

Health Diplomacy under Structural Adjustment Programme: A View from Nigeria

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ABSTRACT

This article examines the role of health diplomacy towards the mitigation of the deleterious consequences of Structural Adjustment Programmes (SAP). The introduction of SAP, a World Bank ideological framework based on fiscal austerity and deflationary policies, privatization of state owned enterprises trade liberalization, currency devaluation and the general deregulation of the economy, heralded a significant negative development in health care delivery in most African countries including Nigeria. This paper analyses the direct and indirect impact of SAP on health care delivery. It argues that improvement in global health had been negotiated within WHO through multilateral negotiations such as the Bamako Initiative 1987 which was adopted by WHO African Region to counter the adverse effects of SAP. It went a step further by reviewing the implementation of the Initiative in Nigeria. It concludes that advances in global health and indeed the health of Nigerians have not been precipitated only by leap in medical sciences and health technologies but also through health diplomacy.

Keywords: World Health Organisation (WHO), Structural Adjustment Programme (SAP), Bamako Initiative, Nigeria, Health Diplomacy

1. Introduction

The 1980s ushered in a world economic recession that negatively impacted on the economies of most African countries including Nigeria. The changing socio-economic environment called for various types of economic reforms such as the Structural Adjustment Programmes (SAPs). SAP can be defined as a 'conscious change in the fundamental nature of economic relationships within a society' (Nkanwadike, 1991). Briefly stated, SAP was an economic reform package designed by external creditors and their finance institutions, International Monetary Fund and World Bank, to reduce a country's trade and balance of payment deficits by cutting down public and private expenditures (Muiu and Guy, 2009). Adjustment package was aimed at socio-economic transformation through economic diversification and the development of the real sectors of the economy. However, SAP was formulated to ensure that the developing countries entangled in external indebtedness were able to save funds towards fulfilling their obligations (Adedeji, 1993).

Typical SAP packages have two elements namely short-to-medium-term macro economic stabilization measures designed to restore internal and external balances. The content included fiscal austerity and deflationary policies, privatization of state owned enterprises trade liberalization, currency devaluation and the general deregulation of the economy. Each of these features of SAP not only weakened local economies, but they also had unfavourable consequences on the health sector. It affected the level of resources available to the public sector to provide resources. There was also increased ill health. This scenario led to interest in other non-state health care providers and of alternative means of funding services. To cushion the deleterious implications of SAP, WHO and UNICEF adopted in 1987 an approach known as Bamako Initiative aimed at tapping into the apparent community resources. It is against this background that this article seeks to discuss the extent to which health diplomacy contributed to the amelioration of the huge burden of SAP particularly in Nigeria.

2. Health Diplomacy in International Relations

Diplomacy is the management of relations between or among nations and between state and other actors. It is a technique of coercion, persuasion, adjustment and of reaching agreements. It is a negotiation. According to Barston, 'diplomacy is the means by which states through their formal and other representatives, as well as other actors, articulate, coordinate and secure particular or wider interests, using correspondence, private talks, exchange of views, lobbying, visits, threat, and other related activities' (Barston, 1997). What about health diplomacy?

Health diplomacy in international relations does not seem to have a specific meaning. As a matter of fact it can vary in meaning according to the context in which it is used. Health diplomacy dates back to the middle of the 19th century and at the same time it is a recent diplomatic innovation (Youde, 2008).

In the past, health diplomacy focused primarily on international collaboration to protect human and commercial interest against the spread of particular diseases. In the past, health diplomacy focused primarily on international collaboration to protect human and commercial interest against the spread of particular diseases (Youde, 2008). It materialized 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). It is important to state that these early efforts represented a narrow conceptualization of health diplomacy and one quite different from what we have today. 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.

Health diplomacy has conjured disparate interpretations in the contemporary period. A proper understanding of health diplomacy is best done by a meticulous survey of its two broad conceptions. First, are those definitions focusing on the field being driven by globalization, diverse actors beyond nation states, health negotiations and health impact of non-health negotiations. For example, Kickbusch et al defined health diplomacy as the ‘multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health’ (Kickbusch *et al*, 2007). Second, are conceptions that deemphasize both negotiations and the primary role of global health. They dwell basically on efforts aimed at improving health of a receiving country within the larger context of supporting the providing country’s national interest.

In other words, they emphasize the use of health interventions as instruments to advance foreign policy interests. For example, Fauci defines health diplomacy as ‘winning the hearts and minds of people in poor countries by exporting medical care expertise and personnel to those who need it most’ (Fauci, 2007). Tommy Thompson, the former United States Secretary and Human Services, promoted the use of what he termed ‘medical diplomacy’ as an important element of the government’s anti-terrorism strategy (Thompson, 2005). Thompson remarked that ‘what better way to knock down the hatred, the barriers of ethnic and religious groups that are afraid of America, and hate America, than to offer good medical policy and good health to these countries’ (Thompson, 2005).

These definitions take a more holistic view of both health and the international community. It moves beyond an explicit focus on particular disease and instead recognizes how various manifestation of ill health can have negative consequences for international community. It would be wise to agree with Buss and Ferreira that health diplomacy addresses health issues that transcend national borders and expose countries to global influences (Buss and Ferreira, 2010). It also ensure a better, more coherent coordination between the government’s health policies and external relations sector, not only in advocating the acceptance of health related goals in the millennium development goals but also ensuring that those are incorporated into the countries health and development plans.

Today, health diplomacy manifests itself in three ways. First, as disaster diplomacy which involves providing relief to areas ravaged by natural disasters like earthquakes, tsunamis and drought (Ratzen, 2005). The second form deals with one country or a group of countries engaged in developing healthcare infrastructure in a country or a group of countries (Youde, 2008). The third form and the one that is the focus of this article concerns international agreements and conventions designed to bring many parties together to address health concerns (Youde, 2008). An important part of health diplomacy takes place within the World Health Organization. It is significant to state that improvement in global health had been negotiated within WHO in such multilateral negotiations like the Bamako initiative. This is an indication that advances in global health and by extension the health of Nigerian people has not been precipitated only by leap in medical sciences and medical technologies but also through health diplomacy.

3. The Genesis of SAP in Nigeria

Specifically, in June 1986, the Nigerian government after the popular ‘political debate’ adopted a comprehensive Structural Adjustment Programme that signalled departure from previous reform efforts. There were external and internal reasons why Nigeria embarked on Structural Adjustment Programme. Significant external reasons included the collapse of the international oil market which led to a drop in Nigeria’s foreign exchange reserve from \$8.50 billion in May 1981 to \$2.85 billion by December 1981 and the downward slide in Nigerians terms of trade as a result of fluctuations in the international commodity market (Kalu, 2000).

Thus, in an attempt to stem the worsening economic situation, Alhaji Shehu Shagari administration instituted the austerity measures through the Economic Stabilization Act of 1982, largely targeting Nigeria's excessive level of imports (NCEMA). The measure emphasised fiscal discipline and reduction of state expenditure on social and welfare services. The measure also included wage freeze and embargo on employment. When the austerity policy did not succeed, government resorted to borrowing from the international financial market. The situation was further compounded by the increasing interest rates resulting from a general decline in economic productivity in the industrialised countries and the subsequent worldwide recession in the early 1980s.

As a result of the recession, it became extremely difficult for Nigeria to generate a sufficient volume of export service. It could not service its debts not to talk about reducing the principal debt stock or financing an adequate level of current imports. According to President Ibrahim Babangida, the failure of international financial institutions and private banks;

... to grant new credits substantially accounted for the widespread shortage of spare parts and raw materials and under-utilization of productive capacity. And of course of massive layoffs and retrenchments in the industrial sector (Obiozor, 1992)

Therefore, the immediate impact of the declining terms of trade, recession, increasing interest rates and the failure of austerity measures, was an increase in Nigeria's external debts from \$30 million in 1973 to well over \$20 billion by 1985 (Kalu, 2000).

The internal reasons can be located in the transformation of Nigeria from a poor agricultural economy into a relatively rich, oil dominated one. In 1969, the oil sector accounted for less than 3 percent of GDP and a modest \$370 million in exports (42 percent of total exports), per capital income was on \$130 and more than half of Gross Domestic Product was generated in agricultural sector (NCEMA). By 1980, the oil sector had come to account for nearly 30 percent of GDP, oil exports totalled \$25 billion (96 percent of total exports) and per capita income exceeded \$1,100 (NCEMA). The economic policy orientation during the 1970s left the country ill prepared for the eventual collapse of the oil prices in the first half of the 1980s. Public investment was concentrated on costly and inappropriate infrastructure projects with questionable rates of return and sizeable cost implications while the agricultural sector was largely neglected. Nigeria's industrial policy was inward looking, with a heavy emphasis on protection and government control which bred an uncompetitive manufacturing sector. Rear Admiral Aikhonmu's remark on the internal reasons for SAP is worth noting. He stated that:

... Nigeria had unfortunately grown to depend on oil as the major and dominant export and foreign exchange earner.... the bureaucracies were large and unwieldy ... the industries were not as efficient as they should have been and were hampered by structural rigidities, over dependence on imports and inadequate and unreliable infrastructures. Public sector spending constituted a large proportion of total national income (Obiozor, 1992).

Therefore, the combined effect of these external and internal factors was low capacity utilisation in the industrial sector, inflation, high employment and virtual economic retrogression (Obiozor, 1992).

The severity of the economic crisis resulted in the loss of investor confidence, a decline in private foreign investment and a consequent decline in aggregate demand which led to further reduction in workers and general incomes. It was therefore in sharp reaction to these events that the Babangida administration attempted to solve the problem of underdevelopment in Nigeria through a home grown structural adjustment programme.

The Nigerian structural adjustment programme was designed to achieve the following goals:

1. restructuring and diversification of the productive base of the economy in order to reduce dependence on the oil sector and on imports;
2. achievement of fiscal balance of payments viability;

3. engendering and accelerating sustainable non-inflationary growth;
4. stimulating domestic private sector involvement;
5. creating conducive conditions for foreign private sector involvement which would bring in its wake increased inflow of capital, skill and expertise and restore investor confidence in the economy;
6. releasing the energies of our people for development and non inflationary growth and
7. using market mechanisms to maintain an exchange rate for the Naira - Nigeria's Official Currency (Federal Government of Nigeria, 1986).

Given the above goals, the government proposed that the following policies would be necessary for their implementation:

1. An extensive review and rationalization of ... (Nigeria's) economic projects past, present and projected to determine their viability.
2. Sharp reduction of aggregate public expenditure and budget deficits;
3. The reduction of non-statutory transport to lower levels of government, which hitherto were used to subsidize ailing or inefficient industries;
4. phased removal of subsidies from petroleum production in grants, loans and subventions to government parastatals,
5. rationalisation of customs tariffs to achieve effective protection for domestic industries;
6. upward review of interest rates and reduction in administrative allocation of credit;
7. review of industrial policies aimed at removing manufacturing and investment obstacles in the economy, such as import licensing and various administrative approvals hitherto required for investment;
8. incentives for farmers to increase agricultural production through the abolition of commodity boards;
9. enhancement in the efficiency of revenue collection agencies;
10. substantial adjustment in the exchange rate, not through traditional devaluation but with the aid of an inter bank market and
11. Rationalisation, commercialisation and privatisation of public sector enterprises with a view to pruning down government involvement in the accumulation process (Federal Government of Nigeria, 1986).

Finally, the structural adjustment programme came into existence in the Nigerian economy in July 1986 and was expected to be operated for two years terminating in June 1988. SAP in Nigeria was pursued in spite of the harsh intolerable sufferings associated with it. The existing problems were further aggravated by SAP. According to the World Bank, the Gross National Product (GDP) fell by over 25 percent between 1987 and 1989, an indication of the general decline (World Bank, 1989). Moreover, rather than attract investment as was anticipated, the crises led to divestment. Frustrated by the decreased purchasing powers and collapsing social infrastructure, foreign investors shifted their attention to Eastern Europe and elsewhere.

4. SAP and Health Care Delivery in Nigeria

One of the influential international policies that impacted on health care delivery in Africa is the Structural Adjustment Programme (SAP). The outcome of SAP is generally believed to have been less positive for health care delivery in resource challenged environments (Oluwole). It cannot be denied that the structural adjustment programme affected not only the lives of Nigerians but the nature of events and social reality in

the country (Oluwole). Leowenson (1993) in his review of SAP, concluded that its impact had been negative in terms of state of health, food security, and access to care. Specifically, in Nigeria, it affected the structure of all the social institutions which included health (Mangvuwat and Mangvuwat, 2010).

A study of the social impact of SAP by the Nigerian Institute of Social and Economic Research (NISER), found out that it breeds mass poverty, declining standards of living deepening inequality between social strata, rising unemployment, retrenchment, school drop out, social disorganisation and hopelessness' ... and succinctly 'suffering and pain heard from every quarter, at school, in the market, on the farm, in offices, at home' (NISER, 1988). However, for the purpose of this study, we shall examine the general impact of SAP on health care delivery from two perspectives, namely direct and indirect impact.

4.1. Direct Impact on Health

SAP affected healthcare delivery through budget cuts and privatisation. It reduced the number of subsidised health services and health centres compelling the individuals to purchase health services from the private sector. The quality of health services deteriorated as foreign exchange to purchase drugs and other imported medical supplies became increasingly scarce. The consequences of the decline in foreign exchange for health care services were severe. It brought about shortages of imported drugs, migration of skilled health workers and development of private medical practice (The Lancet, 1990). Furthermore, budgetary allocations of health which had been below 10 percent in most states in the country since 1982 further reduced as a result of SAP (Emeagwali, 1995). This resulted in the increase in suspended health projects and abandoned constructed sites for health centres and hospital

In the first five years of the structural adjustment programme, 1986 – 1990, government allocation to the health sector ranged from just US 42 cents to US 62 cents per capita, an amount which was grossly inadequate to treat an attack of malaria (Popoola, 1993).

The introduction of SAP and the pressure to reduce government expenditure on health and to reorganise the health sector to bring in private provisions and payments for services was seen as a major threat to equity. For instance, the development of private medical practice created a two tier system (Turshen, 1999). Patients who could pay more could see private practitioners, get better services and attend special clinics and hospitals. In the upper tier of this system, income determined access to services. On the other hand, in the lower tier patients were dependent on national health services where charges put the service out of their reach. Private practice also affected the nation's health status because practitioners did not undertake the preventive and community health measures needed.

4.2 Indirect impact on Health

While SAP affected the delivery of health care directly through budget cuts and privatisation, it also made an impact indirectly by contributing to poverty (Bianca). Poverty is multidimensional and thus has the potential to decrease health care delivery in many ways.

First of all, macroeconomic changes from SAP resulted in reduced incomes and unemployment. It marked the genesis of a considerable decrease in real income and unparalleled increase in food prices. The economic crisis stimulated reduced food consumption, particularly that of nutritious foods and an increase in malnutrition. For example, in Bornu and Yobe states in 1987, SAP contributed to an average decrease in energy and protein intake of 27% and 33% respectively (Igbedioh, 1993). Different surveys of nutritional assessment in Nigeria reveal low intakes of protein, energy, iron, calcium, zinc, thiamine and riboflavin in almost all age groups and in both sexes (Igbedioh, 1993). It is a truism that lack of proper nutrition reduces resistance to disease. For instance, malnutrition is the most common complication of measles, an important cause of death in children (Turshen, 1999). Tuberculosis and cholera are additional diseases which are complicated through lack of food (Bello, 1994).

Available studies have attributed the prevalence of HIV/AIDs to poverty. The prolonged economic crisis in Nigeria occasioned by SAP left the productive age group between 15-50 years unemployed some were either retrenched or retired to meet the conditions of SAP (Mangvuwat and Mangvuwat, 2010). Here, poverty led women in particular into engaging in high risk sexual behaviour in hopes of bettering financial situation. Finally,

the lack of infrastructure also impacted on health outcomes. As earlier mentioned, countries managing debt must comply with SAP that demand decreased government spending.

The government was unable to make the needed reforms such as land distribution, sanitation projects, health care and educational funding as such reforms might affect their ability to service their debts and attract foreign capital (Keifer, 1992). Spending on social goods such as water and sanitation projects, roads and communication were reduced despite the fact that water and sanitation services are associated with decreasing diarrheal diseases and infrastructure development with improving access to health services (Peabody, 1996).

5. Health Diplomacy under Structural Adjustment Programme: The Bamako Initiative

In an attempt to meet the growing crisis of scarcity of drugs and reduced access to quality health care as well as counter the negative impact of SAP, the Bamako Initiative (BI) was launched in 1987 (WHO, 1987). It was introduced against the background of the problem of financing health services experienced in the 1980s in many countries especially in sub-Saharan Africa including Nigeria. Despite the fact that they accepted the core tenets of comprehensive primary health care, they were burdened by lack of resources and practical implementation strategies. In particular, many health facilities lacked the resources and supplies to function effectively. As a result, health workers were sometimes merely prescribing drugs to be bought from private outlets, usually unlicensed and unsupervised. Moreover, many patients lost confidence in the inefficient and under resourced public health facilities.

All these developments, threatened to reverse the gains of 1980s. The core challenges were to promote additional donor investment, stop and reverse the decline of government expenditure on social spending in general and health in particular.

It was in recognition of this dismal situation that the WHO African Region in collaboration with UNICEF in September 1987, proposed measures at its annual meeting of African ministers of health in Bamako, Mali for providing the necessary resources to deal decisively with the problem of health care delivery in many parts of sub-Saharan Africa. These measures formed the basis of what has been described as 'Bamako Initiative (BI). The Bamako Initiative sought to accelerate and strengthen the implementation of comprehensive primary health care with the goal of achieving universal accessibility to these services. The Bamako Initiative was built on eight principles:

1. improving PHC services for all;
2. decentralizing management of PHC services to district level;
3. decentralizing management of locally collected patient fees to community level;
4. ensuring consistent fees are charged at all levels for health services, whether in hospitals, clinics or health centres;
5. high commitment from governments to maintain and expand PHC services;
6. national policy on essential drug should be complementary to PHC;
7. ensuring the poorest have access to PHC;
8. monitoring clear objectives for creative health services (WHO, 1987).

The purpose of community financing was to capture a fraction of the funds households were already spending in the informal sector and combine them with government and donor funding to revitalise health services and improve their quality. Although countries followed different paths in implementing the Bamako Initiative, in practice they had one common core objective of providing a basic package of integrated services through revitalised health centres that employ user fees and community joint management of funds. Several common support structures were organised around the core agenda including the supply of essential drugs, training, supervision and monitoring. The pace of expansion also varied depending on the availability of internal and external resources, local capacities, the need to work at the speed of community needs and pressure from governments and donors. In essence, implementing the BI was a political process that involved changing the prevailing patterns of authority and power.

5.1 Implementation of Bamako Initiative in Nigeria

In 1988, Nigeria adopted the Bamako Initiative as a strategy for strengthening PHC with five major components. These are; community participation through a variety of local government, district and village level committee; improvement of Maternal and Child Health (MCH) services; the provision of essential drugs, cost recovery and enhanced management, supervision and monitoring systems (Ogunbekun et al, 1996). In 1995, out of the 589 local government areas, in Nigeria, 53 were responding to the Bamako Initiative (Ehimwenna, 1996). By 1997 about 60 out of the 774 local governments in Nigeria covering approximately 10 percent of the population had the Bamako Initiative (Shehu, 1997).

There are two identifiable features of implementation of Bamako Initiative in Nigeria. First is decentralisation. Under the BI program each local government was divided into 4-10 districts. Each health district had a health post, a health clinic and a health centre and had access to a referral facility (Ehimwenna, 1996). The health activities in each Local Government Area (LGA) were controlled by a primary health care management committee chaired by a politician. Below this level are district and village development committees. Following the adoption and implementations of Bamako Initiative, community pharmacies were established and innovative financing mechanisms were adopted. The Drug Revolving Funds were created and operated by the local governments. The responsibility of implementation of the programme was placed on the health professionals who were reluctant to involve the communities in their activities. Drugs were supplied directly from central stores to health facilities. District supervisors were responsible for receiving the drugs at the facilities on behalf of the communities and were held accountable for the associated fund. The funds generated by drug sales in each local government area were deposited in its Bamako Initiative account. It was intended that profits derived from drug sales would be shared between the local government, health districts and communities.

However, various problems arose which affected efficiency. One of the problems was the failure of the district supervisor to perform their duties diligently. This led to facility staff collecting drugs from the central stores in the absence of the district supervisors. This scenario resulted in a breakdown in accountability and decapitalisation of district revolving drug fund. There were logistical, financial and quality control issues at operational community levels.

It should be noted that once money had been paid into the a Local Government Area's Bamako Initiative account, the withdrawal of profit for sharing between the three levels proved impossible because of government regulations. At some point, large amount of money accumulated in the Bamako Initiative accounts of certain local government areas because profits were not shared with the communities. Thus, on several occasions especially during the period of financial stringency, some Chief Executives of the local government took funds from those accounts to pay salaries and meet other commitments (Ehimwenna, 1996). Consequently, the drug revolving funds suffered serious decapitalisation.

Misuse and mismanagement of resources meant that services were denied especially to people who were least able to pay for them. To mitigate inequities, exemption policies were introduced, but there was no evidence of effective mechanisms. For instance, none of the LGAs had a consistent and uniform policy for exemption from payment for services. Decisions on this matter were usually made by the development committee which had no means of ensuring implementation because health workers and resources were controlled by the local government.

It was against this background that the National Primary Health Care Development Agency (NPHCDA) organised a conference in 1993 where these issues were considered. The conference recommended that all funds generated in the Bamako Initiative should be retained at the level of generation (Ehimwenna, 1996). This recommendation was accepted by the Federal Government with the consequence that drug revolving funds had to be operated at all levels of implementation. Each LGA, district and village or community received seed drugs and began to run a revolving drug fund.

Each district had a bank account into which the proceeds from drug sales are paid, the authorised signatories being the chairman and treasurer of the district development committee and the district health supervisor. Village

development committees were also encouraged to open bank accounts where local banks exist. However, the decisions on the use of drug revolving funds were made exclusively by committee members.

The second feature is community participation. Juxtaposed with the decentralisation of drug revolving funds was the 'cash-and-carry system' whereby each village committee purchases drugs from its district which in turn buys them from its local government (Ehimwenma, 1996). It was only the local government that was in direct contact with the drug manufacturers from whom the drugs were obtained. The major objective of the new approach was to achieve the greatest possible community participation in health activities through the district and village development committees. These bodies in collaboration with the staff had joint responsibility for managing resources in their districts on the basis of the guidelines issued by the National Primary Health Care Development Agency for the use of surplus funds generated by drug sales. The district supervisors calculated the needs for drug replenishment and which were costed at the 'cash-and-carry' prices set by the local government areas. The committee discusses the matter and if satisfied approve the release of funds for the purchase of drugs.

The decentralisation of resources made the communities more accountable and they also realised that decapitalisation of their drug revolving funds results in an inability to replenish stock. Thus, decentralisation was accompanied by an improvement in the mobilisation of community resources. Community funds were used to build and renovate drug stores and some communities hired vehicles in which drugs were brought to their district rather than waiting for the local government.

However, officials of the LGA were reluctant to accept changes that transferred the control of funds from them to the communities. Health workers resisted suggestions that they should be accountable to the communities and that local people should play a part in the management of drug revolving funds. This obstacle was tackled by the National Primary Health Care Development Agency as Local Government functionaries were visited by an Agency officer bearing a letter detailing actions to be taken and the expected outcome.

Although the profile of equity in access to health was raised, yet there were no concrete accomplishments in this regard. Development committees were directed to consider the subject and NPHCDA also made two proposals for exemption mechanism that might be applied to persons unable to pay for health care. But the final decision on this matter was the responsibility of the committees. It has been argued that all the LGAs that showed increased coverage and utilisation were donor agency supported and it is doubtful if the same can be said about government supported LGAs (Uzochukwu *et al.*)

One remarkable stage in the implementation of Bamako Initiative was the launching of the National Drug Policy in 1990 and the subsequent revision in 2005. The National Drug policy provides direction for the core objective of the Bamako Initiative which is equitable access to essential drugs at the community level.

It is worthy of note that towards the late 1990s the Petroleum Trust Fund (PTF) invested a substantial amount into revitalising the drug revolving fund in public health facilities nationwide (Osibogun, 2005). For instance, a study on the impact of the Bamako Initiative in Oji River Local Government Area Southeast Nigeria has shown that there was a steep rise in some indicators in 1996 (Uzochukwu *et al.*). This development was attributed to the injection of drugs from the Petroleum Trust Fund into the health system which increased drug availability in the public health institutions. However, the efforts suffered serious setbacks. First, planning was highly centralised such that inappropriate drugs were in some cases ordered from the central planning unit and subsequently routed for delivery at peripheral centre. Moreover, the bottlenecks in the process resulted in the late delivery of drugs that soon expired without benefitting the average Nigerian. Furthermore, the implementation of PTF assistance was flawed strategically in view of the fact that PHC management committees at the local level were not revived before the commencement of the scheme. Other managerial problems that arose included the requirement for duplicity of efforts on the part of peripheral health workers who had to maintain two records and reporting systems for their facility drug revolving fund and PTF sponsored drug revolving fund.

In the final analysis, the PTF sponsored drug revolving fund succeeded in most instances in burying the original drug revolving fund. There was a general decline in the basic indicators between 1999 and 2001 following the phasing out of the PTF resulting in scarcity of drugs in health centres. Nevertheless, the new strategy

dramatically increased accessibility through community based health care reform resulting in more efficient and equitable provision of services. Consequently, a comprehensive approach strategy was extended to health care with subsequent improvement in the health care efficiency and cost.

6. Conclusion

There is no doubt that most of the countries including Nigeria that adopted the Bamako Initiative achieved significant results. Nigeria has been reorganising its health system since the adoption of BI in 1987 which promoted community based methods of increasing accessibility of drugs and health care services to the population through the implementation of user fees. However, the Bamako Initiative was not without its limitations. The application of user fees to poor households and the principles of cost recovery drew strong criticisms. Although many African countries adopted the approach, only in a handful were initiatives scaled up. Even in those countries like Nigeria where Bamako Initiative has been deemed a success, poor people viewed price as a barrier. Consequently, a large share did not use essential health services despite exemptions and subsidies. It is interesting to note that the payment of money for services especially health care services is not alien to Africa.

Hence, it may not have been the reason for the low patronage. Der Geest (1992) remark is instructive in this respect; 'money is not a new phenomenon in Africa and that paying for goods and services does not need to conflict with existing traditions of reciprocity in the field of health care'. However, the underlying problem is that a cash payment will not work in a society in which people do not have money during certain periods. In such cases, the Social Health Insurance Scheme with a universal coverage of both the formal and informal sectors can offer a solution. There is also the urgent need to investigate the socioeconomic groups of household that are using and not using the health centres in order to address the equity implications of Bamako Initiative. In addition, the revolving drug funds should be seen not only as an instruments for cost recovery but also as entry points for strengthening the health care system and improving health security. This is attainable through the promotion of partnership between community organizations and health service staff in the delivery of responsive, appropriate, integrated and acceptable health care of good quality including rational drug use. In the final analysis, this article has shown the importance of health diplomacy as a key driver of socio economic progress of developing countries like Nigeria. In this wise it depicts how diplomacy and health interact to promote social development.

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