Region, and at the same time the objectives of the colonizer. However, in the post-independence period, the ideology and character of health care provision remained basically the same with that of the departed British colonialists. For several

⁹³ National Bureau Statistics; Annual Abstract of Statistics: Reported Malaria Cases, 2007-2011

decades after independence, the provision of health services was seen as a means of enabling people to be healthy so as to produce for export in order to increase earning of foreign exchange as stated in the Second National Development Plan, but there was more to it than just providing health services for production only.

Though it is the responsibility of government to the people, the provision of this vital service was also seen as one of the methods of control and the exercise of power by the State. The Sector remained essentially under the control of doctors and other health professionals. It was from 1988 when the first National Health Policy was launched that attempts were made to empower the people to take the matter as their own as part of the new policy requirement. But professional dominance is yet to be reduced. This has led to unhealthy rivalry bet various cadres in the sector. There are today over sixteen professional Associations and Unions in the health sector competing for relevance and working in cross-purposes. Lack of attractive conditions of service, over dependence on foreign countries, corruption etc. combined to keep the sector underdeveloped which led to frustration and then brain drain of medical and health personnel from Nigeria. Mr. Chairman, an insider and Professor of Medicine of long-standing experience, x-rayed and provided an expert insight into the issues and problems of the Nigerian health care system. He explained in detail the problems ranging from funding, poor infrastructure and equipment, power failure, unwholesome practices, poor remunerations, and added that pervasive injustice in the world and in Nigeria makes it impossible to practice just medicine, massive corruption, the impoverishing of Africa by globalization and decline in the standard of academic medicine as some of the major factors contributing to the ineffective, inefficient, unreliable and general underdevelopment of the health sector in Nigeria⁹⁴.

⁹⁴ Muhammad, I.; Academic, Epidemic and Politics: An Eventful Career in Public Health, Ibadan, Bookcraft, 2008, pp. 169-175 and 261-284

Lack of accountability and impunity has become a normal pervasion in all parts of the country. Under these circumstances it will be impossible to achieve health for all as a right of the citizens.

CONCLUSION

By 1960, the Northern Region inherited a modern health care system that was more biased towards curative services than preventive, a health care system that was concentrated in the urban areas, and larger towns, at the expense of the rural areas. The health care system was also unevenly spread with the North Central and North Western parts of the region having the concentration of facilities to the relative neglect of many other parts of the region. Generally, the services were inadequate and there was also the problem of shortage of manpower. These were the major issues that the newly independent government contended with. Also, in spite of the efforts to down-grade the traditional or indigenous health and medical care system, it survived and continued to serve many people especially where the modern health services did not reach and when access became difficult to the poor as a result of the introduction of fees payment, following the introduction of the Structural Adjustment Programme (SAP) from 1986.

The Christian missionaries contributed immensely in the provision of health services especially in areas that were not been penetrated by the Sokoto Jihad. The colonial state literally left these areas to the Missionaries for provision of health services. But they were later accommodated in almost all the Emirates where they established leprosy, maternity and children care centres.

In the 61 years since independence the health sector has undergone significant major reforms to conform to the international trends, new and emerging local and global challenges. Increasing population, dwindling economy, and now, insurgency and banditry, corruption which has distorted the distribution of resources to the detriment of the majority of the population, lawlessness and the

death of patriotism in the country have all combined to undermine the development of Nigerian in general including the health sector. Since independence all efforts made were merely building on what was inherited from the colonialists, not much was done to redefine some of the priorities, strategies and methods. Where or when reviews or redefinitions are done, it was under the directive and direct control of the so-called international community dominated by the western world who are in control of all the levers of economic, social and political developments in the world.

Nigeria, like other African countries has been under the specter of Western dominance under the cover of assistance from the so-called “International Community”. All policy reforms originate from there and imposed on the country. Right from the introduction of the Western health care system in the 19th Century up to today Western countries represented by the United Nations system has been the leading policy designers and implementers in the country directly or indirectly. As Mahadi had noted that the current mantra is the adoption of “Global Standard” (Global Best Practices) which has led to pushing countries to adopt policies with break-neck- speed⁹⁵. Nigeria’s health care sector has been inundated with health sector policy reforms; that before a policy is properly grasped, understood and implemented others are foisted on the country resulting into a state of chaos.

When we do not have control on the trajectory of our development it is impossible to attain any meaningful progress. I concur with Adesina quoting Basil Davidson that Japan was able to develop because it accepted “Westernization” on its own terms and speed. The Asian Tigers followed almost a similar pattern which has made them be ahead of African countries. He went on to posit that in our bid to “catch up with West” our education and knowledge are founded on terms dictated

⁹⁵ Mahadi, A. ; Good Institutions Versus Basic Institutions: An Overview of the Transformation of Nigeria, 2013 Distinguished Annual Lecture Delivered at the National Institute for Policy and Strategic Studies (NIPSS), Kuru, 2013, pp. 17-18

by the West leading to the acceptance of values and models drawn from entirely different socio-economic and political environment⁹⁶.

I want to close this lecture by again concurring with Adesina who agrees with Notter as cited by Berg that historical research is much more than the mere collection of incidents, facts, dates and figures, but it also deals with relationship among issues that have influenced the present and how their effects will manifest in the future⁹⁷. He also rightly posited that “the future does not belong to those who forget their past. It belongs to those who have used the understanding of their past weaknesses and strengths to prepare for the future”⁹⁸

Finally, I submit that the history of the Nigerian health care system should be listened to carefully and attentively to understand what has been going wrong and use the knowledge to improve the situation now and for the future.

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⁹⁶ Adesina, O. C. The Future of the Past, An Inaugural Lecture delivered at the University of Ibadan, Thursday, 8th March, 2012, pp. 48-49

⁹⁷ Adesina, The Future in the Past, p. 34

⁹⁸ Adesina, The Future in the Past, p. 68

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