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Health Services and Military Messianism in Nigeria (1983-1990)

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ABSTRACT

Since the 1983 military coup in Nigeria health services have been declared a major priority of the military regime. This health priority, along with professed commitments to popular welfare and to the resolution of economic problems, constitutes the declared *raison d'être* for intervention. Rather than being a solution, the various reforms which are integral to the overall economic austerity programme have, however, escalated the crisis situation in health care. Aside from the increasing incidence of nutritional disorders directly traceable to the austerity measures, there is more exclusion of the majority from available medical services on the one hand, while privileges such as overseas treatment at public expense continue for top government officials on the other. These obvious contradictions between professed commitment and actual practice are explained against the wider dynamics of economic crisis and attendant adjustments.

Introduction

Until recently, health care in Nigeria has been conceived in official policy documents as apolitical and autonomous, without links to the wider society. The political nature of health care now seems to be recognised, at least since the 1983 military *coup d'état*. This intervention was ostensibly necessitated by the fact that "Health Services are in shambles as our hospitals are reduced to mere consulting clinics without drugs, water and equipment" (Abacha in Iroha, 1984: 3-4).

Since the coup there have been several other indications of the political nature of health care and its links to the wider political economy. The campaigns for the removal of the petrol subsidy in 1986/87, for instance, mentioned availability of drugs as a benefit to be derived from this. Indeed, the entire austerity programme and the *raison d'être* of military rule are now legitimised by pointing to supposed improvements in health services¹.

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Given this declared priority of health care, it is appropriate to examine the health programme of the military. What, for instance, are its programmes to change the 'consulting clinic' status of public hospitals, and stem the health care crisis in general? Would these policies actually stem the tide?

It is to these and related issues that this paper, which focuses on the post 1983 coup, is addressed. The role of the military in post colonial Nigeria is discussed, and the health policies and practices of the military are examined. These developments in health care are then explained in terms of the overall economic crisis within which the former can be more fully interpreted and understood. The true nature of military messianism is sketched in the conclusion.

The military in post colonial Nigeria

Nigeria, a former British colony, gained independence in 1960. Since attaining independence, the country has experienced frequent political turbulence manifest particularly by regular military interventions. The military has ruled the country for all but 10 years of the 30 years of independence. It is therefore possible to classify Nigeria's post colonial polity into the First Republic (1960-66), military rule (1966-79), Second Republic (1979-83), and military rule (1983-date). The coups are explained by the unconstitutional role the military has arrogated to itself as *messiahs* and political *watchdogs*. Beyond matters of defence and warfare, the military in Nigeria now constitute the *de facto* rulers.

Military messianism is a term which refers to the articulation of unemployment, inflation and other problems of Nigeria's political economy in terms of corruption, ineffectiveness and similar vices, particularly under democratic rule, and the position that military intervention would resolve these problems. In other words, military intervention is presented as a messianic initiative to save the country and its people from hardship. Since Africa's first military *coup d'etat* took place in Sudan in 1958, the military has in various countries arrogated this messianic role to itself, in the preformance of which it has periodically ousted elected governments (Cervenka, 1990; Jenkins and Kposowa, 1990).

What is perhaps the most erudite articulation of military messianism in Nigeria was recently provided by General Babangida, the current ruler (in Barrett, 1990:213):

"The military has been forced into governance primarily and principally by the necessity to secure the foundation of our polity from collapse. The option was not a choice between shoring up one coalition of civilian rivals against the opposition of another, but in ensuring we did not dissolve into anarchy. Our intervention remains justifiable by the imperatives of securing

the wholeness and oneness of our economy and nation. If we really understand the implications of the roles of the military in our national agenda - then we can truly appreciate the full significance of the contribution of the military to our survival as a nation. Those who quarrel about how to share the rooms of a house, the foundation of which is collapsing, can only with extreme charity be condemned for lack of wisdom."

However, military messianism in Africa primarily emphasises structural reforms rather than system or revolutionary change. These reforms are ostensibly non ideological. Class contradictions and related problems of Nigeria's market economy are either completely denied or explained as teething problems of development to be overcome by more effective government. As this paper will show, military messianism is perhaps the most important single factor shaping the form, content and process of Nigeria's post colonial polity.

At independence, a parliamentary democracy headed by Tafawa Balewa, which succeeded the colonial masters, was terminated by a military putsch in January 1966. According to the military, the government was corrupt and inept and misrule had brought the country to the brink of an economic and political precipice.

Politically, there were several disturbances in the 1960-66 period, including the constitutional crisis in the Western Region and the Tiv riots. In the former case, the regional premier was removed by democratic process but refused to quit. His action led to violence and riots and the Federal Government had to intervene. A state of emergency was declared in the region and an administrator appointed. However, the constitutional power of the Federal Government to intervene was challenged (Ojiako, 1981). Similarly, rivalry between supporters of two political parties resulted in major riots among the Tiv during the period.

These upheavals were in addition to widespread nepotism, tribalism and "alleged attempts by (the) Ibos to dominate other ethnic groups" (Ojiako, 1981:179). For the military, therefore, a timely intervention was necessary to save the country (Mainasara, 1982; Ademoyega, 1987; Muffet, 1982).

The 1966 intervention led by the late General Ironsi marked the beginning of what has turned out to be a series of coups, counter coups and coup attempts. The Ironsi ascendancy was, however, perceived by a large section of military as part of the Ibo domination. General Ironsi was assassinated six months later and Colonel Gowon took over as head of state. After the countercoup, the Ibos attempted to secede from Nigeria to regroup as Biafra in what was hitherto the Eastern region. These events culminated in a civil war between the Biafran secessionists and the Federal Government in the 1967-1970 period (Ojiako 1981; Muffet 1982). Gowon prosecuted the civil war (1967-1970), and was himself overthrown in 1975 by General Mohammed. The main reasons given for the coup were indecision, corruption and ineptitude. General Mohammed was assassinated in a coup attempt

in 1976 and was succeeded by his deputy, General Obasanjo. It was General Obasanjo who presided over the transition to democratic polity in 1979.

Both Gowon and Obasanjo's regimes were periods of enormous oil wealth. Indeed, the slogan 'money is not the problem but how to spend it' became the rallying cry during this period. The oil boom was, however, short lived as a decline in oil revenue, first manifest during Obasanjo's regime, soon led to a fiscal crisis (Abba *et al.*, 1985; Onimode, 1983).

The Second Republic, as the civil rule between 1979 and 1983 is called, was modelled after the US presidential system and presided over by Shehu Shagari of the National Party of Nigeria. Economically, oil revenues improved in the first two years of this second democratic experiment. This boom was also ephemeral, as a major crisis manifest in high unemployment, unpaid salaries, particularly in the public service, low capacity utilisation, deterioration in social services and accompanying frustration, became ubiquitous (Madunagu, 1984; Forrest, 1986).

The crisis, it could be argued, set the stage for the military coup of December 1983. Hence the coup led by General Abacha received broad based popular support. According to the military "in [the] discharge of our national role as the promoters and protectors of our national interest" intervention was a patriotic imperative to save Nigeria from "grave economic predicament and uncertainty" as well as from "harsh intolerable conditions" (Abacha in Iroha, 1984:4). In General Buhari's more trenchant words, the coup was (in Iroha 1984:6-8):

"In pursuance of the primary objectives of saving our great country from total collapse.... The change became necessary in order to put an end to the serious economic predicament and the crisis of confidence now afflicting our nation."

The Buhari regime tackled these problems with military resolve in which many of its 'solutions' contradicted earlier declarations. Rather than provide jobs, for instance, people were retrenched *en masse*. Similarly, increases in taxes fuelled inflation, and the reintroduction of hospital and school fees abolished during the oil boom restricted access to hospitals and schools (Alubo, 1985a).

Opposition to these policies was suppressed through arrests, detention without trial and the proscription of 'troublesome' organisations. As Bangura has indicated (1987), Buhari's was a regime of creeping fascism.

General Buhari was overthrown in a palace coup led by General Babangida, hitherto Chief of Army Staff. Again, General Abacha, who announced the overthrow of Shagari and held a key position in the Buhari government, remarked that (in Newswatch, 1985, September 7:9):

"The deplorable state of our hospitals and increasing deterioration of our health care delivery, the unemployment of our citizens especially graduates has reached alarming levels."

In other words, military rule was yet to bring any redemption.

President Babangida's first speech was strewn with the same rhetoric as General Buhari's, now a villain. Like the latter's remarks about deposed President Shagari, Babangida observed that (in *NewsWatch*, 1985, September 7:9):

"The last twenty months have not witnessed any significant changes... contrary to expectations, we have so far been subjected to a steady deterioration in the general standard of living; and intolerable suffering of the ordinary Nigerians have risen higher... hospitals still remain mere consulting clinics. While educational institutions are on the brink of decay. Unemployment has stretched to critical dimensions."

This strident condemnation notwithstanding, the economic policies of the two regimes, and indeed those of the deposed civilian government, differ only in form rather than in essence. All of them were primarily informed by monetarism-supply side economics (Bangura, 1987).

During the last two years of the civilian government, negotiation for a \$2.5 billion IMF support loan was initiated. The negotiations were, however, stalled because of the anticipated political costs of the conditionality (devaluation, withdrawal of subsidies and trade liberalisation) the IMF demanded. Rather than bow to these pressures, the government chose fiscal measures to conserve foreign exchange (Forrest, 1986).

The negotiations with the IMF continued during the 20 months of the Buhari government. Again, the conditionality, particularly devaluation, was resisted. The government continued the fiscal measures of its predecessor, in addition to counter trade, ie the direct exchange of oil for various commodities. Counter trade was, however, frowned upon by Western creditors, including the IMF and World Bank, whose support the government needed to maintain credit facilities (Bangura, 1987).

The Babangida regime has now changed this situation. Irrespective of the popular rejection of the IMF loan in a national debate, the government has surreptitiously taken the loan. Since 1986, Nigeria has been implementing an IMF World Bank prescribed austerity programme. Accordingly, the currency has been devalued through public auction by over 500 percent, while subsidies on petroleum, fertiliser and other products have been lifted.

The Babangida government, however, denies that it is implementing any IMF or World Bank programme. It insists that the austerity programmes are home grown. This ability of the government to successfully manipulate the Nigerian people has earned Babangida the soubriquet 'Maradona of Nigeria', after the Argentinian soccer star Diego Maradona famous for dribbling.

The economic policies of the Babangida regime (as detailed below) has led to major confrontations with the populace, including two popular uprisings (Alubo, 1989). Besides intensifying monetarist measures, the continuity between Buhari

and Babangida also extends to other areas such as detentions without trial, proscription of associations thought to oppose government, and the general suppression of dissent (Sagay, 1988; Alubo, 1990a).

Therefore, it seems clear that a wide gulf exists between the rhetoric and realities of military messianism. Indeed, this messianic posturing, now a topic of intense debate (see Ayu, 1985; Beckman, 1987), has been increasingly called into question. Many have argued (Amuo, 1989; Szentfel, 1989; Ayu, 1985) that rather than redemption, military dictatorships only militarise class struggle as well as escalate human rights violations.

Clearly, the experiences in Nigeria lend little credence to any messianic image. The hope and promises for a glorious dawn in the country, as the health reforms discussed below reveal, continue to have a hollow ring.

We conclude this section by noting that there was a coup attempt in April 1990. Like other interventions, the reasons for the unsuccessful attempt were replete with familiar rhetoric: corruption, deteriorating economic conditions and oppression of the citizens². Also, there is a phased programme of transition to civil rule which will fully mature in 1992 (Alubo, 1989; Agbese, 1990).

Health reforms under the military (1983-1990)

Before we turn to the various health reforms of the military, it is germane to outline the main features of the Nigerian health care system. Health care in Nigeria is largely limited to Western biomedicine (Erinosh, 1982) which is available from three parallel sources: voluntary agencies, private medical enterprises and the public sector.

Voluntary agencies (Vola)

Voluntary agency, as religious and non profit organisations are called, medical services predate the formal colonisation of Nigeria by almost a decade (Schram, 1971). Several Christian missionary organisations were involved in these medical activities, the major ones were the Church Missionary Society, Baptist Mission and Catholic Church. In addition to providing medical care, these missionaries also trained Nigerians in their home countries. Through this process, the majority of Nigerians who had early Western education, including medical education, trained abroad and usually became Christians. Vola activities were subsidised both by Nigeria's colonial and independent governments (Alubo, 1983). We must, however, note that medical care was essentially an instrument for evangelism, a process in which it was, as in other underdeveloped countries, a reward for acceptance of the new faith and an incentive for the non believer (Mburu, 1981). Furthermore, Vola has always charged fees, a factor which limited access.

Vola continues to be a major parallel source of Western biomedicine in Nigeria. However, its Christian origins tend to have restricted activities to the predominantly Christian southern half and the non Muslim nationalities in the north (Ityavyar, 1988).

Private medical enterprise (PME)

PME dates back to the slavery period when, by an act of the British parliament (1789), it became obligatory "for all ships carrying slaves to have on board a licenced surgeon" (Schram, 1971). Indeed, it could be argued that Western medicine in Nigeria, as along the West African coast in general, owes its origins more to PME than any other source.

After the abolition of slavery, PME existed mostly in the emerging corporations as well as in the few proprietary hospitals, clinics and maternity homes, mostly in urban centres.

Unlike Vola, which was encouraged and even subsidised by the state, PME has been generally suppressed both by Nigeria's colonial and post colonial governments. According to Pearce (1980), the former used its political and economic power to undercut PME in several ways. It drastically reduced the charges in public hospitals, obviously to render PME unprofitable. In addition, only sick certificates from public facilities were accepted for purposes of sick leave and related sick role benefits.

Many reasons have been adduced for this persecution, primary among which are exploitation and quackery. 'Doctors' in private practice were, for instance, accused of exploiting the popularity of injections for material gain. This menace of 'injection doctoring' (the indiscriminate administration of injections for a fee) was compounded by the problem of quackery. As part of the latter, "unqualified laymen with stethoscopes, lancets and syringes ... even nurses, technical assistants, chemists and radiographers would join the pretence of being medically qualified" (Schram, 1971:347).

In post colonial Nigeria, government's antagonism to PME has persisted until recently. As we have detailed elsewhere, through a military decree the government stipulated a mandatory five year post graduation experience as a prerequisite for entering private practice. The allegations of exploitation through rickety facilities, high fees, quackery and injection doctoring have continued (Alubo, 1990b; Amachuee, 1987).

The economic crisis and the resultant austerity programmes seem to have turned the tide in favour of PME. To ease unemployment problems, including medical unemployment, the mandatory five year post graduation prerequisite has been abolished. Further, through the newly created National Directorate of Employment (NDE), the government now encourages self employment, including

medical self employment, through loans and entrepreneurship courses. Finally, PME has become a particularly significant source of Western biomedicine, more so now that the public sector is in a major crisis.

The public sector

The public medical sector, now run by the Ministry of Health and its parastatal, the Health Services Management Board, originated as part of the efforts of European explorers and later, the colonial government, to contain infectious diseases. Initially, available care was restricted to the Europeans. Services were extended to the natives only as a means of reinforcing the *cordon sanitaire* between the former and the latter (Schram, 1971).

This publicly funded system was inherited at independence, after which the care of government employees, and other members of the elite who took over from the colonialists, continue to take precedence over medical care for the generality of the people (Ityavyar, 1988; Stock, 1985a). Irrespective of its inequalities, the public system has the widest spread and largest clientele.

Health and medical care in Nigeria are characterised by heavy investment in urban based biomedicine, access to which is limited to about 35 percent of the Nigerian population, estimated at 100 million. The majority of Nigerians who have no access to 'formal' western biomedicine utilise the services of traditional and folk healers as well as itinerant drug vendors, injection doctors and 'quacks' (Alubo, 1985b; Stock, 1985b). As a recent government policy document acknowledged (Federal Government, 1986a:4) :

"The health services as currently organised show major defects which are widely recognised. The coverage is inadequate. It is estimated that no more than 35 percent of the population has access to modern health services. Rural communities and the urban poor are not well served. The orientation of the services is inappropriate with a disproportionately high investment on curative services to the detriment of preventive services."

These investments in curative medicine are, however, contradicted by morbidity and mortality experiences which point to nutritional, communicable and parasitic (mostly water borne) diseases. The true nature and etiology of the major health problems are summed up thus (Federal Government of Nigeria, 1975:262):

"Twelve preventable and communicable diseases have been identified as currently accounting for 95 percent of ill health and death in the country. The most prevalent ones are malaria, tetanus, measles, tuberculosis and meningitis."

These hospitals and other centres for curative therapy are almost completely dependent on imported equipment (down to syringes and needles) and drugs, as well as substantial reliance on expatriate personnel, mostly physicians (Alubo,

1985 a/b; Stock, 1985b). This dependency burden requires continued availability of foreign exchange. It was therefore hardly surprisingly that declining foreign reserves during the last years of the Second Republic translated into shortages of drugs and equipment, particularly in public hospitals.

These shortages were unprecedented and generated enormous public outcry. A study during the period indicated that 70 per cent of prescriptions were out of stock and unavailable (Alubo, 1983). To be sure, the shortages, rather than the obvious disjuncture between health problems and investments, were regarded as constituting the crisis of health care. That the military would point to these crippling shortages as justification for intervention is therefore understandable.

The military has addressed this crisis situation through various reforms which are broadly classified here as 1) rationalisation and commercialisation, 2) periodic crisis management, 3) cultivation privileges, and 4) the new policy of implementing health for all.

Rationalisation and commercialisation

Under this rubric erstwhile *free* and/or subsidised services are either withdrawn or user fees are levied. Thus, free meals for patients on admission have been discontinued, while charges for various services (eg consultation, bed, laboratory, surgery) have been reintroduced. These levies are periodically revised to reflect changing market prices.

Besides these general levies, a scheme called the Drug Revolving Fund (DRF) has been instituted. As part of this scheme, itself part of the World Bank prescription in health care financing in underdeveloped countries, a large sum of money (capital) is made available to pharmacy units in public hospitals to purchase drugs. The drugs are sold to patients and the proceeds ploughed back into further purchases of drugs. The DRF scheme, essentially, involves running public pharmacies as businesses.

On the surface, DRF appears to be an ingenious strategy for addressing the shortages in hospitals. There are, however, problems. The scheme does not address the dependency burden which relates to Nigeria's underdevelopment. In this way, revenue generated does not necessarily guarantee a greater availability of drugs. This latter must compete with other commodities for foreign exchange allocation. Secondly, perhaps more seriously, this commercialisation has meant outright exclusion for those without the economic ability to pay. Hence treatment, both for out and in patients, now require payment before service. Indeed, there have been cases of denial of treatment, sometimes with fatal consequences³. Thirdly, the new charges for drugs are superimposed on transportation and other problems, most of which relate to the contradictions between urban based facilities in a country where over 70% of the population is rural.

Periodic crisis management

Periodic crisis management, essentially 'fire fighting', is perhaps best illustrated by the events that led to the nationwide doctors' strike in 1984. The doctors observed that public hospitals had deteriorated from "consulting clinics" to veritable "mortuaries where the sick are helplessly passing away into irretrievable eternity" (Alubo, 1986:473). The doctors who seemed particularly concerned about the implications of the shortages for medical education in the clinical years engaged in strikes to demand improvement.

As part of the agreement to end the strikes a special task force was set up to expedite drug importation. This body had (Alubo, 1986:474): "extra ordinary powers to ensure the procurement of drugs and materials within one month, at the latest. This special task force was able to bring in the first consignment of drugs and materials within a fortnight".

In like manner, after the 1989 riots in protest against the economic austerity programme special grants were made available for drugs. As part of this package, drug manufacturers and pharmacy shops were promised easy access to foreign exchange for direct drug importation.

These periodic panic measures are implicit admissions by government that the crisis situation has not abated. With reference to drugs, prices have more than quadrupled following the currency devaluation. Further, the acute shortages of drugs have persisted, the same is true of equipment. Indeed, as the Chief of General Staff, Nigeria's military Vice President, recently admitted, the country lacks the essential infrastructure for medical care delivery (quoted in *African Concord*, 1989 Sept 25:20).

True, the drug shortage is now compounded by the growing problem of fake drugs, a situation which has now necessitated the promulgation of the Counterfeit and Fake Drugs Decree. This decree is in addition to a special task force empowered to confiscate fake drugs as well as prosecute the widespread illegal sales of prescription drugs.

Like the DRF programme, these periodic panic measure have made a negligible impact on the shortages in public hospitals and on the overall health care crisis. Hospitalised patients are required to have a relation on hand to furnish prescriptions and other supplies. Indeed, the leadership of the military messiahs seems aware of the unabating crisis, hence it seeks medical treatment abroad, mostly in Europe.

Cultivation of privileges

While the majority of Nigerians must cope with shortages and other frustrations of the National Health Service, the same is not true of the top echelons of the military and their civilian counterparts who receive medical care overseas.

It is difficult to provide accurate data on this unique privilege, particularly for those in the private sector who foot their own bills. However secret, overseas medical treatment of public officials and their families frequently leak. In some cases, there are official announcements.

Since the 1983 coup a number of key government personnel have gone abroad for treatment. According to newspaper reports, the wife of General Buhari was in West Germany for treatment when he was ousted in August 1985. In a similar case of this unique privilege, Mr Akabosu, Bendel State Police Commissioner (now retired) was flown abroad for medical care following injuries sustained from armed robbers.

In early 1987 it was the turn of President Babangida himself, who was treated for some foot disease (radiculopathy) at the American Hospital, Paris. While hospitalised in France for a full month an official delegation led by General Domkat Balli (now retired) paid him a visit. The President's 'medical pilgrimage', as medical care abroad has come to be known, generated intense controversy, particularly as his condition could have been treated at home for a fraction of the cost, and because the Babangida government continues to emphasise sacrifice and selfreliance.

Critics who pointed out the obvious contradictions between the *rhetoric* and the *practice* of selfreliance and sacrifice were, however, labelled 'mischievous'. This editorial passage in the Federal Government owned *New Nigerian* (March 7 1987:11) is a good example of the official position:

"Local mischiefmakers would have wanted us to entrust the life of our number one citizen to the inept hands of doctors (in Nigeria) who routinely forget surgical fittings in the stomachs of helpless patients."

Since the president's trip several ministers in his cabinet have followed in his footsteps. These overseas trips are in addition to special provisions at home, where senior staff facilities are segregated from those of the ordinary Nigerian in whose behest the military supposedly intervened (Ityavyar, 1988).

While the cultivation of medical privileges is not unique to military regimes, for a head of State to leave his post for a full month abroad appears legendary. As documented by Ityavyar (1988), Stock (1985b), Alubo (1987), and others, overseas treatment is a manifestation of inequality, including medical inequality. Yet it must be noted that continued medical care abroad by the same people who professed a commitment to resolving the crisis in public hospitals is an implicit admission that the medical care crisis has not been resolved.

The 'New' policy of 'Health for All'

In addition to the reforms already discussed, the military has launched a health policy titled "The Policy and Strategy to Achieve Health for all Nigerians" (Federal

Government of Nigeria, 1986), in pursuit of the Alma Ata Declaration of Health for All by the Year 2000 (HFA 2000). This policy is the second attempt to implement the HFA 2000 programme. The first attempt, the Basic Health Services Scheme (BHSS), was inaugurated during the 1975-80 Development Plan. But, as a government evaluation panel found, most BHSS projects were not completed. The implementation was "haphazard and ineffective" (National Institute for Policy and Strategic Studies, 1988).

Like its abandoned predecessor, the new policy adopts the primary health care strategy and involves:

- * the division of the country into six zones on the basis of geographical location
- * involvement of local governments and the community in data collection on health problems as well as in workshops on how to resolve them
- * the involvement of villages in the selection of its members to be trained as Village Health Workers (VHW), and as Community Health Extension Workers (CHEW)
- * the phased implementation of PHC beginning with 52 local governments in 1986, 80 in 1987, 100 by 1988 and the entire country (over 560 local governments) by the year 2000.

As part of this initiative, there is an intensified immunisation drive, the expanded programme on immunisation (EPI), and Oral Rehydration Therapy (ORT). The ultimate objective is to integrate primary, secondary and tertiary care such that the emergent system would be (Federal Government of Nigeria, 1986a:9) "promotive, protective, preventive, restorative and rehabilitative to every citizen".

The implementation of HFA 2000 is, however, confronted by several problems. In the first place the new initiative has the payment of user fees as a general principle. As earlier observed, there are no provisions for the poor, whose ranks are daily swollen by the structural adjustment programme. By the same token, 'health' care would exclude those without the ability to pay. Secondly, the implementation relies heavily on foreign supplies of vehicles, vaccines, and equipment down to refrigerators. The material basis of this heavy dependency burden is, however, being eroded by the economic crisis. The needed foreign exchange to sustain the importation of these items is jeopardised by the collapse of cash crops (cocoa, groundnuts) and oil prices (the increase in prices triggered by the Iraqi invasion of Kuwait in the fall of 1990 made little difference), and the overall economic crisis. Finally, the implementation has concentrated on medical care, mostly vaccines and solutions, while it is clear that nutritional and parasitic diseases cannot be resolved by medication⁴.

The contradictions between the enunciated objective of HFA 2000 and military messianism in general seem clear. These contradictions derive from the broad dynamics of the political economy.

The political economy of health under the military

This paper has illustrated that the populist rhetoric of the military has not been translated into policies beneficial to the generality of the Nigerian people. These contradictions between populist slogans and the reality of Nigeria's iniquitous system, including the health care system, relates to the political economy of public policy.

Nigeria's political economy, as is now amply documented (see, for example, Bangura, 1987; Onimode, 1983; Usman, 1986; Othman, 1984) 11, 61-65), and is characterised by subsistence agriculture and the overbearing presence of multinational corporations (MNCs) in the key sectors of the economy - oil, banking, and construction. This foreign domination permeates every aspect of Nigerian society, particularly the polity. In essence, therefore, decisions about whether and what the people eat, the availability of social services, including medical care, and human rights are all inextricably linked to this foreign dominated economy, and the internal interests which sustain it. In this way public policies invariably reflect and are constrained by this structure. Hence, it has been suggested, the primary objective of the Nigerian post colonial state is the protection of capital with the people as sacrificial lambs (Ohiorhenuan, 1989; Beckman, 1985).

These foreign interests are realised through an intricate web of controls over machinery, spare parts, and expertise spun to further dependence on the metropole, and, more recently, through the IMF and the World Bank.

Thus, without radical breaks with the *status quo* reforms will not significantly change the situation. The ongoing economic reforms, which foster dependence rather than selfreliance, are illustrative. Indeed as Charney (1987:60) has shown, through the ambit of debt scheduling and renegotiation:

"The International Monetary Fund, clubs of private finance capital and now the World Bank have increasingly used the renegotiation of Africa's debts to negate their economic sovereignty, dictating economic policies and investment orientations."

Coups, he continued, make little difference as:

"The reigning faction changes, but there is no change in the form of state or the position of the foreign bourgeoisie. The world market and foreign firms remain the ultimate sovereigns, and the state continues to diffuse commodity relations within its borders. The situation resembles a game of musical chairs."

It is against this scenario that the role of the military in Nigeria polity can be fully understood. Military rule has not entailed any structural transformation. Indeed, it makes no pretensions to 'revolutionary' change. At best, it has consolidated existing structures and made reforms. In this way, the reality of

military messianism pits itself against the professed advocacy of the 'common man', whose suffering continues to be determined by his class position.

Yet, the military government has foreclosed any discussion of, let alone changes in, the ideology which informs the political economy and breeds poverty, unemployment and consulting clinics. Indeed, the government denies that economic policies and programmes in Nigeria are ideologically based. The impression is thus created that IMF conditionality and the World Bank structural adjustment programme, which constitute the fulcrum of recent economic policies in Nigeria, are non ideological. According to the present military government, Nigeria has no ideology nor would it impose one on the country. However, when the overwhelming majority (in a nationwide study conducted by the government appointed Political Bureau) chose socialism, this choice was rejected by the Babangida government. The capitalist origins of IMF and World Bank therapies are no longer in dispute⁵.

Clearly, when shed of its populist garb, the military is essentially an instrument of the dominant rather than the under classes. Moreover, specific coups have been traced to intra class conflicts between various factions of the former (Turner and Badru, 1985). This class character of the military as an institution also explains the serial negation of its earlier proclamations. Indeed, military dictatorship is more consistent with existing structures of foreign domination as it circumvents and reduces the long process of legislation to military decrees. In Nigeria's case, such decrees cannot be challenged in the law courts. This is not, however, to suggest acquiescence. Military messianism has led to various forms of resistance and opposition.

Military messianism and resistance

The obvious contradictions between the rhetoric and reality of military messianism has led to opposition championed mostly by students and organised labour, including doctors and other health workers.

In challenging the crippling shortages in hospitals, the National Association of Resident Doctors (NARD) argued that hospitals have further deteriorated from 'consulting clinics' to transit camps to the mortuary in spite of the emergency importation of drugs (Alubo, 1986). Consequently, the doctors planned further protest strikes to force the government to stem the deterioration. For them, these strikes, much like military intervention, are patriotic acts (President of the Nigerian Medical Association, in *Newswatch*, 1985, February 25:19):

"The same spirit of patriotism, nationalism and commitment to the cause of the fatherland that made it impossible for the military to sit back and fold its arms while the politicians ran the nation to a standstill makes it difficult

for us of the medical profession to sit back and fold our arms while the medical services of the country remain in shambles."

The government's reaction to 'medical patriotism' was swift and resolute. It denounced the doctors as (New Nigerian, 1985, February 23):

"unpatriotic, selfish and callous professionals who have no regard for the serious economic predicament facing this country and the much needed peace required by the Federal Military Government to revamp the economy.

The Federal Military Government has therefore decided that:

1. The Nigerian Medical Association (NMA) and the National Association of Resident Doctors (NARD) are hereby proscribed with immediate effect.
2. All doctors who are on strike, or have withdrawn their services in any way, are ordered to resume normal work at 7,30 am tomorrow... Failing to do this, they should regard themselves as dismissed from the service with immediate effect."

In addition, private hospitals were prohibited from employing any doctors without prior government approval. Further, their travel documents were impounded to ensure they did not emigrate.

These acrimonious confrontations between professional and state power have not eased the crisis. True, the availability of drugs and equipment are now more precarious due to foreign exchange difficulties. The crisis, as well as the general economic situation, have led to a major medical brain drain, mostly to Saudi Arabia and other Gulf States. In other words, one cannot even talk of 'consulting clinics' as many of the consultants have emigrated.

Indeed, even in terms of budgeting allocation and expenditure, there has been a general decrease since the 1983 coup, although the overall pattern has been quite variable, as Tables 1 and 2 indicate.

Both as a consequence of the brain drain and the continuing crisis many departments in the medical schools in Nigeria are now paralysed. The continuing deterioration in medical education led to the withdrawal of the accreditation of three (out of 13) medical schools in Nigeria. While this withdrawal was, no doubt, to ensure quality, it has long term implications for the supply of medical doctors, more so, that shortages persisted when all 13 medical schools were at full capacity.

Opposition to other aspects of the austerity programme is similarly suppressed. Thus, the leadership of the Nigerian Labour Congress (NLC), the umbrella labour organisation, was disbanded in 1988 for endangering "industrial peace and national security" (Newswatch, 1988, March 8:4), while the Academic Staff Union of Universities (ASUU) was outlawed in 1988 for "confrontation". Similarly, some workers of the National Electric Power Authority (NEPA) received life sentences for engaging in strikes in protest against the austerity programmes. As part of the growing repression, security forces had orders to shoot protestors on

sight during popular revolts against the economic situation and austerity programmes in May 1989.

Besides this overt state violence and suppression, the government has instituted special tribunals, mostly headed by generals, which try economic and political offenses. The verdicts of these tribunals cannot be contested in conventional courts.

Like the other problems, the high handedness, which the Babangida regime supposedly intervened to correct, has been perpetuated by his regime. Further, the Structural Adjustment Programme (SAP), as IMF conditionality and World Bank austerity programmes are called in Nigeria, is being pursued with military resolve in spite of the "harsh intolerable sufferings" associated with it. A recent study of the social impact of SAP found that it breeds (NISER, 1988:3):

"mass poverty, declining standards of living, deepening inequality between social strata, rising unemployment, retrenchment, school drop-out, social disorganisation, hopelessness..."

and, succinctly (:9):

"suffering and pain heard from every quarter, at school, in the market, on the farm, in offices, at home."

In this way SAP has aggravated existing problems. With reference to nutritional diseases, for example, Nigeria has experienced an astronomical increase, including those hitherto unknown to most physicians in the country, or last experienced during the civil war (Alubo, forthcoming).

Nor has military messianism resolved the economic crisis which has been aggravated by the austerity programmes. According to the World Bank (1989), the Gross National Product in Nigeria fell by over 25 percent between 1987 and 1989, an indication of the general decline. Moreover, rather than attract foreign investment, as was anticipated, the crisis has led to divestment. Frustrated by the decreased purchasing power and collapsing social infrastructure, foreign investors are now moving to Eastern Europe and elsewhere. Major banks and corporations are leading this divestment process.

It therefore seems clear that whether in terms of resolving the consulting clinic status of hospitals or the overall 'economic predicament', the reality of military messianism is belied by its rhetoric. This hiatus relates to the class character of military intervention which, as has been seen, stems more from intra class feuds than contradictions between the dominant and under classes.

Conclusion

This paper has discussed the rhetoric and reality of military messianism in Nigeria with particular reference to health services. Rather than deliverance from "harsh and intolerable conditions", military rule has, aggravated these conditions.

Nigeria is by no means a unique case as her experience is shared by and large by most of Africa and Latin America⁶. The military have promised to bring about economic and political salvation (Amuwo, 1989). However, as in Nigeria "those who greeted the advent of the soldiers into politics as a new modernising force that is disciplined and capable of promoting progress, were terribly disappointed" (Cervenka, 1990:132).

With specific reference to health, the situation in most of Africa is similar. As in Nigeria, the health care system is mostly curative, urban centred, dependent and caters mostly to an elite clientele.

The Nigerian situation, however, differs in some respects. Whereas Nigeria is richer in terms of Gross National Product and per capita income than many African and Latin American countries (World Bank, 1989) it does not have any form of social security, subsidised food or other programme targeted at the most vulnerable segments of the population - unlike poor countries like Ghana or Zambia (Anyinam, 1989; Kalumba, 1990). Many Latin American countries such as Brazil, Argentina and Chile also have some form of social security.

As Szenfel has pointed out, militarism is characterised by the tendency (1989:4):

"to increase internal repression; to respond to the demands of external interests while imposing further austerity on their citizenry (though not on themselves); and to increase internal disorder and turmoil ...

Whatever their [messianic] motives, they have inevitably imposed an authoritarian rule and culture on their societies and have invariably defended property against people. At worst they have made life arbitrary, dangerous and violent for their citizens."

The deterioration in both the economic and human rights situation suggest that true solutions to Third World political economic problems, including health problems, must go beyond reforms to structural transformation. The former leads to temporary euphoria, as in Nigeria and Ghana, and the latter to lasting resolution of the social needs of the majority, as in Cuba. Unfortunately, military messianism is essentially antithetical to, rather than a vanguard of, such transformation. As an epithet on military messianism, "Beyond your redeemer" would be most inappropriate.

FOOTNOTES:

1. This is done through several paid advertisements entitled "The Gains of SAP". The primary health care programme is cited as one of these gains. See, for example, *African Concord* (1989) September 4, and President Babangida's speech on the subject in the *New Nigerian*, (1989) August 28.
2. This coup attempt, on April 22, is documented in the popular press. See, for example, Akinrinade S "Coups that crumbled" in *Newswatch*, May 7, 1990. Since the attempt, the human rights situation has deteriorated with sweeping arrests and the closure of three independent papers. Further, 68 people have been executed, after secret trials, for involvement in the coup.

3. Witness, for example, the denial of treatment to a women in Otukpo General Hospital because she could not afford drugs worth N12,50 (now under US\$2). The woman later died. This incident received wide publicity because her death occurred during the military governor's visit. See the *New Nigerian*, (1988) Feb 4, and Stock (1985).
4. The inherent contradictions of the HFA 2000 programme are discussed in Navarro V (1984) "A Critique of the Ideological and Political Position of the Brandt Report and the Alma Ata Declaration" in *International Journal of Health Services*, 14, 159-172; Zaidi A (1988) "Poverty and Disease: Need for Structural Change" in *Social Science and Medicine*, 27, 2, 119-127; Benerji D (1990) "Hidden Menace in the Universal Child Immunisation Programme" in *International Journal of Health Services*, 20, 3, 501-510.
5. This position is clearly articulated by the Permanent People's Tribunal verdict, Tribunal on the Policies of the International Monetary Fund and the World Bank, West Berlin, September 26-29, 1988, in *International Journal of Health Services* (1990) 20, 2, 329-347.
6. The limits of military messianism is mostly clearly illustrated by the experience of Ghana where Jerry Rawlings first took over in June 1979. After the brief democratic period of Hilla Limba, Rawlings returned in December 1981. This latter coup was, at least in the perception of the 'disciples', analogous to the second coming of Jesus. Hence, Rawlings is nicknamed Junior Jesus, an obvious reference to the biblical Jesus, the Redeemer. Under his rule, the military promised to carry out revolutionary and anti-imperialist changes. As it turned out, the 'revolutionary' regime of Rawlings, which initially banded anti-imperialist rhetoric, is now up held by the IMF and the World Bank as the 'success story' of austerity programmes. See Anyinam C (1989) "The Social Cost of the International Monetary Fund's Adjustment Programmes: The Case of Ghana" in *International Journal of Health Services*, 19, 3, 531-547.

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Table 1
Federal Government Expenditure on Health 1980-1989 (N million)

Year	Amount	% of total
1980	190,98	1,58
1981	250,90	2,24
1982	90,75	1,15
1983	254,50	2,21
1984	131,20	1,32
1985	199,40	1,65
1986	320,40	2,77
1987	236,40	1,35
1988	443,20	1,82
1989	452,60	1,50

Source: Central Bank of Nigeria, in the *Nigerian Economist* (1989) 2-16, 27.

Table 2
Sectoral Distribution of Federal Government Annual Budgets: 1983-1989

	1983	1984	1985	1986	1987	1988	1989
Recurrent expenditure Nm	4 708	6 072	5 473	5 636	10 775	13 709	20 810
Capital expenditure Nm	5 283	2 052	5 803	5 946	6 742	10 658	9 297
Total expenditure Nm	9 991	8 124	11 276	11 582	16 887	24 367	30 107
Allocation of total exp. %							
Production	9,6	6,0	9,7	16,4	3,8	6,5	3,7
Agriculture	5,6	5,1	3,0	6,8	1,6	1,8	1,4
Mining	1,5	0,4	4,7	7,3	0,9	3,3	1,2
Manufacturing	2,5	0,5	2,0	2,3	1,3	1,4	1,1
Economic services	17,6	9,7	8,6	10,3	5,3	8,6	3,2
Commerce & finance	1,3	3,5	2,7	3,6	2,2	4,7	0,2
Power	1,2	0,2	1,2	1,2	0,5	0,3	0,2
Transp't & c'ation	15,1	6,0	4,7	5,5	2,8	3,6	2,8
Social services	13,0	16,0	9,3	13,8	5,9	7,1	9,2
Education	8,8	10,1	4,9	9,5	3,9	4,6	7,0
Health	3,1	2,3	1,9	3,1	1,4	1,9	1,5
Social development	1,1	3,6	2,5	1,2	0,6	0,7	0,7
Environment services	13,0	7,4	3,5	4,5	2,5	3,8	3,0
Water & sewerage	9,0	4,5	1,2	1,2	0,6	0,9	0,8
Housing	3,8	2,8	1,9	3,2	1,9	2,2	1,9
Environm'tal planning	0,2	0,1	0,4	0,1	0,2	0,7	0,3
Defence & security	19,1	17,5	9,6	14,6	8,5	9,8	6,9
General administration	13,2	5,7	8,0	8,9	11,5	11,7	11,3
Transfers [to the states] ¹	14,3	36,7	47,8	31,4	62,5	52,7	62,7

Source: Ukwu I U (1989) "Rural Development Policy and Programmes in Nigeria: A Critical Review", mimeo.

¹ The substantial increase in transfers to the states is probably due to the creation of two additional states in 1987.