

INTRODUCTION

The colonial legacy and narrative transcends the physical manifestations of language, borders, hybrid communities, internecine strife, political structure, and nationalism. It also includes the economic, governmental, political, social, infrastructural, and health development of the colonized peoples and nations. Healthcare development in Nigeria has had a history inextricable with that of British economic expansion. The main factor that informed British presence in Nigeria was the search of natural resources, cheap labor and the expansion of the British empire. The need to efficiently control Nigeria's resources and peoples led to eventual colonial rule. Consequently, infrastructural changes were made to better export and exploit goods and services for the benefit of the empire. In order to better understand the development of healthcare, it is important to first understand its origins in British colonial Nigeria. After their arrival and initial evangelism in what is today Nigeria, the first priority of the missionaries and other British officers stationed in Nigeria, were dispensaries to, somewhat, adequately care for their health and wellbeing against the tropical diseases of the unknown climate and indigenous population. As time went on, they established few hospitals, whose primary purpose was to sustain a healthy labor force, augment conversion of the natives through 'supernatural' healing properties of western medicine, and proper treatment for the increasing population of British citizens. Again, with the passing of time, various other plans were implemented to usher in healthcare development to Nigeria, and her peoples but, for the economic gain of her colonizers. These development schemes are of extreme interest because they, and the aforementioned history of health systems in colonial Nigeria, provided the foundation by which the current Nigerian healthcare systems are based. Thus, it is of extreme importance to understand,

disseminate and explore said systems in an attempt to diagnose or pinpoint the origins of the woes of the system that exists today.

There are papers and articles written on either precolonial healthcare systems, or the first hospitals or dispensaries, or critiques of the development schemes, with particular attention to healthcare. However, this information has not been synthesized with corresponding evidence and credible research, to directly identify the relationship that exist between their implementation and the current state of public health and health systems in Nigeria. My research aims to first, map the history of healthcare, secondly, identify the factors that contributed to the various developmental stages, thirdly, identify and analyze the developmental periods and schemes and finally, determine if a causal relationship exists between the history and the current state of healthcare in Nigeria.

CHALLENGES:

Originally, I planned to visit the The National Archives(TNA) in London and the London School of Hygiene and Tropical Medicine(LSHTM), as they seemed most appropriate for my work. Unfortunately, the LSHTM only contained disease specific information and documents on colonial southeast Nigeria, which were of no particular use other than they supported a fact already known to me: the British treated the natives due to fear of their own well being and to sustain a labor force. I also encountered difficulties in the beginning stages of my research in that I could not obtain the appropriate documents. It took about one and a half weeks for me to be fruitful in my search. Furthermore, I found myself frustrated with the public transportation systems and the unwillingness of many of the people to help. However, this frustration became a blessing as I serendipitously discovered a small archive with documents that proved pertinent.

FINDINGS

It is often thought that that the first development plan began in 1946, or, at least its implementation. However, prototypes and various forms of it existed and were widely discussed within the colonial administrative powers, in close correspondence to the England home offices who were to provide the

necessary funding, beginning in 1930. This knowledge, although new, came as no surprise as it is fitting that the conception of the first clearly outlined developmental scheme came after the first world war and its implementation began a year after the second world war. As the many correspondences intimated, economic revival was necessary for Britain after the first world war. Nigeria with its natural resources and high population density was one of the more profitable and economic colonies. It produced goods that were not in competition with the white settler agrarian colonies, which meant that it avoided the worst of excesses of the depression in the 1930's which failed to impact its exports and productions. In response to the depression and the need for economic revival, Britain increased its exportation of goods and services and simultaneously developed infrastructural and social schemes to increase productivity and training in various sectors for her Nigerian colony. The ten year plan, as it was later dubbed, entrusted the colonial administration with the task of allocating national resources and funding to activities and tasks that would engender improvements in the general health and mental conditions and faculties of the people. This, of course, included the physical facilities that would make such improvements possible but with a slight caveat: these facilities would only meet the minimum requirements for the general improvement of the country and its population, to avoid unnecessary expenses. Although I could not find the exact provisions for the scheme, I discovered that it was meant to last until 1954. Additionally, the plan seemed to be largely "successful," from the coloniser's perspective, although its utility, economic value and general worth were greatly questioned. It therefore comes as no coincidence that Nigeria was federated in 1954, with increasing talks of independence and decolonization.

A second plan, the "1955--1960 plan" also known as the five year plan, emerged amongst talks and negotiations for independence. Although not as elaborate as the first, it was still rigorously pursued and largely implemented, although haphazardly, in my opinion. As independence approached, some British expats stayed in Nigeria, to ensure that Nigerians would smoothly take over administration of various sectors, including healthcare. However, due to the underdevelopment of the many health sectors and the

retrospectively minimal preparation of Nigerians, independent Nigeria requested help and medical resources and equipment post 1970. Fittingly, as the correspondences clearly enunciate, the British offered their help, as they did during the 1965 civil war, only for economic gain, a recurring theme in British-Nigerian relations. This led me to question the value or quality of the professionals sent back to train Nigerians, and the quality of the equipments and resources provided to Nigeria and how this may have contributed to the underdevelopment of health services in Nigeria.

To succinctly summarize my findings: the intricate interconnections of British politics, the class system, economics and many more factors evidently muddled the distinction that could have existed in their intentions for the Nigerian people. Only one thing is clear, all of the development was ultimately, whether direct or indirect, for the benefit of Great Britain.

The abovementioned findings do three things for my research:

1. They present British intentions and goals towards medicine and healthcare in Nigeria.
2. They engender questions about implementations, successes or failures, and manifestations of said plans in Nigeria, as told by the Nigerian people.
3. It instigates a thorough exploration of existing work, keeping in mind the inherent bias of intentions and colonialism. It also provokes further research into British goals of health development for her other colonies with less successful economies, and other varying factors, in order to seek the existence, or lack thereof, of a relationship to Nigerian medical tourism.

The findings coincide largely with existing literature on the subject. However, its contribution will be a synthesis and analysis of historical factors that have continued to cast a shadow on Nigerian health systems.

REWARDS

This experience has been very informative and also very humbling. I am very glad that my first “field” research experience involved independent archival work and study as it reinforced the importance of patience, the joys of discovery and served as a great reminder that academic pursuits are not without tremendous frustrations. I was daily reminded how novel experiences present a growth opportunity and how learning is stifled in comfort. Additionally, the largely independent nature of this experience gave me many an opportunity for introspection and reflection on my reasoning for pursuing this academic venture, whom it truly benefits, what I hoped to find and, and how I would cope if plans do not go accordingly. For this I am truly grateful. Most importantly, I better grasped the need to engage the complexities of the health sector and the significance of my preliminary research in my learning how to serve. My time in London also cemented my desire to pursue an M.D/MPH degree upon graduation from Notre Dame so as to continue encouraging discussions and critiques of public health in Nigeria and other nations.

As with many of the experiences Notre Dame has provided me, I have seen myself grow more than I expected or imagined. I remain thankful to Kellogg for their generosity and faith in my potential and research. Words cannot describe the appreciation for such kindness and support.