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PURSUING ITS MANDATE OF HEALTH BY ALL PEOPLES: WHO AND THE DEVELOPMENT OF NIGERIA'S HEALTH SECTOR, 1960 – 1975.

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Abstract

By the middle of the nineteenth century, international health cooperation had become well developed in response to the exigencies of the increasing international trade, migration and warfare. Initially, the approach was limited, as it was concerned with the protection of the Western hemisphere from contagious diseases resulting in the neglect of the developing countries. The establishment of World Health Organisation (WHO) in 1948 was therefore a departure from the existing tradition in view of its universal mandate. Using Nigeria as a case study, this paper examines the role of WHO in pursuance of its mandate of attainment of health by all peoples. It provides a historical analysis of the contributions of WHO to the development of Nigeria's health sector from 1960 to 1975. It argues that Nigeria's full membership of the Organisation in 1960 was a big fillip for the development of its health sector considering the fact that she could not on its own resource provide adequate health services for its teeming population.

Keywords: World Health Organisation(WHO), Nigeria, Health, Development.

Introduction: International Health Cooperation in Historical Perspective

This paper considers it imperative to undertake a cursory historical analysis of international health cooperation prior to the establishment of the World Health Organisation (WHO). This will provide a useful background for our understanding of the contributions of WHO in the development of Nigeria's health sector from 1960 to 1975. International health cooperation dates back to the 14th century (Lee, 1988:1). However, the real attempt at international health cooperation, in the modern sense began in the 19th century. Prior to this period, there was the general notion that there was no way to control diseases. There was little knowledge about the causes of diseases and the way it spreads. Hence, the outbreak and swift spread of diseases was seen as part either of a natural order or as a sign of divine disfavour. Thus, as long as man held on to such belief there was little or no incentive for international cooperation. However, the development of medical science brought some understanding of the causes of diseases and offered a focus for effort at the national and international levels.

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By the middle of the 19th century, international health cooperation had become well developed in response to the exigencies of the increasing international trade, migration and warfare. It materialised first by the creation of international public health institutions as from 1838 and by a succession of international conferences which started in 1851 and the drafting of international sanitary conventions (Beigbeder, 1998:2). This cooperation was informed by the rapid spread of epidemic diseases such as cholera, the plaque and yellow fever. This development can be traced to several factors. First, was the industrial revolution in Europe and the subsequent rapid development of trade and travel through the introduction of steamship c 1810 and railway c1830 and the construction of Suez Canal c1869. The new ease of travel and trade resulted in increased threat of the spread of diseases across national boundaries as it transformed the hitherto foreign epidemic diseases such as cholera into European scourges (Sidiqqi, 1995:14).

One early response of European states to limit the spread of cholera involved the quarantining of ships at different ports. These disparate and strict quarantine regulations, which had no scientific basis, endangered the profits of French and British seaborne commerce. Thus, the urge to negotiate a system that would protect nations from epidemics without hindering the flow of trade, made European countries to support an international collaboration to relieve shipping from the burdensome shackles of quarantine regulations. The second major factor that motivated international health cooperation was the two pandemics of cholera that affected Europe between 1830 and 1847 (Sidiqqi, 1995:14). All efforts to stop the diseases proved abortive. In view of the devastating situation, the European governments found themselves without any other option than to attempt international collaboration against cholera.

Additionally, the 1840's ushered in an era of international conferences. The period witnessed the first international conferences on prisons held in Frankfurt in 1846 and Brussels in 1847. In 1852, the first international conference on public health also took place in Brussels and six others on various subjects were held between 1853 and 1857. Neville Goodman asserted that by 1840, 'international cooperation by conference on technical questions had began and was on the air (Goodman, 1971:42). International health diplomacy took several forms before the establishment of WHO notably; regulation by imposition, regulation by convention, cooperation by conference, organisation by continuing cooperation, and organisation for service and action. In the following section, the growth of the various types will be outlined to show how international health diplomacy evolved and developed.

Several regional health institutions were established in the 19th century. They were created to regulate the implementation of quarantine measures in the Mediterranean region (Beigbeder, 1998:2). It should be noted that these were not genuine international organisations with secretariats and offices. Although, Europeans cooperated internationally, the system worked out was one involving imposition. Turkey was forced to set up a health council made up of Turkish and European representatives. This type of international action, where European powers cooperated to force weaker areas into a system involving Europeans, was used in a number of Middle Eastern, ,North African, and Southeast European regions. The health councils established were the *conseil superieur de la santé de Constantinople* which was created in 1839, the *Conseil sanitaire, maritime et quanrantenaire d'Alexandrie* in 1843, the *Conseil sanitaire* in Tanger in 1840 and that of Terheran in 1867 (Beigbeder, 1998:3). The health councils were able to improve sanitary conditions in their area. In Tangier, for instance, the European powers were able to force the sultanate to pave streets, to improve means of sewage disposal and to make provision for a pure water supply.

Between 1851 and 1903, a series of eleven international sanitary conferences were held which represented the earliest examples of international health cooperation culminating in the

establishment of a permanent international health organisation (Sidiqqi, 1995:14). They were held on ad hoc basis to facilitate international action to control the spread of diseases such as plaque, cholera and yellow fever. A total of four conventions were eventually agreed upon. In 1903, the eleventh International Sanitary Conference codified result of the previous conventions into a single, 184 article international sanitary code. In addition, an agreement was reached on the establishment of a permanent organisation for maintaining and reporting of epidemiological data and coordinating quarantine measures. The new Organisation, the Office of International d'Hygeine Publique (OIHP) was established by the Rome Agreement of 1907 with its headquarters in Paris. Although the ad hoc conferences proved valuable, there was pressure to establish regular machinery for exchanging information. In response, the Pan American Sanitary Bureau was established in 1903. Its establishment could be seen as a faithful implementation of one of the recommendations of the international sanitary conference of Washington (1881). The conference had recommended the adoption of a draft convention to create an international agency that would deal on permanent basis with health issues, in promoting studies on epidemics, projects for implementing quarantine measures and the periodical holding of international sanitary conference (Beigbeder. 1998:2). Its functions include; to stimulate the exchange of epidemiological information, to disseminate data on health in general and to provide assistance in fighting epidemics and for the sanitation of harbours and cities. In 1924, the Pan American Sanitary Code further clarified and expanded these functions.

Like the PASB, the initial work of OIHP also concentrated on epidemiology (Sidiqqi, 1995:18). The first meeting of the OIHP held in Paris in November 1908, consisted of nine national representatives and concentrated on cholera. But as the organisation and its member grew, so did its field of enquiry and staff. In addition to serving as the central collection agency for epidemiological information on public health and communicable diseases subject to quarantine such as plaque cholera and yellow fever, the OIHP discussed measures for the prevention of leprosy, tuberculosis, typhoid, and veneral diseases as well as questions of water pollution and purification. It is significant to mention that the office was the first permanent and global health organisation as its membership cuts across different continents (Sidiqqi: 1995:18). Its activities were reduced during the First World War. During this period, it dealt with war related problems-infected wounds, gangrene, coetaneous parasites, tetanus.

The establishment of the League of Nations in 1920 necessitated the reappraisal of the means of international collaboration in all fields including health. Article 23 (f) of the Covenant stipulates that the League of Nations was 'to endeavour to take steps in matters of international concern for the prevention and control of disease. After several meetings and discussions, the League Health Organisation was finally set up in 1923. It dealt specifically with issues outside the domain of OIHP, although some of its activities overlapped. The work of the health organisation was extensive and varied. It conducted studies on rural hygiene, housing and the health of the school children. The Organisation introduced a system of epidemiological information for diseases not covered by OIHP. In Europe, the work of the health organisation extended beyond epidemiological work to a variety of educational initiatives. Another aspect of the Health Organisation's was its standardization efforts. The Health Organisation of the League in its health work collaborated with other organisations both governmental and non-governmental, as well as within and outside the League. For instance, OIHP and the League collaborated mainly in the field of epidemiological information. The health organisation also cooperated with the Rockfeller Foundation from which it received generous subsidies (Goodman, 1971:42). Several factors accounted for the success of the Health Organisation of the League. First, is that it begun with the then enormous prestige of the League behind it. Second, it was established at a time when the needs of international medicine had extended beyond the capability of the hitherto existing bodies. Third, the structure of the Organisation with the effective governing body consisting of a small

group of medical experts in public health administration not officially representing their government was of great advantage to the Organisation.

Despite its remarkable achievements, the Health Organisation was adversely affected by the decline of the League as an instrument of world government (Goodman, 1971:134). Moreover, the activities of the Health Organisation of the league were marred by the existence of two independent bodies, the Office and the Health Organisation, which in some cases beneficial but on the whole harmful. Nevertheless, the Health Organisation activities represented a change in the approach to health by international law (Nelson, 2000:14). It acted as a catalyst to national reactions and exposed the nations to the idea of international health cooperation and also provided useful experiences for its successors. In view of the foregoing, we cannot but agree with Neville Goodman that 'the proof of the value of Health Organisation's work is that what it created has not been abandoned but taken over by a new owners and extended very largely on the original foundations.'[24.]

The beginning of the Second World War affected the activities of both OIHP and the Health Organisation of the League. In view of these developments and faced with emergency situation occasioned by the war, the Allied Powers decided in 1941 to establish an Inter-Allied Relief Committee to forestall the disastrous situations of 1918-1920. The committee worked for only two years and was replaced in 1943 by the United Nations Relief and Rehabilitation Adminisration (UNRRA). It recorded huge success in controlling typhus and malaria through his massive utilisation of DDT, and cholera by providing the necessary vaccine. UNRRA also assumed responsibility for administering the International Sanitary Conventions and the handling of epidemiological intelligence. Furthermore, it championed the revision of 1926 Convention on Maritime Navigation and the 1933 Convention on Air Navigation (Woodbridge, 1950:2). Finally, UNRRA was dissolved in 1946 and its activities in the health field were transferred as well as the remaining funds to the newly established WHO and UNICEF.

The period also saw the emergence of several health related non-governmental organisations. For instance, the League of Red Cross Societies, later known as the International Federation of Red Cross and Red Crescent Societies was established in 1919 'in view of a worldwide crusade to improve health, prevent sickness and alleviate suffering' (ICRC, 1992:15). Similarly, the Save the Children Fund (SCF) was created in 1919 by the British woman Eglantyne Jebb in response to the humanitarian needs of people in Europe affected by the First World War. In 1920, the Save the Children International Union was formed in Geneva as an umbrella body for organisations in France, Germany, Ireland, Sweden and the United Kingdom. SCF work involved famine relief and the provision of shelter, health and education services for disadvantaged children throughout the world (Penrose and Seaman, 1996:241-269) Other non-governmental organisations with international health programmes during the period include Rockefeller Foundation and Oxfam International founded in the United Kingdom in 1943.

From the foregoing, it could be argued that the establishment of the World Health Organisation (WHO) in 1948 was a turning point in the history of international health cooperation. This has led Amy Staples to describe the founding of WHO, FAO and the World Bank as;

> the birth of development- when discrete groups of people with international stature, expertise, money, power, influence, and the best of intentions began working to better the lives of other human beings whom they had never met or known, for no reason other than the desire to improve the fate of the human face. (Amy Staples, 2006: 1)

Its establishment could be seen culmination of nearly one hundred years of international health cooperation in public health. However, the universal scope of WHO's objective which is the 'attainment by all peoples of the highest possible level of health' (WHO, 1948), stood in sharp contrast to the earlier international health cooperation. The orientation of the international health organizations created before the Second World War focused mainly on the protection of civilized nations from contagious diseases (Horward-Jones,1975). Obviously, improving world's health was not their main concern. The distinction is based on the fact that health diplomacy during the early period focused on diseases rather than health. Thus, international collaboration in the field of health focused on those diseases that threatened to interrupt commerce rather than a general concern for human wellbeing.

Conversely, the constitution of WHO defined health 'as a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity' (WHO, 1946) which was crucial in determining the mandate of the Organisation. Since health is a state of complete, physical, mental and social well being of an individual, it is quite important in the development of every society. The importance of health as a developmental issue is better understood in terms of the components of good health which include freedom from pain, discomfort, boredom and stress; absence of illness, infirmity and diseases; balanced nutrition; qualitative and quantitative housing; water supply; good working and living conditions; education that is concerned with environmental issues and the aim of elongating a healthy or good life expectancy (ROAPE, 1986:66-67). WHO's objective therefore demonstrates a total shift in paradigm.

It is on record that most of the health and other socio-economic institutions in Nigeria were created to a large extent by the British colonial regime (Ityavyah, 1987:487- 499). The paternalistic administration left behind a habit on the part of the Nigerian citizens of expecting their government to provide all social services free of charge without recourse to the limited resources available. In addition to this syndrome of 'great social expectation' is the fact that Nigeria was faced with the colonial heritage of most health facilities having been located in the urban centres.

The unchanging colonial system resulted in two contradictions. First, whereas 70 per cent of the population is rural, health and services and other amenities are available only in urban areas. Consequently, there are wide disparities between urban and rural health indices. Thus, the vast majority of the rural population, who in most cases produce over 60% of national wealth was subjected to benign medical neglect (Garba, 1978). The situation was such that in the first decade of independence, Nigeria was confronted with enormous social and economic challenges. It also faced the urban bias in health resources and distribution in the country. The dilemma was made more difficult when a painful choice was to be made on how to allocate limited financial resources between health facilities and development projects in industry, agriculture and education (Garba, 1978). Viewed against this background, it goes without saying that Nigeria could not on its own resource provide adequate medical facilities for its urban and rural population. As Robert Cooper, one of Europe's pre-eminent diplomat aptly noted, 'in the past...it was enough for a nation to look after itself. Today it is no longer sufficient' (Cooper: 2003:1). This is particularly true in the health arena. In view of this the support from the World Health Organisation became inevitable. This paper therefore examines the contributions of WHO to the shaping of Nigeria's health sector between 1960 and 1975.

. **WHO Activities in Nigeria Before 1960**

The World Health Organisation activities were introduced into Nigeria during the period of colonialism. This was made possible by Britain's membership of WHO as one of the founding members after the Second World War. The relationship was facilitated by two major developments in the country during the colonial period precisely after the Second World War. One of such

changes was the transition from a colonial to a technical assistance structure with the attendant increase in the number of agencies which supplied international medical aids to Nigeria (Schram, 1971:312). Another development was the administrative and constitutional changes that took place during the period. Administratively, the Ten Year National Development Plan known as the Walter-Harkness Plan was issued by the colonial government in 1946 (Government of Nigeria, 1946). It was during the Plan period that a Ministry of Health was founded and all health services became coordinated by one body. Furthermore, in accordance with the constitutional changes that took place in Nigeria between 1951 and 1954, public health and medical matters were passed to the exclusive jurisdiction of the Regions while the federal government became responsible for the medical and health services in Lagos and the medical research services of the Federation. (Olusanya,1980:534). These developments provided the institutional foundation for the relations between Nigeria and WHO.

It is not certain as to the actual date of the commencement of WHO activities in Nigeria, but available records show that between 1949 and 1953, WHO had been engaged in the fight against malaria and other diseases in the country in line with the Organisation's strong offensive against the diseases that cause serious damage after the Second World War (Beigbeder, 1998:18). It is important to note that WHO described the period after the Second World War as a world in a 'state of emergency'. For instance, in 1952 there was a general agreement where Birnin Kebbi was chosen as the centre for WHO malaria project in Northern Nigeria (Schram, 1971:320). The Malaria Eradication Programme launched in 1955 brought Nigeria into the mainstream of WHO global activities. To achieve success on a global scale, the World Health Organisation had recognised the need to train more health professionals. As a result, a Malaria Eradication Training School was established in Yaba, Lagos for the whole of WHO African region. WHO also sponsored an international malaria conference in Lagos in 1955. It also convened regional meetings of malaria eradication officials to facilitate mutual sharing of experiences. Another WHO assisted campaign which influenced public health in Nigeria was one directed against yaws (Schram, 1971;328). WHO also provided assistance for the supply of yellow fever vaccine in Eastern Nigeria in 1952 (National Archives, Ibadan). For the control of tuberculosis, WHO provided assistance for conducting prevalence survey on samples of the population of Ibadan in the Western Region in 1957. Furthermore, WHO paid attention to the provision of basic facilities to medical institutions in the country. It provided teaching aids such as textbooks, models, duplicating machines, and combined epidiascope and filmstrip projector for the following medical institutions: Nurses Preliminary Training School, Lagos, School of Dental Hygiene, Field Unit Training School, Makurdi and Kano Medical School (National Archives, Ibadan).

The Organisation also contributed to manpower development during the period through fellowship awards. Between 1950 and 1954, WHO provided fellowship awards on different subjects to Nigerians.

Table 1: WHO FELLOWSHIP AWARD TO NIGERIAN 1950 – 1954

Name	Year	Subject
Dr. M. O. Alakija	1950	Tuberculosis
Dr. V.W Hetreed	1951	Tuberculosis
Dr. B.M. Nicol	1952	Nutrition
Dr. J.E. Henshaw	1953	Tuberculosis
Dr. E.W Awoliyi	1953	Maternal and Child Health
Dr. O Adeniyi-Jones	1954	Public Health Administration
Dr. L.J. Bruce-Chwat	1954	Malaria Control
Dr. A Zahra	1954	Insect Control

Source: National Archives, Ibadan D.1.4.1.5B MH(Fed)1/7 'Evaluation of WHO Fellowships'

It is interesting to note that Nigeria was admitted as an associate member in May 1956. Such membership status is granted based on the provision of WHO constitution which states that:

> Territories or groups of territories which are not responsible for the conduct of their international relations may be admitted as associate members by the Health Assembly upon application made on behalf of such territory or group of territories by the member of other authority having responsibility for their international relations… (WHO, 1948)

However, much was not achieved both before and during the period of associate membership. The relationship was bedeviled by administrative hiccups caused by the fact that Nigeria was not in control of its international relations. Hence, all requests for international assistance must be routed through the colonial office in London. Nevertheless, the granting of the new status offered Nigeria the opportunity of attending the World Health Assembly as a delegation. This was in line with WHO resolve that representatives of the associate members should be chosen from native population in order to ensure their genuine representativity and to prevent colonial powers from leading several delegations.

Pre Civil War Era

The attainment of independence by Nigeria in 1960 marked a new beginning in Nigeria's relationship with the World Health Organisation. The privilege of full membership after four years of associate membership opened up a new vista for the Organisation to contribute to Nigeria's development. Membership of the Organisation was to guarantee greater participation in the activities of WHO. It also provided the opportunity to directly request and obtain useful technical assistance from the Organisation. Nigeria had the opportunity to vote on issues discussed yearly at the World Health Assembly and also occupy official positions of the Organisation. Membership at independence also provided a new avenue for Nigeria under its own indigenous administrators to derive optimal benefits from the Organisation.

It would be recalled that one of the major preoccupations of all large United Nations agencies in the 1960s was the intensive preparation of programmes promoting the progress and growth of developing countries (Beigbeder, 1998:20). WHO in the 1960s witnessed a tremendous increase in its membership with the attainment of independence by many developing countries. These new states had several challenges, such as inadequate public health infrastructure, lack of qualified health personnel and basic institutions to train their health personnel. This was the context that shaped WHO orientations in the 1960s which were basically: campaigns against the principal communicable diseases, strengthening of national basic health services, education and training of medical and paramedical personnel, nutrition and environmental sanitation (Beigbeder, 1998;20).

Prior to the Nigerian Civil War, WHO embarked on programmes aimed at shaping the health sector of Nigeria as a new independent state in line with its commitment to promoting progress and growth of developing countries and the aspiration of Nigeria leaders who adopted the ideology of development to replace that of independence. To this end, WHO made invaluable contributions to the strengthening of medical and other health institutions in Nigeria. The Organisation did not only provide experts in various fields but also assisted in the development of medical curricula for the training of a wide variety of health personnel. In order to increase the number of health and medical personnel, assistance was provided for their training in all the medical schools as well as in the schools of hygiene and nursing in the country. University teachers were provided for the teaching of the following subjects in the medical schools: anatomy, microbiology, psychiatry, pathology and public health. For instance, WHO appointed a Professor of Microbiology in the Faculty of Medicine, Ahmadu Bello University, to strengthen the undergraduate teaching of

microbiology (WHO Country Cooperation Strategy). Similarly, it also provided a visiting Professor of Mental Health for the University of Ibadan in 1967 (WHO Archives, Geneva). The provision of these teachers was undertaken by WHO because it was difficult to find teachers locally for these disciplines (African Pilot, 1974:2).

Furthermore, teachers were also provided for the training of sanitary engineers in the Faculties of Engineering at the University of Lagos and the Ahmadu Bello University, Zaria (Federal Ministry of Information, 1973). In the department of Nursing at the University of Ibadan, nurse tutors and administrators were trained with WHO assistance. A WHO teacher was also attached to the School of Radiography for the training of radiographers in Lagos (WHO Archives, Geneva). Apart from providing teachers for these institutions, WHO also sponsored medical researches in these institutions. At the World Health Organisation training centre in Yaba, Lagos, which was a regional project, training of all categories of personnel including laboratory technicians, microcopist, health centre superintendents, health sisters were carried out. (Federal Ministry of Information, 1973). Health education consultants also helped in the provision of advice in community health education and school health education throughout the country (WHO Archives, Geneva). Experts were also provided by WHO to give technical assistance in the field of vital and health statistics. (WHO Archives, Geneva). Supplies and equipment were also provided for these projects.

Another method adopted by WHO for health manpower development was the granting of WHO fellowships to Nigerians to train in various fields. Many Nigerians received training under this scheme in public health, health education, nutrition, statistics, public health, nursing, occupational health, leprosy control among others (Federal Ministry of Information, 1973). Between 1959 and 1974, WHO awarded twenty two fellowships for study in health education alone. Eleven was at the post graduate level and ten at the certificate diploma level (WHO Archives Geneva). As part of WHO contribution to manpower development, financial support was also given to candidates to enable them participate in seminars, workshops, conferences and training courses.

Table 3: WHO Fellowships Awarded For Study in Health Education 1959 – 1973

S/N	Name	Duration Of Fellowship	Level Of Study
1	Mrs. Newmatic	1959 – 60	-
2	Dr. R. N. Onyemelukwe	1959 – 60	Postgraduate
3	Mr. Abgana	1960 – 61	Certificate Diploma
4	Mr. E. R. Dallah	1960 – 61	Postgraduate
5	Mr. M. Wada	1960 – 61	Certificate Diploma
6	Mr. B. C. Onuoha	1961 – 62	Postgraduate
7	Mr. E. Osin	1962 – 63	Certificate Diploma
8	Mrs. S. Akinyobi	1963 – 64	Certificate Diploma
9	Mr. Okwu	1963 – 64	Certificate Diploma
10	Mr. E. O. Olawoye	1963 – 64	Certificate Diploma
11	Mr. G. C. Okezie	1964 – 65	Postgraduate
12	Mr. S. N. C. Ezeugwa	1964 – 65	Certificate Diploma
13	Dr. G. Ademola	1964 – 65	Postgraduate
14	Dr. M.A. Silver	1965 – 66	Postgraduate
15	Dr. J. A. Laoye	1965 – 66	Postgraduate
16	MR. A. E. Eno	1966 – 67	Certificate Diploma
17	Mr. Kalu Olua	1966 – 67	Certificate Diploma
18	Dr. Z. A. Ademuwagen	1967 – 68	Postgraduate
19	Dr. A. Adeniyi Jones	1967 – 68	Postgraduate
20	Mrs. Emokpae-Gamak	1972 – 73	Postgraduate
21	Mr. A. K. Fabiyi	1973 – 74	Postgraduate
22	Mr. J. D. Adeniyi	1973 – 74	Postgraduate

Source: WHO Archives Geneva, NIE, ESD-005 'Epidemiological Services North Western Nigeria'

Traditional methods were not neglected by WHO. The Organization emphasized that the preservation of health is dependent on diseases prevention and sanitation. The Organization recommended for less developed countries to keep to familiar and well tested sanitation measures and to show to the populations how to apply these methods in the family and in the community (Beigbeder, 1998:18). For instance, in an attempt to promote environmental health, comfort stations were provided throughout the city of Ibadan in the Western Region in 1966. The people were taught to use the stations for their washing and waste disposal. (WHO Archives, Geneva). WHO also provided incinerators. One important outcome of this project was that other state governments began to request for these facilities because of the impact they made on environmental health in Ibadan. (Federal Ministry of Information, 1973)

Epidemiological services were provided by WHO at federal and state levels for the control of the common communicable disease in Nigeria, such as, small pox, yellow fever, cholera, leprosy, tuberculosis, onchocerciasis, cerebro-spinal, menigitis among others. Advisers, epidemiologists, consultants and technicians were provided by WHO as well as vaccines, drugs and equipment for these services. In 1967, a research team was sent to Nigeria by the World Health Organisation to cooperate with the department of Preventive and Social Medicine of University of Ibadan and the Federal Ministry of Health (Morning Post, 1967:11). The project was expected to establish the most effective ways of measuring the amount of sickness and number of deaths for which Bilharziasis was directly and indirectly responsible. Prominent among the research team were Dr. D. Vellimirovic, an epidemiologist, the project leader, and Dr. B. C. Dazo; a malacologist. The team also had a parasitologist and a laboratory technician as its members. The smallpox eradication programme and the control of cholera were outstanding achievements in the assistance of WHO for disease control in the country during the period.

Another WHO assisted campaign was one directed against malaria. WHO assisted the Nigerian government to the limit of their capacity through, fellowships, grants, staff, the establishment of a malaria eradication centre in Lagos, for the whole of WHO African region, the supply of drugs and transport and the sponsoring of international conferences on malaria (Schram, 1971:319). In the development of laboratory service, the World Health Organisation provided consultants, technicians and equipment. These services include the production of smallpox, yellow fever and rabies vaccine. In the public health component of Kainji Lake resources project and Lake Chad irrigation project, WHO assisted with the recruitment of consultants.

The Civil War Era, 1967- 1970

The Nigerian Civil War caused a serious setback in the relations between Nigeria and the World Health Organisation relations. As a result of the war, some of the World Health Organisation programmes were abandoned and others modified. The abandoned programmes include the temporary transfer of Malaria Eradication Training School to Togo, the suspension of the Birnin-Kebbi Malaria Scheme and the suspension of all the World Health Organisation projects in Eastern Nigeria (Morning Post, 1968:3). WHO was criticized for its inaction on the issue of emergency assistance to the war affected areas. The criticism came most poignantly from Professor Jean Mayer of School of Public Health, Harvard University and the Chairman of the United States Biafra Study Mission. Mayer complained about the lack of WHO action in Nigeria, not only in the field of nutrition, but also in the general health services including epidemiological services (Report of the Biafran Study Mission, 1969). He remarked that:

> there is very little that can be said in the defense of WHO's inaction in the face of one of the great medical disasters of modern times except that so far, more through luck than through foresight or the exercise of medical procedures, there has not yet been any large scale infectious disease of epidemics ….We found that WHO had done absolutely nothing in a country which already had had 1.5 million dead from famine and disease where hospitals have been systematically bombed and strafed and where basic drugs and sanitary equipment are missing. Unlike its sister organisation, UNICEF which waved aside diplomatic technicalities to help sick and starving children who has lacked the basic courage to risk being criticized by a few states-essentially the Soviet Union-while fulfilling what clearly is its duty (Report of the Biafran Study Mission, 1969).

He reminded the personnel of WHO that they are doctors and should not let political considerations stand between them and their patients emphasising that "with a population weakened by famine with millions of refugees, many of whom are on the march, only the closest surveillance and control and prompt medical action can prevent the spread of one or several large epidemics'.[66] In his recommendation to the United States Senate on the Biafra situation in 1969 he stated thus:

> I am strongly in favour of turning over to the churches and to International Committee of the Red Cross the money earmarked for the WHO Assembly here as a way of reminding WHO why it was founded. The aims of the organisation are closely more important than the social functions (Report of the Biafran Study Mission, 1969).

It is true that WHO was conspicuously absent in the provision of emergency assistance for the war affected areas. However, WHO acted according to its constitution which barred it from forced intervention in order to implement assistance in the country (WHO, 1948). WHO actually made the move in 1968 when Dr Kyarasu, an official of the organisation approached the ministry of External Affairs on the need to extend assistance to the Eastern region, but received no sympathetic response. (WHO Archives, Geneva).

Within the Ministry of Health the Chief Medical Adviser was of the view that any assistance to the East other than through the International Committee of the Red Cross would be regarded as assisting the rebels.. Nevertheless, WHO was not totally impervious. Its technical assistance during the war came in the form of provision of booklets that guided the field workers in Biafra on the treatment of severe cases of malnutrition (Dean and Jelliffie, 1960). It also offered technical advice to ICRC. (WHO Archive, Geneva). The ICRC sought the advice of WHO on the technical propriety of evacuating malnourished children from Biafra to another neighbouring country. The ICRC explained that they had the facilities for transporting food and other materials from Fernando Po to Biafra and thought it would be a good idea to take advantage of such trips to take malnourished children from Biafra to be treated in another country. The ICRC did not wish to implement this idea, but was prepared to provide the transport facilities to any international or charitable organisation willing to take the responsibility.

WHO emphasised that this type of action would be difficult to implement for several reasons. (WHO Archives, Geneva). First, the young children would have to be evacuated with their mothers and the rest of the children of the same family would remain without the mother's protection in Biafra. Second, this type of action would require in practice, the evacuation of the total members of the malnourished families and this would prove a tremendous task. Therefore, from the technical point of view, WHO discouraged the possibility because of its complexities. Another

reason was the possible political implications because the Federal Government of Nigeria would definitely object to such action (WHO Archives, Geneva).

Indeed, one of the biggest hindrances to relief work in Nigeria during the Civil War was the poor relations between the ICRC and the Federal Government (WHO Archives, Geneva). The reasons for the state of affairs are diverse. One of the more notable was the suspicion by the Federal Military Government that the secessionist authorities were secretly using the relief air corridor to fly in arms and ammunition which they used in sustaining their resistance and prolonging the war (Mohammed, 1989:242). Again, the act of double crossing displayed by Dr. August Lindt of the ICRC seriously provoked the Federal Military Government. (Mohammed, 1989:242). It was against this background that the Federal Government decided to assert its rights under the fourth Geneva Convention in relation to the relief to the civilian victims of the war. It issued an official policy statement to regulate the conduct of Relief Agencies in the country. As a result, the Nigerian Red Cross was allowed by the Federal Government to take over the assets of the ICRC in Nigeria for the continuance of relief operations in federal held areas of the war (Mohammed, 1989:242).

Another difficulty resulted from the creation of 12 states in 1967. The Civil War and the mass of refugees presented an intolerable burden for the infant administrations of the new states in the affected areas. As a result, the infrastructure and the local resources through which relief measures are normally operated are often lacking or only partially organised. Faced with this system, the Federal Ministries desiring to give help had to tread on the part of caution in order not to infringe on the prerogatives of the new state. In addition, their efforts were further hindered by the difficulty of getting professional staff from other areas, despite the inducement of extra pay. Thus, with the exception of teaching hospitals, the bulk of doctors in the public services were employed by the various states governments and not by the federal government (WHO Archives, Geneva).

In this wise, the valuable assistance WHO could offer was the reconstruction and improvement of new states medical services. WHO achieved this through stimulating federal aid for the war stricken areas because without minimal regular state services, outside aid was likely to be ineffective. The Organisation believed that it was only when the federal government had assisted these states to recreate their minimum medical services that its personnel would be able to function in their true role. Otherwise, the WHO staff would be doing executive jobs because the country has been unable to persuade or force Nigerian doctors to assist in these affected areas. Indeed, the request for emergency assistance from WHO came on February 5, 1969 when the Federal Ministry of health formally requested for emergency aids to the war stricken areas. The assistance from WHO did not come until the end of the Civil War in 1970.

Post Civil War Era, 1970-1975

In the post Civil War era, WHO contributed immensely to the programmes under the health components of the second and the third National Development Plans. The Second National Development Plan contains the policy framework for and the programme of the reconstruction of the war damaged areas as well as the construction and development of the rest of the country. (Second National Development Plan, 1970-74). The Plan sets out clearly the national objectives and priorities of post war Nigeria. The programmes within the health sector are in general terms designed to revivify health services disrupted during the civil war and to develop and expand existing medical and health services to the extent that will bring them more within the reach of the entire population. In this connection, the greatest emphasis was given to preventive measures designed to reduce to the minimum the incidence of deadly diseases in the various communities. Thus, in compliance with the programmes under the health component of the four year Second National Development Plan 1970 – 74, the World Health Organisation assistance on request were

designed based on two objectives; to ensure the supply of a strong and healthy labour force and to ensure that health services and amenities are within easy reach of the people in the country (Federal Ministry of Information Press Release, 1973).

In the Eastern State, which was adversely affected by the war, the World Health Organisation was committed to the restoration of health services to the level existing before the outbreak of war. The health institutions badly damaged by the war were physically rehabilitated. WHO gave assistance in the form of roofing sheets and accessories for reroofing of selected health institutions. Between 1970 and 1973, basic supplies and equipment were issued to the categories of health institutions in the East Central State: hospitals 10, health centres 35, maternities 111, and dispensaries 135. (WHO Archives, Geneva). The teaching institutions in Aba, Enugu, Emekuku and Nsukka Schools of Nursing and Midwifery received teaching aids, furniture and other equipment. Other recipient institutions were the Specialist Hospital Enugu and the Health Education Unit in Oji River. (WHO Archives, Geneva). Furthermore, funds amounting to $26,000 was provided for in-service training courses in these institutions.(WHO Archives, Geneva). Moreover, WHO provided 57 vehicles for the supervision of health services. To assist with the warehousing space for pharmaceutical and medical supplies, a pre fabricated warehouse with a storage area of 7200 sq:ft was constructed (WHO Archives, Geneva). For the period between 1972 and 1973, the following categories of staff was provided by WHO in the East Central State: Public health administrator (2), medical officer epidemiology (2), and midwifery tutor (2) (WHO Archives, Geneva). However, it is important to note that premises, personnel and services were also provided by the East Central State to ensure smooth operations. In other areas of the country not directly affected by the war, the World Health Organization also assisted in several areas such as strengthening of health services, health manpower development, public health engineering and disease prevention and control.

The World Health Organisation also assisted Nigeria during the Third National Development Plan 1975-1980. However, the assistance came basically at the planning stage. In January, 1973, the Federal government of Nigeria approached WHO to provide preparatory assistance mission with a view to carrying out an initial study of needs and possibilities upon which overall proposals could then be formulated for inclusion in the Third National Development Plan scheduled for completion in October 1974 (WHO Archives, Geneva). In sharp response, the World Health Organisation provided two staff for the preparatory mission namely Dr. H. Duran, a senior health planner and Dr. T. W. Helminist, a health economist with broad experience in system analysis (WHO Archives, Geneva). The mission was funded by the United Nations Development Programme (UNDP). The task of defining government policy, setting targets and making projections were undertaken by the National Health Planning Project as the preparatory mission was later called. The project examined the guidelines for the Third National Development Plan and the initial recommendations of the Ministries of Health of all 12 Nigerian States and the Federal Government to determine how well the submitted statements conform to the guidelines and stated government objectives (Attah, 1976:256). All the states were visited and the policy fulfilment gaps in the health plans submitted were discussed. The project identified the factors affecting the achievements of health objectives as: shortage of medical and paramedical staff, inadequate preventive health service management and inadequate planning (Attah, 1976:256). It was the recommendation of this Project that gave birth to the Basic Health Scheme Service, which was incorporated into the Third Development Plan as its focus. The Basic Health Scheme Service which was incorporated into the Development plan had the following objectives:

1. to initiate the provision of adequate and effective health facilities and care for the entire population;
2. to correct the imbalances in the distribution of health infrastructure for all preventive and curative care;

3. to provide the infrastructure for all preventive health services, such as control of communicable diseases, family health, environmental health, nutrition among others;
4. to establish a health care system best adapted to the local conditions and to the level of health technology.

The Third National Development Plan was elaborate in its health reform attempt. The Plan allocated the sum of N20 million for the National Malaria Programme. In addition, intensive vaccination campaigns on smallpox were organised in collaboration with local and international voluntary organisations. The period also witnessed the rapid expansion of the number of federally managed teaching hospitals for the training of various categories of health workers, particularly doctors, nurses, midwives, and technicians. Schools of health technology were also established for the training of intermediate level manpower for community health.

Conclusion

So far we have shown that the World Health Organisation has contributed in no small measure to the development of the Nigeria's health sector. To achieve this, the Organisation adopted several methods such as manpower training and development, provision of epidemiological services and support for planning and implementation of development plans. All these were made possible by the universal mandate of WHO which is the 'attainment by all peoples of the highest possible level of health'. The Organisation was also convinced that without a healthy population most countries would find it difficult to carry out economic programmes. Javier Solana corroborated this view when he wrote that 'a society which is not physically healthy cannot be politically healthy. When large parts of the population suffer from a disease it has an impact on the economy and on governance' (Solana, 2006:10). However, it is important to state that Nigeria was not only at the receiving end. The country also contributed immensely during the period to the attainment of WHO objective. The Organisation derived great benefits from eminent authorities sent by Nigeria to attend the World Health Assemblies, Executive Board sessions and meetings of Expert Committees and of Regional Committees. WHO capacity building efforts in Nigeria also brought essential dividends to the Organisation through the trained Nigerian health professionals who provided consultancy services to other countries within the African region and beyond. Nigeria supported WHO programmes through donations and extra budgetary contributions. Finally, Nigerians also featured prominently on high-level appointments in WHO.

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